

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/24/2014
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-CAROLINA POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC 27705		
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F 000	INITIAL COMMENTS	F 000			
F 323 SS=J	<p>The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section began a complaint investigation survey on 10/20/14. A partial extended survey was conducted during the survey and an exit conference was held with the facility on 10/24/14. The Immediate Jeopardy began on 9/2/14 and was removed on 9/15/14. Therefore, the citation for F323 is past non-compliance.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to secure the wheelchair with the transportation van securement system for 1 of 5 residents (Resident # 11) during transport.</p> <p>Findings included:</p> <p>Operation instructions for the wheelchair retractor system Rev. 02/11 included steps to secure the wheelchair and restrain the occupant. 1) Position the wheelchair and occupant facing forward. The wheelchair tie-downs need</p>	F 323	Past noncompliance: no plan of correction required.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 approximately a 45 degree angle from the floor anchor system to where they attach to the wheelchair. Apply the wheelchair hand break. 2) Install the rear retractors. Locate and install rear retractors into the floor anchor system 12 to 18 inches apart, between the rear wheels of the wheelchair. Pull on the fitting to ensure it is properly locked in the floor anchor system and keeper is facing away from wheelchair. Retractor systems with 4 identical retractors and stud fittings may be installed in any position. 3) Install the front retractors. Locate and install the front retractors in the floor anchor system 3 to 8 inches outside the front wheels. Pull on the fitting to ensure the properly locked in the floor anchor system and keeper is facing away from wheelchair. 4) Attach to wheelchair. Starting with the rear retractors, pull out the webbing and place the S-hook securely around the structural member of the wheelchair. Pull the S-hook to ensure full engagement around the structural member. Repeat procedure for other retractors. Tension the front or rear retractors as needed by turning the handles until the tie-downs are tight. 5) Attach the combination Lap/Shoulder Belt. Grasp the buckle connector and pull the webbing out of the retractor. While holding onto the sidewall triangular fitting, slide the buckle connector up the webbing a full arms length. Grasp the triangular fitting on the retractable belt (this will install on the side of the occupant that is closest to the vehicle sidewall) and thread it down and through the gap between the wheelchair back and seat or side panel and seat. Connect the triangular fitting to the stud fitting on the rear retractor tie-down. 6) Tension the lap belt. Insert the buckle connector into the push-button buckle. Tension	F 323			

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F 323	<p>Continued From page 2</p> <p>the buckle connector belt comfortably using the web adjuster. Ensure the lap belt is worn low across the front of the pelvis, bearing upon the boney structure of the body and that the push-button buckle is located near the occupant ' s hip opposite of the side from where the shoulder belt is anchored. Pull on the lap belt to ensure attachment of the triangular fittings to the rear retractor studs and the connection of the push-button buckle and buckle connector.</p> <p>Resident #11 was admitted to the facility on 1/23/2014. His active diagnoses included Quadriplegia. The quarterly Minimum Data Set (MDS) dated 9/19/2014 revealed Resident #11 was cognitively intact. Resident #11 was totally dependent on staff for his activities of daily living.</p> <p>A record review of the facility transportation log revealed on 9/2/2014 Resident #11 was transported to and from an appointment in the facility van.</p> <p>On 10/20/2014 at 5:30 PM an interview with Resident #11 revealed during transport in the facility van on 9/2/2014 NA#1 (Nurse Assistant/Facility Van Driver) turned the steering wheel of the van and the wheelchair tipped onto one wheel. Resident #11 reported all of his body weight was on his right arm and he used his right arm to try to push himself upright. NA#1 stopped the van and strapped Resident #11 in. Resident #11 stated he recommended NA#1 report the incident on 9/3/2014 because he woke up the next morning with right shoulder pain.</p> <p>A record review of the facility Resident Incident Report dated 9/2/2014 for Resident #11 included</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>the location as the facility van and the associate involved as NA#1. The narrative read as: Resident (Resident #11) reports having been strapped into the van securely by transportation staff. Once traveling, a right turn was made and the wheelchair tilted. No apparent injuries observed upon assessment. Right arm pain reported by resident. The immediate action taken reads as: LOC (Level of Consciousness) and head to toe assessment. STAT (immediate) x-ray ordered.</p> <p>A record review of the facility investigation included a statement from Resident #11 on 9/3/2014 at 2:50 PM summarized as: NA#1 put Resident #11 in the van, strapped him in, and tested to make sure he was secure. During the trip NA#1 made a turn (direction not indicated) and tilted to the right. Resident #11 stated that his shoulder (side not indicated) landed on the van wall. Resident #11 shouted and NA#1 looked in the rearview mirror, saw he was tilted, pulled the van over, and put Resident #11 back on both wheels. Resident #11 stated NA#1 re-strapped him and the trip was okay from then on. Resident #11 told NA#1 there was no need to report the event because he was not in pain. Resident #11 reported waking up on 9/3/2014 and the same shoulder he landed on was in pain and he informed NA#1.</p> <p>A record review of the facility investigation included a statement from NA#1 on 9/3/2014 summarized as: on 9/2/2014 NA#1 checked the locks, and applied safety procedure, shaking and unlocking wheelchair twice to make sure all belts and locks were functioning correct. During a left turn Resident #11 's upper body and wheelchair leaned towards the right of the van. The left side</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>wheelchair wheels were off the ground about 2 inches.</p> <p>NA#1 stated during the moment Resident #11 said he was fine. NA#1 pulled the van over, repositioned his upper body, rechecked the equipment and then left for the appointment.</p> <p>A record review of the facility investigation included a statement from the Director of Nursing (DON) summarized as: on 9/2/2014 at 6:30 PM Resident #11 and NA#1 returned from a transport. Resident #11 joined the DON at the nurse station and he did not report the event that occurred while he was being transported in the facility van. The DON stated she was informed of the event on 9/3/2014 at 1:30 PM by NA#1.</p> <p>A record review of the facility investigation included a statement from the Maintenance Director that revealed he was informed of the event on 9/3/2014 and inspected the straps in the van. All straps were in good working condition. He asked NA#1 to walk him through the procedures and he displayed good knowledge and the correct use of straps.</p> <p>A record review of the facility investigation included NA#1 ' s wheelchair securement system program training worksheet and a Certificate of Completion dated 8/13/2014.</p> <p>A record review of the radiology report dated 9/3/2014 for the right shoulder read: No acute fracture, dislocation or destructive bony process; No soft tissue abnormality; No acute osseous abnormality.</p> <p>A record review of the hospital radiology report dated 9/5/2014 for the right shoulder read: No</p>	F 323			

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F 323	<p>Continued From page 5 acute fracture or dislocation.</p> <p>A record review of an orthopedic follow up dated 9/12/2014 revealed a diagnosis of Tendonitis of the right shoulder and an order for Physical Therapy.</p> <p>An interview on 10/21/2014 at 2:00 PM with the Therapy Coordinator revealed Resident #11 received Occupational Therapy from 9/9/2014 through 10/7/2014 for his right shoulder.</p> <p>On 10/21/2014 at 11:50 AM during an interview with the Director of Maintenance he demonstrated his knowledge and a step by step demonstration of the wheelchair securement system. He reported he inspected the facility van and there were no maintenance concerns. The Director of Maintenance had NA#1 walk through the wheelchair securement system steps and perform a return demonstration on 9/3/2014 when he used all 4 floor anchors and the lap/shoulder belt. NA#1 demonstrated the wheelchair securement system procedure correctly including verbalizing performing the second check prior to exiting the parking lot. At 1:07 PM the Director of Maintenance reported on 9/5/2014 the van was taken to the supplier for a strap inspection and no concerns were identified and additional precautionary straps were ordered and placed in the van on 9/18-25/2014. An observation at 3:13 PM with the Director of Maintenance revealed 5 shoulder straps present in the facility van and 4 floor anchors with S-hooks.</p> <p>NA#1 no longer worked at the facility and was unavailable for an interview.</p> <p>An interview on 10/22/2014 at 9:40 AM with the</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>Administrator revealed the facility does not have any staff members that are van drivers. Transportation was provided by contracted companies.</p> <p>An interview on 10/24/2014 at 9:30 AM with the Administrator revealed NA#1 should have reported the event immediately and secured the resident safely according to the operational instructions. She was not holding a position at the facility when the event occurred and the action plan was initiated.</p> <p>The facility action plan was initiated on 9/3/2014.</p> <p>A record review of the In-service Education Program Summary Form that was completed on 9/4/2014 titled: proper secure of resident and wheelchair in van revealed program content of re-training on proper secure of resident/wheelchair during transport e.g. glossary of terms, pre trip check list, and wheelchair restraint system hardware. The In-service signature log contained NA#1.</p> <p>NA#1 was suspended from employment on 9/15/2014 for failure to report an accident and terminated on 9/26/2014.</p> <p>On 9/15/2014 the facility van was removed from service and no facility transportation was conducted after this date.</p> <p>A record review of the service receipt for the facility van dated 9/25/2014 included 3 shoulder belt, 1 sidewall mount kit, and one lap belt.</p> <p>Monitoring Tool</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>A record review of Quality Assurance (QA) checks for wheelchair (Wheelchair check tool) to ensure they are in working order revealed completion dates of 9/4/2014, 9/5/2014, and 9/8/2014 with no issues identified. The Wheelchair check tool will be utilized for the first 5 transports upon hiring a van driver and 3 per month with QA review.</p> <p>A record review of Quality Assurance (QA) checks for the facility van (Van Observation Tool) to ensure the seatbelt was secure around a resident and the wheelchair was secure to the van revealed completion dates of 9/4/2014, 9/5/2014, and 9/8/2014 with no issues identified. The Van Observation tool will be utilized for the first 5 transports upon hiring a van driver and 3 per month with QA review.</p> <p>Systemic Change Record review of facility tool Van Driver Check off Form used for knowledge and return demonstration of van driver included: use of lift on van, securing wheelchair in van, securing stretcher in van, and safety e.g. calling 911, reporting to facility, and report immediately.</p> <p>A statement provided by the Medical Director on 10/22/2014 revealed on 9/3/2014 the facility investigated the event and the Administrator would perform a process improvement on the event and discuss it at the next quarterly assurance performance improvement committee meeting.</p> <p>An interview on 10/24/2014 at 9:46 AM with the Maintenance Director revealed his knowledge of the facility monitoring tools and systemic change. He reported the training will consist of the</p>	F 323			

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F 323	Continued From page 8 wheelchair securement system training program and the Van Driver Check off Form on hire and annually. He will complete the van and wheelchair observation tool for the first 5 transports upon hiring a van driver and then 3 a month. All results will be taken to the quarterly assurance performance improvement committee meeting. Date of Compliance 9/15/2014 The Past Non Compliance date was established on 10/24/2014 at 9:46 AM when the interview with the Maintenance Director confirmed he had knowledge of the future use of the WheelChair Check tool and the Van Observation tool. The WheelChair Check monitoring tool and Van Observation monitoring tool reviewed. The Medical Director was interviewed and was knowledgeable about the event and the corrective action plan. The new Van Driver Check Off Form was reviewed and will be implemented upon hire of a facility van driver.	F 323			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to give in-stock, scheduled and	F 333	This plan of correction constitutes a written allegation of compliance.	11/21/14	

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F 333	<p>Continued From page 9</p> <p>as-needed, medications to 1 of 4 sampled residents, (Resident #6), until a day after admission.</p> <p>Findings included: The Emergency Medication Kits (E-Kits) policy dated May 2013 stated, "In order to prevent patient/resident harm or discomfort an emergency supply of medications will be maintained in the healthcare center. This emergency supply of medications will typically include medications required to be started before the routine pharmacy delivery will arrive." Resident #6 was admitted on 8/30/14 at 2:15 pm. Her diagnoses included deconditioning secondary to left total knee replacement on 8/27/14, diabetes, hypertension, bipolar depression, and anxiety. The Admission/Nursing Observation Form dated 8/30/14 indicated the resident was alert, oriented, anxious, agitated, sad/crying, and restless. Her speech was clear. She took antianxiety and antidepressant medications for which there were supporting diagnoses. The Medication Administration Record (MAR) dated 8/30/14-8/31/14, and signed by the physician, indicated the following scheduled medications ordered for Resident #6 for pain, hypertension, diabetes, bipolar depression, and anxiety: Benicar 40-25 mg po daily. Scheduled at 9:00 am. Byetta 5 mcg subcutaneous injection (sq) twice a day. Scheduled at 9:00am and 5:00pm. Valium 10 mg po three times a day. Scheduled at 8:00 am, 2:00 pm, and 8:00 pm. Hydrochlorothiazide 25 mg po every morning. Scheduled at 9:00 am. Novolog 15 units sq four times a day. Scheduled at 9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm.</p>	F 333	<p>Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law</p> <p>F333 Corrective Action for the resident affected. Resident #6 no longer resides in the facility.</p> <p>Corrective Action for Those with the Potential to be affected.</p> <p>All new medication orders will be reviewed daily to ensure medications were ordered, received, and given.</p> <p>Systemic Changes to Prevent Deficient Practice.</p> <p>New orders for medications will be checked by the unit manager/week-end supervisor to ensure medications were faxed to pharmacy, received, transcribed, and given.</p> <p>Education with licensed nurses began on Oct 27, 2014 by the Interim Director of Nursing on use of the Emergency-Kit (E-Kit) for medications needed immediately, utilization of the back-up pharmacy for medications that are not available in the Emergency-kit (E-kit), and</p>		

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F 333	Continued From page 10 Lantus 30 units sq at hour of sleep. Scheduled at 9:00 pm. Lexapro 20 mg po daily. Scheduled at 9:00 am. Lisinopril 40 mg po daily. Scheduled at 9:00 am. Novolog Mix 70-30 15 units sq twice a day. Scheduled at 9:00 am and 5:00 pm. Seroquel 200 mg po at hour of sleep. Scheduled at 9:00 pm. Zoloft 150 mg po every morning. Scheduled at 9:00 am. Record review of the 8/30/14 MAR revealed no signatures indicating any of the resident's scheduled medications were given. The MAR dated 8/30/14-8/31/14 indicated the following as-needed medications ordered for Resident #6 for pain and anxiety: Tylenol 650 mg po every 4 hours as-needed for mild pain. Oxycodone 5 mg po every 4 hours as-needed for moderate pain. Oxycodone 10mg po every 4 hours as-needed for severe pain. Valium 2 mg po every 8 hours as-needed for anxiety. Record review of the 8/30/14 MAR revealed one dose of Oxycodone 10mg was given at 6:00 pm. There were no other as-needed medications signed as being given. Nurse #1's note dated 8/30/14 and un-timed stated, "[Resident #6] arrived around 2:15pm from [the hospital]. [Resident] was crying and very emotional over several different things. She was impossible to calm. She [complained of] pain. I got [as-needed] pain [medication] from e-kit and when I returned she was going off [because] nobody answered the intercom. Told her I had to finish my med pass for the rest of my residents	F 333	new medication administration. Education will be provided in orientation for new licensed nurses on use of emergency kit (E-kit) and back-up pharmacy. How will Corrective Action be monitored? The Director of Nursing will conduct a weekly review of the Unit Managers'/week-end supervisor's audit findings of new medications. Findings will be brought to the monthly Quality Assurance Performance Improvement Committee.		

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F 333	<p>Continued From page 11</p> <p>and then I would sit down and write her MAR in time for her to get bedtime meds that we have available. I explained to resident that we have e-kit backup."</p> <p>During an interview with Nurse #1 on 10/21/14 at 2:22pm she stated, "I was not on the hall after 7:00 pm. Nurse #2 was the nurse that took over. We were explaining to [Resident #6] that we would get her whatever she needed. She was just upset. I left around 7:00 pm from her hallway. I gave the orders to Nurse #2 to do a second check on her medications. I faxed the discharge summary to the pharmacy prior to 5pm. They will fill the meds from the discharge summary and call us if there are questions. The pharmacy cut off for new orders is 5pm on Saturday. The resident was very upset. I gave her oxycodone for pain at 6pm."</p> <p>Nurse #2's note dated 8/30/14 and untimed stated, "Resident rang call light and requested 'Tylenol' twice. Requests were fulfilled."</p> <p>During an interview with Nurse #2 on 10/21/14 at 2:40 pm she stated, "I wonder what time I wrote the note. I am not sure why I wrote 'twice'. She was ringing the call bell many times. If she asked for Tylenol, she got Tylenol. I did not have a clear understanding of how to document the standing orders until recently. Her Tylenol was a standing order so I did not document it on the MAR."</p> <p>During an interview with Nurse #2 on 10/22/14 at 8:47 am she indicated she could not remember why she did not give the resident's ordered medications to her on the first day/evening of her admission. She further indicated when a resident is admitted that available medications should be taken out of the e-kit to give the resident until all the medications are sent from the pharmacy.</p> <p>Nurse #3's note dated 8/31/14 at 7:30 am stated, "[Family member] expressed concern about</p>	F 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/24/2014
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-CAROLINA POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC 27705		
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F 333	<p>Continued From page 12</p> <p>resident not receiving medications. Writer called back-up pharmacy to deliver meds to facility, [family member] notified."</p> <p>Nurse #3's note dated 8/31/14 at 11:00 am stated in part,"Husband delivered home meds to staff until meds delivered and available from pharmacy."</p> <p>During an interview with Nurse #3 on 10/21/14 at 2:55 pm she stated, "Sometimes the meds aren't here on the weekend. We will call the pharmacy back-up. I was manager on duty. I was asked for assistance with the resident and checked the cart to see what meds were not available from pharmacy. The ones not available the husband did bring in." Nurse #3 indicated the resident received her medications out of the e-kit on 8/31/14 and the same medications available on 8/31/14 from the e-kit were available on 8/30/14 from the e-kit.</p> <p>During an interview with the Interim Director of Nursing (DON) on 10/21/14 at 2:07 pm she stated, "[Nurses] put the meds on an order form and fax to the pharmacy. If the pharmacy is closed, the back-up pharmacy would be a local pharmacy. The pharmacy should be notified within an hour of the resident getting here. Sometimes we have the meds even prior to the resident's arrival. There are back-up meds here too. We have an emergency kit [for routine medications] and the narcotic emergency kit with hydrocodone, morphine, stuff like that. August 30th was a Saturday so we would have had to get her meds from the back-up pharmacy. When [nurse's] give a standing order, they should document it and add it to the MAR."</p> <p>During an interview with the Interim DON on 10/22/14 at 8:47 am she indicated her expectations were that a newly-admitted resident get their medications on the day of admission</p>	F 333			

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F 333	Continued From page 13 unless they are not available in the e-kit. She indicated Resident #6's anti-anxiety and muscle relaxer medications would not have been in the e-kit but that her other medications would have been available. She indicated her expectations were that a resident admitted at 2:15 in the afternoon would receive their medications that day. The Interim DON indicated there was no available documentation regarding medications taken out of either of the e-kits on 8/30/14. During an interview with the Vice President of Clinical Services on 10/24/14 at 11:29 am she stated, "[The nurses] should have called the local pharmacy back-up to get her meds if the meds were not available in the e-kit." She indicated she did not have a specific policy about the time frame in which a newly-admitted resident should receive medications, but she would expect that the resident would have received her meds on 8/30/14, whether by the e-kit or pharmacy delivery.	F 333			