STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	07/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

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F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		8/8/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/03/2018

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F 578	Continued From page 1 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and resident interviews, the facility failed to accurately obtain and document the type of resuscitation procedure and advance medical treatment to be provided for 1 of 1 sampled resident (Resident #33) investigated for advance directives. Findings included: Resident #33 was admitted to the facility on 6/28/13 with diagnoses which included: heart failure, malaise, hereditary and idiopathic neuropathy, hypertension, and hypothyroidism. The review of the quarterly minimum data set dated 6/20/18 indicated Resident #33 was cognitively intact. Review of the monthly physician's orders for March 2018 through July 2018 documented Resident #33's Advance Directive as Full Code status (emergent measures in attempt to resuscitate the patient). However, the portable medical form dated 6/15/15 and the posting on the outside cover of the resident's medical record documented the resident's status as DNR (Do Not Resuscitate). During an interview on 7/11/18 at 11:07 A.M., the RPh (Registered Pharmacist) revealed Resident #33 signed a "Request for Withholding and/or Discontinuing Extraordinary Measures" form and the portable DNR form which was signed by the Physician on 6/15/15 and placed in the resident's	F 578	Corrective action to be accomplished for the resident found to be affected by the deficient practice: Resident #33 □ On 7/11/18, Provider (Nurse Practitioner) met with resident #33 to determine her preference regarding her code status. Resident made decision to have a code status of do not resuscitate and appropriate paperwork signed. Physician wrote the order for the do not resuscitate status and all forms were updated to reflect this order. It was determined facility policy and procedure was not followed in this specific case to write the do not resuscitate order after the residents wishes were determined upon admission. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: Current facility policy was reviewed on July 31, 2018 and no changes were identified. The social worker will begin asking all new admissions and/or their responsible party about advanced directives beginning August 3, 2018. If the resident/responsible party wishes to have a do not resuscitate code status, the social worker will have them sign the	

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F 578	Continued From page 2 medical record. The RPh revealed a physician's order was never written for the advance directive and should have been; therefore, the monthly re-orders were never updated by the Pharmacist to reflect the change of order from Full Code to DNR status. Also, there was no physician's order available for the nurse to verify the resident's change of code status when the monthly orders were reconciled. During an interview on 7/11/18 at 3:45 P.M., Resident #33 indicated she did not want drastic advance medical treatment such as a feeding tube, if she became incapacitated.	F 578	appropriate form. If the resident/responsible party requests further information regarding advanced directives, the social worker will provide written materials and arrange for follow up with nursing and/or provider. Upon admission, nursing staff will review the resident/responsible party wishes and ensure proper documentation of preference. Based on the resident/responsible party wishes and documentation, the appropriate physician order will be obtained. Education will be completed with all licensed staff concerning the facility policy and procedure on code status. This education will be completed by August 8, 2018. How we will monitor our performance to make sure that solutions are sustained: Chart audits were completed on all other current residents on 07/31/2018 by the unit secretary. All charts had orders for the appropriate code status according to resident or responsible parties wishes. There will be an audit of all new admissions for code status paperwork completion at the weekly care plan meeting by the MDS coordinator beginning the week of July 30, 2018. Code status will also be reviewed quarterly at all care plan meetings with residents/responsible party by the MDS coordinator to determine if changes need	

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F 578	Continued From page 3	F 578	to be made. The MDS coordinator will report results monthly at the Quality of Life and House-wide QI committee meetings.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to follow its abuse policy to submit a 24 hour initial allegation report and a 5 working day investigation report to the State Survey Agency within the required timeframes for 1 of 1 residents (Resident #4) reviewed for injury of unknown origin. The findings included: Review of the facility's Abuse, Neglect, and Misappropriation policy last revised in November 2017 revealed guidance to direct staff members on the "screening and training of employees, protection of resident/patients and the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, diversion of drugs,	F 607	Corrective action to be accomplished for the resident found to be affected by the deficient practice: Resident #4 - N/A. All records were reviewed concerning this resident. It was determined facility policy for abuse was followed for the investigation of the incident. The risk manager provided these findings to the hospital based reporting structure but not to the State Survey Agency and Adult Protective Services. It was determined the policy did not include the steps and timeframes required for reporting for the initial allegation report and subsequent investigation report.	8/8/18

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F 607	Continued From page 4 fraud, injury of unknown source, and misappropriation of property". It stated that an injury should be classified as an injury of unknown source when both of the following conditions are met: 1) the source of the injury was not observed by any person and cannot be explained by the resident 2) when the injury is suspicious because of the extent of the injury or the location of it. The policy also stated that the Chief Nursing Officer (CNO) or Director of Nursing (DON) would ensure that the State Survey Agency would be notified as soon as possible, but not to exceed 24 hours after discovery. Upon completion of the investigation, the facility will report investigative details and conclusion to the State Survey Agency and the administrator within 5 working days. Resident #4 was admitted to the facility on 6/15/2015 with diagnoses that included dementia and osteopenia (weak or brittle bones). Review of the a quarterly admission minimum data set (MDS) assessment for resident #4 dated for 4/4/18 revealed the resident was severely cognitively impaired, did not exhibit any abnormal behaviors and did not reject care. Resident #4 required one to two person extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident had impaired mobility on one side of the body for upper and lower extremities, A review of the facility's Interdisciplinary Progress Notes and Skin Tears/Bruising Tracking Log dated for 6/7/18 at 7:40 AM revealed resident #4's right foot was swollen with blue discoloration and her right lower leg had a knot above her ankle.	F 607	Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: Facility policy has been updated to reflect all steps needed in abuse investigation and reporting process. The social worker verified the ombudsman preferred method of communication of suspected abuse is via fax. This information has been placed in the policy. Education will be completed with all staff regarding policies and procedures regarding abuse and reporting structure and timing. This education will be completed by August 8, 2018. How we will monitor our performance to make sure that solutions are sustained: There will be weekly audits of 3 random staff members for 6 weeks to determine if the staff member understands the abuse policy. This auditing will be completed by the Director of Nursing or designee. Results will be reported at the Quality of Life and House-wide QI committee meetings monthly. All cases of possible Abuse, Neglect and Misappropriation will be investigated per policy and procedure. Upon notification of any allegations, a focus group of a minimum of administrative and nursing management personnel on call will	

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F 607	Continued From page 5 An x-ray was ordered and the results were reported to the facility on 6/7/18 at 12:45 PM. The x-ray revealed the resident had an oblique fracture to her right distal tibia (right lower leg above ankle bone). The x-ray also noted resident #4 to have osteopenia. The investigation was completed on 6/7/18, and the facility focus group consisting of the Medical Director, CNO, and DON met to discuss the outcome of the investigation and to determine interventions for prevention. Further review of the investigation report revealed it was not sent to the State Survey Agency. On 7/11/18 at 2:25 PM an interview was completed with the Administrator. She said policies on abuse are reviewed with staff upon hire, annually and on an as needed basis. She stated the staff member assigned to the investigation of Resident #4's injury of unknown origin had attempted to notify the State Survey Agency, but had not notified the correct department. The administrator determined the new staff member had called the hospital's emergency contact and was not instructed to call anyone else or to fax a report. She stated that it was her expectation for staff to know and follow the policy and report injuries of unknown origin to the State Survey Agency within the required timeframes.	F 607	convene to ensure the policy and procedure is being followed for the investigation and reporting elements. Results will be reported by the DON at the Quality of Life and House-wide QI committee meetings monthly.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		8/8/18

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F 609	Continued From page 6 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit a 24-hour initial report and 5 working day investigation report to the State Agency within the required timeframes for 1 of 1 sampled resident (Resident #4) reviewed for injury of unknown origin. Resident #4 experienced a fractured right ankle of unknown origin which was not reported to the State Survey Agency within 24 hours of discovery of the injury. The findings included:	F 609	Corrective action to be accomplished for the resident found to be affected by the deficient practice: Resident #4 - N/A. All records were reviewed concerning this resident. It was determined facility policy for abuse was followed for the investigation of the incident. The risk manager provided these findings to the hospital based reporting structure but not to the State Survey Agency and Adult Protective	

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F 609	Continued From page 7 Review of the facility's Abuse, Neglect, and Misappropriation policy last revised in November 2017 revealed guidance to direct staff members on the "screening and training of employees, protection of resident/patients and the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, diversion of drugs, fraud, injury of unknown source, and misappropriation of property". It stated that an injury should be classified as an injury of unknown source when both of the following conditions are met: 1) the source of the injury was not observed by any person and cannot be explained by the resident 2) when the injury is suspicious because of the extent of the injury or the location of it. The policy also stated that the Chief Nursing Officer (CNO) or Director of Nursing (DON) would ensure that the State Survey Agency would be notified as soon as possible, but not to exceed 24 hours after discovery. Upon completion of the investigation, the facility will report investigative details and conclusion to the State Survey Agency and the administrator within 5 working days. Resident #4 was admitted to the facility on 6/15/2015 with diagnoses that included dementia and osteopenia (weak or brittle bones). Review of the a quarterly admission minimum data set (MDS) assessment for resident #4 dated for 4/4/18 revealed the resident was severely cognitively impaired, did not exhibit any abnormal behaviors and did not reject care. Resident #4 required one to two person extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident had impaired mobility on one side of the body for upper and lower extremities,	F 609	Services. It was determined the policy did not include the steps and timeframes required for reporting for the initial allegation report and subsequent investigation report. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: Facility policy has been updated to reflect all steps needed in abuse investigation and reporting process. The social worker verified the ombudsman preferred method of communication of suspected abuse is via fax. This information has been placed in the policy. Education will be completed with all staff regarding policies and procedures regarding abuse and reporting structure and timing. This education will be completed by August 8, 2018. How we will monitor our performance to make sure that solutions are sustained: There will be weekly audits of 3 random staff members for 6 weeks to determine if the staff member understands the abuse policy. This auditing will be completed by the Director of Nursing or designee. Results will be reported at the Quality of Life and House-wide QI committee meetings monthly. All cases of possible Abuse, Neglect and	

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F 609	Continued From page 8 A review of the facility's Interdisciplinary Progress Notes and Skin Tears/Bruising Tracking Log dated for 6/7/18 at 7:40 AM revealed resident #4's right foot was swollen with blue discoloration and her right lower leg had a knot above her ankle. An x-ray was ordered and the results were reported to the facility on 6/7/18 at 12:45 PM. The x-ray revealed the resident had an oblique fracture to her right distal tibia (right lower leg above ankle bone). The x-ray also noted resident #4 to have osteopenia. The investigation was completed on 6/7/18, and the facility focus group consisting of the Medical Director, CNO, and DON met to discuss the outcome of the investigation and to determine interventions for prevention. Further review of the investigation report revealed it was not sent to the State Survey Agency. On 7/11/18 at 2:25 PM an interview was completed with the Administrator. She said policies on abuse are reviewed with staff upon hire, annually and on an as needed basis. She stated the staff member assigned to the investigation of Resident #4's injury of unknown origin had attempted to notify the State Survey Agency, but had not notified the correct department. The administrator determined the new staff member had called the hospital's emergency contact and was not instructed to call anyone else or to fax a report. She stated that it was her expectation for staff to know and follow the policy and report injuries of unknown origin to the State Survey Agency within the required timeframes.	F 609	Misappropriation will be investigated per policy and procedure. Upon notification of any allegations, a focus group of a minimum of administrative and nursing management personnel on call will convene to ensure the policy and procedure is being followed for the investigation and reporting elements. Results will be reported by the DON at the Quality of Life and House-wide QI committee meetings monthly.	

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