STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

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F 000	INITIAL COMMENTS A complaint investigation was conducted on-site in the facility from 07/07/20 through 07/08/20 and continued remotely through 07/09/20. 2 of 25 complaint allegations were substantiated resulting in federal deficiencies.	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 physician interview, staff interview, and record review the facility failed to further assess 1 of 1 sampled residents (Resident #1) who experienced an elevated blood pressure which flagged in the electronic medical record's alert system. Findings included: Record review revealed Resident #1 was admitted to the facility on 10/19/16. The resident's documented diagnoses included hypertension, Parkinson's disease, diabetes, nutrition via feeding tube, and late onset Alzheimer's disease without behavioral symptoms. A 05/14/20 physician order started Resident #1 on prn (as needed) clonidine (Catapres) 0.1 milligrams (mg) every 8 hours for the management of mild to moderate hypertension. Administration Instructions documented, "For systolic blood pressure greater than or equal to 170 or diastolic blood pressure greater than or	F 658	Identified Problem: Elevated B/P flagged in system with no follow up/communication among staff. Goal: Identify, communicate, and follow up with all flags in the EPIC system; utilize orders as indicated; communicate through documentation; notification to MD and staff regarding interventions in place along with notification of change for individual resident. Action items: Acknowledge all hard stops/red flags in EMR - Education provided with staff signage sheet for understanding; audits from clinical(Daily EMR documentation) and pharmaceutical staff (Monthly), utilization of medications ordered/prescribed. Communicate abnormal vital signs: Education provided to clinical staff regarding verbal communication with signage noting understanding; Monitoring	7/24/20

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

Electronically Signed | 07/17/2020

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F 658	Continued From page 1 equal to 100. Recheck blood pressure 1 hour after clonidine is given. If blood pressure is still elevated, notify physician." Resident #1's 05/22/20 quarterly minimum data set (MDS) documented she had impaired short and long term memory, she was severely impaired in decision making, she exhibited no behaviors including rejection of care, she was dependent on the staff for all of her activities of daily living (ADLs), and she received at least 51% of her calories and at least 501 cubic centimeters (cc)/day of fluid from her tubefeeding. Resident #1's vital signs record documented her blood pressure was 157/105 at midnight on 06/27/20 (the blood pressure reading triggered the electronic medical record's alert system and flagged in red with an exclamation point beside it). Review of Resident #1's June 2020 electronic medical administration record (e-MAR) revealed the resident did not receive prn clonidine on 06/27/20 even though her diastolic blood pressure exceeded 100. Review of the resident's progress notes and vital sign record revealed no further blood pressure readings were documented for Resident #1 after midnight on 06/27/20. In a 06/27/20 8:25 AM progress note Nurse #1 documented, "During morning med pass at (5:45 AM) walked by room and noted emesis down the front of elder's gown and in her open mouth. Head of bed was elevated 45 degrees. Elder is a tube feeder and had (Glucerna 1.5) infusing at rate of 55 mL (milliliters)/hr with 180 mL flushes every 4 hours. Upon entering room suctioned	F 658	of EMR for documented vital signs; Documentation and follow up with interventions and notifications in EMR. Notification to Medical Director for abnormalities and utilization of PRN interventions. Vital Sign Reporting All vital signs are to be documented All abnormal vital signs are to be reported to the nurse Any/All protocols are to be followed for abnormal vital signs Notification to the Medical Director for all abnormalities Any red flags/BPA(Best Practice) flags are to be acknowledged and documented within the EMR Follow up vital signs are to be obtained for all abnormalities and as indicated Communication with the clinical team for all patient care Education began on 7/14/2020 and completion date for all staff to review action plan and protocol is 7/24/2020. This too will be ongoing as audits and rounding are daily and will be a part of the EMR documentation. Audits will be completed daily for abnormalities with vital signs/red flags in the EMR by the charge nurse/unit manager; Documentation will be indicative of the abnormality and the intervention utilized. All audit results will be incorporated in the QAPI report/meeting. QAPI meeting scheduled for 8/18/2020.	

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F 658	Continued From page 2	F 658		

elder's mouth out and got back about 100 mL of yellowish brown colored liquid noted her not to be responsive. Checked pulse and noted to be pulseless with no rise and fall of chest noted, no heart tones heard or lung sounds auscultated. Elder is AND (allow natural death) code status...."

During a telephone interview with Nurse #1 on 07/07/20 at 3:56 PM (phone) he stated he did not recall seeing an alert in the e-MAR regarding Resident #1's blood pressure on 06/27/20, and he did not recall Nursing Assistant (NA) #1 telling him that Resident #1 had an elevated blood pressure on 06/27/20. He reported the facility had a double alert system for abnormal vital signs with the abnormal vital being highlighted in red in the e-MAR and the NA collecting vital signs verbal alerting the nurse about the abnormal vital sign. He commented that the parameters for prn clonidine were about the same for every patient with administration warranted when the resident's systolic blood pressure was equal to or greater than 170 or 180 or when the resident's diastolic blood pressure was equal to or greater than 100. According to Nurse #1, the resident's blood pressure was supposed to be checked an hour after clonidine administration, and if the resident's blood pressure was still elevated, the resident's primary physician was to be contacted for guidance.

During a telephone interview with NA #1 on 07/07/20 at 5:01 PM she stated 06/26/20 - 06/27/20 was her first time caring for Resident #1. She reported she began taking vital signs in Resident #1's unit around 11:15 PM on 06/26/20, and remembered reporting to Nurse #1 that Resident #1 had a spike in her blood pressure. She commented she assumed the nurse would

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F 658	Continued From page 3 take follow-up blood pressure readings on the resident, but she was not sure this happened because she had other duties to perform. During a telephone interview with Resident #1's primary physician on 07/09/20 at 3:08 PM he stated Nurse #1 did not have to automatically administer the prn clonidine to the resident on 06/27/20 based on one blood pressure reading, but the nurse should have taken follow-up blood pressures subsequently to determine if the elevated blood pressure was a one time fluke or the resident's blood pressure remained elevated for a more extended period of time. He commented if multiple readings were elevated then the prn clonidine should have been administered, with the resident's blood pressure checked again an hour after medication administration. According to the physician, it could not be determined if the elevated blood pressure played a part in Resident #1's death. He explained the resident could have had an event that triggered vomiting, or the resident could have vomited and then there was a resulting event which contributed to her death. He commented the resident did not present with the reddish-blue coloring that was typical with aspiration. During a telephone interview with the facility administrator on 07/09/20 at 4:24 PM she stated there was a breakdown in communication between the nurse and NA on 06/27/20 regarding Resident #1's blood pressure. She reported Nurse #1 should have reassessed Resident #1's blood pressure after the elevated value of 157/105 was obtained at midnight on 06/27/20.	F 658		
F 685	Treatment/Devices to Maintain Hearing/Vision	F 685		7/24/20

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F 685 SS=D	Continued From page 4 CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility failed to carry out a psychiatry order to recheck the functionality of a hearing aid for 1 of 1 sampled residents (Resident #2) who depended on the use of a hearing aid to communicate with staff. Findings included: Record review revealed Resident #2 was admitted to the facility on 06/28/18. Her documented diagnoses included bilateral hearing loss, Alzheimer dementia with behavioral disturbances, bipolar disorder, and schizophrenia. Record review revealed Resident #2 received a notice on 07/25/19 that her telecoil hearing aid had been approved. A 01/07/20 psychiatry consult documented, "Pt. (Patient) is accompanied by the social worker (SW) from (the facility). Per SW, patient's behavior has improved since she received her	F 685	Identified Problem: Order for hearing aid functionality given by outside provider to assist in identifying potential communication barrier for resident was not followed up on by staff. Goal: Identify, communicate, and follow up with orders that are written by providers outside the system that are unable to document in the EMR system being utilized at Southeastern Health. Action Items: Acknowledge all orders written from outside providers/appointments Communicate interventions with appropriate staff for follow up Notify Medical Director on recommendations from outside provider Document and follow up with all interventions identified Secretary/Designee to scan orders into	

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F 685	Continued From page 5	F 685		

hearing aides but at times continues to 'holler out', may be due to patient not being able to hear....During the visit patient appears to be hard of hearing and answers one word sentences to questions. Pt. has a hearing aid noted to her left ear...."

A 01/07/20 order written by Nurse Practitioner (NP) #1, who worked for psychiatry services, documented to have the audiologist re-evaluate Resident #2's hearing aid.

On 02/20/20 the facility's former SW documented in her spiral notebook that she had identified the company which provided Resident #2 with her hearing aid, and noted that "need to take hearing aide to office."

Resident #2's 05/19/20 annual minimum data set (MDS) documented her cognition was severely impaired, she was dependent on the staff for all of her activities of daily living, she experienced moderate difficulty hearing with the speaker having to increase their volume and speak distinctively, she utilized a hearing aid, and she sometimes understood others.

A 05/27/20 Care Plan note documented, "She (Resident #2) is alert and oriented to person. Her speech is clear, and she is sometimes understood and sometimes understands. She is moderately hard of hearing requiring speaker to use loud tone of voice or staff will write out questions. She has a hearing aid in left ear and staff still must raise voice or repeat several times to be heard. She can answer simple direct questions or follow simple commands when she understands and/or hears what is being ask. Will often furrow brow and have puzzled look on her

EMR
Social Worker to schedule and follow up with intervention ordered (Hearing Aids).

On 7/9/2020, Social Worker made an appointment for hearing aid assessment for identified resident; on 7/10/2020 hearing aids were assessed/cleaned and returned to facility for resident.

On 7/14/2020, education for all clinical staff was started regarding the following protocol:
All orders from outside physicians will be acknowledged by staff (Documentation in the EMR/Communication among staff)
All orders from outside appointments/physicians will be communicated during rounding and with appropriate staff (Social Worker)
Medical Director will be notified of outside provider recommendations
Secretary/Designee will scan orders in EMR
Follow up documentation will be provided in the EMR by appropriate staff

On 7/10/2020, Social Worker completed a facility audit for residents with hearing aids; Social worker added hearing aid assessments to resident care plan agenda.

Completion for education and protocols for staff will be 7/24/2020 with ongoing audits and review within the EMR and through care plan documentation (MDS).

Weekly audits will be completed by the

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F 685	Continued From page 6 face when she does not hear what is said or understands. Will yell out loudly 'what did you say' or 'I can't hear you.'" During a 07/08/20 3:03 PM interview with Nurse #2 who cared for Resident #2 she stated she did not always think that the resident's hearing aid was effective in enhancing her communication. During a 07/08/20 3:57 PM interview with Nursing Assistant (NA) #4 who cared for Resident #2 she stated she was not sure the resident's hearing aid was working correctly because it did not seem to help the resident hear any better. During an interview with Resident #2's Unit Manager on 07/08/20 at 4:04 PM she stated the hall nurse should have noted the 01/07/20 order and followed up to obtain an appointment to get Resident #2's hearing aide serviced. She reported the hall nurse should have input the appointment date into the facility's electronic medical record system. During an interview with the facility's current SW on 07/08/20 at 4:15 PM she stated she just made contact with the company which furnished Resident #2's hearing aid, and the company reported the hearing aid had not been brought back in for follow-up service since it was furnished. She reported the person she talked with stated it was past time to check the tube in the hearing aid which could effect the amplification. During an interview with Resident #2's primary physician on 07/09/20 at 3:08 PM he stated hearing aides should be taken periodically for servicing so that they continued to work at peak	F 685	unit managers/social worker for outside physician appointments in effort to identify any new order/intervention. Information obtained through weekly audits will be included in the QAPI agenda/meeting. QAPI meeting scheduled for 8/18/2020.	

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F 685	Continued From page 7	F 685		

proficiency. He commented not being able to communicate with staff effectively could affect resident quality of life.

During a telephone interview with the facility administrator on 07/09/20 at 4:24 PM she stated there was a problem in getting Resident #2's hearing aid serviced because the psychiatric NP did not have rights to place orders into the facility's electronic medical record system, and the order was placed in the resident's paper chart after hours. She explained that normally the unit secretary would have scanned the order into the electronic medical record, and the SW would have followed up to make sure an appointment was secured.