

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

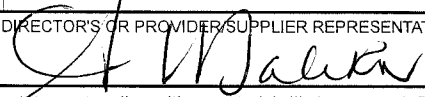
PRINTED: 11/01/2017
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345318 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 10/20/2017 |
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| NAME OF PROVIDER OR SUPPLIER BRUNSWICK COVE NURSING CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1478 RIVER ROAD WINNABOW, NC 28479 |
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| (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 |
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| <p>F 000</p> <p>F 157 SS=H</p> | <p>INITIAL COMMENTS</p> <p>A complaint survey was conducted from 10/16/17 through 10/20/17. Substandard quality of care was identified at: CFR 483.13 at tag F224 at a scope and severity of H CFR 483.25 at tag F309 at a scope and severity of H An extended survey was also conducted. 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>(g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> | <p>F 000</p> <p>F 157</p> | <p>F 157- NOTIFY OF CHANGES (INJURY/ DECLINE/ ROOM)</p> <p><i>This plan of correction represents Brunswick Cove Living Center's allegation of compliance. The submission of the following plan of correction does not constitute an admission or agreement by the provider as to the truths of the facts as alleged or conclusions presented by survey consultants from NCDHSR relating to alleged deficient practice. Please accept this corrective action as our plan of correction for F157, F223, F224 & F309.</i></p> <p>1. The plan correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited.</p> <p>Per the CMS 2567, based on Medical Director (MD) interview, Physician Assistant (PA) interview, staff interview and record review the facility failed to notify the MD of results from the Doppler ultrasound he ordered 8/26/17 and failed to notified the PA for six days of resident refusal of a vascular consult which he ordered resulting in the inability of treatments options to be discussed with 1 of 1 sampled residents (Resident #4) before the resident experienced an above-the-knee amputation (AKA) after being hospitalized on 10/11/17. The facility also failed to inform the physician for 1 of 2 sampled residents (Resident #10) with orders for vascular consults that they were unable to schedule the resident's appointment for venous surgical consultation.</p> | <p>Completion Date 11/18/17</p> |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE ADMINISTRATOR | (X6) DATE 11-17-17 |
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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 (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on Medical Director (MD) interview, Physician Assistant (PA) interview, staff interview, and record review the facility failed to notify the MD of results from the Doppler ultrasound he ordered on 08/26/17 and failed to notify the PA for six days of resident refusal of a vascular consult which he ordered resulting in the inability of treatment options to be discussed with 1 of 1 sampled residents (Resident #4) before the resident experienced an above-the-knee amputation (AKA) after being hospitalized on 10/11/17. The facility also failed to inform the physician for 1 of 2 sampled residents (Resident #10) with orders for vascular consults that they were unable to schedule the resident's appointment for venous surgical consultation. Findings included: | F 157 | 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. Based on the root cause analysis findings, we determined a more comprehensive assessment of the process for reporting diagnostic testing and laboratory test results to the ordering Physician and/or Practitioner and reporting to the Physician when scheduled appointments had not been successfully made was needed. The Administrator and Director of Nursing completed the comprehensive assessment and based on the results the following process and procedures were changed: <u>Reporting Lab and Diagnostic results</u> <ul style="list-style-type: none"> Lab and diagnostic tests results that are not of a critical value are placed in a communication book that is located at each nurse's station. The Physician/Practitioner's will sign/initial the result sheet attesting they have reviewed the results, along with the date of the review. The Physician/Practitioner will leave the result sheet in the communication book. The licensed staff nurse will check the communication book during his/her shift to determine if the results have been reviewed by the Physician/Practitioner. For those that have been reviewed, the licensed nurse will forward the results to the Medical Records Clerk to file onto the Medical Record. Results not reviewed by the Physician/Practitioner will remain in the communication book until reviewed by the Physician/Practitioner. If more than 3 days pass without Physician/Practitioner review, the Licensed Nurse will fax the results to the Physician/Practitioner's office. | | |

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| F 157 | Continued From page 2 1. Record review revealed Resident #4 was admitted to the facility on 08/14/17 with documented diagnoses that included peripheral vascular disease (PVD), polyneuropathy, diabetes, nicotine dependence, and compromised immune system. The resident was readmitted to the facility on 10/17/17 following hospitalization with diagnoses that included ischemic leg (leg with inadequate supply of blood), arterial occlusion (blockage), dry gangrene of the right lower extremity (RLE), and right AKA. A 08/26/17 physician progress note (written by Physician #1 who became the facility's MD effective the early part of September 2017) documented, "He (Resident #4) now c/o (complaints of) bilateral foot pain. He has NIDDM (non-insulin dependent diabetes mellitus) and evidence of PAD (peripheral artery disease) with diminished pulses. I ordered Lyrica (medication for management of diabetic neuropathy) and bilateral leg arterial studies with ABI's (ankle-brachial indices)." The physician's physical exam documented, "Peripheral Pulses: Dorsalis Pedis Pulse (pulse across the top of the foot): decreased on the left and the right. Popliteal Pulse (pulse across the back of the knee): decreased on the left and the right." The physician's Assessment and Plan documented, "Pain in both feet: ABI and PAD studies." A 08/26/17 physician order documented, "Lyrica 50 mg TID (milligrams three times daily), bilateral leg arterial duplex with ABI-dx (diagnoses) PAD/leg pain." Findings from a 08/28/17 mobile ultrasound | F 157 | <ul style="list-style-type: none"> When labs or other diagnostic tests are ordered, the Lab Liaison checks each order to assure a) the lab/test was completed and b) the results are obtained. All Licensed Nurses and Lab Liaison will be trained regarding the updated policy/ procedure. <p><u>Reporting unscheduled appointments</u></p> <p>The facility has implemented a policy that when a requested consult/ appointment has not occurred as ordered or as scheduled, the Physician must be notified via the nursing staff, DON, ADON or Administrator. This protocol will be treated as a Critical Lab/Diagnostic situation per the facility scale of triage.</p> <p>3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/ or in compliance with regulatory requirements.</p> <ul style="list-style-type: none"> The DON or designee will audit at least 5 charts weekly for 3 weeks to assure the Physician/Practitioner acknowledged receipt of results. Then 5 charts every other week for 2 weeks. The DON or designee will audit all appointments scheduled to assure they have been scheduled and/or if not the Physician was notified. This will be done once weekly for 3 weeks. The results of the audit will be reviewed and discussed in the monthly Quality Assurance Meeting. | | |

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| F 157 | <p>Continued From page 3</p> <p>documented Resident #4's right ankle brachial index was 0, and there was no flow detected in the right proximal femoral (thigh) artery, right Popliteal artery, right anterior tibia (ankle) artery, and right posterior tibia artery. (These ultrasound results were not found in the resident's chart on 10/19/17).</p> <p>PA #2's 09/25/17 progress note (not present in Resident #4's medical record on 10/19/17, and not electronically signed by PA #2 until 10/22/17) documented, "Nursing is asking for clarification on a verbal order given earlier to the station nurse by (PA #1) for a Doppler US (ultrasound) study of resident's lower extremities. It is my understanding that the verbal order was given by (PA #1) after station nurse informed her that the resident had been reporting intermittent leg pain. The station nurse now informs me she has discovered a lower extremity (LE) Doppler in the resident's chart dated 08/28/17. PA #2 documented, "....I reviewed with him the results of the 08/28/17 LE Doppler study, and told him that I might need to send him to the hospital ED (emergency department) today, or to a vascular surgeon for further evaluation." (This was the first documentation in Resident #4's medical record that a physician had reviewed his 08/28/17 Doppler results).</p> <p>A 09/25/17 order, written by PA #2, documented that Resident #4 was being referred for consultation with a vascular surgeon, and results of the 08/28/17 ultrasound were to accompany the resident to this appointment.</p> <p>A 09/27/17 nurse's note documented an appointment with the vascular surgeon was scheduled for Resident #4 on 10/05/17, and the</p> | F 157 | <p>4. The title of the person responsible for implementing the acceptable plan of correction.</p> <ul style="list-style-type: none"> • Revision of the Policy/ Process titled "Lab and Diagnostic Testing" will be assigned to the Administrator. • The development of the Physicians communication book and updated communication sheets have been assigned to the DON and medical Records Clerk. • The Administrator and/or DON will conduct the training for the licensed nurse's and Lab Liaison. • The Administrator and DON has educated the nursing and transportation staff regarding the policy for making appointments and ensuring the appointment has been completed. | | |

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| F 157 | <p>Continued From page 4</p> <p>transportation aide was aware of the appointment.</p> <p>A 10/09/17 12:00 PM nurse's note documented, "Communication sheet made to see dr (doctor) patient's foot swollen and black and blisters found on right foot. Wound referral also made. Patient not complaining of pain in foot."</p> <p>A 10/10/17 2:30 PM nurse's note documented, "Resident is up in w/c. Resident refused care (with name of vascular surgeon). Resident would not sign paperwork giving (name of vascular surgeon) permission to give care. Resident is alert and oriented."</p> <p>A 10/11/17 2:30 PM nurse's note documented, "...Resident's foot has gotten worse since the visit to (name of vascular surgeon)'s office. Resident agreed to be sent to the hospital today....Unable to feel pulse in (right) foot."</p> <p>PA #2's 10/11/17 progress note (not present in Resident #4's medical record on 10/19/17, and not electronically signed by PA #2 until 10/22/17) documented, "(Resident #4's) station nurse paged me this morning to request that I see him today, because of sudden skin discoloration; especially involving his toes on his right foot....Prior to going into (Resident #4's) room, the station nurse informed me that he was transported to (name of vascular surgeon)'s office several days ago. However, (Resident #4) refused to allow (name of vascular surgeon) to examine him; so (facility) transporter brought back to SNF (skilled nursing facility). I had not been informed of (Resident #4's) refusal of treatment. When I entered (Resident #4's) room, (facility) wound care nurse was already checking</p> | F 157 | | | |

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| F 157 | <p>Continued From page 5</p> <p>for distal pulses in the right foot. He is not able to illicit pedis or posterior tibia pulses. His right leg below the knee is cold. His left leg is warm. I am unable to palpate a femoral (thigh) pulse in the right leg...."</p> <p>A 10/17/17 hospital Discharge Summary documented, "The patient was admitted on 10/11/17 for dry gangrene of RLE up to mid-calf. Discussion was had with HCPOA (health care power of attorney) for right above knee amputation. The patient underwent the above procedure. He was hemodynamically stableThe AKA wound was clean, dry and intact. There were no signs of infection or hematoma formation. He was discharged back to SNF on 10/17/17 in a stable medical condition ..."</p> <p>At 5:12 PM on 10/19/17 Physician #1, the facility's MD, stated he was not notified of the resident's Doppler results, but he only took on responsibilities as medical director around first of September 2017, and he was not exactly sure what system the facility had in place at that time for notification of lab and test results. He reported he supervised two PAs who were more familiar with the facility and residents, and they mainly looked at test and lab results. He stated the PAs called him with abnormal lab results or if they had questions about results. After reviewing Resident #4's 08/28/17 Doppler results, he stated the resident should have seen a vascular surgeon immediately, "as soon as possible", so treatment options could have been discussed with the resident. He commented if nothing was done, the resident would start losing parts of his legs. The MD explained the results of the 08/28/17 Doppler were "poor" with the resident's right lower extremity completely occluded. However, he</p> | F 157 | | | |

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| F 157 | <p>Continued From page 6</p> <p>stated that the surgeon or vascular specialist should have had the opportunity to assess and decide if options such as laser treatment, stents, or bypasses could have possibly saved Resident #4's right foot and leg. The MD commented that he had seen incidents in which if the proximal circulation was enhanced then there could be some improvement in the distal circulation also. He reported the treatment goal was obviously to save the resident's foot and leg if at all possible.</p> <p>At 9:40 AM on 10/20/17 the Director of Nursing (DON) stated once lab or test results were reviewed by the physician or PAs they were supposed to be initialed and placed back in the medical record.</p> <p>At 11:20 AM on 10/20/17 PA #2 stated he started working with/for the new MD (Physician #1) on 09/06/17. He reported this MD was Resident #4's physician prior to assuming his new role on 09/06/17. According to PA #2, he first saw Resident #4 on 09/25/17 in conjunction with the hall nurse's concern over appearance of the resident's right leg and foot. He stated 09/25/17 was the first time he had reviewed the 08/28/17 Doppler results. He commented on 09/25/17 there were faint pedal pulses and there was warmth to the resident's feet and toes. (PA #1 documented on the same day the resident's right lower extremity was cool to touch and without pulses). He stated the resident was lethargic which he thought was his baseline. He reported at that time there was no blackness to the toes. He stated he saw the resident again on 10/11/17 in response to hall nurse's concerns about changes in the appearance of the resident's right foot. He reported on 10/11/17 the resident's toes on his right foot were now black, and the right foot</p> | F 157 | | | |

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| F 157 | <p>Continued From page 7</p> <p>had gotten worse with no pulses in the right foot. According to PA #2, the resident's leg from the knee down was "ice cold". PA #2 stated on 10/11/17 he was told that Resident #4 refused his vascular consult on 10/05/17 and so he sent the resident to the ED on 10/11/17. The PA stated he would not comment on the apparent gap of almost a month between the 08/28/17 Doppler and the first review of Doppler results on 09/25/17 (because the MD ordered the Doppler on 08/26/17, and he was not working for the MD at that time). The PA reported lab/test results from tests which he ordered were left in a box in the facility for him to review when he was in the building on Mondays, Wednesdays, and Fridays. However, he commented he was not the one who ordered the resident's Doppler on 08/26/17, and he was not sure what system the MD had in place to make sure the lab/test results he ordered were obtained and available for review.</p> <p>At 1:10 PM on 10/20/17 the Director of Nursing (DON) stated mobile lab/test results were faxed to the facility. She reported when faxes were collected, and there were mobile lab/test results among the faxes, this information was given to medical records to forward to the physicians so they could sign off on them and write orders that might be generated from the results.</p> <p>At 2:54 PM on 10/20/17 the Medical Records Clerk stated it was her responsibility to retrieve faxes and distribute them to the nurses who in turn made sure lab/test results got to the respective physicians who ordered them. She reported she handled so many faxes that she was unsure if she ever collected any Doppler results for Resident #4.</p> | F 157 | | | |

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| F 157 | <p>Continued From page 8</p> <p>2. Resident #10 was admitted to the facility on 12/29/16. Review of Resident #10's Quarterly Minimum Data Set (MDS) revealed diagnoses of peripheral vascular disease, diabetes, and cerebral vascular accident (CVA). Resident #10 was cognitively aware and had 3 arterial/venous ulcers.</p> <p>Review of the diagnoses listed in Resident #10's medical record included venous insufficiency and lymphedema.</p> <p>Review of the Medication Record - Treatments for September 2017 revealed Resident #10 was scheduled to receive daily treatments for venous ulcers on the right and left lower legs.</p> <p>Review of the physician's Telephone Order dated 09/04/17 revealed an order to send Resident #10 out for a venous surgical consult.</p> <p>In an interview on 10/19/17 at 11:30 AM the Transportation Aide (TA), who also scheduled resident appointments, stated she called to schedule an appointment for a venous surgical consult for Resident #10 on 09/05/17. She indicated she was unable to schedule the appointment because the surgeon's office needed to speak with Resident #10's family before an appointment could be scheduled. The TA stated she had left several messages for Resident #10's Responsible Party (RP) to contact the surgeon's office but had not heard back from the RP or the surgeon's office. She indicated Resident #10's RP visited often but she had not approached the RP to ask about the scheduling of the appointment. The TA stated she had made no attempt to follow-up with the vascular</p> | F 157 | | | |

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| F 157 | <p>Continued From page 9</p> <p>surgeon's office to see if the consult appointment could be scheduled following the initial contact with the office. She indicated she had not notified the Physician that there was a delay in getting the requested consult.</p> <p>In an interview on 10/19/17 at 11:40 AM the Director of Nursing (DON) indicated if a staff member was unable to schedule a requested consult she expected them to speak with the physician within a few days to see if a referral to a different physician for consult would be appropriate.</p> <p>In an interview on 10/19/17 at 4:55 PM Resident #10's Physician #1 stated he was not aware that the surgical consult he ordered had not been scheduled. He indicated that when he wrote an order for an outside consult it was because he felt he needed the assistance of a specialist to provide the resident the best care possible. He stated when he wrote an order he expected it to be carried out right away and he should have been notified that the surgical consult could not be scheduled. He indicated Resident #10 could have been sent to a different vascular surgeon or he could have ordered a Venous Doppler study instead.</p> <p>In a telephone interview on 10/20/17 at 10:08 AM Resident #10's RP stated she was aware that a surgical consult had been ordered but had not been told when it was scheduled or which physician the appointment would be with. She stated that she had not requested Resident #10 be sent to any particular vascular surgeon. She indicated it would have been fine with her to send Resident #10 to another surgeon if an appointment could not be made with the surgeon</p> | F 157 | | | |

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| F 157 | Continued From page 10 the facility had picked. In a follow-up interview on 10/20/17 at 1:06 PM the DON stated that there was not a nurse who followed up to make sure appointments or consults were scheduled and completed. She indicated if there was an issue with making an appointment the TA would let her know. The DON stated the TA had not informed her that Resident #10's venous consult had not been scheduled. | F 157 | | | |
| F 223 SS=D | 483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and record review the facility failed to prevent the misappropriation of property belonging to 1 of 1 resident, Resident # 5. Findings included: Resident #5 was admitted to the facility on 11/19/16 with diagnoses that included | F 223 | F 223- FREE FROM ABUSE/ INVOLUNTARY SECLUSION 1. The plan correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited. Per the CMS 2567 - Resident # 5 was admitted to the facility on 11/19/16 with diagnoses that included Osteoarthritis and Neuropathy. The Administrator became aware on 10/2/17 that forty-one Oxycodone 5mg tablets belonging to Resident # 5 were missing along with the narcotic count down sheet for the missing medication. The label for Oxycodone belonging to Resident #5 had been removed from a narcotic count down sheet, placed on a medication card containing Lexapro 10mg tablets then placed in the narcotic drawer in place of the Oxycodone 5 mg tablets. Eighteen (18) pills had been popped out from the mislabeled card and forty one (41) Oxycodone 5 mg tablets were missing along with the documentation sheet. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. | Completion Date 11/18/17 | |

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| F 223 | <p>Continued From page 11 Osteoarthritis and Neuropathy.</p> <p>Review of the quarterly Minimum Data Set dated 08/28/17 revealed that Resident #5 had moderately impaired cognition and required limited assistance for most activities of daily living. He was receiving Hospice Services. He had received as needed pain medication during the assessment look back period and described his pain as "frequent" with a rating of "4" on a scale of 0-10 during the assessment interview.</p> <p>Review of the October 2017 Medication Administration Record showed physician orders for Oxycodone 5mg (1) tablet by mouth every 4 hours as needed for pain and Oxycodone 5mg (2) tablets by mouth every 4 hours as needed for severe pain.</p> <p>Record review of a facility letter addressed to a local law enforcement office, dated 10/05/17, documented that on 10/02/17 the Administrator became aware that forty-one Oxycodone 5mg tablets belonging to Resident #5 were missing along with the narcotic count down sheet for the missing medication. The facility filed a 24-Hour Initial Report on 10/03/17 and a 5-Working Day Report on 10/05/17 to the Department of Health and Human Services.</p> <p>In an interview conducted with the Administrator on 10/17/17 at 1:45 PM she revealed that a label for Oxycodone 5 mg belonging to Resident #5 had been removed from a narcotic count down sheet, placed on a medication card containing Lexapro 10 mg tablets and then placed in the narcotic drawer in place of the Oxycodone 5mg tablets. She reported that on the mislabeled card that 18 pills had been popped out. She stated</p> | F 223 | <p>The Administrator immediately began an investigation on 10/2/17, as well as contacted the local law enforcement. A 24-hour Initial Report was filed on 10/3/17 and a 5 day working report on 10/5/17 to DHSR. Local law enforcement completed an investigation for drug diversion, but a report was not released because the investigation was still open. All nurses who had worked and passed medication to Resident # 5 were suspended until drug testing had been completed. All nurses except for the alleged nurse tested negative. The alleged nurse refused the drug testing and was terminated immediately (10/5/17).</p> <p>A new process for accounting for narcotics was developed by the Administrator and Director of Nursing. The process is as follows:</p> <ul style="list-style-type: none"> • A new "Narcotic Count Sheet" was developed to record the number of narcotic cards housed on each medication cart with a correlating prescription number. • At the beginning/end of each shift, the off-going and on-coming staff nurses will compare the number of pills per card to the number recorded on the Controlled Drug Record. . The current count is then recorded on the Controlled Drug Record and signed by both nurses. • Then the nurses will compare the number of narcotic cards to the number recorded on the Narcotic Count Sheet. The number of controlled drug records is then recorded as well as the number of narcotic cards. This count is completed for each medication cart. | | |

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| F 223 | <p>Continued From page 12</p> <p>that the forty-one Oxycodone 5 mg tablets were missing along with the documentation sheet. She said that as soon as she was made aware of the missing narcotics on 10/02/17 she began an investigation and contacted local law enforcement. She reported that all nurses who had worked and passed medication to Resident #5 were drug tested, and others were either suspended or terminated.</p> <p>In an interview conducted with Detective #1 on 10/18/17 at 8:59 AM he revealed that the investigation of drug diversion at the facility was an open case and a report could not be released until the investigation was concluded. He reported that Nurse #7 had been offered a polygraph test three times and had refused. He also reported that Nurse #7 had not passed a Urine Drug Screen requested by the facility.</p> <p>In an interview with Nurse #7 on 10/18/17 at 9:22 AM he reported that on 09/30/17 while counting narcotics at change of shift that a card belonging to Resident #5 did not have a red "C" on it (indicating that it was a controlled narcotic). He said he also noticed that the label had been tampered with. He stated he looked up the pills contained in the mislabeled bubble pack on the internet pill identifier and discovered it was Lexapro 10mg not Oxycodone. He stated that he immediately called the ADON who came to the facility to look at the medication card. He reported that Resident #5 also had another medication card containing thirty Oxycodone 5mg and that was placed in the narcotic drawer for use. He said the Assistant Director of Nursing (ADON) kept the mislabeled card of Lexapro. Nurse #7 reported that he had worked 5 shifts in a row and he had not noticed anything wrong with</p> | F 223 | <ul style="list-style-type: none"> Any discrepancies in the count or other suspicions of drug diversion will be reported to either the Director of Nursing or Administrator immediately. Neither staff nurse is allowed to leave the facility until the discrepancy is resolved. Licensed nurses will be educated on the new (Narcotic counting process) by DON/ designee <p>3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/ or in compliance with regulatory requirements.</p> <ul style="list-style-type: none"> At least 2 times a week for one month and weekly thereafter, the DON or designee will compare the number of Controlled Drug Records, the number of narcotic cards, the number recorded on the "Narcotic Count Sheet" to the list of narcotics dispensed by Pharmacy. The Pharmacy provides this list weekly to the Administrator. The results of the audit will be reviewed and discussed in the monthly Quality Assurance Meeting. <p>4. The title of the person responsible for implementing the acceptable plan of correction.</p> <p>The Administrator and Director of Nursing</p> | | |

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| F 223 | Continued From page 13 any of the narcotic medication cards in the locked drawer prior to 09/30/17. The ADON was called on 10/17/17 at 10:59 and on 10/18/17 at 12:07 PM. Messages were left both times. The ADON did not return either call. In an interview with the Pharmacy Manager on 10/18/17 at 10:20 AM he reported that he examined the mislabeled medication card. He said that there was no way that it was mislabeled at the pharmacy. He stated that all narcotics are filled in a separate room at the pharmacy, stamped by the pharmacist and the technician filling the prescription, and marked with a red "C" on the card to indicate it was a controlled medication. He reported that the pharmacy did not mark narcotic count down sheet labels with a red "C" and it is not stamped by a pharmacist or a technician. He stated that was how the pharmacy knew it was the Oxycodone count down sheet label that was placed on the Lexapro bubble pack of medication by someone at the facility. | F 223 | | | |
| F 224 SS=H | 483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and | F 224 | F 224- PROHIBIT MISTREATMENT/ NEGLECT/ MISAPPROPRIATION 1. The plan correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited. Per the CMS 2567 - The facility neglected Resident #4 who experienced an above the knee amputation (AKA) by failing to provide the vascular consultation and failing to consistently document assessment of the resident's right lower extremity (RLE) before the resident experienced the AKA. | Completion Date 11/18/17 | |

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| F 224 | <p>Continued From page 14</p> <p>exploitation of residents and misappropriation of resident property,</p> <p>(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, Medical Director (MD) interview, Physician Assistant (PA) interview, resident interview, staff interview, and record review the facility neglected 1 of 1 sampled residents (Resident #4) who experienced an above-the-knee amputation (AKA) by failing to provide vascular consultation and failing to consistently document assessment of the resident's right lower extremity (RLE) before the resident experienced the AKA. Findings included:</p> <p>Record review revealed Resident #4 was admitted to the facility on 08/14/17 with documented diagnoses that included peripheral vascular disease (PVD), polyneuropathy, diabetes, nicotine dependence, and compromised immune system. The resident was readmitted to the facility on 10/17/17 following hospitalization with diagnoses that included ischemic leg (leg with inadequate supply of blood), arterial occlusion (blockage), dry gangrene of the right lower extremity (RLE), and right AKA.</p> <p>A 08/26/17 physician progress note (written by Physician #1 who became the facility's MD effective the early part of September 2017) documented, "He (Resident #4) now c/o (complaints of) bilateral foot pain. He has NIDDM</p> | F 224 | <p>2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.</p> <p>Based on the root cause analysis findings, we determined a more comprehensive assessment of the process for reporting diagnostic testing and laboratory test results to the ordering Physician and/or Practitioner was needed. The Administrator and Director of Nursing completed the comprehensive assessment and based on the results the following process and procedures were changed:</p> <ul style="list-style-type: none"> • Lab and diagnostic tests results that are not of a critical value are placed in a communication book that is located at each nurse's station. The Physician/Practitioner's will sign/initial the result sheet attesting they have reviewed the results, along with the date of the review. The Physician/Practitioner will leave the result sheet in the communication book. • The licensed staff nurse will check the communication book during his/her shift to determine if the results have been reviewed by the Physician/Practitioner. For those that have been reviewed, the licensed nurse will forward the results to the Medical Records Clerk to file onto the Medical Record. Results not reviewed by the Physician/Practitioner will remain in the communication book until reviewed by the Physician/Practitioner. If more than 3 days pass without Physician/Practitioner review, the Licensed Nurse will fax the results to the Physician/Practitioner's office. • When labs or other diagnostic tests are ordered, the Lab Liaison checks each order to assure a) the lab/test was completed and b) the results are obtained. | |
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| F 224 | <p>Continued From page 15</p> <p>(non-insulin dependent diabetes mellitus) and evidence of PAD (peripheral artery disease) with diminished pulses. I ordered Lyrica (medication for management of diabetic neuropathy) and bilateral leg arterial studies with ABI's (ankle-brachial indices)." The physician's physical exam documented, "Peripheral Pulses: Dorsalis Pedis Pulse (pulse across the top of the foot): decreased on the left and the right. Popliteal Pulse (pulse across the back of the knee): decreased on the left and the right." The physician's Assessment and Plan documented, "Pain in both feet: ABI and PAD studies."</p> <p>A 08/26/17 physician order documented, "Lyrica 50 mg TID (milligrams three times daily), bilateral leg arterial duplex with ABI-dx (diagnoses) PAD/leg pain."</p> <p>Findings from a 08/28/17 mobile ultrasound documented there was no flow detected in Resident #4's right proximal femoral (thigh) artery, right Popliteal artery, right anterior tibia (ankle) artery, and right posterior tibia artery. The Impression section documented, "Evidence of significant bilateral inflow senses to both lower extremities, more severe on the right side. Occlusion of the right proximal femoral, popliteal and tibial arteries." (These ultrasound results were not found in the resident's chart on 10/19/17).</p> <p>On her undated Physician Communication Form Nurse #10 documented Resident #4 had "swollen right foot and toes" and "complaining of pain in right foot and toes, also noted discoloration". PA #1's undated response was, "RLE (right lower extremity) cool to touch, purple discoloration. (No) DP (Doppler) noted. STAT (at once)</p> | F 224 | <ul style="list-style-type: none"> All Licensed Nurses and Lab Liaison will be trained regarding the updated policy/ procedure. The Administrator and Director of nursing also conducted a root cause analysis concerning the assessment of residents and based on those results implemented the following process changes: Any resident with a peripheral or vascular arterial diagnosis will be assessed by the Wound Care team weekly unless the Physician has ordered anything other specifically. These assessments will be completed in addition to the routine admission, weekly skin assessments and daily assessment completed by the Licensed Staff Nurses. The assessment will include palpating pedal pulses, observation of skin color, palpating skin temperature. Any adverse assessment results or changes will be reported to the Physician/ Practitioner. All licensed staff nurses will be in-serviced by the DON and/or designee on care and assessment related to Peripheral and Arterial Vascular disease. <p>3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/ or in compliance with regulatory requirements.</p> <ul style="list-style-type: none"> The DON and/or Administrator will monitor the charts of resident's with a peripheral or vascular arterial diagnosis weekly for 2 weeks to assure the Wound Team has completed and documented a weekly assessment. | | |

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| F 224 | <p>Continued From page 16 Doppler U/S (ultrasound) arterial RLE."</p> <p>A 09/25/17 cancellation notice documented the STAT Doppler for Resident #4 was canceled because "this was already performed."</p> <p>PA #2's 09/25/17 progress note (not present in Resident #4's medical record on 10/19/17, and not electronically signed by PA #2 until 10/22/17) documented, "Nursing is asking for clarification on a verbal order given earlier to the station nurse by (PA #1) for a Doppler US (ultrasound) study of resident's lower extremities. It is my understanding that the verbal order was given by (PA #1) after station nurse informed her that the resident had been reporting intermittent leg pain. The station nurse now informs me she has discovered a LE Doppler in the resident's chart dated 08/28/17. PA #2 documented, "...I reviewed with him the results of the 08/28/17 LE Doppler study, and told him that I might need to send him to the hospital ED (emergency department) today, or to a vascular surgeon for further evaluation." (This was the first documentation in Resident #4's medical record that a physician had reviewed his Doppler results).</p> <p>A 09/25/17 order, written by PA #2, documented that Resident #4 was being referred for consultation with a vascular surgeon, and results of the 08/28/17 ultrasound were to accompany the resident to this appointment.</p> <p>A 09/27/17 nurse's note documented an appointment with the vascular surgeon was scheduled for Resident #4 on 10/05/17, and the transportation aide was aware of the appointment.</p> | F 224 | <ul style="list-style-type: none"> The DON and/or designee will assess at least 2 residents with a peripheral or vascular arterial diagnosis weekly for 2 weeks and compare the assessment results to the Wound Team assessment and licensed nursing staff assessment for accuracy. Any discrepancies found will be addressed with the individual staff person. The results of the audit will be reviewed and discussed in the monthly Quality Assurance Meeting. <p>4. The title of the person responsible for implementing the acceptable plan of correction.</p> <p>The Administrator and Director of Nursing</p> | | |

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| F 224 | Continued From page 17 A 10/09/17 12:00 PM nurse's note documented, "Communication sheet made to see dr (doctor) patient's foot swollen and black and blisters found on right foot. Wound referral also made. Patient not complaining of pain in foot." A 10/10/17 2:30 PM nurse's note documented, "Resident is up in w/c. Resident refused care (with name of vascular surgeon). Resident would not sign paperwork giving (name of vascular surgeon) permission to give care. Resident is alert and oriented." A 10/11/17 2:30 PM nurse's note documented, "...Resident's foot has gotten worse since the visit to (name of vascular surgeon)'s office. Resident agreed to be sent to the hospital today....Unable to feel pulse in (right) foot." (A 10/09/17 nurse's note and this 10/11/17 nurse's notes were the only ones in the medical record which documented information about the appearance of or the pulses in the resident's foot). PA #2's 10/11/17 progress note (not present in Resident #4's medical record on 10/19/17, and not electronically signed by PA #2 until 10/22/17) documented, "(Resident #4's) station nurse paged me this morning to request that I see him today, because of sudden skin discoloration; especially involving his toes on his right foot....Prior to going into (Resident #4's) room, the station nurse informed me that he was transported to (name of vascular surgeon)'s office several days ago. However, (Resident #4) refused to allow (name of vascular surgeon) to examine him; so (facility) transporter brought back to SNF (skilled nursing facility). I had not been informed of (Resident #4's) refusal of | F 224 | | | |

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| F 224 | <p>Continued From page 18</p> <p>treatment. When I entered (Resident #4's) room, (facility) wound care nurse was already checking for distal pulses in the right foot. He is not able to illicit pedis or posterior tibia pulses. His right leg below the knee is cold. His left leg is warm. I am unable to palpate a femoral (thigh) pulse in the right leg...."</p> <p>A 10/11/17 hospital History and Physical documented, "...His right foot is black, is insensate. There is no motor. The ischemia (loss of blood supply) extends for the entire foot onto the distal leg. There was no evidence of cellulitis or erythema but simply terminal ischemia. He has no Doppler signals. He is not able to provide a time line as to when the events occurred, and there is no information from the data sent from the care facility. He is not a candidate for revascularization or limb salvage. The degree of ischemia of the right lower extremity is severe and terminal, and his only option is an amputation...."</p> <p>A 10/17/17 hospital Discharge Summary documented, "The patient was admitted on 10/11/17 for dry gangrene of RLE up to mid-calf. Discussion was had with HCPOA (health care power of attorney) for right above knee amputation. The patient underwent the above procedure. He was hemodynamically stableThe AKA wound was clean, dry and intact. There were no signs of infection or hematoma formation. He was discharged back to SNF (skilled nursing facility) on 10/17/17 in a stable medical condition ..."</p> <p>At 4:07 PM on 10/19/17 Resident #4's primary first shift Nursing Assistant, (NA) #9, stated for the last 1 ½ months prior to going out to the</p> | F 224 | | | |

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| F 224 | <p>Continued From page 19</p> <p>hospital on 10/11/17 the resident gradually deteriorated physically and mentally. He reported the resident was mumbling, not making sense, sometimes would not even talk, sometimes could not even feed himself, stayed in bed, and did not walk during the week before going out to the hospital. However, the NA commented the resident never complained of pain. The NA remarked the level of care required by Resident #4 definitely increased. According to NA #9, he provided the resident bed baths on first shift. He stated in early September the resident's feet had reddened and blackened areas, two weeks later the resident's right foot was getting darker/blacker, and the week that the resident went out to the hospital the resident's right foot had blisters on it. He commented he reported these changes to the hall nurses.</p> <p>At 4:17 PM on 10/19/17 Nurse #1, who cared for Resident #4 from 7:00 AM to 7:00 PM, stated she filled out the preliminary paperwork with Resident #4, and he stated he would see the vascular surgeon. She stated the transporter reported to her that when she got the resident to the surgeon's office, and she requested for him to sign the release, the resident shook his head no. She commented she told PA #2 that the resident refused to be seen by the surgeon so PA #2 sent the resident out to the hospital where they felt the resident would be more willing to cooperate with doctors. She stated the resident did not complain of pain in his feet, but was not getting out of his bed or ambulating as much the last 2 - 3 weeks before being sent out to the hospital.</p> <p>At 5:12 PM on 10/19/17 Physician #1, the facility's MD, stated he was not notified of the resident's Doppler results, but he only took on</p> | F 224 | | | |

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| F 224 | <p>Continued From page 20</p> <p>responsibilities as medical director around first of September 2017, and he was not exactly sure what system the facility had in place at that time for notification of lab and test results. He reported he supervised two PAs who were more familiar with the facility and residents, and they mainly looked at test and lab results. He stated the PAs called him with abnormal lab results or if they had questions about results. After reviewing Resident #4's 08/28/17 Doppler results, he stated the resident should have seen a vascular surgeon immediately, "as soon as possible", so treatment options could have been discussed with the resident. He commented if nothing was done, the resident would start losing parts of his legs. The MD explained the results of the 08/28/17 Doppler were "poor" with the resident's right lower extremity completely occluded. However, he stated that the surgeon or vascular specialist should have had the opportunity to assess and decide if options such as laser treatment, stents, or bypasses could have possibly saved Resident #4's right foot and leg. The MD commented that he had seen incidents in which if the proximal circulation was enhanced then there could be some improvement in the distal circulation also. He reported the treatment goal was obviously to save the resident's foot and leg if at all possible.</p> <p>At 10:07 AM on 10/20/17 Nurse #1 stated she observed Resident #4's feet daily, but may not have documented on the appearance of his legs and feet, and the only thing she noticed was that the resident's right foot became gradually darker in coloration.</p> <p>At 11:20 AM on 10/20/17 PA #2 stated he started working with/for the new MD (Physician #1) on 09/06/17. He reported this MD was Resident #4's</p> | F 224 | | | |

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| F 224 | Continued From page 21 physician prior to assuming his new role on 09/06/17. According to PA #2, he first saw Resident #4 on 09/25/17 in conjunction with the hall nurse's concern over appearance of the resident's right leg and foot. He stated 09/25/17 was the first time he had reviewed the 08/28/17 Doppler results. He commented on 09/25/17 there were faint pedal pulses and there was warmth to the resident's feet and toes. (PA #1 documented on the same day the resident's right lower extremity was cool to touch and without pulses). He stated the resident was lethargic which he thought was his baseline. He reported at that time there was no blackness to the toes. He stated he saw the resident again on 10/11/17 in response to hall nurse's concerns about changes in the appearance of the resident's right foot. He reported on 10/11/17 the resident's toes on his right foot were now black, and the right foot had gotten worse with no pulses in the right foot. According to PA #2, the resident's leg from the knee down was "ice cold". PA #2 stated on 10/11/17 he was told that Resident #4 refused his vascular consult on 10/05/17 and so he sent the resident to the ED on 10/11/17. The PA stated he would not comment on the apparent gap of almost a month between the 08/28/17 Doppler and the first review of Doppler results on 09/25/17 (because the MD ordered the Doppler on 08/26/17, and he was not working for the MD at that time). The PA reported lab/test results from tests which he ordered were left in a box in the facility for him to review when he was in the building on Mondays, Wednesdays, and Fridays. However, he commented he was not the one who ordered the resident's Doppler on 08/26/17, and he was not sure what system the MD had in place to make sure the lab/test results he ordered were obtained and available for review. | F 224 | | | |

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| F 224 | Continued From page 22 At 12:12 PM on 10/20/17 Resident #4 stated he had pain at a level of 10 daily in the weeks before going out to the hospital. He reported he told staff members about this pain, but became silent, and would or could not identify those staff members that he had communicated his pain to. (Pain was only documented by the staff on 08/23/17, 08/24/17, and 09/01/17 in Daily Skilled Nurses Notes between 08/14/17 and 09/20/17. There were no nurse's notes in the medical record between 09/21/17 and 09/26/17, and sporadic nurse's notes between 09/27/17 and 10/11/17 did not document the presence of pain). At 1:10 PM on 10/20/17 the Director of Nursing (DON) stated assessment of Resident #4's pain associated with his lower extremities and assessment of the resident's right foot, including appearance and pulses, should be documented in the nurse's notes. At 1:38 PM on 10/20/17 PA #1 (who saw the Resident #4 before PA #2 on 09/25/17) stated there were no Doppler results in the chart when she reviewed it on 09/25/17. She reported on 09/25/17 Resident #4's right leg was blue and cold, and his right foot was cold and purple/blue. She also commented there were no pedal pulses in the right lower extremity. According to PA #1, after examining Resident #4 on 09/25/17 she knew the resident had serious problems so told the hall nurse if she could not get a STAT (immediate) Doppler to make sure the resident got to a vascular doctor as soon as possible (later PA #2 canceled the STAT Doppler because he obtained the results from the resident's 08/26/17 Doppler). | F 224 | | | |

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| F 224 | <p>Continued From page 23</p> <p>At 2:50 PM on 10/20/17 Nurse #1 stated she thought she checked the pulses in Resident #4's lower extremities maybe every other day, and they were consistently getting fainter. She reported she should have documented the pulses and appearance of the right foot in her nurse's notes, but did not always do that. She commented she thought the Treatment Nurse was checking the pulses sometimes. (The only nurse's note documenting information about pulses in Resident #4's right LE was made on 10/11/17).</p> <p>At 4:25 PM on 10/26/17, during a returned phone call, Nurse #11, who cared for Resident #4 from 7:00 PM to 7:00 AM, stated she was very alarmed when she found out that Resident #4 did not go to his vascular consult on 10/05/17 because she remembered thinking that the resident's right foot had undergone major changes since his admission. She reported she thought the resident's right leg was getting colder, and his right foot was getting darker. She commented she thought most of the assessment of the resident's right foot (appearance and pulses) was done by the 7:00 AM to 7:00 PM nurse because the resident was early to bed and early to rise so she did not see him that much. According to Nurse #11, she did not recall Resident #4 being in chronic pain, but she was sure she sometimes administered prn (as needed) pain medications due to pain in his right leg and foot. She stated Resident #4 was sometimes slow to respond and did not talk a lot, but she considered him to be alert and oriented and able to express his needs.</p> | F 224 | | |
| F 309 SS=H | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING | F 309 | F 309- PROVIDE CARE/ SERVICES FOR HIGHEST WELL BEING | Completion Date 11/18/17 |

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| F 309 | <p>Continued From page 24</p> <p>483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.</p> <p>483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:</p> <p>(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, Medical Director (MD), Physician Assistant (PA), resident, and staff interviews, and record review the facility failed to</p> | F 309 | <p><i>This plan of correction represents Brunswick Cove Living Center's allegation of compliance. The submission of the following plan of correction does not constitute an admission or agreement by the provider as to the truths of the facts as alleged or conclusions presented by survey consultants from NCDHSR relating to alleged deficient practice. Please accept this corrective action as our plan of correction for F157, F223, F224 & F309.</i></p> <p>1. The plan correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited.</p> <p>Per the CMS 2567 – The facility failed to provide arterial/venous circulatory consultation following a Doppler ultrasound on 8/28/17 during which there would have been discussion about available treatment options for one resident - Resident # 4 who later experienced a loss of limbs. The lack of documented follow up assessment by staff and the lack of consultation contributed to the deterioration of the resident's right foot and leg for over a 40-day period resulting in an above the knee amputation (AKA) after the resident was hospitalized on 10/11/17.</p> <p>2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.</p> <p>Based on the root cause analysis findings, we determined a more comprehensive assessment of the process for reporting diagnostic testing and laboratory test results to the ordering Physician and/or Practitioner was needed. The Administrator and Director of Nursing completed the comprehensive assessment and based on the results the following process and procedures were changed:</p> | | |

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| F 309 | <p>Continued From page 25</p> <p>provide arterial/venous circulatory consultation, following a Doppler ultrasound on 08/28/17, during which there could have been discussion about available treatment options for 1 of 1 sampled residents (Resident #4) who later experienced a loss of limbs. The lack of documented follow-up assessment by staff and the lack of consultation contributed to the deterioration of the resident's right foot and leg for over a 40-day period, resulting in an above-the-knee amputation (AKA) after the resident was hospitalized on 10/11/17. Findings included:</p> <p>Record review revealed Resident #4 was admitted to the facility on 08/14/17 with documented diagnoses that included peripheral vascular disease (PVD), polyneuropathy, diabetes, nicotine dependence, and compromised immune system. The resident was readmitted to the facility on 10/17/17 following hospitalization with diagnoses that included ischemic leg (leg with inadequate supply of blood), arterial occlusion (blockage), dry gangrene of the right lower extremity (RLE), and right AKA.</p> <p>The resident's 08/14/17 Admission Nursing Assessment documented he was alert but disoriented to time and place.</p> <p>The resident's 08/21/17 admission minimum data set (MDS) documented the resident's cognition was moderately impaired, he had sleeping and appetite problems, exhibited no behaviors including resistance to care, he required extensive assistance from a staff member with bed mobility/dressing/hygiene/bathing, he required limited assistance from a staff member</p> | F 309 | <ul style="list-style-type: none"> • Lab and diagnostic tests results that are not of a critical value are placed in a communication book that is located at each nurse's station. The Physician/Practitioner's will sign/initial the result sheet attesting they have reviewed the results, along with the date of the review. The Physician/Practitioner will leave the result sheet in the communication book. • The licensed staff nurse will check the communication book during his/her shift to determine if the results have been reviewed by the Physician/Practitioner. For those that have been reviewed, the licensed nurse will forward the results to the Medical Records Clerk to file onto the Medical Record. Results not reviewed by the Physician/Practitioner will remain in the communication book until reviewed by the Physician/Practitioner. If more than 3 days pass without Physician/Practitioner review, the Licensed Nurse will fax the results to the Physician/Practitioner's office. • When labs or other diagnostic tests are ordered, the Lab Liaison checks each order to assure a) the lab/test was completed and b) the results are obtained. • All Licensed Nurses and Lab Liaison will be trained regarding the updated policy/ procedure. • The Administrator and Director of nursing also conducted a root cause analysis concerning the assessment of residents and based on those results implemented the following process changes: | | |

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| F 309 | <p>Continued From page 26</p> <p>with transfers, he required staff supervision in the form of set-up help with locomotion on and off the unit and eating, he did not walk in his room or the corridor during the look-back period, he was frequently incontinent of bowel and bladder, and he was on scheduled pain medications but reported no presence of pain during the look-back period.</p> <p>A 08/23/17 Daily Skilled Nurses Note documented Resident #4 was experiencing pain in his right foot at an intensity of 8 on a scale of 1 - 10, with 10 being the highest level of pain.</p> <p>A 08/24/17 Daily Skilled Nurses Note documented Resident #4 was experiencing pain in his right foot at an intensity of 6 on a scale of 1 - 10.</p> <p>The resident's 08/25/17 care plan identified "at times has episodes of decreased cognition" as a problem. An intervention to this problem was "explain all procedures and treatments."</p> <p>A 08/26/17 physician progress note (written by Physician #1 who became the facility's MD effective the early part of September 2017) documented, "He (Resident #4) now c/o (complains of) bilateral foot pain. He has NIDDM (non-insulin dependent diabetes mellitus) and evidence of PAD (peripheral artery disease) with diminished pulses. I ordered Lyrica (medication for management of diabetic neuropathy) and bilateral leg arterial studies with ABI's (ankle-brachial indices)." The physician's physical exam documented, "Peripheral Pulses: Dorsalis Pedis Pulse (pulse across the top of the foot): decreased on the left and the right. Popliteal Pulse (pulse across the back of the</p> | F 309 | <ul style="list-style-type: none"> Any resident with a peripheral r or vascular arterial diagnosis will be assessed by the Wound Care team weekly unless the Physician has ordered anything other specifically. These assessments will be completed in addition to the routine admission, weekly skin assessments and daily assessment completed by the Licensed Staff Nurses. The assessment will include palpating pedal pulses, observation of skin color, palpating skin temperature. Any adverse assessment results or changes will be reported to the Physician/Practitioner. All licensed staff nurses will be in-serviced by the DON and/or designee on care and assessment related to Peripheral and Arterial Vascular disease. <p>3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/ or in compliance with regulatory requirements.</p> <ul style="list-style-type: none"> The DON and/or Administrator will monitor the charts of resident's with a peripheral or vascular arterial diagnosis weekly for 2 weeks to assure the Wound Team has completed and documented a weekly assessment. | | |

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| F 309 | <p>Continued From page 27</p> <p>knee): decreased on the left and the right." The physician's Assessment and Plan documented, "Pain in both feet: ABI and PAD studies."</p> <p>A 08/26/17 physician order documented, "Lyrica 50 mg TID (milligrams three times daily), bilateral leg arterial duplex with ABI-dx (diagnoses) PAD/leg pain."</p> <p>Findings from a 08/28/17 mobile ultrasound documented there was no flow detected in Resident #4's right proximal femoral (thigh) artery, right Popliteal artery, right anterior tibia (ankle) artery, and right posterior tibia artery. The Impression section documented, "Evidence of significant bilateral inflow senses to both lower extremities, more severe on the right side. Occlusion of the right proximal femoral, popliteal and tibial arteries." (These ultrasound results were not found in the resident's chart on 10/19/17).</p> <p>A 09/01/17 Daily Skilled Nurses Note documented Resident #4 was experiencing pain in his feet and bilateral lower extremity, but the intensity of the pain was not assessed.</p> <p>A 09/08/17 nurse's note documented, "(no) foot problems nail care provided."</p> <p>A 09/11/17 Physical Therapy (PT) Discharge Summary documented Resident #4 had been on PT caseload since 08/15/17, and was being discharged from PT on 09/11/17, having met his ambulation goal of ambulating 60 feet safely with front wheeled walker and modified independence on even surfaces.</p> <p>A 09/15/17 nurse's note documented, "(up) to w/c</p> | F 309 | <ul style="list-style-type: none"> The DON and/or designee will assess at least 2 residents with a peripheral or vascular arterial diagnosis weekly for 2 weeks and compare the assessment results to the Wound Team assessment and licensed nursing staff assessment for accuracy. Any discrepancies found will be addressed with the individual staff person. The results of the audit will be reviewed and discussed in the monthly Quality Assurance Meeting. <p>4. The title of the person responsible for implementing the acceptable plan of correction.</p> <p>The Administrator and Director of Nursing</p> | | |

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| F 309 | <p>Continued From page 28</p> <p>(wheelchair) daily & goes out to smoke ad lib, tries to get others to push him. Routine Lyrica for BLE (bilateral lower extremity) pain. Walks (with) walker short distances(no) s/s (signs and symptoms) of discomfort or distress noted."</p> <p>On her undated Physician Communication Form Nurse #10 documented Resident #4 had "swollen right foot and toes" and "complaining of pain in right foot and toes, also noted discoloration". PA #1's undated response was, "RLE (right lower extremity) cool to touch, purple discoloration. (No) DP (Doppler) noted. STAT (at once) Doppler U/S (ultrasound) arterial RLE."</p> <p>A 09/25/17 cancellation notice documented the STAT Doppler for Resident #4 was canceled because "this was already performed."</p> <p>PA #2's 09/25/17 progress note (not present in Resident #4's medical record on 10/19/17, and not electronically signed by PA #2 until 10/22/17) documented, "Nursing is asking for clarification on a verbal order given earlier to the station nurse by (PA #1) for a Doppler US (ultrasound) study of resident's lower extremities. It is my understanding that the verbal order was given by (PA #1) after station nurse informed her that the resident had been reporting intermittent leg pain. The station nurse now informs me she has discovered a LE Doppler in the resident's chart dated 08/28/17. PA #2 documented, "This is the first time I have met this resident. He is a heavy smoker, and he tells me he has been a heavy smoker throughout his entire adult life...On today's visit, he admits to having occasional intermittent foot pain & some increased weakness in both legs. He feels the pain mostly on the tops of his feet. He says the pain is</p> | F 309 | | | |

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| F 309 | <p>Continued From page 29</p> <p>slightly worse in right foot. He denies loss of LE sensation....I reviewed with him the results of the 08/28/17 LE Doppler study, and told him that I might need to send him to the hospital ED (emergency department) today, or to a vascular surgeon for further evaluation. I would categorized his overall affect as flat, but he was alert & oriented. He spoke few words to me, and most responses to my...questions were yes or no answers, or a shake or nod of his head. I did my best to educate him about the seriousness of his LE PVD. I did not sugar coat this for him. I explained that in almost 100% of serious PVD (peripheral vascular disease) cases like his--the natural progression leads to amputation of the affected extremities. I urged him to immediately stop smoking, and offered him assistance with smoking cessation medications. He answered no to my offer. Based on my exam findings today, I told (Resident #4) that I was going to be sending him to a vascular surgeon for further evaluation of his PVD. I further explained to him that he may or may not be a surgical candidate for fixing the arteries in his legs." The physical exam portion of PA #2's note documented, "...dorsalis pedis & distal tibia (ankle) pulses are palpable in both feet. 2 point sensory discrimination intact bilateral feet & toes. No pain elicited in either foot during b/l (bilateral) foot exams. Skin intact bilaterally with left leg slightly warmer than right. When right leg is elevated for approx (imately) 2 to 3 minutes the right leg approximates that of left leg."</p> <p>A 09/25/17 order, written by PA #2, documented that Resident #4 was being referred for consultation with a vascular surgeon, and results of the 08/28/17 ultrasound were to accompany the resident to this appointment.</p> | F 309 | | | |

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| F 309 | Continued From page 30 A 09/27/17 nurse's note documented an appointment with the vascular surgeon was scheduled for Resident #4 on 10/05/17, and the transportation aide was aware of the appointment. A 10/09/17 12:00 PM nurse's note documented, "Communication sheet made to see dr (doctor) patient's foot swollen and black and blisters found on right foot. Wound referral also made. Patient not complaining of pain in foot." A 10/10/17 2:30 PM nurse's note documented, "Resident is up in w/c (wheelchair). Resident refused care (with name of vascular surgeon). Resident would not sign paperwork giving (name of vascular surgeon) permission to give care. Resident is alert and oriented." A 10/11/17 2:30 PM nurse's note documented, "...Resident's foot has gotten worse since the visit to (name of vascular surgeon)'s office. Resident agreed to be sent to the hospital today....Unable to feel pulse in (right) foot." (A 10/09/17 nurse's note and this 10/11/17 nurse's notes were the only ones in the medical record which documented information about the appearance of or the pulses in the resident's foot). PA #2's 10/11/17 progress note (not present in Resident #4's medical record on 10/19/17, and not electronically signed by PA #2 until 10/22/17) documented, "(Resident #4's) station nurse paged me this morning to request that I see him today, because of sudden skin discoloration; especially involving his toes on his right foot....Prior to going into (Resident #4's) room, the station nurse informed me that he was | F 309 | | | |

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| F 309 | <p>Continued From page 31</p> <p>transported to (name of vascular surgeon)'s office several days ago. However, (Resident #4) refused to allow (name of vascular surgeon) to examine him; so (facility) transporter brought back to SNF (skilled nursing facility). I had not been informed of (Resident #4's) refusal of treatment. When I entered (Resident #4's) room, (facility) wound care nurse was already checking for distal pulses in the right foot. He is not able to illicit pedis or posterior tibia pulses. His right leg below the knee is cold. His left leg is warm. I am unable to palpate a femoral (thigh) pulse in the right leg. (Resident #4) denies leg pain today. He would not answer me when I asked him why he refused to allow (name of vascular surgeon) to examine him several days ago. I informed him that he was now facing a serious medical emergency & reminded him of our conversation we had earlier in late September. He has continued to smoke unabated. He gave me permission to send to the Hospital ED (emergency department) for evaluation & treatment."</p> <p>A hospital ED (emergency department) report, history and physical, and discharge summary documented Resident #4 was hospitalized from 10/11/17 - 10/17/17. "Patient presents to the emergency department for a cold leg. This is a pleasant ... male who comes from (name of facility) for arterial occlusion of the right lower extremity. Patient has a history of bad vascular disease and family says that a couple years ago he was just put on medicine because of the bad flow of blood in his legs but did not need surgery and sometime recently he has had problems with some pain and decreased flow to the leg. He is unable to tell me when it started hurting how long it was hurting when it stopped hurting and he</p> | F 309 | | | |

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| F 309 | Continued From page 32 cannot tell me much history as to how this occurred today nursing home sent him in because he had a very cold foot with black toes and no pulses they could palpate. I was able to get some notes from the nursing home, notes from today and also speaking with his family member who is his medical power of attorney, showing that patient saw (name of vascular surgeon) in the office on October fifth for a possible arterial occlusion but refused care at that time and then sent back to the nursing home. Patient's family members here who is his medical power of attorney and she says he does not have the capacity to make any medical decisions for himself and cannot make an informed decision. She said the nursing home had not notified her that he had gone to the doctor that day or was being sent to the doctor that day so she could be with him." "The patient ... is not able to consent. His (family member designation) who is his power-of-attorney is present and consenting for him. He was referred from (name of nursing home) with a mummified right foot, severe ischemia (inadequate supply of blood) of some period of time more than hours if not days. His right foot is black, is insensate. There is no motor. The ischemia extends for the entire foot onto the distal leg. There was no evidence of cellulitis or erythema but simply terminal ischemia. He has no Doppler signals. He is not able to provide a time line as to when the events occurred, and there is no information from the data sent from the care facility. He is not a candidate for revascularization or limb salvage. The degree of ischemia of the right lower extremity is severe and terminal, and his only option is an amputation. This was discussed with (family member designation) in front of the patient as much as the patient can understand. They | F 309 | | | |

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| F 309 | <p>Continued From page 33</p> <p>were informed of the options of no intervention which could lead to progressive complications which could lead to death versus ... amputation." "The patient was admitted on 10/11/17 for dry gangrene of RLE up to mid-calf. Discussion was had with HCPOA (health care power of attorney) for right above knee amputation. The patient underwent the above procedure. He was hemodynamically stable The AKA wound was clean, dry and intact. There were no signs of infection or hematoma formation. He was discharged back to SNF on 10/17/17 in a stable medical condition ..."</p> <p>At 12:06 PM on 10/19/17 the Transport Aide stated on 09/27/17 she obtained the first available appointment with the vascular surgeon for Resident #4. She documented on her own forms in her own handwriting that she had notified Family Member #1 of the appointment on 09/29/17 at 11:13 AM by leaving a voice mail on the family member's phone. She explained that she received no response or return call from Family Member #1 so on 10/02/17 at 2:50 PM she attempted to make phone contact again. As documented on her own forms in her own handwriting, the Transport Aide was unable to leave a message this time because the voice mailbox was full. The transporter reported she took Resident #4 to his 10/05/17 vascular surgery appointment. She commented the resident was asked to sign consent papers so the doctor could examine him. The transporter stated the resident did not seem to understand why he was signing his name so she explained to him that he was giving the doctor permission to examine him, the resident stated okay, but then again asked why he was signing the form, she explained again, the resident said okay, but instead of signing the</p> | F 309 | | | |

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| F 309 | <p>Continued From page 34</p> <p>form, shook his head and stated "no." She reported she had no alternative but to bring the resident back to the facility. (Observation of the resident's face page in his medical record and the transport form supplied to the transporter revealed Family Member #1 was documented as the first emergency contact. However, there was a handwritten sticky note in Resident #4's medical record documenting Family Member #2 was to be contacted first).</p> <p>At 12:42 PM on 10/19/17 the facility Administrator stated Resident #4 was his own responsible party (RP), he had not been deemed incompetent, and therefore notifying his family of appointments and changes in condition was a courtesy.</p> <p>At 12:50 PM on 10/19/17 Social Worker (SW) #2 and #3 and the Care and Admissions Coordinator stated Resident #4 signed all his admission paperwork, and review of hospital paperwork revealed no documentation of guardianship or power of attorney, but two family members were named as emergency contacts. They reported there was discussion with all residents and families that residents were considered their own responsible parties unless documentation was provided which was registered through the court system naming family members as legal guardians or POAs. They commented Resident #4 was alert and oriented, but had periods of confusion. SW #3 stated she was assigned to Resident #4, and she commented she had only spoken to the two emergency contacts over the phone during a care plan meeting. She stated initially Family Member #1 was listed as the first emergency contact on facility paperwork, but because Family Member #2 lived closer to the nursing home, Family Member #1 gave</p> | F 309 | | | |

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| F 309 | <p>Continued From page 35</p> <p>permission for Family Member #2 to be contacted first, and a note was put in the resident's record to this effect. According to SW #3, during the admission process Resident #4 stated no family had any papers having control over his health or financial information. All three staff members stated Resident #4 was considered his own responsible party.</p> <p>At 4:07 PM on 10/19/17 Resident #4's primary first shift Nursing Assistant, (NA) #9, stated for the last 1 ½ months prior to going out to the hospital on 10/11/17 the resident gradually deteriorated physically and mentally. He reported the resident was mumbling, not making sense, sometimes would not even talk, sometimes could not even feed himself, stayed in bed, and did not walk during the week before going out to the hospital. However, the NA commented the resident never complained of pain. The NA remarked the level of care required by Resident #4 definitely increased. According to NA #9, he provided the resident bed baths on first shift. He stated in early September the resident's feet had reddened and blackened areas, two weeks later the resident's right foot was getting darker/blacker, and the week that the resident went out to the hospital the resident's right foot had blisters on it. He commented he reported these changes to the hall nurses.</p> <p>At 4:17 PM on 10/19/17 Nurse #1, who cared for Resident #4 from 7:00 AM to 7:00 PM, stated she filled out the preliminary paperwork with Resident #4, and he stated he would see the vascular surgeon. She stated the transporter reported to her that when she got the resident to the surgeon's office, and she requested for him to sign the release, the resident shook his head no.</p> | F 309 | | | |

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| F 309 | <p>Continued From page 36</p> <p>She commented she told PA #2 that the resident refused to be seen by the surgeon so PA #2 sent the resident out to the hospital where they felt the resident would be more willing to cooperate with doctors. She stated the resident did not complain of pain in his feet, but was not getting out of his bed or ambulating as much the last 2 - 3 weeks before being sent out to the hospital. She reported there was a note in the resident's chart to call Family Member #2 first when there were changes in the resident's condition. She commented Resident #4 was alert and able to express his needs before going out to the hospital, but he was frequently confused about time and location and was not always reliable or understandable.</p> <p>At 5:12 PM on 10/19/17 Physician #1, the facility's MD, stated he was not notified of the resident's Doppler results, but he only took on responsibilities as MD around first of September 2017, and he was not exactly sure what system the facility had in place at that time for notification of lab and test results. He reported he supervised two PAs who were more familiar with the facility and residents, and they mainly looked at test and lab results. He stated the PAs called him with abnormal lab results or if they had questions about results. After reviewing Resident #4's 08/28/17 Doppler results, he stated the resident should have seen a vascular surgeon immediately, "as soon as possible", so treatment options could have been discussed with the resident. He commented if nothing was done, the resident would start losing parts of his legs. The MD explained the results of the 08/28/17 doppler were "poor" with the resident's right lower extremity completely occluded. However, he stated that the surgeon or vascular specialist</p> | F 309 | | | |

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| F 309 | <p>Continued From page 37</p> <p>should have had the opportunity to assess and decide if options such as laser treatment, stents, or bypasses could have possibly saved Resident #4's right foot and leg. The MD commented that he had seen incidents in which if the proximal circulation was enhanced then there could be some improvement in the distal circulation also. He reported the treatment goal was obviously to save the resident's foot and leg if at all possible.</p> <p>At 9:25 AM on 10/20/17 the facility's Treatment Nurse stated he did not assess Resident #4's right leg/foot before his 10/11/17 hospitalization because the impairment was vascular in nature, and there was no wound for him to observe.</p> <p>At 9:40 AM on 10/20/17 the Director of Nursing (DON) stated once lab or test results were reviewed by the physician or PAs they were supposed to be initialed and placed back in the medical record.</p> <p>At 10:07 AM on 10/20/17 Nurse #1 stated she observed Resident #4's feet daily, but may not have documented on the appearance of his legs and feet, and the only thing she noticed was that the resident's right foot became gradually darker in coloration. She reported Resident #4 needed more assistance with his activities of daily living, was a little more lethargic, but still got out of bed with staff assistance before he went out to the hospital on 10/11/17.</p> <p>At 10:12 AM on 10/20/17 NA #2 stated she cared for Resident #4 a couple of days before he went out to the hospital on 10/11/17, and she noticed the resident's right foot was swollen, darker in color than the rest of his body, and the resident was lethargic. However, she reported the</p> | F 309 | | | |

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| NAME OF PROVIDER OR SUPPLIER BRUNSWICK COVE NURSING CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1478 RIVER ROAD WINNABOW, NC 28479 | | |
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| F 309 | <p>Continued From page 38</p> <p>resident was able to express his needs, and did not complain of pain. She commented the resident did get out of bed, but needed a lot of assistance.</p> <p>At 10:47 AM on 10/20/17, during a telephone interview, Nurse #10 stated she could not remember the exact date of her Physician Communication Form (believed to be 09/25/17 based on physician orders generated from the PA assessments) regarding changes in Resident #4's right foot, but she reported a PA was in the building and immediately assessed the resident. She commented NA #9 had come to her stating the resident's right foot was getting very dark, and the resident was complaining of pain in the foot. According to Nurse #10, Resident #4 told her his pain level was just less than 5 on a 1 - 10 scale, and the right foot and toes were a very dark brown. She also commented the right foot was slightly swollen.</p> <p>At 11:20 AM on 10/20/17 PA #2 stated he started working with/for the new MD (Physician #1) on 09/06/17. He reported this MD was Resident #4's physician prior to assuming his new role on 09/06/17. According to PA #2, he first saw Resident #4 on 09/25/17 in conjunction with the hall nurse's concern over appearance of the resident's right leg and foot. He stated 09/25/17 was the first time he had reviewed the 08/28/17 Doppler results. He commented on 09/25/17 there were faint pedal pulses and there was warmth to the resident's feet and toes. (PA #1 documented on the same day the resident's right lower extremity was cool to touch and without pulses). He stated the resident was lethargic which he thought was his baseline. He reported at that time there was no blackness to the toes.</p> | F 309 | | | |

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| F 309 | Continued From page 39 He stated he saw the resident again on 10/11/17 in response to hall nurse's concerns about changes in the appearance of the resident's right foot. He reported on 10/11/17 the resident's toes on his right foot were now black, and the right foot had gotten worse with no pulses in the right foot. According to PA #2, the resident's leg from the knee down was "ice cold". PA #2 stated on 10/11/17 he was told that Resident #4 refused his vascular consult on 10/05/17, and so he sent the resident to the ED on 10/11/17. He stated on 10/11/17 he raised the resident's leg up in hopes of getting warmth, but the intervention was not successful. He reported there were no blisters or edema to the resident's right foot, but there was dry skin and the toes were black. He stated the right LE was now completely occluded which had been foreshadowed by severe stenosis documented on the 08/28/17 Doppler and a heavy smoking habit. He commented he asked the resident why he would not see the surgeon, and the resident stated he did not know. However, he reported the resident agreed to go to the hospital for treatment. The PA stated he would not comment on the apparent gap of almost a month between the 08/28/17 Doppler and the first review of Doppler results on 09/25/17 (because the MD ordered the Doppler on 08/26/17, and he was not working for the medical director at that time). The PA reported lab/test results from tests which he ordered were left in a box in the facility for him to review when he was in the building on Mondays, Wednesdays, and Fridays. However, he commented he was not the one who ordered the resident's Doppler on 08/26/17, and he was not sure what system the MD had in place to make sure the lab/test results he ordered were obtained and available for review. | F 309 | | | |

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| F 309 | <p>Continued From page 40</p> <p>At 11:43 AM on 10/20/17, during a telephone interview with Family Member #2, she stated she was the medical power of attorney for Resident #4 in the hospital, but did not have court registered documents yet. She reported the facility was aware she was in the process of getting legal documents. She commented previously when the resident was in another facility in this same area he was sent out for an arteriogram. She reported the family was told that the resident was at high risk for severe vascular issues and that the right foot and leg needed to be monitored carefully. She stated she thought it would have made a difference if family went with Resident #4 to the surgical appointment because the resident trusted his family, and they could have talked him into being seen by the surgeon.</p> <p>At 12:12 PM on 10/20/17 Resident #4 stated he had pain at a level of 10 daily in the weeks before going out to the hospital. He reported he told staff members about this pain, but then he became silent, and would or could not identify those staff members that he had communicated his pain to. (Pain was only documented by the staff on 08/23/17, 08/24/17, and 09/01/17 in Daily Skilled Nurses Notes between 08/14/17 and 09/20/17. There were no nurse's notes in the medical record between 09/21/17 and 09/26/17, and sporadic nurse's notes between 09/27/17 and 10/11/17 did not document the presence of pain).</p> <p>At 1:10 PM on 10/20/17 the Director of Nursing (DON) stated mobile lab/test results were faxed to the facility. She reported when faxes were collected, and there were mobile lab/test results among the faxes, this information was given to</p> | F 309 | | | |

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| F 309 | <p>Continued From page 41</p> <p>medical records to forward to the physicians so they could sign off on them and write orders that might be generated from the results. The DON also commented assessment of Resident #4's pain associated with his lower extremities and assessment of the resident's right foot, including appearance and pulses, should be documented in the nurse's notes.</p> <p>At 1:38 PM on 10/20/17 PA #1 (who saw the Resident #4 before PA #2 on 09/25/17) stated there were no Doppler results in the chart when she reviewed it on 09/25/17. She reported on 09/25/17 Resident #4's right leg was blue and cold, and his right foot was cold and purple/blue. She also commented there were no pedal pulses in the right lower extremity. According to PA #1, after examining Resident #4 on 09/25/17 she knew the resident had serious problems so told the hall nurse if she could not get a STAT (immediate) Doppler to make sure the resident got to a vascular doctor as soon as possible (later PA #2 canceled the STAT Doppler because he obtained the results from the resident's 08/26/17 Doppler).</p> <p>At 2:50 PM on 10/20/17 Nurse #1 stated she thought she checked the pulses in Resident #4's lower extremities maybe every other day, and they were consistently getting fainter. She reported she should have documented the pulses and appearance of the right foot in her nurse's notes, but did not always do that. She commented she thought the Treatment Nurse was checking the pulses sometimes. (The only nurse's note documenting information about pulses in Resident #4's right LE was made on 10/11/17).</p> | F 309 | | | |

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| F 309 | <p>Continued From page 42</p> <p>At 2:54 PM on 10/20/17 the Medical Records Clerk stated it was her responsibility to retrieve faxes and distribute them to the nurses who in turn made sure lab/test results got to the respective physicians who ordered them. She reported she handled so many faxes that she was unsure if she ever collected any Doppler results for Resident #4.</p> <p>At 4:25 PM on 10/26/17, during a returned phone call, Nurse #11, who cared for Resident #4 from 7:00 PM to 7:00 AM, stated she was very alarmed when she found out that Resident #4 did not go to his vascular consult on 10/05/17 because she remembered thinking that the resident's right foot had undergone major changes since his admission. She reported she thought the resident's right leg was getting colder, and his right foot was getting darker. She commented she thought most of the assessment of the resident's right foot (appearance and pulses) was done by the 7:00 AM to 7:00 PM nurse because the resident was early to bed and early to rise so she did not see him that much. According to Nurse #11, she did not recall Resident #4 being in chronic pain, but she was sure she sometimes administered prn (as needed) pain medications due to pain in his right leg and foot. She stated Resident #4 was sometimes slow to respond and did not talk a lot, but she considered him to be alert and oriented and able to express his needs.</p> | F 309 | | | |