STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT REIDSVILLE TRANSITIONAL CARE & REHAB CNTR	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 11/18/19 through 11/21/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# OFSR11.	E 000		
F 000	INITIAL COMMENTS A recertification with complaint investigation survey was conducted from 11/18/19 through 11/21/19. 1 of the 16 complaint allegation(s) was substantiated resulting in deficiencies F658.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and resident interview the facility failed to provide relief for nausea and vomiting for 1 of 1 residents. (Resident #52). Findings included: Resident #52 was admitted to the facility on 7/10/2014 with diagnosis including transient ischemic attack, cerebral infarction without residual deficits, high blood pressure, type 2 diabetes, heart failure, and chronic obstructive pulmonary disease. The most recent quarterly minimum data set	F 658	F-658 For resident #52 non-emergency treatment was provided by sending resident to the emergency room at the local hospital. Resident #52 was returned the facility after treatment at the hospital with orders for p.r.n. medication, and follow up with the facility medical staff. The facility recognizes the alleged deficient practice has the potential to affect other residents; therefore, the facility unit manager will conduct an audit of current residents with a change of condition in the last 30 days which	12/16/19

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

Electronically Signed | 12/12/2019

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F 658	Continued From page 1 (MDS) dated 10/25/2019 indicated Resident #52 was cognitively intact, had functional vision and hearing, and was able to make her needs known. The MDS also indicated the resident had no behavioral symptoms, no psychosis and no history of refusing care during the assessment period. Additionally, the MDS indicated the resident was independent with activities of daily living requiring only verbal cueing when needed. The resident was noted to be independent in mobility using an assistive device (cane). In an interview with Resident #52 on 11/19/2019 at 10:27am she stated she remembered the incident in August when she was taken to hospital with high blood pressure. Resident #52 stated she had been vomiting that morning but did not know why. She stated she also had some diarrhea. Resident #52 further stated she did not keep her morning medications down, including her blood pressure medications, because of her vomiting. She stated it was a Sunday morning and she went to church with her family. Resident #52 stated her daughter took her lunch after church but she could not eat due to nausea. She further stated she still did not feel good on return to the facility around 2 or 2:30 pm. Resident #52 reported that when she returned to the facility, the nurse continued to try and get in touch with the on call provider to get an order for medication to help with her nausea and vomiting but the nurse could not get in touch with the doctor. Resident #52 stated that she continued to feel worse until her daughters requested the nurse have her sent to the Emergency Room. Resident #52 stated her nurse called the Director of Nursing (DON) regarding lack of response from the on call provider and was told if she needed to go to the ER, her family would have to take her or call 911.	F 658	required contacting the on-call medical provider to determine if other residents were impacted. The audit will be completed by 12/16/2019. Additionally, the facility and the medical staff implemented a policy which directs the nurse in non-emergent situations to call the medical provider, if a response is not received within 30 minutes the nurse is to place another Call to the on call medical provider. If a call is not received after an additional 30 minutes the nurse is to immediately call the Director of Nursing. The nursing staff will be educated on the policy and procedure by the Staff Development Coordinator by December 16, 2019 then the Unit Manger and Staff Development Coordinator will audit residents which require on call medical provider notification for timely response and policy compliance. The audits will be conducted 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 4 weeks. Corrective action will be applied as indicated. The Director of Nursing will present a summary of finding to the QAPI Committee monthly for their review and input. The Director of Nursing will ensure continued compliance with the input and oversight of the facility QAPI Committee. Completed by: 12/16/2019	

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F 658	Continued From page 2	F 658		

An interview with Nurse #6 was conducted on 11/19/2019 at 10:00am. Nurse #6 stated she was the nurse caring for Resident #52 on the day of the incident in August and did remember the incident. She stated she gave resident #52 her medications in the morning but did not recall if she was able to keep the medications down or if she vomited after medication administration. Nurse #6 stated she recalls trying to contact the provider on call at least once before the resident left the facility with her family. She stated she did not take the resident's blood pressure because the resident's orders were to obtain blood pressures daily at noon and the resident was out of the facility, at church, during that time. Nurse #6 stated that when the resident returned to the facility some time mid afternoon, she did try and contact the provider at least twice to obtain and order for something to control resident's nausea and vomiting. She never got a return call and had to report this to the night shift nurse. Nurse #6 stated she did not recall taking the resident's blood pressure or other vitals on return to the facility after church.

Nurse #7 was an agency nurse working the night of 8/18/2019. The facility did not provide contact information for Nurse #7. However, her nursing progress note with the effective dated 8/18/2019 at 7:33pm (entered on 8/19/2019 at 7:05 am) indicated Nurse #7 received report from Nurse #6 and was told she had made several calls to on-call provider in an attempt to get medication for resident #52's nausea and vomiting but the provider had not returned calls. The nursing documentation revealed resident #52's daughter had requested the resident be sent to the emergency room for nausea/vomiting and

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F 658	Continued From page 3	F 658		

general weakness. Nurse #7 documented that she called and spoke with the Director of nursing (DON), who directed her to explain to the resident's daughter that the resident did not meet the criteria for an emergency room visit and that the family would need to take the resident themselves or call EMS. Nurse #7's documentation indicated she relayed this message to resident #52's family and they did call EMS and have the resident transported.

On 11/19/19 at 11:41pm an interview with DON was conducted. She stated she did meet with Nurse #6 the day after this incident to review what happened on 8/18/19. She stated an in-service was conducted with Nurse #6 regarding notification. She further stated Nurse #6 should have called her after two failed attempts to contact provider. The DON stated she did not know what provider was on call that day or why they did not return calls from Nurse #6.

On 11/19/19 at 2:54 pm a phone interview with the facility medical director was conducted. He denies any knowledge of the incident on 8/18/19 regarding resident #52. He stated, if the nurse felt like the issue could be handled in house, then he supported keeping the resident in the facility and attempting to treat her. He stated he was not on call the Sunday that this incident occurred, but the staff knows they can always call him.

Hospital record review revealed resident #52 arrived in the emergency room on 8/18/2019 at 9:01pm with a chief complaint of vomiting. The ER physician's note indicated resident #52 had dull upper abdominal pain on exam. Hospital records indicated the resident was given intravenous fluids, intravenous Zofran for

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F 658	Continued From page 4 vomiting, and intravenous hydralazine for her elevated blood pressure. Resident #52 was discharged from the ER at 12:15am on 8/19/2019 with a final diagnosis of non -intractable vomiting with nausea.	F 658		