

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345116</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/30/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>STARMOUNT HEALTH AND REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>109 S HOLDEN ROAD</b> <b>GREENSBORO, NC 27407</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 692 SS=D	<p>Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)</p> <p>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record reviews, family interview and staff interviews the facility failed to provide tube feeding as ordered by the physician for a resident that experienced significant weight loss (Resident #4).</p> <p>Findings Included:</p> <p>Resident #4 was admitted to the facility on 3/29/18 and diagnoses included intracerebral hemorrhage and dysphagia.</p> <p>Review of a Registered Dietitian (RD) note dated 3/30/18 for Resident #4 stated new enteral order</p>	F 692	<p>483.25(g)(1-3) NUTRITION/HYDRATION STATUS MAINTENANCE</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared because it is required by the provision of the Federal &amp; State Law.</p> <p>Resident #4 was discharged from the facility on 5/24/18 for shortness of breath</p>	6/22/18	

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

TITLE

(X6) DATE

Electronically Signed

06/15/2018

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 692	<p>Continued From page 1</p> <p>for (brand name formula) 240cc ' s 6 times a day. Provided 2160 calories and 93 grams protein. Current body weight was 130 pounds (lbs.). Ideal body weight was 154 lbs. Nutritional needs were 1750 to 2100 calories and 70 to 84 grams of protein.</p> <p>An admission minimum data set (MDS) dated 4/6/18 for Resident #4 revealed he received tube feeding that provided 51% or greater of his total daily calories, weight was 130 lbs. and he had severely impaired cognition.</p> <p>A review of the weight record in the electronic medical record (EMR) for Resident #4 revealed the following weights: 3/28/18 - 130.2 lbs., 5/8/18 - 109.3 lbs., 5/9/18 - 109.6 lbs., 5/11/18 - 109.6 lbs., 5/13/18 - 109.3 lbs., 5/15/18 - 116 lbs., and 5/16/18 - 115.1 lbs. The weights were identified as being done using the mechanical lift scale except for the 5/16/18 weight which did not identify what scale was used.</p> <p>Review of the physician orders for Resident #4 identified an order dated 3/30/18 for (brand name formula) 240 cc ' s 6 times daily via gastrostomy tube (g-tube).</p> <p>Review of the April 2018 medication administration record (MAR) for Resident #4 revealed an order with an origination date of 3/30/18 and stop date of 4/13/18 for (brand name formula) 240 cc ' s via g-tube 6 times a day. The MAR identified the administration times as 0000, 0400, 0800, 1200, 1600 and 2000. A check mark with staff initials identified the feeding was administered. The following dates and times were blank on the MAR: 4/1/18 - all 6 feeding times, 4/2/18 - 0000, 0400 and 2000, 4/3/18 - 0000 and</p>	F 692	<p>and respiratory concerns to Moses Cone Hospital.</p> <p>Per the medication administration record review, omissions were noted on the MAR for the month of April. The process was broken due to the lack of monitoring from nursing administration.</p> <p>The breakdown occurred when no order was obtained for weekly weights on a resident with enteral feeding who was experiencing weight loss.</p> <p>The facility DON, ADON, and Staff Development Coordinator audited all medication administration records for the month of May. Any omissions were documented as medication errors and submitted for physician review. Any new orders obtained by the physician were carried out in response to the medication error report. This was completed on 6/5/18.</p> <p>All nurses and medication aids have been inserviced on medication administration preparation and general guidelines to include signing the medication administration record at the time of administering medications to the resident. This was completed on 6/5/18. New nurses and medication aids will receive this education prior to working the floor.</p> <p>The DON, ADON, SDC, Weekend Supervisor, and Unit Managers will audit all resident Medication Administration Records daily to ensure compliance to the</p>		

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F 692	<p>Continued From page 2</p> <p>0400, 4/4/18 - 2000, 4/5/18 - 0000, 0400, 0800, 1200 and 1600, 4/7/18 - 0800, 1200, 1600 and 2000, 4/8/18 - 0000 and 0400, 4/9/18 - 0800, 1200 and 1600, 4/10/18 - 1600 and 2000, 4/11/18 - 0000, 0400, 0800, 1200 and 1600.</p> <p>Review of a physician ' s order for Resident #4 dated 4/14/18 identified an order for (brand name formula) at 70 cc ' s per hour via g-tube to start at 2:00 pm and stop at 10:00 am.</p> <p>Review of the April 2018 MAR for Resident #4 revealed an order with a start date of 4/14/18 and a stop date of 4/21/18 for (brand name formula) at 70 cc ' s per hour via g-tube from 2:00 pm until 10:00 am. A check mark with staff initials was present on 4/14/18, 4/15/18, 4/16/18, 4/19/18 and 4/20/18. The dates of 4/17/18 and 4/18/18 were blank.</p> <p>Review of a RD note dated 5/8/18 for Resident #4 stated current body weight was 116.6 lbs. Ideal body weight was 148 lbs. Significant weight loss of 21% in 30 days. Enteral regimen changed to (brand name formula) at 70 cc ' s per hour for 20 hours a day and provided 2100 calories a day.</p> <p>Review of a nurse practitioner progress note dated 5/8/18 for Resident #4 stated he was seen for an acute visit due to abnormal weight loss. Weight went from 130 lbs. to his current weight of 116 lbs. He was being fed via a PEG (percutaneous endoscopic gastrostomy) tube. He has had no recent illnesses and no reports of fever. Plan to check labs, placed resident on daily weights and changed his feeding to a more caloric formula.</p> <p>Review of a RD note dated 5/15/18 for Resident</p>	F 692	<p>standard. This audit will be conducted daily for 4 weeks, then 3 times a week for 4 weeks. This audit started on 6/2/18. The audit will be conducted by the DON, ADON, SDC, Weekend Supervisor, and Unit Managers by reviewing the Missed Medication Admin audit report.</p> <p>All residents have been reweighed in the facility and entered into the electronic medical record. This was completed on 6/8/18. Any significant change in weight was presented to the physician and registered dietician. This was completed on 6/12/18.</p> <p>The facility has designated two staff members, certified nursing assistants, to complete weights on a monthly and weekly basis. The two certified nursing assistants have been inserviced and educated on the standards of gathering weights. This occurred on 6/4/18.</p> <p>The Registered Dietician (RD) and Dietary Manager (DM) were inserviced on pulling weights out of the Point Click Care system to avoid any discrepancies in obtaining the correct weights for residents. This occurred on 6/18/18.</p> <p>Weekly the DON, ADON, Unit Manager, Registered Dietician, and Nurse Practitioner will audit all weights to ensure weights were captured appropriately. This will be documented on the At Risk Review Worksheet. This audit started on 6/12/18 and will continue weekly thereafter.</p>		

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F 692	<p>Continued From page 3</p> <p>#4 stated current weight was 109.3 lbs. Weight continued to decline. 20.6% weight loss in 30 days. Increased (brand name formula) to 85 cc ' s per hour for 20 hours a day and provided 2550 calories.</p> <p>A phone interview on 5/30/18 at 9:30 am with a family member for Resident #4 revealed she had visited the resident at 7:30 pm in April 2018 (she could not remember the exact date) and his tube feeding wasn ' t running. She stated Resident #4 ' s tube feeding was supposed to be turned on at 2:00 pm and run until 10:00 am. The family member explained she went and told his nurse and the nurse replied to her that she must have forgotten to turn his tube feeding on at 2:00 pm that afternoon. She stated about 8:45 pm another nurse came in and turned the tube feeding on. The family member added she was concerned because Resident #4 was so thin and losing weight. She explained she informed the Director of Nursing (DON) of the incident and the DON told her she would look into it. The family member stated the DON never got back to her about why his feeding tube wasn ' t on until she had approached the DON about another issue and then the DON told her she had spoken to the nurse about it and the nurse had forgotten to turn the tube feeding on.</p> <p>An interview on 5/30/18 at 10:10 am with Nursing Assistant (NA) #1 revealed he routinely provided care for Resident #4. He stated the resident couldn ' t eat and received tube feeding. NA #1 added the nurses handled the tube feeding, but it was on and off throughout the day. He stated the resident was very thin.</p> <p>An interview on 5/30/18 at 12:45 pm with the RD</p>	F 692	<p>Nurses and med aids have been inserviced on the initiation of tube feeding and stopping of tube feeding per physician ' s order. This was completed on 6/18/18. All new nurse and med aids will receive this inservice prior to starting a shift.</p> <p>An audit tool was developed to assist the DON, ADON, and Unit Managers with starting and stopping of tube feeding per the physician ' s order. This will be conducted 5 X a week for 4 weeks then weekly X 4 weeks. This began on 6/12/18.</p> <p>All audit results will be presented to the QAPI committee to determine effectiveness and duration of the audit.</p> <p>The Director of Nursing is responsible for implementation of this plan of correction.</p>		

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F 692	<p>Continued From page 4</p> <p>revealed newly admitted residents to the facility were supposed to be weighed weekly for the first four weeks of admission. She stated the nursing department obtained the weights and were responsible for putting the weights in the EMR. The RD added the Dietary Manager (DM) would receive the weights from nursing and enter them into a dietary computerized weight program called meal tracker. The RD explained she would use the weights that were entered in the meal tracker program. She added the weights for Resident #4 in meal tracker were 137.8 lbs. on 4/24/18, 116 on 5/8/18, 116.8 on 5/11/18 and 115.1 on 5/17/18. The RD stated she didn ' t know why the weights for Resident #4 were different in the EMR weight record and the meal tracker program, but there had been a lot of changes in the nursing department. The RD stated she could not locate any weights for Resident #4 between 3/30/18 and 4/24/18 and that he should have been weighted weekly during that time. She explained Resident #4 had experienced a significant weight loss in 30 days and should have received 2100 calories a day if his tube feeding was administered as ordered. She added the resident ' s tube feeding was changed from bolus feedings to continuous feedings via a pump because he had some intolerance to the bolus feedings. She acknowledged even with the changes in the tube feeding orders the resident ' s total calories stayed at 2100 calories a day until the tube feeding order was changed on 5/15/18 and then provided 2550 calories a day. The RD stated she went by the physician ' s order to calculate the number of calories a resident received daily and would expect to be notified by nursing if there was any omission in his tube feeding.</p> <p>An interview on 5/30/18 at 12:55 pm with the NP</p>	F 692			

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F 692	<p>Continued From page 5</p> <p>revealed Resident #4 ' s tube feeding had been changed from bolus feedings to continuous feedings because he had some intolerance issues. She stated the continuous tube feedings were ordered for 20 hours a day to allow time for his gut to rest. The NP explained the resident had issues with his nutritional status from the beginning of his stay and had to be treated for dehydration with intravenous fluids even though he was on a tube feeding. She added Resident #4 had lost weight and she thought there could be something underlying going on with him because his tube feeding was supposed to be providing 2100 calories a day which she thought was adequate. The NP stated she was in the process of obtaining CT scans on the resident when he had an acute episode and was hospitalized. She stated she was not aware of the resident missing any tube feedings and she expected the feedings would be administered as ordered. The NP added she would expect to be notified if a resident ' s tube feedings were not administered as ordered.</p> <p>An interview with the DON on 5/30/18 at 1:45 pm revealed she had been notified by Resident #4 ' s family that his tube feeding had not been turned on at 2:00 pm as ordered by the physician. She stated she could not remember the exact date and had not documented the incident. The DON explained she went to the resident ' s room and confirmed that his tube feeding was off. She stated she spoke to the nurse for the resident who came on shift at 7:00 pm who told her Resident #4 ' s tube feeding had not been started by the previous shift and she would start it. The April 2018 enteral feeding MAR for Resident #4 was reviewed with the DON. She stated the facility charted by exception and if the nurses hadn ' t given the tube feeding they should have</p>	F 692			

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F 692	Continued From page 6 documented why and notified the physician. The DON stated she was not sure why there were different weights in the EMR and the tray tracker program or why Resident #4 had not been weighed weekly on admission. She added it was her expectation that resident ' s tube feeding be administered according to the physician ' s orders especially because it was the sole source of nutrition for Resident #4.  A list of nurses who were working and responsible for administering Resident #4 ' s tube feeding for the dates identified as blank on the April 2018 MAR was provided by the DON. Most of the nurses no longer worked at the facility and / or were contract agency nurses whose personal contact information was not available.  A phone interview was conducted on 5/30/18 at 5:21 pm with Nurse #2 who was identified as the nurse for Resident #4 on 4/5/18, 4/11/18, 4/14/18, 4/15/18, 4/18/18, 4/19/18, 4/20/18, 4/21/18, 4/24/18 and 4/25/18. She stated she worked at the facility for about 6 weeks through an agency. Nurse #2 added she did remember the resident received tube feeding because often after the NAs provided him with care they would come and tell her that his tube feeding was disconnected. She stated she would go in and try and secure the feeding tube the best she could. The nurse added she usually worked form 7:00 pm until 7:00 am so she would not have been responsible for starting his tube feeding.	F 692			
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)  The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		6/22/18	

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F 760	<p>Continued From page 7 medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to administer an anesthetic and steroid cream to a rectal fissure, causing discomfort for 1 of 1 Residents reviewed for medication errors, Resident #2.</p> <p>Findings included:</p> <p>Resident #2 was admitted to the facility on 10/29/17 with diagnoses of traumatic amputation of left lower leg, Colitis, and Rectal Fissure. The most recent Minimum Data Set (MDS) assessment revealed he was cognitively impaired and required extensive assistance with moving in bed, transferring to and from the bed, and toileting; and he could feed himself with assistance of setting up his tray.</p> <p>Review of Resident #2's orders dated 5/24/18 revealed an order for Hydrocortisone-Pramoxine Cream 2.5-1.0%, a topical anesthetic and steroid cream, to be applied rectally three times a day for anal fissure.</p> <p>Review of May 2018 Medication Administration Record for Resident #2 revealed Hydrocortisone-Pramoxine Cream was not administered on 5/26/18 at 10:00 am, 4:00 pm and 10:00 pm; 5/27/18 at 10:00 am; and on 5/29/18 at 10:00 am and 4:00 pm.</p> <p>On 5/30/18 at 1:25 pm during an interview with Resident #2, he stated he had orders for a cream for his anal fissure but the nurses had told him it was not available and had not been applying the cream. He stated the rectal fissure was painful.</p>	F 760	<p>483.45(f)(2) RESIDENTS ARE FREE OF ANY SIGNIFICANT MEDICATION ERRORS.</p> <p>Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared because it is required by the provision of the Federal &amp; State Law.</p> <p>Resident #2 was provided his anesthetic and steroid cream and a medication error report was completed and given to the nurse practitioner for review on 6/1/18. No new orders were received in response to the medication error report.</p> <p>The breakdown was a result of lack of education and knowledge of the pharmacy policy governing medications not being available and what to do when a nurse encounters this situation.</p> <p>The DON, ADON, and SDC completed a medication cart audit in relation to the medication and treatment administration records to ensure all medications were available for all residents in the facility. This was completed on 6/2/18. Any medications not available at the time of the audit were corrected and provided.</p> <p>Nurses and med aides have been</p>		



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F 760	Continued From page 8  Interview on 5/30/18 at 3:55 pm with Nurse #1 revealed she had worked on 5/29/18 and had not been able to find the Hydrocortisone-Pramoxine Cream. She stated she didn't apply the medicine at 10:00 am or 4:00 pm during that shift. She also stated she had documented or notified anyone the medication was missing. Nurse #1 said she did find the medication on the evening of 5/29/18 but the next dose was due at 10:00 pm so she let the nurse on night shift know where the medication was located.  On 5/30/18 at 4:10 pm an interview with Nurse #2 revealed the Hydrocortisone-Pramoxine Cream was not available on 5/26/18 for the 10:00 am dose. She stated she called the pharmacy and requested the medication be sent. She stated Resident #2 had missed the 10:00 am, 4:00 pm, and 10:00 pm doses of the medication on 5/25/18 and the 10:00am dose on 5/27/18. She stated the medication was delivered by the pharmacy on 5/27/18. She stated she did not let the physician know the resident had missed doses of the Hydrocortisone-Pramoxine Cream.  On 5/30/18 at 4:35 pm an interview with the Nurse Practitioner revealed her expectation was the Hydrocortisone-Pramoxine Cream would be given as ordered.	F 760	inserviced on medication unavailability from our pharmacy policy manual. This was completed on 6/5/18. All new staff will receive this inservice prior to working a shift.  The DON, ADON, SDC, and Unit Managers will audit the Medication Admin Audit report daily to ensure that all medications are available for administering. This audit will be conducted daily X 4 weeks, then 5 X a week thereafter for 4 weeks. The audit began on 6/2/18.  The audits will be presented to the QAPI committee to determine the effectiveness and duration of the audit.  The Director of Nursing is responsible for implementation of the plan of correction.		