

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2016
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805		
(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 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have documentation in the medical record concerning the assessment and cause of hospitalization for 2 of 2 residents (Resident #7 and Resident #2) reviewed for hospitalization and failed to have documentation of a resident fall for 1 of 4 residents reviewed for falls (Resident #3).</p> <p>The findings included:</p> <p>1. Resident #7 was admitted to the facility on 03/11/16 with diagnoses of fractured right femur, history of falling and unsteadiness when walking.</p> <p>Review of the Orthopedic Physician progress note dated 03/25/16 revealed Resident #7's right hip fracture was healing well and a x-ray revealed right rib fractures that required no treatment at the time. Follow up in 4 to 6 weeks.</p>	F 514	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.</p> <p>F514</p> <p>Resident #7 has been discharged home. Resident successfully completed her course of therapy prior to discharge with no issues regarding accurate documentation. Resident #2 has been discharged from the facility. Prior to discharge, the resident had no issues regarding acute</p>	5/11/16	

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

TITLE

(X6) DATE

Electronically Signed

05/06/2016

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 514	Continued From page 1 Review of the nurse's notes for Resident #7 from 03/24/16 through 03/28/16 revealed the following: <ul style="list-style-type: none"> · 03/25/16 No changes in resident condition. · 03/26/16 No changes in resident condition. · 03/27/16 No changes in resident condition. · 03/28/16 5:30 AM no changes in resident condition. · 03/28/16 6:00 PM Resident #7 sent to emergency room this morning at 10:30 AM. Suspected interstitial crepitus, a presence of air or gas in the connective tissue. Resident #7 was admitted to the hospital. Review of the Physician progress note on 03/28/16 revealed Resident #7 was seen for management of rib fractures. Resident #7 apparently fell in the bathroom 3 days prior. Resident #7 was seen by her Orthopedic Surgeon on 03/25/16 and diagnosed with rib fractures on the right side. The facility physician was asked to see Resident #7 due to swelling of her arms. She had mild shortness of breath, denied significant pain of her ribs and she was afebrile. Denied cough. The assessment and plan were fracture of multiple ribs of the right side development of subcutaneous emphysema, presence of air or gas in the connective tissues, of both upper extremities. Referred Resident #7 to the emergency room urgently for treatment. Physician discussed care with Resident #7 as well as Emergency Management System (EMS) that transported her to the emergency room (ER). Review of the nurse's notes for Resident #7 revealed no indication of a fall or broken ribs on 03/25/16 and no change in condition leading to hospitalization for interstitial crepitus on 03/28/16.	F 514	documentation as to condition. All residents have the potential to be affected by the all the alleged deficient practice. Licensed nurses were re trained regarding expectation for documentation regarding acute conditions, transfers and acute episodes by the Director of Nursing on 4/27/16. Documentation in the medical record will be reviewed in the weekday clinical meeting by the Director of Nursing or designee to monitor for ongoing compliance with documentation of acute events, for 3 months and randomly thereafter. The Director of Nursing will present finding to the facility's Quality Assurance Committee monthly for 3 months for continued compliance. Additional training will be initiated for any identified concerns.		

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F 514	<p>Continued From page 2</p> <p>During an interview conducted on 04/21/16 at 1:48 PM Nurse #1 stated Resident #7's family member had taken her to see her Orthopedic Surgeon for a follow up on 03/25/16 and when they returned to the facility the family member informed her Resident #7 had 2 rib fractures. Nurse #1 stated the Orthopedic Surgeon did an x-ray due to Resident #7 complaining of shortness of breath and she told him she had a fall earlier that morning. Nurse #1 stated that was the first time she was made aware Resident #1 had a fall on 03/25/16. She stated she went to Resident #7's room and questioned her about the fall and was told she had tried to go to the bathroom unassisted about 4:30 AM and slid to the floor between her wheel chair and the commode. Resident #7 informed Nurse #1 the NA came in and assisted her back to the wheelchair and she did not have any complaints of pain. Nurse #1 stated she reported the fall to the Director of Nursing but did not document the fall in Resident #7's medical record. Nurse #1 stated she worked with Resident #7 again on 03/28/16 and when she went in to administer her morning medications she observed Resident #7 to have a large fluid filled pocket on the right side of her neck and edema in both arms. Nurse #1 stated the facility physician was in the building and assessed Resident #7 and sent her to the ER for interstitial crepitus. Nurse #1 stated she did not document her assessment of Resident #7 in the nurse's notes only that she was sent to the ER.</p> <p>During an interview on 04/21/16 at 2:00 PM the Director of Nursing stated it was her expectation for documentation to be in the nurse's notes relating to any acute resident episodes. She further stated Resident # 7's fall and symptoms</p>	F 514			

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F 514	<p>Continued From page 3</p> <p>leading to her hospitalization were acute episodes and should have been documented in the nurse's notes.</p> <p>2. Resident #2 was admitted to the facility on 02/12/16. His diagnoses included congestive heart failure, chronic obstructive pulmonary disease, diabetes, and renal disease.</p> <p>Review of the medical record revealed the following nursing notes: *On 02/18/16 at 6:41 AM a nursing note listed his vital signs as temperature 96.1 degrees Fahrenheit, blood pressure 130/70, heart rate 71 beats per minute, respiration 21, and pulse ox was 97 percent. He was alert and oriented. He was noted receiving oxygen at 3 liters per minute had productive cough, breath sounds noted wheezing in both left and right lungs, and he was short of breath lying, sitting and upon exertion. *On 02/18/16 at 5:12 PM a nursing note stated Resident #2 was noncompliant with drinking nectar liquids. *On 02/18/16 at 10:00 AM a nursing note stated his temperature was 98.2 degrees Fahrenheit, blood pressure was 128/76, respirations were 20, pulse ox was 93% and heart rate was 94 beats per minute. He was noted with diminished breath sounds in the left and right lungs, was short of breath upon exertion and received oxygen at 3 liters per minute.</p> <p>The physician progress notes dated 02/19/16 revealed the physician was asked to see the resident as the resident had been coughing and had yellow sputum. The resident was noted with</p>	F 514			

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F 514	<p>Continued From page 4</p> <p>increased wheezing. He was afebrile (no temperature) and denied any chest pains. The physician assessed him with acute bronchitis with plans for Albuterol treatments and titration of oxygen to keep saturation levels greater than 90 percent. He ordered the antibiotics Rocephin 1 milligram (mg) intramuscular now and Augmentin 875 mg by mouth twice a day for 10 days. He also ordered a chest Xray.</p> <p>The Xray results dated 02/19/16 received via fax to the facility at 2:30 PM noted borderline cardiac enlargement and aortic atherosclerosis, pulmonary venus congestion, and right lower lung infiltrate.</p> <p>The next and last nursing note was dated 02/19/16 at 8:14 PM which noted he had left and right lung crackles, a productive cough with frothy white sputum. His Xray was noted positive for upper respiratory infection and he had a temperature of 100.4 degrees Fahrenheit.</p> <p>Review of the Minimum Data Set tracking system revealed he was unexpectedly discharged from the facility to the hospital on 02/20/16 with return anticipated.</p> <p>Review of the medical record revealed there was no documentation that indicated any changes or reason for the hospitalization after the antibiotics were started.</p> <p>Review of the hospital history and physical dated 02/20/16 noted the resident had been sent to the hospital "over concern of increased lower extremity and facial edema." The resident denied any shortness of breath, had intermittent cough, was noted with shallow respirations and</p>	F 514			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 5</p> <p>diminished rales in breath sounds. He also was noted with 3 plus bilateral lower extremity edema. He was subsequently admitted to the hospital.</p> <p>Interview with the Director of Nursing (DON) on 04/21/16 at 1:56 PM revealed her expectation was that there would be documentation in the nursing notes relating to any acute episodes. She further stated that she could not find any information in the medical record relating to his hospitalization, which she considered an acute episode. The DON stated that the 24 hour sheets filled out by nursing noted he was hospitalized but that this was not part of the medical record.</p> <p>3. Resident #3 was admitted to the facility on 03/30/16. Her diagnoses included gastrointestinal bleed secondary to diverticulitis and left side hemiparesis due to a history of cerebral vascular accident.</p> <p>Review of nursing notes included entries dated 04/04/16 at 10:20 AM, 04/05/16 at 3:54 AM, 04/05/16 at 10:37 AM, 04/06/16 at 3:23 AM and 04/06/16 at 10:03 AM.</p> <p>Review of the incident log revealed Resident #3 fell on 04/05/16. Review of the incident report revealed on 04/05/16 at 8:40 PM, a nurse aide witnessed the resident slide to the floor. She received no injury.</p> <p>The admission Minimum Data Set (MDS) dated 04/06/16 noted Resident #3 had intact cognition, exhibited no behaviors, and required extensive assistance with most activities of daily living skills including bed mobility, transfers and ambulation. This MDS also noted she had one fall with no injury.</p>	F 514			

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F 514	Continued From page 6 Resident #3 was interviewed on 04/20/16 at 3:12 PM. Resident #3 stated that she slid out of her wheelchair. A staff member was in the room, however could not prevent the resident from falling to the floor. The staff member assisted her back to her wheelchair and she was not injured. Review of the medical record revealed there was no mention that the resident had fallen or any assessment of her condition at the time of the fall. On 04/21/16 at 1:57 PM, The Director of Nursing (DON) revealed her expectation was that there would be documentation in the nursing notes relating to any acute episodes. She further stated that she could not find any information in the medical record relating to Resident #3's fall which she considered an acute episode. The DON stated there was mention of the fall in the nurse to nurse reports, however this was not part of the medical record.	F 514			