

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345550	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2014
NAME OF PROVIDER OR SUPPLIER WHITE OAK OF WAXHAW			STREET ADDRESS, CITY, STATE, ZIP CODE 700 HOWIE MINE ROAD WAXHAW, NC 28173		
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F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to provide nail care to 1 of 5 sampled residents reviewed for activities of daily living (Resident #23).</p> <p>The findings included:</p> <p>An interim care plan for ADLs dated 03/31/14 indicated Resident #23 required staff assistance with all ADL care. The goal stated Resident #23 would be able to participate in part of ADL care through next review. The ADL care plan included approaches to assist Resident #23 by setting up personal grooming items within reach in front of sink and encouraging the resident to wash her face and complete oral care.</p> <p>Resident #23 was admitted to the facility on 03/31/14 with diagnosis including glaucoma. The most recent comprehensive Minimum Data Set (MDS) dated 04/07/14 revealed Resident #23 was severely cognitively impaired and was unable to make her needs known. The admission MDS further revealed Resident #23 required extensive assistance of staff for personal hygiene, dressing, and transfer. Rejection of care was not noted during the assessment period.</p>	F 312	<p>The Residents at White Oak of Waxhaw who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal hygiene.</p> <p>Resident #23's finger nails are trimmed and clean. Upon next review, the IDT (interdisciplinary Team) will address the need for assistance specifically with the personal hygiene and bathing.</p> <p>The Administrative Team (Administrator, DON (Director of Nursing), ADON (Assistant Director of Nursing), SDC (Staff Development Coordinator), and Nursing Supervisors, Social Workers and Activity Workers) have observed each resident's finger nails to identify any resident in need of nail care and assure this care is provided. This was completed on 6/3/14.</p> <p>The nursing staff were re-educated on providing nail care with bathing and PRN (as needed) by the DON/ADON/Nursing Supervisors and completed on or before 6/12/14.</p> <p>Newly hired nursing staff will receive this training during their job specific orientation by the SDC.</p> <p>The nursing supervisors will check</p>	6/12/14	

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

TITLE

(X6) DATE

Electronically Signed

06/03/2014

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 312	<p>Continued From page 1</p> <p>The Care Area Assessment (CAA) summary for activities of daily living (ADL) dated 04/07/14 revealed Resident #23 required extensive staff assistance with ADL tasks. The CAA summary did not address assistance with personal hygiene and bathing.</p> <p>A review of a nurse aide assignment sheet dated 05/08/14 and 05/12/14 identified Resident #23 received her showers on Monday and Thursday during the 3:00 PM to 11:00 PM shift. The assignment sheet noted Resident #23 had received her shower on 05/08/14 and 05/12/14.</p> <p>During an observation on 05/12/14 at 3:20 PM revealed Resident #23 had all 10 fingernails extended approximately 1/8 inch beyond the end of her finger tips with uneven edges and had brown colored debris under her nails.</p> <p>During an observation on 05/13/14 at 2:20 PM revealed Resident #23 had all 10 fingernails extended approximately 1/8 inch beyond the end of her finger tips with uneven edges and had brown colored debris under her nails.</p> <p>During an observation on 05/14/14 at 8:49 AM revealed Resident #23 had all 10 fingernails extended approximately 1/8 inch beyond the end of her finger tips with uneven edges and had brown colored debris under her nails.</p> <p>During an observation on 05/14/14 at 2:32 PM revealed Resident #23 had all 10 fingernails extended approximately 1/8 inch beyond the end of her finger tips with uneven edges and had brown colored debris under her nails.</p> <p>On 05/14/14 at 3:07 PM Nursing Aide (NA) #1</p>	F 312	<p>resident finger nails after each bath daily for 2 weeks, then randomly for 2 weeks to assure ongoing compliance of F 312. The IDT will review each resident quarterly, to assure the need for assistance with personal hygiene and bathing are addressed on the CAA summary and care plan, this is an ongoing process. Identified trends are addressed with the QI (Quality Improvement) team Monday-Friday during the morning meeting for 4 weeks, with recommendations made as indicated. The DON is responsible for ongoing compliance to F312.</p>		

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F 312	Continued From page 2 stated she was familiar with Resident #23 and had assisted with her care. NA #1 described the system for showers noting residents would get showers at least 2 times a week. She further explained during a shower, residents would get their faces and hair washed, their body washed head to toe, shaving as appropriate and nail care provided. NA #1 said they made sure fingernails were clean, cut, and filed to ensure the residents looked nice. NA #1 stated she had only assisted with showers for Resident #23. On 05/15/14 at 9:47 AM NA #2 stated he was familiar with Resident #23, was assigned to her care and confirmed Resident #23's morning care was completed. NA #2 also confirmed Resident #23 was totally dependent on staff for ADL care. When asked about the resident's fingernails, NA #2 said her fingernails needed to be cleaned and trimmed. On 05/15/14 at 9:50 AM Nurse #1 stated she was familiar with the care of Resident #23. Nurse #1 stated it was her expectation residents' nails were clean and trimmed. Nurse #1 confirmed Resident #23 's nails needed to be cleaned and trimmed. During an interview on 05/15/14 at 2:21 PM the Director of Nursing (DON) stated it was her expectation residents' nails were clean and filed smooth.	F 312			
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.	F 333		6/12/14	

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F 333	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to discontinue administration of an anti-coagulant medication as instructed by the physician for 1 of 1 sampled residents on dual anticoagulant medications.</p> <p>The findings are:</p> <p>Resident #76 was admitted to the facility 02/11/14 with diagnoses which included right femoral intertrochanteric fracture and atrial fibrillation.</p> <p>The initial care plan dated 02/11/14 for Resident #76 included the problem area, At risk for signs/symptoms of abnormal bleeding related to use of anticoagulant medication secondary to diagnosis of atrial fibrillation. Approaches to this problem area included, medications as ordered for atrial fibrillation.</p> <p>Admission orders for Resident #76 included Lovenox (an injectable anticoagulant) 30 mg every 24 hours until INR (International Normalization Ratio) greater than or equal to 2.0 for one reading. In addition to the Lovenox, Resident #76 was on Coumadin (an anticoagulant which is dosed based on INR results).</p> <p>Review of labwork in the medical record of Resident #76 noted INR results on 02/24/14 with an INR level of 2.6. Review of the Medication Administration Record (MAR) for Resident #76 noted receipt of the Lovenox at 8:00 AM from 02/12/14-02/26/14. Nurse #3 had initialed on the MAR administration of the Lovenox to Resident</p>	F 333	<p>White Oak of Waxhaw ensures residents are free of significant medication errors. Resident #76 was discharged home on 3/21/14.</p> <p>Other current residents receiving dual anticoagulant medications with INR parameters determining if medication is to be administered have been audited to assure compliance to F333. The audit was completed by ADON (Assistant Director of Nursing) and Nursing Supervisor on 5/14/14.</p> <p>The licensed nursing staff have been re-educated on checking for lab results for all labs in both the clinical record and the physician book, this training was conducted by DON (Director of Nursing) on 5/20/14.</p> <p>Additionally, White Oak of Waxhaw is purchasing a hand held INR machine to provide on the spot results for INR labs. Upon arrival of this machine the licensed nursing staff and nursing supervisors will be trained by the manufacturer of the product, this will be completed approximately by 6/30/14. Newly hired licensed nurses will receive this training during their job specific orientation by the SDC (Staff Development Coordinator).</p> <p>The nursing supervisors will maintain an accurate list of residents on anticoagulant medications that have attached parameters for INR in determining administration. They will compare the INR results with the physician orders for those residents daily for 2 weeks, weekly for 2</p>		

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F 333	<p>Continued From page 4 #76 on 02/25/14 and 02/26/14.</p> <p>On 05/15/14 at 9:08 AM Nurse #3 stated labwork was done by an outside contract agency and the lab results were communicated to the facility nursing supervisors electronically. Nurse #3 stated after the nursing supervisors received labwork, the physician was notified of results and the paper copy of the labwork was placed in the physicians book for signature. Nurse #3 stated the labs for INRs are typically drawn in the morning with the results available by shift change at 2:00-3:00 PM. Nurse #3 reviewed the 02/24/14 INR lab results for Resident #76 which noted they had been received at the facility on 02/24/14 by Nursing Supervisor #1. Nurse #3 stated she always checked labwork in the residents medical record to determine what the current INR results were when there was an order like the Lovenox for Resident #76. Nurse #3 stated she did not know what the delay was in her receiving the paperwork with the INR results; noting the paperwork could have been in the physician's book or medical records before it was placed on the medical record of Resident #76. Nurse #3 stated there could have been a delay in receipt of the lab work because after the supervisor calls the physician with results lab work was placed in the physicians book for signature. Nurse #3 noted after the physician signed the lab work it was given to medical records for placement in the individual resident's chart. Nurse #3 stated she could not access lab results via the electronic record, that nursing staff was dependent on the paperwork to know lab results.</p> <p>On 05/15/14 at 11:05 AM the Administrator, Nurse Consultant, Director of Nursing (DON), Consultant Pharmacist and Assistant Director of</p>	F 333	<p>weeks, then randomly for 2 months to assure ongoing compliance to F333. The Pharmacy Consultant will also review these orders along with the Medication Administration Record monthly. Identified trends are discussed with the QI (Quality Improvement) team Monday-Friday during the morning meeting for 2 weeks, weekly for 2 weeks, then monthly for 2 months. QI team will make recommendations as needed. The DON is responsible for ongoing compliance to F333.</p>		

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F 333	<p>Continued From page 5</p> <p>Nursing (ADON) discussed the facility procedure for receiving labwork from the contract agency that provided services. The DON stated the nursing supervisors received lab results and notified physicians to determine if there needed to be any change in resident orders. The DON stated if there was a change in orders those were given immediately to the nurse in charge of the individual resident. The DON noted the nursing supervisor was the only person who could access lab results. The ADON reviewed the 02/24/14 INR lab results for Resident #76. The ADON noted Nursing Supervisor #1 wrote the last order for Coumadin on the lab result so this could be communicated to the physician along with the INR. The last dose change was noted as 02/20/14 with 7.5 milligrams of Coumadin ordered daily. The ADON stated the nursing supervisor signed the labwork noting the physician was notified with a telephone order to check the INR level again on Thursday (02/27/14). The lab work was signed by the physician on 02/25/14. The ADON stated after the physician signed the labwork it was delivered to medical records and medical records placed lab results in the residents medical record. The ADON stated because of the system there was a delay in lab results being available in each residents' medical record which was most likely why the Lovenox had been given through 02/26/14 for Resident #76.</p> <p>On 05/15/14 at 2:30 PM the medical records director stated she worked Monday-Friday. The medical records director stated lab results were delivered to her after signed by the physician and she attempted to file the paperwork in each residents medical record on a daily basis. The medical records director stated she could not</p>	F 333			

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F 333	<p>Continued From page 6</p> <p>recall when the 02/24/14 INR lab work for Resident #76 was placed in the medical record.</p> <p>On 05/15/14 at 3:46 PM Nursing Supervisor #1 stated she worked second shift, Monday through Friday. Nursing Supervisor #1 stated the electronic system to obtain lab results was stored in the supervisors office which was why all lab results were received and processed by the supervisors. Nursing Supervisor #1 stated it was her practice to notify the residents physician of lab results, process any telephone orders and then place the labwork in the physician's book for their signature. Nursing Supervisor #1 stated she wrote any prior medication orders pertinent to the lab so it would be available when the physician was notified. Nursing Supervisor #1 stated it was her practice to only write the prior Coumadin dose on the labwork for INR results. Nursing Supervisor #1 stated the nurses could access the lab results located in the physician's book or call her for the current results if the latest results were not available in the medical record. Nursing Supervisor #1 verified she wrote the last dose of Coumadin (from 02/20/14) on the 02/24/14 INR labwork for Resident #76 and the telephone order for another INR level on Thursday, 02/27/14. Nursing Supervisor #1 stated after receiving the telephone order the lab results would have been placed in the doctors book (located at each nursing station) for the physician to sign.</p> <p>Review of labwork in the medical record of Resident #76 noted on 02/27/14 (after the Lovenox had been given 2/25/14 and 2/26/14) the INR was 7.8. The physician of Resident #76 was notified of the critical lab value and orders were received to hold the Coumadin and administer Vitamin K.</p>	F 333			

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F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441		6/12/14	

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F 441	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to disinfect a blood glucose meter per facility policy between each resident use for 4 residents during medication pass for 1 of 3 nurses interviewed regarding disinfecting blood glucose meters (Resident #92, #101, #111, and #113).</p> <p>The findings included:</p> <p>A facility policy titled "Fingerstick Blood Sugar" dated 01/22/14 read in part: "10. Clean glucometer (blood glucose meter) with bleach wipe. a. Clean glucometer with one wipe and discard. b. Cover glucometer with a clean wipe for 4 minutes. c. After 4 minutes, remove the bleach wipe, place the glucometer on a clean barrier (ie: paper towel), and allow to dry prior to using again and/or storing in medication cart. Note: 1. Glucometer to be cleaned using PDI saniwipe 1:10 bleach dilution only. 2. Glucometer to be cleaned (per procedure #10 above) between resident use or after use of individual resident. 3. Glucometer must remain visibly wet with 1:10 bleach solution for minimum of 4 minutes."</p> <p>Observations of the 200 hall nurse's station on 05/13/14 at 3:50 PM revealed instructions for cleaning/disinfecting blood glucose meters as outlined in the facility policy were posted at eye level at the desk.</p> <p>On 05/13/14 at 3:55 PM Nurse #2 was</p>	F 441	<p>White Oak of Waxhaw has an established Infection Control Program that is designed to provide a safe, sanitary, and comfortable environment and helps prevent the development and transmission of disease and infection. Nurse #1 has received a formal re-education on the proper procedure for cleansing of the glucometer machines. The re-education was completed by DON (Director of Nursing) on 5/13/14. Residents #92, #103, #111, and #113 receive finger stick blood sugars per physician orders only after the glucometer has been cleansed per policy. The licensed nurses were re-educated on the cleansing of the glucometer process per policy by the DON and ADON (Assistant Director of Nursing) and completed by 6/12/14. Newly hired licensed nurses receive this training during their job specific orientation with SDC (Staff Development Coordinator). Additionally the procedure will continue to be visually posted at each neighborhood nursing station as a reminder. The glucometer cleansing procedure was added to the new hire orientation skills check list for return demonstration observation by the SDC. This has also been added to the annual in-service list to be reviewed with each licensed nurse annually by the SDC. The Nursing Administration (DON, ADON, SDC, and Nursing Supervisors) to observe 4 finger stick blood glucose daily for 1 week, weekly for 2 weeks, then</p>		

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F 441	<p>Continued From page 9</p> <p>approached for observations of medication pass and had just placed a blood glucose meter in the top drawer of the medication cart. Nurse #1 indicated she had completed all her afternoon finger stick blood sugars and did not have any insulin to administer at that time. When asked how she had disinfected the blood glucose meter Nurse #1 opened the top drawer of the medication cart and showed the surveyor an alcohol wipe. Nurse #1 then asked this surveyor if she had answered correctly. It was suggested to her she ask a supervisor for information regarding the facility's policy for cleaning and disinfecting blood glucose meters.</p> <p>A follow up interview was conducted with Nurse #2 on 05/13/14 at 4:02 PM when she returned to the 200 hall medication cart. She was carrying a container of 1:10 bleach dilution wipes and when she opened the bottom drawer of the medication cart a container of the bleach wipes was observed already in the drawer. Nurse #1 stated she had just been instructed by a supervisor how to use 1:10 bleach dilution wipes to clean/disinfect blood glucose meters and did not recall being instructed to use anything other than alcohol wipes to disinfect blood glucose meters. Nurse #2 further stated she worked as needed for the facility and the last time she worked was four months ago. Nurse #2 confirmed she had disinfected the blood glucose meter between resident use with an alcohol wipe when she completed her finger stick blood sugars on Resident #92, #103, #111, and #113 that afternoon. The interview further revealed she had never noticed the instructions for cleaning/disinfecting blood glucose meters posted in the nurse's station.</p>	F 441	<p>monthly for 2 months to ensure ongoing compliance to F441.</p> <p>The Pharmacy Consultant will continue to make random observations for finger stick blood sugars during their routine monthly medication pass observations, and make recommendations as necessary.</p> <p>Trends identified during the observations are discussed daily Monday-Friday during the morning QI (Quality Improvement) meeting for 1 week, then weekly for 2 weeks, then monthly for 2 months with recommendations made as made as indicated.</p> <p>The DON is responsible for ongoing compliance to F441.</p>		

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F 441	<p>Continued From page 10</p> <p>During an interview on 05/13/14 at 4:30 PM the Director of Nursing (DON) stated she expected staff to clean/disinfect blood glucose meters between each resident use with 1:10 bleach dilution wipes per the facility's policy.</p> <p>A follow up interview was conducted with the DON on 05/14/14 at 10:13 AM. A copy of the instructions for cleaning and disinfecting blood glucose meters used during Nurse #2's orientation on 11/01/11 revealed nurses were instructed to use a disinfectant wipe of at least 10% bleach concentration for disinfecting blood glucose meters utilized for multiple residents. The interview further revealed the instructions for cleaning and disinfecting blood glucose meters as outlined in the facility policy were posted at each nurse's station on 11/26/13.</p>	F 441			