STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility failed to recognize an acute change in condition, gastrointestinal (GI) bleed, when bleeding was first identified for 1 of 1 resident (resident #1) reviewed for GI bleeding. The findings included: Resident #1 was re-admitted to the facility on 2/11/2016 with diagnoses to included history of gastrointestinal (GI) hemorrhage, ileostomy, stroke, end stage renal disease, and cognitive function decline. A review of medical center discharge summary dated 3/26/2015 revealed a hospital stay for 10 days for hemorrhagic shock. Had lower GI bleed requiring more than 4 units of blood in 24 hours, intensive care unit and on 3/19/2015 a total abdominal colectomy with end ileostomy (removal of colon with ileostomy site for waste collection). Her quarterly Minimum Data Set (MDS) assessment dated 4/19/2016, revealed she had severe cognitive impairment, and required extensive to total assistance for activities of daily living (ADLs). She was always incontinent of bladder and had an ostomy site for bowel. A review of the medical transport document dated 5/14/2016, listed Resident #1 as Patient and as	F 309	8) F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL-BEING River Trace Resident # 1 is no longer a resident of this facility. 100% audit of all residents' progress notes for all current residents was conducted and completed by the Director of Nursing on 5/16/16 for the past 30 days to identify any change in resident condition, to include fatigue, vomiting, and signs and symptoms of GI bleed to ensure if any change was noted that resident was properly assessed timely with MD and RP notification. No concerns were identified during the audit. All licensed nurses to include Nurse #1 were re-educated by the Director of Nursing beginning 6/3/16 regarding the need to conduct a timely thorough assessment for any resident with a noted change in condition to include fatigue, vomiting, and signs and symptoms of GI	6/17/16

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

Electronically Signed | 06/03/2016

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F 309	Continued From page 1 Departure Time 4:28 PM and the Time of Pick-up 4:36 PM. The Departure time from the facility to the hospital was 4:45 PM. A review of emergency department (ER) record dated 5/14/2016, revealed the physician observed resident #1 unresponsive with coffee ground emesis on her chest, face and on the bed. The resident did not have a pulse and cardiopulmonary resuscitation (CPR) was started immediately. The resident was resuscitated twice and was declared dead at 6:53 PM. On 5/19/2016 at 8:37 AM, an interview was conducted with nursing assistant, (NA #1), who stated she had cared for resident #1 on 5/14/2016, the day she went to the hospital. The NA stated the resident would not eat any breakfast, and when she gave her bath, sometime after breakfast, she had a little blood in her colostomy bag. The NA indicated she went to tell the nurse, but couldn't find her at that time. The NA stated she saw nurse #1 before lunch and told her the resident had some blood in the colostomy bag and was spitting up brown stuff. The NA stated the resident's family came in before lunch and she asked the family if they wanted to feed her lunch, as she had refused to eat any breakfast. The family said she would feed the resident lunch. The NA stated the resident did not eat any lunch. The NA indicated the resident threw up about 4 or 5 times and each time it covered the corner area of the emesis basin. Nurse #1 told NA #1 not to empty the emesis basin one time, because the supervisor needed to check if it was blood. On 5/18/2016 at 4:26 PM, an interview was conducted with the family of resident #1. The family stated she was in the facility right before lunch on 5/14/2016 and the resident was complaining of her stomach hurting. The family	F 309	bleed, physician notification, initiate appropriate treatment as indicated, and document in the clinical record. All licensed nurses to include Nurse #1 were also re-educated by the Director of Nursing on 6/3/16 regarding signs and symptom of GI bleed. 100% of all nursing assistants to include NA #1 were re-educated by the Director of Nursing beginning on 6/3/16 regarding observation and timely reporting any change in condition to include fatigue and vomiting to the licensed nurse. All newly hired licensed nurses will be in-serviced regarding the need to conduct a timely thorough assessment for any resident with a noted change in condition to include fatigue, vomiting, and signs and symptoms of GI bleed, physician notification, initiate appropriate treatment as indicated, and document in the clinical record, and signs and symptoms of GI bleed during orientation by the staff facilitator. All newly hired certified nursing assistants will be in-serviced regarding observation and timely reporting any change in condition to include fatigue and vomiting to the licensed nurse by the staff facilitator during orientation. The Director of Nursing will complete audits of all residents' progress notes to ensure any change in resident condition, to include fatigue, vomiting, and signs and symptoms of GI bleed, to ensure the acute change in condition was appropriately assessed timely, physician and resident representative notified, and appropriate treatment initiated as	

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F 309	Continued From page 2 member told the nurse the resident needed a pain pill, and the nurse told her the resident had refused her morning medicines. The family member indicated she coaxed the resident to take the pain pill and then the resident threw up some black stuff, which the family member thought was blood. The family member stayed with the resident for a while, but she wouldn't eat her lunch. The family member stated she had to leave at some point and was uncertain how much more she had vomited because she wasn't at the facility. She stated the supervisor called her and said they were sending the resident to the hospital. An interview was conducted with Nurse #1 on 5/18/2016 at 3:31 PM. The nurse stated resident #1 wasn't herself on 5/14/2016, and was more fatigued, and was spitting up tea. The resident's family came in right after she ate lunch, and told the nurse the resident was having pain. The nurse gave resident #1 a pain pill, but she threw it right back up with more brown colored liquid. The nurse indicated the resident spit up about 4 times and the vomitus was not measured. The nurse stated she did an occult test on the vomitus for blood and it was positive, so she told the weekend supervisor, and the resident was sent out. She indicated she did not know if she vomited after that, because she was busy getting her ready to send out. On 5/19/2016 at 1:40 PM, a second interview was conducted with nurse #1. The nurse stated she forgot to chart when the pain pill was given, but she knew it was after lunch, because the resident was spitting up her tea. She stated the aide had told her the resident was spitting up. The nurse stated the resident had verbalized her stomach pain when the family member was at the bedside, but the resident did not have enough cognitive	F 309	indicated, 5 x per week x 4 weeks then twice weekly x 4 weeks, then weekly x 4 weeks using a Change in Condition QI Monitoring Tool. The Director of Nursing will address any identified areas of concern immediately by assessing the resident and MD and RP made aware of findings with appropriate treatment put in place as indicated and retraining with the licensed nurse. The Administrator will review and initial the Change in Condition QI Monitoring Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all identified areas of concern were addressed. The results of the Change in Condition QI Monitoring Tool will be compiled by the Administrator and presented to the Quality Improvement Committee monthly x 3 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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function to classify the pain on a pain scale. The nurse stated she did not listen for bowel sounds or assess the resident's abdomen for firmness. The nurse indicated after a while, she realized there was too much spit up for it to be tea, and she went to the weekend supervisor and told her. The supervisor got the items needed for the nurse to check for blood and the nurse performed the test 2 times on the resident's vomitus and then reported back to the supervisor and was told she needed to send her out.

Immediately following the interview, the nurse retrieved the sign-out sheet for the narcotic pain pill and had documented 12:30 PM on 5/14/2016 as the time she signed out the pain pill for the resident.

An interview was conducted on 5/19/2016 at 12:30 PM with the weekend supervisor. The supervisor stated nurse #1 had come to tell her the resident was vomiting brown stuff at about 4:30 PM on 5/14/2016. She told nurse #1 to check to see if it was blood with an occult test, and shortly after nurse #1 brought her the results and it was positive for blood. The supervisor stated she then called the on call doctor and received an order to send the resident to the hospital. The supervisor stated she saw the resident, who was alert but confused, at that time. The supervisor indicated the transport arrived very shortly after that and the resident was taken to the hospital sometime about 5:00 PM that afternoon.

On 5/19/2016 at 2:10 PM, an interview was conducted with the Nurse Practitioner (NP) for the facility. The NP stated the time frame of giving the resident a pain pill with vomiting brown stuff at 12:30 PM until notifying the supervisor after 4:00 PM, was a reasonable time frame to wait. She indicated the resident was known to her and

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F 309	Continued From page 4 waiting to see if the vomiting got worse was reasonable to her. On 5/26/2016 at 11:38 PM, an interview was conducted with the ER physician. The physician stated she would have expected the facility to send the resident to the hospital as soon as the brown emesis was noticed. However, she could not make a determination if the resident had been sent to the hospital sooner would have changed the outcome, since the resident had multiple on going disease processes.	F 309		