STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HILLCREST RALEIGH AT CRABTREE VALLEY	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

(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 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interviews for one (Resident # 1) out of 10 sampled residents, the facility failed to implement	F 226	This plan of correction constitutes Hillcrest Raleigh at Crabtree Valley's written allegation of compliance for the	6/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/25/2017

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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policies and complete a thorough investigation and file a 24 hour and five day report to the state health care personnel investigation agency when they received a detailed letter from a family member stating Resident # 1 had been subjected to terrible, inexcusable, and unnecessary pain.
The findings included:

On 5/10/17 the administrator provided the facility's current policies related to identification and investigation of neglect. Review of the policy revealed passive neglect was defined as "unintentionally harming a person by physically, emotionally or mentally failing to provide needed care." According to the policy all allegations of neglect would be thoroughly and promptly investigated by facility management. The policy further stated the administrator would provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency, the local police department, the ombudsman, and others as may be required by state or local laws within 5 working days of the reported incident." Interview with the facility administrator on 5/10/17 at 12:16 PM revealed allegations and investigations of neglect are also filed with the state survey and certification agency, and an initial report is sent by her within 24 hours.

Record review revealed Resident # 1 resided at the facility from 1/12/17 until the date of his death on 1/20/17. According to the resident's hospital discharge summary, dated 1/12/17, the resident had undergone hip surgery on 1/4/17 and following the procedure had required an indwelling catheter secondary to urinary retention. According to the record the resident also had a diagnosis of mild dementia.

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deficiencies cited. However, submission of the 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 226]

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

A 24 hour and 5 day report regarding the allegations addressed in the survey will be submitted to the State Health Care Personnel investigation Agency. Specific actions regarding Resident #1 cannot be taken because Resident #1 died on January 20, 2017.

Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice.

The administrator/designee audited grievance logs from the last six months to determine if there were other allegations of abuse or neglect that had been reported and not investigated. No other allegations were found.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;

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Review of the facility's "admission evaluation and interim care plan," dated 1/12/17, revealed the resident was documented as having a size 16 French indwelling catheter in place. There were no care plan interventions or physician orders to clamp the resident's catheter during his facility residency.

Review of facility physician orders revealed there were multiple telephone orders obtained on 1/18/17 regarding the resident's care. Three of the orders were for a U/A and C& S (urine analysis and culture and sensitivity) to be obtained; IV (intravenous fluids) to be started; and for the resident to have a "now" dose of Lasix 20 milligrams. There were no documented times the orders were received.

There was no documentation in the resident's nursing notes noting the time or method used to obtain the urine specimen. A review of Resident # 1's urine lab result revealed a "draw date" and time of 1/18/17 at 1:05 PM.

A review of Resident # 1's January 2017 MAR (medication administration record) revealed the resident was documented as receiving 20 mg (milligrams) of Lasix at 2 PM on 1/18/17. According to this same MAR the resident was documented as having the IV started on the 7AM-3PM shift of 1/18/17. There was no specific time documented for the IV start time.

Nurse # 2 was the 7-3 supervisor on 1/18/17. Nurse # 2 was interviewed on 5/8/17 at 3:45 PM. Nurse # 2 stated Resident # 1 began not doing well during the dayshift of 1/18/17. Nurse # 2 stated the resident was more lethargic and

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Random audits of grievance logs will be performed to ensure policy and procedures are followed relating to reporting of abuse/neglect. Audits will be performed 5x weekly for 1 week, then 3x weekly for 3 weeks, and then bi-weekly for 2 months. If issues are identified, an investigation will be done to determine the cause of issues and additional in-servicing will be completed as necessary.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting and evaluated for effectiveness. The Quality Assurance Committee will also review the results of the audits and consider whether additional steps need to be taken based on the audit results.

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congested. Nurse # 2 stated the physician had been contacted for new orders on 1/18/17 and the urine specimen order was one of the new orders received. Nurse # 2 stated the urine specimen had been obtained by Nurse # 1, and this had been reported to the resident's 3P-11PM Nurse (Nurse # 3) at 3 PM shift change.

Nurse # 1 was the 7AM -3PM nurse who had cared for Resident # 1 on 1/18/17. Nurse # 1 was interviewed on 5/8/17 at 3:55 PM. Nurse # 1 stated on 1/18/17 she had obtained the urine specimen around "tenish or elevenish." The nurse stated she had not clamped the catheter in order to obtain the specimen, but had instead changed the entire drainage bag and obtained the specimen from the new bag.

Review of the record revealed no nursing notes by Nurse # 3 for the 3-11PM shift on 1/18/17. Record review revealed no additional orders for a second urine specimen were given during the 3P-11 PM shift of 1/18/17.

A review of Resident # 1's January 2017 MAR revealed Nurse # 3 documented she administered 5 mg (milligrams) of Morphine SL (sublingual) to Resident # 1 on 1/18/17 at 6:30 PM and 9:15 PM per a PRN (as needed) order located on the resident's MAR. There was no reason documented on the back of the MAR by Nurse # 3 for the reason the PRN morphine was given.

Interview with the DON (Director of Nursing) on 5/8/17 at 10 AM revealed Nurse # 3 was no longer an employee of the facility. Nurse # 3 could not be reached for interview during the survey.

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Nurse # 4 was interviewed on 5/8/17 at 11:50 AM. Nurse # 4 stated the resident's family member had come to get her between 12 midnight and 12:30 AM on 1/19/17 because of the resident's pain. The nurse stated she knew a urine specimen had been obtained on 1/18/17 and therefore she checked the resident's catheter to determine if the catheter was pulling and causing problems. The nurse stated she found the catheter to be clamped, and therefore she unclamped it. The nurse stated the resident had been mildly distended and she got a urine return of 200 cc (cubic centimeters). The nurse was interviewed regarding why the catheter had been clamped and not open to drainage. Nurse # 4 stated Nurse # 3 had told her in report that she had clamped it around 9 PM to get a urine specimen. Nurse # 4 was not aware of a second urine specimen order on 1/18/17 or a reason why Nurse # 3 should have clamped the catheter.

The resident's RP (responsible party) was interviewed on 5/6/17 at 1:34 PM. This interview revealed the responsible party had been with Resident # 1 most of the day on 1/18/17. The RP stated as the afternoon of 1/18/17 progressed in time, Resident # 1 began experiencing more and more pain. The RP stated he would say he felt like his insides were splitting open. The RP stated the pain became excruciating and the nurses gave him all the pain medication that they could. The RP stated the night nurse, who had come on duty at 11 PM on 1/18/17, found Resident # 1's catheter to be clamped. It was the RP's understanding that the catheter had not been draining since the urine specimen had been obtained earlier in the morning of 1/18/17. The RP stated the nurses had just seemed too busy

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to pick up on what was going wrong with Resident # 1, and therefore they had not picked up on the fact that his catheter was clamped and causing pain. The RP stated she had written a letter following the incident to the administrator, the DON, social worker, and rehabilitation director expressing her concerns about the incident and his overall care. The RP stated she never heard from the DON or administrator or was asked any further questions about the incident she reported.

The surveyor was provided a copy of the letter sent by Resident # 1's RP to the administrative staff. The letter was dated February 20th, 2017 and contained the following statements in regards to the resident's catheter being found clamped: "Wednesday evening and into the night up until the shift change, he became more and more uncomfortable to the point that from probably 8 until 11 PM I had to ask several times for additional pain meds for him. He was screaming, cursing, saying he felt like he was being ripped in two. The staff checked on him after I would go and find them and gave him as much medicine as they said they could. After the shift changed, a fresh staff member discovered that his catheter had been clamped since the urine sample had been taken that morning. The bag had not been checked so no one had realized that no fluid was entering it. It was all backing up into his body. In addition to all he was dealing with, he was subjected to terrible, unnecessary and inexcusable pain."

During an interview with the DON on 5/8/17 at 1:45 PM, the DON acknowledged the facility had received the letter with the statement as written above. The DON was interviewed in regards to their investigation into the incident. The DON

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stated she had talked to the night nurse who had confirmed the resident's catheter had been found clamped on night shift following the urine specimen being obtained on dayshift of 1/18/17. The DON stated the night nurse (Nurse #4) had reported that the evening shift nurse (Nurse #3) had clamped the catheter around 9 PM. Interview with the DON revealed she was aware there was no order or reason to have clamped the catheter on the evening of 3PM -11PM on 1/18/17. The DON confirmed Nurse # 3 was an employee in February 2017 when the letter was received by the facility, but the DON had not interviewed the nurse about the events of the resident's care. The DON was not able to provide written evidence of a thorough investigation into the incident to show the facility had tried to determine why and when the catheter had been clamped; the length of time it had been clamped; and if the resident had unnecessary pain as the RP alleged due to the staff's failure to assess the resident and find the error.

The administrator was interviewed on 5/10/17 at 12:16 PM. The administrator acknowledged she had received a letter from the resident's family member. The administrator stated she had read the paragraph related to the catheter being found clamped and which stated the resident had been in pain. Interview with the administrator revealed she had not perceived the letter to imply the resident had potentially been neglected and thus had not implemented the facility's neglect investigation policy. The facility administrator was not able to provide evidence of a written investigation into the incident and that the facility had filed a 24 hour and five day report with the state survey agency.

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F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interviews for one (Resident # 1) out of 10 sampled residents the facility failed to assure it followed professional standards of practice in administering and documenting a controlled substance. The findings included: Record review revealed Resident # 1 resided at the facility from 1/12/17 until the date of his death on 1/20/17. According to the resident's hospital discharge summary, dated 1/12/17, the resident had undergone hip surgery on 1/4/17 and was transferred to the facility for rehabilitation. Review of the record revealed a nursing entry on 1/18/17 at 4 PM noting that the resident was experiencing lethargy and low oxygen levels. The nurse further noted the resident's RP (responsible party) was present and wished for the resident not to be hospitalized, but to be kept comfortable at the facility. Review of physician orders revealed, on 1/19/17, Nurse # 1 received an order for one tablet of Ativan 0.5 mg (milligrams) every six hours by mouth PRN (as needed) for anxiety. There was a	F 281	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the 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 281] Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Specific actions regarding Resident #1 cannot be taken because Resident #1 died on January 20, 2017. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. The DON/designee audited charts of	6/8/17

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place on the physician order for the nurse to note the time the order was received. It was blank.

Review of the resident's January 2017 MAR (medication administration record) revealed the order for Ativan 0.5 mg every six hours PRN was transcribed to the MAR on 1/19/17. By this PRN Ativan 0.5 mg order, there was documentation it was administered one time. This was documented by Nurse # 1 at 7:40 AM on 1/19/17.

The records for the facility's back up emergency controlled substance medications were reviewed. This review revealed an Ativan 0.5 mg tablet was signed out by Nurse # 1 from the back up storage four times on 1/19/17 for Resident # 1. These times were at 7:47 AM; 8:24 AM; 1:12 PM and 1:17 PM.

A review of Resident # 1's Ativan controlled medication utilization record was done. According to the record the pharmacy filled 30 doses of 0.5 mg Ativan on 1/19/17. There were two tablets which were signed out from this individual supply of Resident # 1's Ativan. This was by Nurse # 5 on 1/20/17 at 12 AM. Nurse # 5 signed out two doses at this one time.

A pharmacist, who works for the facility's pharmacy, was interviewed on 5/8/17 at 12:15 PM. The pharmacist verified that their records showed Nurse # 1 had signed out Ativan 0.5 mg on 1/19/17 at 7:47 AM; 8:24 AM; 1:12 PM and 1:17 PM from the emergency back- up supply located at the facility for Resident # 1. The pharmacist stated they had received the Ativan order for Resident # 1 at 8:10 AM on 1/19/17 and they sent the resident's personal supply of Ativan 0.5 mg on 1/19/17 at 8:30 PM. The pharmacist

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current residents with orders for Ativan to ensure documentation of order times were accurately documented. All nurses, including Nurse #1, were educated on policy and procedures relating to documentation of telephone orders, including time and date, and narcotic administration and documentation and the importance of accurate documentation.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;

Random audits of resident charts with orders for narcotics will be performed to ensure clarity of time, dates, and charting of medications. Audits will be performed 5x weekly for 5 weeks, then 3x weekly for 3 weeks, and then bi-weekly for 2 months. If issues are identified, an investigation will be done to determine the cause of issues and additional in-servicing will be completed as necessary.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting and evaluated for effectiveness. The Quality Assurance Committee will also review the results of the audits and consider whether additional steps need to be taken based on the audit results.

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stated the records showed the facility signed as receiving the resident's individual supply on 1/19/17 at 11:30 PM.

A review of the above records revealed therefore a total of 6 doses of Ativan 0.5 mg had been signed out by nurses for Resident # 1. As noted above, four were from the emergency kit and two were from his personal supply filled on 1/19/17. This review showed that nurses signed for the total removal of 3 mg of Ativan for Resident # 1.

Record review revealed Nurse # 1 obtained a second order on 1/20/17 to change the resident's Ativan dosage to a 1 mg tablet and administer it on a scheduled basis of every six hours. There was a place on the physician order for the nurse to note the time the order was received on 1/20/17. It was blank.

Review of the nursing notes revealed Resident # 1 expired on 1/20/17 at 10:30 AM.
Review of Resident # 1's January 2017 MAR revealed nurses documented they administered 1 mg of Ativan to Resident # 1 on 1/20/17 at 2 AM and 8 AM. They also continued to document they administered it after his death at the following times: 2 PM and 8 PM.

On 5/11/17 at 10:45 AM Nurse # 1 was interviewed. Nurse # 1 stated she had dated the Ativan 1 mg order wrong. Nurse # 1 stated the order for Ativan 1 mg every six hours was received on 1/19/17 when the physician was making rounds around 8 AM. The nurse stated it had been decided that Resident # 1 would receive comfort measures because he was not doing well, and the physician had changed the original PRN order to a scheduled dose at a

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F 281	Continued From page 10 greater dosage because the resident was anxious and nervous. The nurse verified the resident should have gotten 1 mg of Ativan on a routine schedule of every six hours following the date and time of 1/19/17 at 8 AM. The nurse stated she also transcribed the order wrong on the MAR. The nurse stated she had in error drawn lines through the date of 1/19/17 on the MAR, and placed the order to start on the MAR on 1/20/17. The nurse stated all her signatures on the MAR for the administration of 1 mg of Ativan on 1/20/17 were actually for 1/19/17. According to the nurse she pulled the first dose of Ativan 0.5 mg at 7:47 AM and then the physician decided to soon change the order. Therefore she pulled the second 0.5 mg tablet from the emergency kit at 8:24 AM to equal the full 1 mg dosage. The nurse stated she pulled the 0.5 mg Ativan from the emergency kit at 1:12 PM and 1:17 PM on 1/19/17 in order to give the resident his 2 PM scheduled dose. The nurse stated the order had been faxed to the pharmacy and she did not recall if she had called to inform the pharmacy the 8 PM dose would be needed. According to an administrative nurse staff member interview on 5/11/17 at 9:30 AM, there were no Ativan doses left in the emergency kit on 1/19/17 after Nurse # 1 removed the 0.5 mg tablet of Ativan at 1:17 PM. The administrative nurse stated the resident would have been due for his 8 PM dose on 1/19/17 by Nurse # 3. The administrative nurse stated Nurse # 3's initials were by the 8 PM dose signed on the MAR on 1/20/17 at 8 PM when the resident was deceased. The administrative nurse stated she did not how the nurse could have administered it on 1/19/17 at 8 PM when it was due because the emergency supply was depleted and his personal	F 281		

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supply had not been sent from the pharmacy.

Interview with the DON (Director of Nursing) on 5/8/17 at 10 AM revealed Nurse # 3 was no longer an employee of the facility. Nurse # 3 could not be reached for interview during the survey.

Interview with Resident # 1's RP (responsible party) on 5/6/17 at 1:34 PM revealed she was present on the evening of 1/19/17 and the resident was anxious, hurting, and could not rest well. The RP stated the Ativan was not readily available when it was needed for administration.

According to the controlled substance records there had been only one time the resident had received a dosage of Ativan following 1/19/17 at 1:17 PM. As noted above this was at 1/20/17 at 12 AM. According to the interview with the administrative nurse on 5/11/17 at 9:30 AM, the resident was on the six hour schedule of 8 AM; 2 PM; 8 PM and 2 AM. The administrative nurse stated she did not know why Nurse # 5 signed out for the Ativan at 12 midnight on 1/20/17 and signed on the MAR at 2 AM. The administrative nurse stated she also did not know why the Ativan was never given again after 12 AM on 1/20/17. According to the administrative nurse, Nurse # 5 was not available for interview during the survey. The administrative nurse stated Nurse # 6 was the nurse who had cared for the resident on 1/20/17 when the dose would have been due at 8 AM. The administrative nurse stated since the order had not been transcribed correctly, and nurses had signed for doses on the 20th which were given on the 19th, this left no where for Nurse # 6 to sign on 1/20/17 at 8 AM. The administrative nurse stated there was no

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F 281	Continued From page 12 indication the medication was given by looking at the MAR or the controlled substance records. The administrative nurse stated the resident soon passed away on 1/20/17 and he may have not been able to take the medication or needed it, but the administrative nurse stated Nurse # 6 should have indicated this on the resident's record. According to the administrative nurse interview, Nurse # 6 was no longer an employee and was not available for interview. It was confirmed with the administrative nurse that the total amount of Ativan signed out for Resident # 3 from the facility was a total of 3 mg. According to the above interviews, the resident should have received 1 mg on a six hour schedule beginning on 1/19/17 at 8 AM. Thus this would have equated to a total of 5 mg the resident should have received from the start of the order until his death. There was no documentation to explain the discrepancies between the ordered amount of Ativan and the amount the controlled narcotic records showed Resident # 1 received.	F 281		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 315		6/8/17

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F 315	Continued From page 13 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interviews, for one (Resident # 1) out of three residents with an indwelling catheter, the facility staff failed to assure the catheter remained open to drainage. The findings included: Record review revealed Resident # 1 resided at the facility from 1/12/17 until the date of his death on 1/20/17. According to the resident's hospital discharge summary, dated 1/12/17, the resident had undergone hip surgery on 1/4/17 and following the procedure had required an indwelling catheter secondary to urinary retention.	F 315	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the 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 315] Address how corrective action will be	

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According to the record the resident also had a diagnosis of mild dementia.

Review of the facility's "admission evaluation and interim care plan," dated 1/12/17, revealed the resident was documented as having a size 16 French indwelling catheter in place. There were no care plan interventions or physician orders to clamp the resident's catheter during his facility residency.

Review of facility physician orders revealed there were multiple telephone orders obtained on 1/18/17 regarding the resident's care. Three of the orders were for a U/A and C& S (urine analysis and culture and sensitivity) to be obtained; IV (intravenous fluids) to be started; and for the resident to have a "now" dose of Lasix 20 milligrams. There were no documented times the orders were received.

There was no documentation in the resident's nursing notes noting the time or method used to obtain the urine specimen. A review of Resident # 1's urine lab result revealed a "draw date" and time of 1/18/17 at 1:05 PM.

A review of Resident # 1's January 2017 MAR (medication administration record) revealed the resident was documented as receiving 20 mg (milligrams) of Lasix at 2 PM on 1/18/17. According to this same MAR the resident was documented as having the IV started on the 7AM-3PM shift of 1/18/17. There was no specific time documented for the IV start time.

Nurse # 2 was the 7-3 supervisor on 1/18/17. Nurse # 2 was interviewed on 5/8/17 at 3:45 PM. Nurse # 2 stated Resident # 1 started not doing

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accomplished for those residents found to have been affected by the deficient practice;

Resident #1's catheter had been unclamped, opening it for drainage between 12 midnight and 12:30 am on January 19, 2017. Further specific actions regarding Resident #1 cannot be taken because Resident #1 died on January 20, 2017.

Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice.

The DON/designee checked all current patients with a foley catheter to ensure patient's foley catheters were not clamped, were properly secured and had privacy bags. Audit included checking for input/output sheets in place on all patients with foley catheters. In-services conducted on how to obtain a urine sample from a closed drainage system.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;

Weekly for 5 weeks, audits of foley catheters will be conducted to ensure catheters are open to drainage, input/output sheets are completed, leg straps and privacy bags are in place. If issues are identified an investigation will be done to determine cause of issues and

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F 315	Continued From page 15 well during the dayshift of 1/18/17. Nurse # 2 stated the resident was more lethargic and congested. Nurse # 2 stated the physician had been contacted for new orders on 1/18/17 and the urine specimen order was one of the new orders received. Nurse # 2 stated the urine specimen had been obtained by Nurse # 1, and this had been reported to the resident's 3P-11PM nurse (Nurse # 3) at 3 PM shift change. Nurse # 1 was the 7AM -3PM nurse who had cared for Resident # 1 on 1/18/17. Nurse # 1 was interviewed on 5/8/17 at 3:55 PM. Nurse # 1 stated on 1/18/17 she had obtained the urine specimen around "tenish or elevenish." The nurse stated she had not clamped the catheter in order to obtain the specimen, but had instead changed the entire drainage bag and obtained the specimen from the new bag. Review of the record revealed no nursing notes by Nurse # 3 for the 3-11 shift on 1/18/17. Record review revealed no additional orders for a second urine specimen were given during the 3P-11 PM shift of 1/18/17. A review of Resident # 1's January 2017 MAR revealed Nurse # 3 documented she administered 5 mg of Morphine SL (sublingual) to Resident # 1 on 1/18/17 at 6:30 PM and 9:15 PM per a PRN (as needed) order located on the resident's MAR. There was no reason documented on the back of the MAR by Nurse # 3 for the reason the PRN morphine was given. Interview with the DON (Director of Nursing) on 5/8/17 at 10 AM revealed Nurse # 3 was no longer an employee of the facility. Nurse # 3 could not be reached for interview during the	F 315	additional in-servicing will be completed as necessary. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting and evaluated for effectiveness. The Quality Assurance Committee will also review the results of the audits and consider whether additional steps need to be taken based on the audit results.	

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survey.

An interview was held with Resident # 1's RP (responsible party) on 5/6/17 at 1:34 PM. This interview revealed the family member had been with Resident # 1 most of the day on 1/18/17. The RP stated as the afternoon of 1/18/17 progressed in time, Resident # 1 began experiencing more and more pain. The RP stated he would say he felt like his insides were splitting open. The RP stated the pain became excruciating and the nurses gave him all the pain medication that they could. The RP stated the night nurse, who had come on duty at 11 PM on 1/18/17, found Resident # 1's catheter to be clamped. It was the RP's understanding that the catheter had not been draining since the urine specimen had been obtained earlier in the morning of 1/18/17. The RP stated the night nurse unclamped it when she found it to be clamped. The RP expressed concern that the resident was receiving continuous IV fluids while the catheter had been clamped. The RP stated the first nurse to check the resident's catheter during the time that his pain was intensifying was the 11PM to 7 AM nurse.

Nurse # 4 was the nurse who had cared for Resident # 1 on the 11 PM to 7 AM shift, which began on 1/18/17. Review of Nurse # 4's nursing notes revealed an entry dated 1/19/17 at 1 AM noting Resident # 1's family member had reported that the resident was having abdominal pain. Nurse # 4 documented she gave the resident morphine which had been ineffective. Nurse # 4 noted the resident became more restless and talkative, and he was repositioned and offered fluids. The nurse documented she held the residents hand until he became more

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calm.

Nurse # 4 was interviewed on 5/8/17 at 11:50 AM. Nurse # 4 stated the resident's family member had come to get her between 12 midnight and 12:30 AM on 1/19/17 because of the resident's pain. The nurse stated she knew a urine specimen had been obtained on 1/18/17 and therefore she checked the resident's catheter to determine if the catheter was pulling and causing problems. The nurse stated she found the catheter to be clamped, and therefore she unclamped it. The nurse stated she had found the resident to be mildly distended and she got a urine return of 200 cc (cubic centimeters) when she unclamped the catheter. Interview with the nurse revealed the resident was having generalized pain, and the pain had not been localized just to his abdomen when she found the catheter clamped. The nurse was interviewed regarding why the catheter had been clamped and not open to drainage. Nurse # 4 stated Nurse # 3 had told her in report that she had clamped it around 9 PM to get a urine specimen. Nurse # 4 was not aware of a second urine specimen order on 1/18/17 or a reason why Nurse # 3 should have clamped it.

The DON was interviewed on 5/8/17 at 1:45 PM. The DON stated she had received a letter from Resident # 1's family member in February 2017 and within the letter the family member wrote that the resident's catheter had been found clamped on the night shift after a urine specimen had been obtained on dayshift of 1/18/17. The DON stated, following the receipt of the letter, she had talked with Nurse # 4 and had confirmed the catheter had been found clamped. The DON stated there was no reason or order the catheter should have

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F 315	Continued From page 18 been found clamped on 1/19/17. Interview with the DON revealed she had not spoken to Nurse # 3 about the catheter being found clamped nor determined the reason why it had been so.	F 315		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 514		6/8/17

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F 514	Continued From page 19 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure medication orders and medication administration records were accurate and complete for one (Resident # 1) out of ten sampled residents. The findings included: Record review revealed Resident # 1 resided at the facility from 1/12/17 until the date of his death on 1/20/17. a. Review of the record revealed a nursing entry on 1/18/17 at 4 PM noting that the resident was experiencing lethargy and low oxygen levels. The nurse further noted the resident's RP (responsible party) was present and wished for the resident not to be hospitalized, but to be kept comfortable at the facility. Record review revealed a physician's order on 1/18/17 to take .25 ml (milliliters) of morphine 20 mg (milligrams)/ ml sublingually as needed every two hours for pain. This would equate to 5 mg of morphine. Review of the record revealed on 1/20/17, Nurse # 1 received a physician's order to administer 0.5 mg of morphine 20mg/ml every two hours on a schedule of every two hours. There was a place on the order form where a time was to be noted. It was blank. Review of the resident's morphine controlled medication utilization records revealed the nurses starting signing as removing .5 ml (milliliters) of morphine on 1/19/17 at 8 AM every two hours for	F 514	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the 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 514] Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Specific actions regarding Resident #1 cannot be taken because Resident #1 died on January 20, 2017. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. The DON/designee audited charts of all current residents with orders for Morphine to ensure documentation of order times were accurately documented. Nurses were educated on policy and procedures relating to documentation of telephone orders, narcotic administration and documentation.	

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administration use for Resident # 1. This would equate to 10 mg of Morphine.

On 5/11/17 at 10:45 AM Nurse # 1 was interviewed. Interview with Nurse # 1 revealed the 1/20/17 morphine order was dated wrong and also did not accurately reflect the dosage order she received. The nurse stated the 1/20/17 order was received on 1/19/17 by her when the physician was making rounds at approximately 8 AM, and she had in error placed the date of 1/20/17. This interview also revealed the morphine dosage should have been 0.5 ml as the physician had given her, and not the 0.5 mg she had written. Interview with the nurse also revealed the order had been transcribed incorrectly to the January MAR (Medication Administration Record). The nurse stated she placed the order to start on the MAR on the date of 1/20/17, and therefore the nurse stated any times she had signed as administering the morphine on 1/20/17 were actually done on 1/19/17.

An administrative nurse staff member was interviewed on 5/11/17 at 9:30 AM. Interview with the administrative nurse revealed the nurses' initials showing morphine was administered on 1/20/17 at 4 PM; 6 PM; 8 PM; and 10 PM were an error. The nurse stated the doses signed as administered at these times would have been given on 1/19/17. The nurse confirmed the resident had expired on 1/20/17 at 10:30 AM and the nurses could not have administered medications to him as the medical record reflected.

The administrative nurse was asked about the dose of morphine which would have been due on

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Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;

Random audits of resident charts with orders for narcotics will be performed to ensure clarity of time, dates, and charting of medications. Audits will be performed 5x weekly for 5 weeks, then 3x weekly for 3 weeks, and finally bi-weekly for 2 months. If issues are identified, an investigation will be done to determine cause of issues and additional in-servicing will be completed as necessary.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting and evaluated for effectiveness. The Quality Assurance Committee will also review the results of the audits and consider whether additional steps need to be taken based on audit results.

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1/20/17 at 8 AM. The administrative nurse stated there was nowhere on the MAR for the nurse to have signed for the medication on 1/20/17 at 8 AM since Nurse # 1 had made the error and signed there on 1/19/17. The administrative nurse verified that the record did not reflect what occurred with the dose that was due on 1/20/17 at 8 AM, and this information should have been reflected in the medical record.

b. Review of physician orders revealed, on 1/19/17, Nurse # 1 received an order for one tablet of Ativan 0.5 mg (milligrams) every six hours by mouth PRN (as needed) for anxiety. There was a place on the physician order for the nurse to note the time the order was received. It was blank.

Review of the resident's January 2017 MAR (medication administration record) revealed the order for Ativan 0.5 mg every six hours PRN was transcribed to the MAR on 1/19/17. By this PRN Ativan 0.5 mg order, there was documentation it was administered one time. This was documented by Nurse # 1 at 7:40 AM on 1/19/17.

The records for the facility's back up emergency controlled substance medications were reviewed. This review revealed an Ativan 0.5 mg tablet was signed out by Nurse # 1 from the back up storage four times on 1/19/17 for Resident # 1. These times were at 7:47 AM; 8:24 AM; 1:12 PM and 1:17 PM.

A review of Resident # 1's Ativan controlled medication utilization record was done. According to the record the pharmacy filled 30 doses of 0.5 mg Ativan on 1/19/17. There were two tablets which were signed out from this individual supply

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of Resident # 1's Ativan. This was by Nurse # 5 on 1/20/17 at 12 AM. Nurse # 5 signed out two doses at this one time.

A pharmacist, who works for the facility's pharmacy, was interviewed on 5/8/17 at 12:15 PM. The pharmacist verified that their records showed Nurse # 1 had signed out Ativan 0.5 mg on 1/19/17 at 7:47 AM; 8:24 AM; 1:12 PM and 1:17 PM from the emergency back- up supply located at the facility for Resident # 1. The pharmacist stated they had received the Ativan order for Resident # 1 at 8:10 AM on 1/19/17 and they sent the resident's personal supply of Ativan 0.5 mg on 1/19/17 at 8:30 PM. The pharmacist stated the records showed the facility signed as receiving the resident's individual supply on 1/19/17 at 11:30 PM.

A review of the above records revealed therefore a total of 6 doses of Ativan 0.5 mg had been signed out by nurses for Resident # 1. As noted above, four were from the emergency kit and two were from his personal supply filled on 1/19/17. This review showed that nurses signed for the total removal of 3 mg of Ativan for Resident # 1.

Record review revealed Nurse # 1 obtained a second order on 1/20/17 to change the resident's Ativan dosage to a 1 mg tablet and administer it on a scheduled basis of every six hours. There was a place on the physician order for the nurse to note the time the order was received on 1/20/17. It was blank.

Review of the nursing notes revealed Resident # 1 expired on 1/20/17 at 10:30 AM.

Review of Resident # 1's January 2017 MAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING ______ B. WING ______	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST RALEIGH AT CRABTREE VALLEY	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

(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	Continued From page 23 revealed nurses documented they administered 1 mg of Ativan to Resident # 1 on 1/20/17 at 2 AM and 8 AM. They also continued to document they administered it after his death at the following times: 2 PM and 8 PM. On 5/11/17 at 10:45 AM Nurse # 1 was interviewed. Nurse # 1 stated she had dated the Ativan 1 mg order wrong. Nurse # 1 stated the order for Ativan 1 mg every six hours was received on 1/19/17 when the physician was making rounds around 8 AM. The nurse stated it had been decided that Resident # 1 would receive comfort measures because he was not doing well, and the physician had changed the original PRN order to a scheduled dose at a greater dosage because the resident was anxious and nervous. The nurse verified the resident should have gotten 1 mg of Ativan on a routine schedule of every six hours following the date and time of 1/19/17 at 8 AM. The nurse stated she also transcribed the order wrong on the MAR. The nurse stated she had in error drawn lines through the date of 1/19/17 on the MAR, and placed the order to start on the MAR on 1/20/17. The nurse stated all her signatures on the MAR for the administration of 1 mg of Ativan on 1/20/17 were actually for 1/19/17. According to the nurse she pulled the first dose of Ativan 0.5 mg at 7:47 AM and then the physician decided to soon change the order. Therefore she pulled the second 0.5 mg tablet from the emergency kit at 8:24 AM to equal the full 1 mg dosage. The nurse stated she pulled the 0.5 mg Ativan from the emergency kit at 1:12 PM and 1:17 PM on 1/19/17 in order to give the resident his 2 PM scheduled dose. The nurse stated the order had been faxed to the pharmacy and she did not recall if she had called to inform the pharmacy	F 514		

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F 514	Continued From page 24 the 8 PM dose would be needed. According to an administrative nurse staff member interview on 5/11/17 at 9:30 AM, there were no Ativan doses left in the emergency kit on 1/19/17 after Nurse # 1 removed the 0.5 mg tablet of Ativan at 1:17 PM. The administrative nurse stated the resident would have been due for his 8 PM dose on 1/19/17 by Nurse # 3. The administrative nurse stated Nurse # 3's initials were by the 8 PM dose signed on the MAR on 1/20/17 at 8 PM when the resident was deceased. The administrative nurse stated she did not how the nurse could have administered it on 1/19/17 at 8 PM when it was due because the emergency supply was depleted and his personal supply had not been sent from the pharmacy. Interview with the DON (Director of Nursing) on 5/8/17 at 10 AM revealed Nurse # 3 was no longer an employee of the facility. Nurse # 3 could not be reached for interview during the survey. According to the controlled substance records there had been only one time the resident had received a dosage of Ativan following 1/19/17 at 1:17 PM. As noted above this was at 1/20/17 at 12 AM. According to the interview with the administrative nurse on 5/11/17 at 9:30 AM, the resident was on the six hour schedule of 8 AM; 2 PM; 8 PM and 2 AM. The administrative nurse stated she did not know why Nurse # 5 signed out for the Ativan at 12 midnight on 1/20/17 and signed on the MAR at 2 AM. The administrative nurse stated she also did not know why the Ativan was never given again after 12 AM on 1/20/17, but it should have been reflected in the resident's medical record. According to the administrative	F 514		

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F 514	Continued From page 25 nurse, Nurse # 5 was not available for interview during the survey. The administrative nurse stated Nurse # 6 was the nurse who had cared for the resident on 1/20/17 when the dose would have been due at 8 AM. The administrative nurse stated since the order had not been transcribed correctly, and nurses had signed for doses on the 20th which were given on the 19th, this left nowhere for Nurse # 6 to sign on 1/20/17 at 8 AM. The administrative nurse stated there was no indication the medication was given by looking at the MAR or the controlled substance records. The administrative nurse stated the resident soon passed away on 1/20/17 and he may have not been able to take the medication or needed it, but the administrative nurse stated Nurse # 6 should have indicated this on the resident's record. According to the administrative nurse interview, Nurse # 6 was no longer an employee and was not available for interview. It was verified with the administrative nurse that the medical record did not accurately reflect the resident's medications orders and administration of medications.	F 514		