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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	C 02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBRIDGE HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

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F 000	INITIAL COMMENTS 483.25 (F 329) at J Immediate jeopardy began on 01/22/16 when the facility failed to draw Resident #2's blood for anticoagulation monitoring. Immediate jeopardy was removed on 02/19/16 when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective.	F 000	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
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	F 157	F157 Resident #1 is no longer a resident at our facility. All residents have the potential to be affected. Electronic medical records progress notes have been audited daily, Monday through Friday, in the morning clinical meeting by the DON, Unit Managers, Social Services and MDS Director to ensure notification of MD and/or family occurs.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/10/16

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 157	Continued From page 1 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 record review and staff interviews, the facility failed to notify the responsible party of the administration of intravenous fluids (IV) and a change in the resident's decision related to health care directives and failed to notify the physician of the IV not being started when ordered due to complications for 1 of 3 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 02/02/16 from a hospital. Her diagnoses included atrial fibrillation, hypertension, arterial embolism of the right leg and thrombosis of arteries of the lower extremities. The hospital discharge summary for Resident #1, last updated on 02/02/16 at 8:12 AM specified that all medications were stopped, her wound vacuum was discontinued and that palliative/hospice would manage her care. Included in the hospital information was a Medical Orders for Scope of Treatment (MOST) form dated 01/28/16 which specified the information on the form was discussed and agreed to by the	F 157	Nurses and the Social Worker will receive education by the DON and/or designee on the requirement to notify physician, resident and responsible party/interested family member, when changes occur. To monitor compliance with notification of changes, the MDS Director and/or designee, will perform an audit daily, Monday through Friday for 4 weeks then weekly for 4 weeks then once a month for one month. Compliance/audit findings will be monitored by the QAPI Committee. The QAPI Committee will evaluate need for continued monitoring and/or further education. Date of Completion: 3/13/16	

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F 157	Continued From page 2 resident and the health care power of attorney and signed by the health care power of attorney (also referred to as the responsible party). This MOST form stated Resident #1 was a DNR, wanted limited additional interventions, including IV fluids for a defined trial period. Review of the medical record revealed a copy of Resident #1's living will, the financial power of attorney and health care power of attorney, both naming the responsible party (RP) as her legal representative. The resident's medical record contained another MOST form, undated but signed by the RP which indicated Do Not Attempt Resuscitation (DNR/no CPR), comfort measures, no antibiotics, no IV fluids, and no feeding tube as discussed and agreed to by the patient and attorney in fact with power to make health care decisions. Interview with the Social Worker (SW) on 02/18/16 at 5:10 PM revealed the RP completed the admission paperwork the day Resident #1 arrived to the facility and signed the MOST form. SW stated the form would be dated the day the physician signed the MOST form. The SW stated the MOST form was placed in the physician's file for his signature. Interview with the Medical Records Director on 02/18/16 at 4:31 PM revealed forms that the physician needs to sign are placed in a file which he took back to his office to sign. She then goes every Monday to pick up the file from the physician so she can file the signed papers. She stated she could not recall this MOST form being signed or returned.	F 157		

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F 157	Continued From page 3 a. Physician progress notes dated 02/03/16 included the plan for "IVs for 2 days to improve hydration." A telephone order revealed an order for IV fluids D5 1/2 NS (normal saline) at 125 ml/hr. This was noted by Nurse #1 on 02/03/16 at 11:00 PM. A phone interview with Nurse #1 on 02/19/16 at 3:16 PM revealed she noted this telephone order for Resident #1 on 02/03/16 at around 11:00 PM. She stated she did not call the resident's RP about the order as it was late and she never called families at night related to new orders. She would just let day shift call the families. She also stated that she tried to start the IV but was unsuccessful. She then had the other nurse in the facility try to start the IV and that attempt was unsuccessful. Nurse #1 stated she decided to wait until the next morning when nurses arrived for the 7 AM shift to see if they could start the IV. Nurse #1 stated she did not call the physician to alert him the IV insertion was unsuccessful and obtain further instructions. She stated the resident was drinking fluids so she did not see the need to call the doctor. Interview with the Assistant Director of Nursing (ADON) on 02/18/16 at 3:34 PM revealed when she arrived to work at 7:00 AM on 02/04/16, Nurse #3 asked her to start the IV fluids for Resident #1 as night shift was unsuccessful. ADON stated that it took two attempts but she started the IV on Resident #1. ADON stated she did not call the family to inform them of the IV orders or administration of the IV fluids. Progress notes created on 02/05/16 at 12:07 PM and noted as late entry for 02/04/16 at 12:01 PM were written by SW. The note stated that SW	F 157		

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F 157	Continued From page 4 spoke with the resident's RP's wife (listed as second contact on the facility 's face sheet) regarding treatment administered to Resident #1. The RP's wife stated she did not want resident to have IV fluids that she was to only have comfort measures. Interview with the SW on 02/18/16 at 5:10 PM revealed Resident #1's family was very upset on 02/04/16 because IV fluids were started on Resident #1 and she explained to the RP's wife that Resident #1 spoke with the physician and wanted the IVs. Progress notes dated 02/05/16 at 3:54 PM written by the Director of Nursing revealed on 02/05/16 at 1:50 PM the resident's RP summoned her to the room and argued that the IV's were not to be in place as she was supposed to be palliative care. The Director of Nursing (DON) was interviewed on 02/19/16 at 2:57 PM. She stated she expected nursing staff to notify the resident's RP when IVs were started and that should be documented in the progress notes or on a skilled observation note. DON also stated that the physician should have been notified when staff could not start Resident #1's IV to obtain further directions. The Administer stated during interview on 02/19/16 at 5:23 PM she expected the family to be notified that the physician ordered an IV and expected the physician to be notified about the delay in starting the IV. b. Progress notes dated 02/05/16 at 12:07 PM written by SW revealed SW met with Resident #1 to complete a MOST form. The note specified the	F 157		

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F 157	Continued From page 5 resident answered all questions appropriately and thought about responses before answering. When asked if she wished for Cardiopulmonary Resuscitation (CPR) she stated "yes if you could bring me back." When the accompanying nurse explained there was no guarantee, the resident voiced understanding. The note continued stating the resident was asked each question on the MOST form answering "yes if would help me" to several issues. The resident attempted to sign the MOST form and made a mark in the signature box. Review of the MOST form dated 02/05/16 signed by the resident with an "X" and the physician revealed the resident wanted CPR, limited additional interventions, antibiotics if life can be prolonged, IV fluids long term if indicated, and a feeding tube for a defined trial period. Interview with the SW on 02/18/16 at 5:10 PM revealed that she, her assistant and Nurse #4 met with Resident #1 on 02/05/16 and completed the MOST form with the resident. The SW stated she took the completed MOST form to the physician's office and had it signed by the physician on 02/05/16. The SW stated during this interview, she had not called the RP to inform them Resident #1 had changed the MOST form which altered her treatment. When asked why the SW did not inform the RP, the SW stated Resident #1 was capable of making her own decisions and she provided no reason why she did not inform the RP of this change in treatment. The DON stated during an interview on 02/19/16 at 2:57 PM that she was not sure what the policy was for informing the RP of changes to the MOST form.	F 157		

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F 157	Continued From page 6 On 02/19/16 at 5:23 PM, the Administrator stated the RP should have been informed about the changes to the MOST form as it changed the plan of care for Resident #1.	F 157		
F 329 SS=J	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff and physician interviews and record review the facility failed to	F 329	F329 Resident #2 is no longer a resident at our facility. Residents requiring lab monitoring for therapeutic drug levels have the potential to be affected. A 100% audit was completed on 2/18/16 on the identified residents receiving Coumadin. Four residents were identified. The MDS Director reviewed/audited the medical records of the identified residents. 100% compliance was found. An audit was conducted on 2/19/16 for residents receiving other medications that need to be monitored including digoxin, Dilantin, seizure medications, Depakote, synthroid and hypo-glycemics. The audit was con-conducted by the ADON, and Medical Records staff.	

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F 329	Continued From page 7 monitor a resident's clotting time while taking an anticoagulation medicine, the resident experienced critical blood levels which increased the risk of bleeding and resulted in treatment in the hospital for 1 of 3 residents (Resident #2) reviewed for anticoagulant therapy. Immediate jeopardy began on 01/22/16 when the facility failed to draw Resident #2's blood for anticoagulation monitoring. Immediate jeopardy was removed on 02/19/16 when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective. The findings included: A policy, not dated, titled "ANTICOAGULATION PT/INR MONITORING" read in part, "residents on anticoagulation therapy will be monitored to ensure the maintenance of safe laboratory parameters as established by the attending physician. The protocol for managing anticoagulant therapy will ensure resident safety and prevent negative effects from the use of anticoagulants." Resident #2 was admitted to the facility on 01/13/14 with diagnoses that included venous thrombosis and embolism, anxiety, Alzheimer's disease and others. The most recent Minimum Data Set (MDS) dated 12/23/15 specified the resident had severe cognitive impairment, required extensive assist with activities of daily living and had received an anticoagulant for all 7	F 329	A new policy and procedure was developed on 2/3/16. Our contracted nurse consultants in-serviced the nurses who give Coumadin, (7am to 7pm shift nurses) and (2) 7pm to 7am nurses on the changes. Changes to the policy were as follows: The nurses transcribe the order for the current Coumadin dosage onto the MAR. A vertical line is drawn and the word STOP is written for Coumadin on the date the next PT/INR is to be drawn. The order for the next PT/INR is entered onto the MAR by drawing a box around the date the PT/INR is due. This is to remind the nurse that a lab is due that day. The PT/INR will be drawn on the date due by the day shift nurse assigned to the resident, prior to the arrival of the lab courier and the specimen will be sent to the lab. The weekend RN Supervisor will check for needed labs on Saturday and Sunday and ensure they are obtained and sent to the hospital. The nurse will obtain the results of the PT/INR from the lab. The nurse will call the attending Physician with the results of the PT/INR as soon as available but no later than 4:00pm to obtain new orders	

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F 329	Continued From page 8 days of the assessment period. Review of Resident #2's care plan updated on 01/05/16 specified the resident was on anticoagulant therapy related to history of venous thrombosis and embolism. An intervention included in the care plan was to perform labs as ordered. An original physician's order dated 12/23/15 read in part, clarification order Coumadin (anticoagulant) order remains 4 mg (milligrams) Tuesday, Wednesday, Thursday, Saturday and Sunday and 3 mg on Monday and Friday. Re-check PT/INR (prothrombin time test to measure clotting time) on 12/30/15. Review of the medical record revealed that laboratory testing was performed on 12/30/15 and the PT/INR results were: PT 29.0 High (normal range is 11.6 - 14.4) INR 2.73 High (normal range is 0.86 - 1.13) Further review of the medical record revealed physician's orders were to continue the same dose of anticoagulation medication and re-check PT/INR on 01/06/16. Laboratory testing was performed on 01/08/16 and the PT/INR results were: PT 28.6 High (normal range is 11.6 - 14.4) INR 2.68 High (normal range is 0.86 - 1.13) The physician was notified of the results on 01/08/16 and ordered to continue the same dose of anticoagulation medication and re-check PT/INR on 01/22/16.	F 329	for Coumadin. DO NOT ADMINISTER ANY COUMADIN ON THE DATE OF THE PT/INR UNTIL THERE IS A NEW ORDER FROM THE PHYSICIAN. The physician will order the Coumadin dose and the date of the next PT/INR. The nurse will enter the new order for the Coumadin with the stop date being the date for the next PT/INR. The order for the next PT/INR is entered onto the MAR by drawing a box around the date due. If the date falls within the next month, the nurse will note it on the MAR where it states (next PT/INR due). The nurse will fill out the anticoagulation PT/INR monitoring flowsheet. In-servicing on the new policy began on 2/18/16. All nurses were in-serviced on the new policy by the DON, ADON and/or the MDS Director. In-service included a copy of the policy with verbal explanation and an example of how the MAR should look. Nurses were not allowed to work until they had the in-service. PT/INR results will be reviewed during the morning clinical meeting. A PT/INR board will be utilized during the meeting to record last PT/INR, Coumadin dose and when next lab is due.	

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F 329	Continued From page 9 Review of the medical record revealed that no laboratory testing was performed on 01/22/16. The Medication Administration Record (MAR) for January 2016 specified Resident #2 was to have her PT/INR checked on 01/22/16 but the box was left blank. Further review of the medical record revealed that on 02/01/16 Resident #2's PT/INR was obtained and the results were: PT >100.0 High (normal range is 11.6 - 14.4) INR >13.5 High High (normal range is 0.86 - 1.13) On 02/01/16 the physician was notified of Resident #2's PT/INR and ordered 5mg Vitamin K to be given. Vitamin K is capable of reversing the anticoagulant activity of the anticoagulant, Coumadin. Review of the nurses' notes from 01/22/16 through 02/01/16 did not indicate if the resident was assessed for signs or symptoms of bleeding. A nurse's note dated 02/02/16 specified Resident #2's family reported that the resident had "decreased responsiveness." The nurse documented that Resident #2 was lethargic and not easily aroused. The nurse notified the physician of family's request to send the resident to the Emergency Department. Resident #2 was hospitalized on 02/02/16 for a urinary tract infection, dehydration and hypernatremia. Further review of the hospital records revealed Resident #2 received Vitamin K and fresh frozen plasma for her INR of 13.5. On 02/07/16 Resident #2 was readmitted to the	F 329	Nurses are to check the lab book and lab box every morning for needed labs. Monday through Friday the ward secretary and/or the Medical Records Director will reconcile received lab reports against labs that were drawn to ensure all results have been received. If a result has not been received they will call the lab to obtain it. New nurses will be in-serviced on the PT/INR monitoring policy during orientation. CNA's were in-serviced on reporting signs and symptoms of bleeding beginning 2/19/16. CNA's were not allowed to work until they had received the training. The training was conducted by the DON, ADON, MDS Coordinator, the Weekend Supervisor, and/or hall charge nurse. Facility alleges immediate jeopardy has been removed on 2/19/16. Facility alleges they will be back in compliance with this allegation and immediate jeopardy will be removed on 2/19/16.	

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F 329	Continued From page 10 facility. On 02/18/16 at 2:23 PM Nurse #3 was interviewed on the telephone and explained that he was assisting with end of month MAR checks. He stated that when he reviewed Resident #2's MAR for January 2016 he noticed that on 01/22/16 the order to draw PT/INR was left blank. Nurse #3 stated that he reviewed the medical record and contacted the lab and learned the blood work was not obtained and Resident #2 had not had her PT/INR level checked on 01/22/16. He stated that he immediately notified the interim Director of Nursing (DON) and the physician. On 02/18/16 at 2:37 PM Nurse #9 was interviewed. She explained that when PT/INR results were returned to the facility, the nurse was responsible for notifying the physician of the results and transcribing new orders on the MAR. Nurse #9 recalled that 01/08/16 she received telephone orders from the physician to continue Resident #2's Coumadin dose and re-check the PT/INR on 01/22/16. Nurse #9 reviewed Resident #2's medical record where she documented on the MAR the lab was due. Nurse #9 was not aware the PT/INR had not been drawn on 01/22/16. On 02/18/16 at 5:20 PM Nurse #2 was interviewed on the telephone and reported that she had been assigned to care for Resident #2. Nurse #2 was aware that Resident #2 had been on Coumadin and required blood work to check PT/INR levels. The nurse explained that her usual practice was to check the "lab box" located above the medical records for lab slips that specified a lab was to be drawn for a resident;	F 329		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	C 02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBRIDGE HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

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F 329	Continued From page 11 and also she would review the Medication Administration Record (MAR) for residents on Coumadin to see if they had a PT/INR due. Nurse #2 stated that she could not recall what happened on 01/22/16 but that she did not draw blood on Resident #2 to have her PT/INR checked. Nurse #2 offered no explanation as to how the lab was missed. On 02/19/16 at 10:11 AM the interim DON was interviewed and reported that Nurse #3 notified her on 02/01/16 that Resident #2 had missed a PT/INR lab and this was the same day she assumed her role as interim DON. She explained that a STAT (right away) lab was ordered by the physician. The interim DON added that the results came back extremely high and Resident #2 had to be treated with Vitamin K. On 02/19/16 at 11:50 AM the physician was interviewed on the telephone and explained that Coumadin was a "powerful" blood thinner that required close monitoring to keep PT/INR levels in safe ranges. The physician stated that low PT/INR levels could result in blood clots and high PT/INR levels could be life threatening. The physician added that Resident #2 had experienced an acute illness due to an overall decline in health that resulted in a combination of urinary tract infection, severe hypernatremia and dehydration from refusing to eat or drink that likely resulted in the increased PT/INR. He stated that he expected labs to be drawn as ordered but stated he did not feel the resident was harmed by the high PT/INR. On 02/18/16 at 2:10 PM the Administrator was notified of immediate jeopardy for failing to obtain blood work to check Resident #2's PT/INR. The	F 329		

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F 329	Continued From page 12 facility provided an acceptable credible allegation of compliance on 02/19/16 at 2:53 PM. The following interventions were put into place to remove the immediate jeopardy. GLENBRIDGE HEALTH AND REHAB F329 ALLEGATION OF COMPLIANCE 2/18/16 1) Resident #2 was scheduled to have a PT/INR drawn on 1/22/16 due to chronic Coumadin usage. The lab was not obtained and was not identified as missing until 2/1/16. On 2/1/16, a blood specimen was drawn for a PT/INR and sent to the lab on a STAT basis. Her results indicated both the PT and INR levels were >13.5. The physician was contacted and orders received to hold Coumadin until further notice. Vitamin K 5mg was given by mouth. On 2/1/16, the resident was assessed by the Interim DON and showed no signs or symptoms of bleeding but did have old bruising noted on upper and lower extremities. On the morning of 2/2/16, it was discovered that the resident had not swallowed the Vitamin K tablet. The physician was notified at 9:00am and an order received to give Vitamin K 10mg IM [intramuscularly] now. Also that morning, resident had a change in level of consciousness and was not accepting anything by mouth. Per her MOST [Medical Orders for Scope of Treatment] form, she was to receive comfort measures only and not to transfer to hospital unless comfort needs could not be met. The Interim DON discussed the resident's status with one of the daughters that was present at bedside. She stated she would discuss it with her sister and let us know if they wanted her transferred to the ER [Emergency Room]. The family did	F 329		

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F 329	Continued From page 13 choose to have her sent to the ER for evaluation. Her transfer to the ER was not related to the Coumadin or lab results. Resident's attending physician examined her on 2/18/16 at 6:35pm. He stated that resident had not experienced any harm related to the elevated PT/INR. A progress note written by the physician has been placed in resident's chart. 2) A 100% audit was completed on 2/18/16 on the identified residents receiving Coumadin. Four residents were identified. The MDS Director reviewed/audited the medical records of the identified residents. 100% compliance was found. An audit will be conducted on 2/19/16 for residents receiving other medications that need to be monitored including digoxin, Dilantin, seizure medications, Depakote, synthroid and hypoglycemics. The audit will be conducted by the DON, ADON, MDS Director and/or Medical Records Director. 3) A new policy and procedure was developed on 2/3/16. Our contracted nurse consultants in-serviced the nurses who give Coumadin, (7am to 7pm shift nurses) and 2 7pm to 7am nurses on the changes. As this issue was placed in our QAPI [Quality Assessment Performance Improvement] program on 2/2/16, we decided to wait on further training to allow for analysis and revisions of the process. Changes to the policy were as follows: · The nurses transcribe the order for the current Coumadin dosage onto the MAR. A vertical line is drawn and the word STOP is written for Coumadin on the date the next PT/INR is to be drawn.	F 329		

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F 329	Continued From page 14 · The order for the next PT/INR is entered onto the MAR by drawing a box around the date the PT/INR is due. This is to remind the nurse that a lab is due that day. · The PT/INR will be drawn on the date due by the day shift nurse assigned to the resident, prior to the arrival of the lab courier and the specimen will be sent to the lab. The weekend RN Supervisor will check for needed labs on Saturday and Sunday and ensure they are obtained and sent to the hospital. · The nurse will obtain the results of the PT/INR from the lab. The nurse will call the attending Physician with the results of the PT/INR as soon as available but no later than 4:00pm to obtain new orders for Coumadin. DO NOT ADMINISTER ANY COUMADIN ON THE DATE OF THE PT/INR UNTIL THERE IS A NEW ORDER FROM THE PHYSICIAN. · The physician will order the Coumadin dose and the date of the next PT/INR. · The nurse will enter the new order for the Coumadin with the stop date being the date for the next PT/INR. · The order for the next PT/INR is entered onto the MAR by drawing a box around the date due. If the date falls within the next month, the nurse will note it on the MAR where it states (next PT/INR due). · The nurse will fill out the anticoagulation PT/INR monitoring flowsheet. 4) In-servicing on the new policy began on 2/18/16. All nurses will be in-serviced on the new policy by the DON, ADON and/or the MDS Director. In-service will include a copy of the policy with verbal explanation and an example of how the MAR should look. Any nurse that has not been in-serviced will not be allowed to work	F 329		

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F 329	Continued From page 15 until they have completed it. 5) PT/INR's will be reviewed during the morning clinical meeting. A PT/INR board will be utilized during the meeting to record last PT/INR, Coumadin dose and when next lab is due. 6) Nurses are to check the lab book and box every morning for needed labs. Monday through Friday the ward secretary and/or the Medical Records Director will reconcile received lab reports against labs that were drawn to ensure all results have been received. If a result has not been received they will call the lab to obtain it. 7) New nurses will be in-serviced on the PT/INR monitoring policy during orientation. 8) CNA's will be in-serviced on reporting signs and symptoms of bleeding beginning 2/19/16. CNA's will not be allowed to work until they have received the training. The training will be conducted by the DON, ADON, MDS Coordinator, the Weekend Supervisor, and/or hall charge nurse. 9) Facility alleges immediate jeopardy has been removed on 2/19/16. Facility alleges they will be back in compliance with this allegation and immediate jeopardy will be removed on 2/19/16. Immediate Jeopardy was removed on 02/19/16 at 5:22 PM when the facility provided evidence of additional training provided to the nursing staff that proved they were aware of the new system for monitoring and reporting PT/INR lab work and were aware of signs and symptoms of bleeding.	F 329		
F 514	483.75(l)(1) RES	F 514		

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F 514 SS=D	Continued From page 16 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate and complete medical records for 1 of 3 sampled residents. Resident #1's clinical record did not contain complete orders for 1. intravenous (IV) therapy, documentation of IV administration, documentation of unsuccessful IV insertion attempts, documentaion of the delay in IV administration, and documentation of IV fluid intake and 2. documentation of an indwelling urinary catheter change and documentation of urinary output. The findings included: Resident #1 was admitted to the facility on 02/02/16 from a hospital. Her diagnoses included atrial fibrillation, hypertension, arterial embolism of the right leg and thrombosis of arteries of the lower extremities.	F 514	F514 Resident #1 is no longer a resident at our facility. All residents have the potential to be affected. The DON and/or designee will audit medical records of other residents with indwelling urinary catheters to determine if catheter changes have been documented. The DON and/or designee will also audit medical records of residents receiving IV therapy, including IV antibiotics, to determine if the therapy has been documented. Documentation for IV therapy, as well as documentation of urinary catheter changes will be placed on the MAR's. Nurses will be educated on documentation requirements by the DON and/or designee.	

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F 514	Continued From page 17 a. Physician progress notes dated 02/03/16 included the plan for "IVs for 2 days to improve hydration." A telephone order revealed an order for IV fluids D5 1/2 NS (normal saline) at 125 ml/hr. This was noted by Nurse #1 on 02/03/16 at 11:00 PM. There was no time frame for the IVs to be administered on the physician's order. The Medication Administration Record for February 2016 had the hand written orders for "IV fluids D 5 1/2 NS at 125 ml/hr." The start date was 02/03/16 and there was no end date or duration date for the IV fluids to run. The MAR was blank relating to the administration of any IV fluids. A phone interview with Nurse #1 on 02/19/16 at 3:16 PM revealed she noted the 02/03/16 telephone order around 11:00 PM. She stated that she tried to start the IV soon after transcribing the orders around 11:00 PM but was unsuccessful. She then had the other nurse (Nurse #5) in the facility try to start the IV and that attempt was unsuccessful. Both times the IV infiltrated immediately. She then decided to wait until the next morning when nurses arrived for the 7 AM shift to see if they could start the IV. Nurse #1 stated she did not document any IV fluids provided as she was unsuccessful in starting the IV. She stated she should have documented the unsuccessful attempts to start the IV in the progress notes or the Skilled Charting Observation Tool. A phone interview with Nurse #5 on 02/19/16 at 12:36 PM revealed she was the nurse who	F 514	Documentation of IV therapy and urinary catheter changes will be audited weekly for 4 weeks then monthly for 3 months by the wound care supervisor. The QAPI Committee will evaluate audit results and need for continued auditing and/or education. Audits will be conducted by the Nurse Managers and/or Medical Records staff. Date of Completion: 3/13/16	

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F 514	Continued From page 18 worked the night shift beginning 02/03/16 and attempted to start an IV on Resident #1 after Nurse #2 was unsuccessful. She stated she was also unsuccessful but did not document anything as Resident #1 was not her resident, she was just assisting the other nurse. Interview with the Assistant Director of Nursing (ADON) on 02/18/16 at 3:34 PM revealed when she arrived to work at 7:00 AM on 02/04/16, Nurse #3 asked her to start the IV fluids for Resident #1 as night shift was unsuccessful. ADON stated that it took two attempts but she started the IV on Resident #1. The ADON further stated that IV fluids should be documented in the medical record relating to the site, patency, warmth, infiltration and rate of infusion and amount infusing. She stated if the IV could not be started as ordered, the date on the MAR should be circled with an explanation on the back. This should also be noted on the 24 hour reports. She also confirmed the MAR was blank. She stated that the information concerning the IV should be documented on an IV flow sheet with the amount left to infuse at the end of each shift in order to document the amount of fluids a resident received. Follow up interview with ADON on 02/18/16 at 4:57 PM revealed that she had to reinsert the IV about 2 and a half hours after the initial insertion because it infiltrated. The only nursing progress notes which mentioned IV fluids being administered were: *On 02/04/16 at 12:01 noted as a late entry by the Social Worker as the responsible party (RP) was upset that Resident #1 was receiving IVs as the MOST form signed by the PA on admission stated no IVs; *On 02/04/16 at 9:30 PM by Nurse #7 who stated	F 514		

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F 514	Continued From page 19 the IV bag was due to be changed and was changed when the family left the room; *On 02/05/16 at 3:24 PM by the Director of Nursing (DON) who wrote the RP was upset and instructed staff to stop the IV. The Skilled Charting Observation Tools dated 02/03/16 at 2:57 PM written by Nurse #8, 02/03/16 Nights at 4:07 AM written by Nurse #1, 02/04/16 at 9:47 PM written by Nurse #7 did not address anything about IV fluids even though there was a section for documentation which addressed orders and IV fluids. The Skilled Charting Observation Tools dated 02/04/16 at 3:27 PM written by Nurse #8 and 02/05/16 at 11:00 AM noted IV fluids were being administered but did not indicate the amount infused. Interview with the DON on 02/19/16 at 2:57 PM revealed Resident #1 did receive IVs and the amount administered should have been captured in the narrative progress notes, on the MAR or on the Skilled Charting Observations Tool. She stated there were no flow records being used for IV documentation. The Administrator stated during interview on 02/19/16 at 5:23 PM she expected the MAR to reflect the amount of IV fluids Resident #1 was ordered and received and documentation of any problems with the IV insertion or delay in treatment. b. The Admission Data Collection tool dated 02/02/16 at 2:33 PM written by Nurse #6 indicated she had a 18 French indwelling urinary catheter which was draining clear amber urine on	F 514		

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F 514	Continued From page 20 admission. Physician orders dated 02/02/16 included a #18 French catheter with 10 cc balloon to straight drainage, leg strap to left thigh and catheter care every shift and as needed with soap and water. Another order dated 02/02/16 included to change the catheter every 30 days per standing orders. The Skilled Charting Observation Tool dated 02/03/16 at 2:57 PM written by Nurse #8 indicated Resident #1's catheter was patent and draining dark yellow urine with sediment. The Skilled Charting Observation Tool dated 02/03/16 at 4:07 AM (night) by Nurse #1 indicated pads/briefs were used and she had yellow urine. The Skilled Charting Observation Tool dated 02/04/16 at 3:57 PM by Nurse #8 noted the catheter was patent and draining, the color was "oliguria" (a diminished capacity to form and pass urine) and with sediment. A nursing progress note dated 02/04/16 at 9:30 PM written by Nurse #7 revealed when she entered Resident #1's room to give bedtime medications, Resident #1 was not responding to touch or verbal stimuli. Her oxygen level was not registering. Resident was receiving IV fluids at this time and the catheter bag was noted to have little output. The Skilled Charting Observation Tool dated 02/04/16 at 9:47 PM by Nurse #7 noted pads and briefs were used and her urine was yellow. Review of the 24 hour reports revealed no documentation was made on 02/03/16, 02/04/16 or on 02/05/16. The DON stated during interview	F 514		

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F 514	Continued From page 21 on 02/19/16 at 9:10 AM that the 24 reports were not required by staff to utilize. The Skilled Charting Observation Tool dated 02/05/16 at 11:00 AM by Nurse #4 patent catheter draining dark yellow urine with sediment. An interview with Nurse #4 on 02/19/16 at 10:00 AM revealed when she arrived to work at 7:00 AM on 02/05/16 she received report that Resident #1 was not doing well during the previous night and that they had replaced the catheter because there was no output, which resulted in little urinary output. She stated she had observed no output in the catheter drainage bag when she checked on her after receiving report from the night nurse. When checked around lunch time or a little after, Resident #1 still had no urine in her drainage bag. She stated she documented the Skilled Charting Observation Tool as her urine normally was but stated she did not have output during her shift. She knew she had decreased urine output over the previous night from report from the nurse. She stated that around 4:00 PM she decided to call the physician about the lack of output and he agreed to send her to the hospital. Review of the February 2016 Medication Administration Record (MAR) revealed the catheter was blocked off on 02/24/16 indicating it needed to be changed on 02/24/16. The MAR indicated catheter care was to be provided every shift starting 02/02/16 with a line for documentation during the 7A - 7P shift and another line for documentation of care to the catheter during the 7P - 7A shift. Review of this MAR revealed neither shift documented catheter care on 02/02/16 and there was no documentation at all for catheter care being provided for 7P- 7A shift on any day she was in	F 514		

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F 514	Continued From page 22 the facility, 02/02/16 through 02/05/16. No change of the catheter was noted being provided. Interview with the Medical Records Director on 02/18/16 at 4:31 PM revealed she had no way of capturing fluid input or output via the point click care system. Review of the Resident Transfer Form dated 02/05/16 with no time, the reason for transfer was no urinary output in greater than 16 hours. Interview with the Administrator on 02/19/16 at 5:23 PM revealed she expected documentation in the medical record reflecting catheter care being provided and documentation that the catheter was changed. She also stated there should be documentation of when Resident #1 showed signs of having little output and some form of tracking for urinary output.	F 514		