STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 11/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and physician interviews, the facility failed to notify the physician regarding bleeding around the	F 157	Greendale Forest Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies	12/1/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/25/2015

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F 157	Continued From page 1 gastrostomy tube site and the inability to verify gastrostomy tube placement before medication administration for one of one resident, Resident # 116, who had a feeding tube and was receiving anticoagulant therapy. Findings included: A review of Resident # 116's quarterly assessment dated 10/02/2015 revealed that she was totally dependent upon staff members for activities of daily living needs and that she had a partial list of diagnoses which included heart failure, gastro-esophageal reflux disease, atrial fibrillation, and adult failure to thrive. The same assessment indicated Resident # 116 was receiving anti-coagulant medication 6 out of 7 days per week and that she received 51% or more of her caloric needs via a gastrostomy tube. Resident # 116's nursing care plan which was initiated on 07/29/2013 and last updated on 10/20/2015 revealed the following goal regarding her potential for bleeding and trauma related to anticoagulant therapy: "Will be free from signs/symptoms of bleeding through the next evaluation." One intervention related to this goal included: " ...Monitor for signs/symptoms of bleeding ....bleeding from superficial injuries. Notify physician as necessary." Additionally, the same nursing care plan included the following goal related to her gastric tube needs: "Will be free from complications of the g-tube feeding, (gastrostomy tube) such as aspiration, formula intolerance, and infection of the stoma site through next evaluation." One intervention related to this goal included: "Monitor for signs/symptoms of tube feeding complications, i.e., aspiration ...infection or irritation of the stoma site." Another intervention was: "Observe and monitor for signs/symptoms of infection at feeding tube site and notify physician of changes."	F 157	and proposes this plan of correction to the extent that this summary of finding is factually correct and in order to maintain compliance with applicable rules and provision of quality of care for the residents. The plan of correction is submitted as a written allegation of compliance. Greendale Forest Nursing and Rehabilitation Center's response to the Statement of Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greendale Forest Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or other administrative or legal proceedings. 157 The physician for resident #116 was notified by the patient care coordinator on 11-13-15 of bleeding around the gastrostomy tube site and the inability to verify the gastrostomy tube placement before medication administration. The resident was repositioned on 11-13-15 and the medication was administered as ordered by hall nurse supervised by the MDS nurse. Nurse #1 was in-serviced on 11-13-15 by the staff development coordinator (SDC) regarding if resident is	

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F 157	Continued From page 2 A review of the physician's medication orders revealed an order dated 10/19/2015 for Resident # 116 to receive warfarin (an anti-coagulant), 3.5 milligrams every Tuesday, Wednesday, Friday, Saturday, and Sunday, and to receive warfarin, 5 milligrams every Monday and Thursday. A nursing progress note dated 11/13/2015 at 5:49 AM revealed the following: "Resident noted with blood on her gown in area of g-tube (gastrostomy tube) site. Gown changed and g-tube site was cleaned with soap and water. Placed towel around g-tube to prevent any drainage to getting on her clothing. Skin referral done to treatment nurse." This progress note was signed by Nurse #1. In an interview with the Director of Nursing (DON) on 11/13/2015 at 8:10 AM, she stated that if there was a skin referral due to bleeding for a resident who was receiving anticoagulant therapy, such as warfarin, the treatment nurse would typically see the resident immediately, on the same shift. On 11/13/2015 at 8:25 AM, an interview was conducted with Nurse #1, who discovered and documented the bleeding at the gastrostomy tube site at 5:49 AM on 11/13/2015. Nurse #1 reported that she made a skin referral to the treatment nurse regarding the bleeding, and that typically she would report the bleeding to her verbally. Nurse #1 explained that the usual treatment nurse was not working that day and that she did not verbally pass along the information to the oncoming day shift staff during report. Nurse #1 stated she had not reported this episode of bleeding to the physician or the DON, but that she had in the past. In an observation of medication administration for	F 157	on anti-coagulant and any bleeding noted report immediately to the DON and medical doctor (MD.) If unable to contact DON, contact MD as soon as possible. Nurse #1 was in-serviced on 11-13-15 by the SDC on checking for placement prior to administration through the gastrostomy tube and to notify the MD if placement cannot be verified. For residents having potential to be affected by the same practice, all residents with gastrostomy tubes were checked on 11-13-15 by the charge nurse for proper placement and bleeding around the gastrostomy tube site. No new issues were identified. A 100% return demonstration with all licensed nurses was completed on 11-15-15 on verification of gastrostomy tube placement by the SDC. All licensed nurses, to include nurse #1, were in-serviced by 11-15-15 by the SDC and DON of the requirements regarding notification of the physician of significant changes in residents' condition to include bleeding around the gastrostomy tube site and the need for documentation of notification of the physician in the clinical record; if unable to reach the physician, the licensed nurse will indicate this on the 24 hour report and the oncoming nurse will continue to try to contact the physician. Nurses will check the 24 hour report when coming on duty for any changes in resident condition and the need to contact the physician. On 11-24-15, an in-service was conducted by the SDC with all licensed nurses regarding the procedure to check for	

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F 157	Continued From page 3 Resident # 116 on 11/13/2015 at 8:45 AM by Nurse #2, there was no bleeding noted at the gastrostomy tube site. Nurse #2 attempted to check placement and patency of the gastrostomy tube prior to the administration of medication per the facility's gastrostomy tube medication administration policy, revised 12/03/2012, by pouring 30 milliliters of water into a large syringe inserted into the gastrostomy tube. The water did not flow through the gastrostomy tube by gravity, and Nurse #2 then attached the piston to the syringe and pushed the water through the syringe into the gastrostomy tube. Nurse #2 then attempted to administer the resident's first medication (levothyroxine, 175 micrograms), which was crushed and mixed with 15 milliliters of water via the syringe attached to the gastrostomy tube; however the medication did not flow through the gastrostomy tube. Nurse #2 poured the medication solution back into the medication cup, then used the syringe piston to plunge 50 milliliters of air into the resident's gastrostomy tube. Nurse #2 then tried changing the tubing valve and pouring warm water into the open syringe. The water did not flow through the tubing by gravity again. Nurse #2 repeated the attempts to check placement and patency by using the piston to push 30 milliliters of water, and then 50 milliliters of air into the gastrostomy tube four more times each. Nurse #2 then poured the first medication from the medicine cup back into the syringe attached to the gastrostomy tube, and again, the medication did not flow by gravity through the tube. During Nurse #2's third attempt to check placement for the gastrostomy tube, the resident began to cough with audible congestion. After a prompt by the surveyor to stop her attempts to check for placement, Nurse #2 continued to push air and water through the	F 157	gastrostomy tube placement prior to medication administration and to contact the MD if placement cannot be verified. All newly hired licensed nurses will be in-serviced by the SDC during orientation regarding notification of the physician of significant changes in residents' condition to include bleeding around the gastrostomy tube site and the need for physician notification in the clinical record; if unable to reach the physician, the licensed nurse will indicate this on the 24 hour report and the oncoming licensed nurse will check the 24 hour report when coming on duty for any changes in resident condition and the need to contact the physician and regarding the procedure to check for gastrostomy tube placement prior to medication administration and to contact the physician if placement cannot be verified. To prevent re-occurrence, the administrative nurses (SDC, quality improvement, MDS and patient care coordinator) will review progress notes and 24 hour reports for all resident to include resident #116, Monday-Friday, x4 weeks, weekly x4 weeks, then monthly x2 months to ensure notification of the physician for all significant changes in the residents' condition to include bleeding around the gastrostomy tube site, utilizing the Physician Notification Audit Tool. The DON will review and initial the Physician Notification Audit Tool weekly x8 weeks, then monthly x2 months for completion and to ensure all areas of concern were addressed and documented in the	

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F 157	Continued From page 4 gastric tube. Nurse #2 was prompted a second time by the surveyor, and then Nurse #1 stated she would stop her attempts to give the medication and report to the Director of Nursing that she was unable to administer the remaining medications. The observation ended at 9:17 AM. In an interview at 12:32 PM on 11/13/2015 with Nurse #2 she stated she had not been aware that Resident # 116 had bleeding around the gastrostomy tube site during the previous shift. Nurse #2 stated she had not received this information during change of shift, and that she had not reviewed the nursing progress note dated 11/13/2015 at 5:49 AM which indicated there had been bleeding. The acting treatment nurse stated in an interview on 11/13/2015 at 12:35 PM that she had not received any skin referrals for Resident # 116 that day, and that she was not certain whether skin referrals were to be given to her on a paper document or if they were in the electronic charting system. At 12:40 PM, the DON stated that skin referrals should be either made orally directly to the treatment nurse or hall nurse, and that paper referrals were no longer used. The DON explained that the other alternative for communicating a skin referral to the treatment nurse or hall nurse was to make an alert in the electronic chart. The DON then checked the electronic record to determine whether an alert had been made for Resident # 116's gastrostomy tube site bleeding. After checking the electronic record, the DON reported there was no alert created regarding Resident #116's bleeding. The DON added that she would have expected for the	F 157	medical records including retraining of the responsible staff member. Medication pass audits will be conducted by the administrative nurses on 10% of all licensed nurses x2 weekly x4 weeks, weekly x4 weeks and then monthly x2 months on all licensed nurses on all shifts to include nights and weekends observing medication administration to residents with gastrostomy tubes to include resident #116 to ensure nurses are checking for placement prior to administration through the gastrostomy tube and to notify the physician if placement cannot be verified. The DON will review and initial the Medication Pass Audit Tool weekly x8 weeks, then monthly x2 months for completion and to ensure all areas of concern were addressed including re-training of the responsible person. To ensure that physician notification is made and documented by the licensed nurse on an ongoing basis, the DON will compile results from the Physician Notification QI Audit Tool and medication pass audits and present the results to the Quality Improvement Committee monthly x4 months. Identification of trends will determine the need for further action and/or frequency of required monitoring.	

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F 157	Continued From page 5 bleeding to be reported to her or the physician. The DON also stated she would not have wanted Nurse #2 to attempt to check placement of the gastrostomy tube repeatedly prior to medication administration and that she would have expected her to get another nurse to attempt to check placement after a couple of attempts. In an interview with the physician on 11/13/2015 at 1:55 PM, she stated she would have expected the facility nurse to have notified that there had been bleeding around the gastrostomy tube site in order to determine how much bleeding was present. The physician also stated she would have also expected the medication nurse to notify her that she had difficulty checking placement and patency of the gastrostomy tube, and that she would not have wanted the nurse to repeatedly plunge water, air, or medication through the gastrostomy tube, especially if the resident was coughing. The physician stated bleeding combined with the difficulty verifying placement could have been a sign that the gastrostomy tube was out of place. During an interview with the facility's Regional Vice President on 11/13/2015 at 3:00 PM, she stated that in-service education had been initiated for the nursing staff regarding checking gastric tube placement, reporting placement issues to the DON or supervisor and/or the physician, and for reporting bleeding to the DON and/or the physician.	F 157		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --	F 322		12/1/15

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F 322	Continued From page 6 (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and physician interviews, the facility failed to verify gastrostomy tube placement safely prior to medication administration for one of two residents reviewed for gastrostomy tube services, Resident # 116. Findings included: A review of Resident # 116's quarterly assessment dated 10/02/2015 revealed that she was severely cognitively impaired and was totally dependent upon staff members for all her activities of daily living, including bed mobility, dressing, personal hygiene, and bathing. The same assessment indicated Resident # 116 had diagnoses of heart failure, gastro-esophageal reflux disease, and failure to thrive, and that she received 51% or more of her caloric needs via a gastrostomy tube.	F 322	The physician for resident #116 was notified by the patient care coordinator on 11-13-15 of bleeding around the gastrostomy tube site and the inability to verify the gastrostomy tube placement before medication administration. The resident was repositioned on 11-13-15 and the medication was administered as ordered by hall nurse supervised by the MDS nurse. Nurse #1 was in-serviced on 11-13-15 by the staff development coordinator (SDC) regarding if resident is on anti-coagulant and any bleeding noted report immediately to the DON and medical doctor (MD.) If unable to contact DON, contact MD as soon as possible. Nurse #1 was in-serviced on 11-13-15 by	

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F 322	Continued From page 7 Resident # 116's nursing care plan which was initiated on 07/29/2013 and last updated on 10/20/2015 revealed the following goal related to her gastrostomy tube needs: "Will be free from complications of g-tube (gastrostomy tube) tube feeding, i.e., aspiration, formula intolerance, infection of the stoma site through next evaluation. " One intervention related to this goal included: "Monitor for signs/symptoms of tube feeding complications, i.e., aspiration - dyspnea or fever; formula intolerance - nausea, vomiting, or diarrhea; infection or irritation of the stoma site." Another intervention was: "Care of g-tube site per facility protocol." A review of the facility's "Administration of Oral Medications Through a Nasogastric or Gastrostomy Tube" protocol, revised 12 03/2012, step # 13 stated, "For stabilized gastrostomy tubes (i.e., surgically placed or stabilized by external device): pour small amount of water, 1-2 ounces (30-60 milliliters) into the syringe [attached to gastric tube] to verify patency and moisten tubing to prevent feeding/medication from adhering to the tube." Step # 15 was, "Pour the diluted medication into the syringe barrel. To prevent air from entering the patient's stomach, hold the tube slightly higher to increase the flow rate. Slowly add more diluted medication to the syringe until the entire dose has been given." Step # 16 was, "Flush tube by pouring at least 15 milliliters of water into the syringe barrel." Step #17 was, "Repeat steps 15 and 16 until each medication has been administered." During an observation of medication administration to Resident #116 via her gastric tube on 11/13/2015 at 8:45 AM, Nurse #2 prepared Resident # 116's ordered medications (5 different medications) in separate medication	F 322	the SDC on checking for placement prior to administration through the gastrostomy tube and to notify the MD if placement cannot be verified. For resident having the potential to be affected by the same practice, all residents with gastrostomy tubes were checked on 11-13-15 by the charge nurse for proper placement of the gastrostomy tube. No new issues were identified. A 100% return demonstration with all licensed nurses was completed on 11-15-15 on verification of gastrostomy tube placement by the SDC. On 11-24-15, an in-service was conducted by the SDC with all licensed nurses regarding the procedure to check for gastrostomy tube placement prior to medication administration and to contact the physician if placement cannot be verified. Medication pass audits will be conducted by the administrative nurses on 10% of all licensed nurses x2 weekly x4 weeks, weekly x4 weeks and then monthly x2 months on all shifts to include nights and weekends observing medication administration to residents with gastrostomy tubes to include resident #116 to ensure nurses are checking to verify gastrostomy tube placement safely prior to administration through the gastrostomy tube and to notify the physician if placement cannot be verified. The DON will review and initial the Medication Pass Audit Tool weekly x8 weeks, then monthly x2 months for completion and to ensure all areas of	

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F 322	Continued From page 8 cups and then took them into resident's room. Nurse #2 placed each medication cup on the resident's bedside table and added 15 milliliters of water to each one. Nurse #2 raised the level of Resident # 116's bed to a comfortable height. (The head of Resident # 116's bed was elevated upon entry to the room.) Nurse #2 disconnected the resident's continuous feeding formula tubing from the gastrostomy tube and attached a large open syringe (without the piston attached) to the gastrostomy tube. Nurse #2 poured 30 milliliters of water into the syringe, and the water did not flow through the gastrostomy tube by gravity. Nurse #2 then attached the piston to the syringe and pushed the water through the syringe into the gastrostomy tube. Nurse #2 then attempted to administer the resident's first medication (levothyroxine, 175 micrograms), which was crushed and mixed with 15 milliliters of water, by pouring it into the syringe attached to the gastrostomy tube; however the medication would not flow through the gastrostomy tube. Nurse #2 poured the medication solution from the syringe back into the medication cup. Nurse #2 then re-attached the piston to the syringe and plunged 50 milliliters of air into the resident's gastrostomy tube. Then Nurse #2 poured the first medication solution back into the open syringe and attached the piston and pushed the medication through the tubing. Nurse #2 then removed the syringe and the valve on the gastrostomy tube and placed a new valve on the gastrostomy tube, then re-attached the syringe. Nurse #2 poured 30 milliliters of warm water into the gastrostomy tube and pushed the water through the tubing using the piston. Resident # 116 started to cough with audible congestion, and Nurse #2 continued the attempts to verify placement by using the piston to push 30 milliliters of water, and then 50	F 322	concern were addressed including retraining of the responsible staff member. To ensure on an ongoing basis that nurses are verifying gastrostomy tube placement safely prior to medication administration through the gastrostomy tube and to notify the physician if placement cannot be verified and documentation of physician notification is made in the clinical record, the DON will compile results from medication pass audits and physician notification audits and present the results to the Quality Improvement Committee monthly x4 months. Identification of trends will determine the need for further action and/or frequency of required monitoring.	

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F 322	Continued From page 9	F 322		

milliliters of air into the gastric tube four more times each. After two prompts by the surveyor, Nurse #2 stopped checking for placement and stated she would report to the Director of Nursing that she was unable to administer the remaining medications.

In an interview with the DON on 11/13/2015 at 12:50 PM, she stated she would not have wanted Nurse #2 to attempt to check placement of the gastrostomy tube repeatedly and that she would have expected her to get another nurse to attempt to check placement after a couple of attempts. The DON also stated that gastrostomy tube placement should be verified before administering any medications.

In an interview with the physician on 11/13/2015 at 1:55 PM, she stated she would have expected the facility nurse to contact her that she had difficulty checking placement for the gastrostomy tube, and that she would not have wanted the nurse to repeatedly plunge water, air, or medication through the gastrostomy tube, especially if the resident was coughing. The physician added that the difficulty checking patency and placement of the gastrostomy tube could have been a sign the tube was not placed correctly or that the resident needed to see the gastroenterologist.

During an interview with the facility's Regional Vice President on 11/13/2015 at 3:00 PM, she stated that in-service education had been initiated for the nursing staff regarding checking gastrostomy tube placement, and reporting placement issues to the DON or supervisor and/or the physician.