STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. BUILDING ______ B. WING ______	C 04/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING REHAB CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

(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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to implement their policy and complete background/reference checks for 2 of 5 employees (NA#1 and NA #2). The findings are: 1. Review of the facility's undated abuse policy stated: "Section A-Screening The facility screens all prospective employees by conducting a criminal background check." Review of Nursing Assistant (NA) #1's employee file revealed the date of hire was 1/18/11. Information within the file indicated NA #1 had lived in North Carolina since 2008. A background check was completed but no documentation was found indicating NA#1 was fingerprinted prior to or after employment with the facility. Interview with the Director of Nursing (DON) on 4/26/11 at 12:40 p.m. revealed she was unaware of the requirement for fingerprinting non-licensed applicants who have lived in North Carolina less than five years prior to their hire. During an interview on 4/27/11 at 9:30 a.m., the	F 226	" Submission of this response to the Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or were correctly cited and/or require correction". 1. Nursing Assistant # 1 has had fingerprinting done as of 5/05/2011. No residents were affected by the alleged deficient practice. An audit of all unlicensed staff was completed by the Administrator on 5/11/2011. Unlicensed staff identified in the audit will have a fingerprint card completed by 5/20/2011. Unlicensed staff that have not completed a fingerprint card will not be allowed to work after 5/20/11. All newly hired unlicensed staff will have fingerprint cards completed before beginning work. Administrative staff were in-serviced regarding the Abuse and Neglect Prohibition plan on 5/17/2011 by the Administrator. The Payroll Director will audit all newly hired unlicensed staff to ensure that a residency history was obtained and that fingerprints were completed as identified by the residency history. The Payroll Director will provide the Administrator with an audit weekly x one year.	5/20/11 5/20/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Conrade, NHA — TITLE: Administrator — (X6) DATE: 5/18/11

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 226	Continued From page 1 Administrator acknowledged awareness of the need for fingerprinting applicants who have lived in North Carolina less than five years. The Administrator stated fingerprinting was done by the State Bureau of Investigation. The Administrator confirmed that fingerprint checks for NA #1 were not done prior to her being hired on 01/18/11 as specified in the facility's policy and procedure. 2. Review of the facility's undated abuse policy stated: "Section A-Screening The facility screens all prospective employees by securing at least two personal or professional references. Review of Nursing Assistant (NA) #2's employee filed revealed the date of hire was 2/1/11. A background check was completed but no documentation was found in her employee file indicating references were checked prior to or after her employment with the facility. During an interview on 4/26/11 at 12:40 p.m., the Director of Nursing (DON) confirmed there were no references available in NA #2's file. Speaking about the missing references, the DON stated, "This is it. If it isn't here, it isn't anywhere." During an interview on 4/27/11 at 9:30 a.m., the Administrator stated reference checks were required prior to being hired by the facility and confirmed there were no references available in NA #2's file.	F 226	The Administrator will evaluate the results of the audit to ensure that the plan was effective. The Payroll Director will provide the results of her audits for the QA & A Committee one time per month x one year. NA # 2 no longer works at the facility effective 3/11/11. Her last day worked was 2/4/11. An audit of all employee files has been completed as of 5/16/2011. All reference checks have been performed per the Abuse and Neglect Prohibition Plan as of 5/16/11. All management staff have been in-serviced as of 5/16/11 by the Administrator regarding reference checks on all employees per the Abuse and Neglect Prohibition Plan. The Staff Development Coordinator/ Assistant Director will ensure that two Professional or personal references are obtained prior to employment for all facility staff going forward. The Payroll Director will audit all new hire files to ensure that 2 reference checks have been obtained prior to the person being hired going forward.	
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	The Payroll Director will report the	

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F 309	Continued From page 2 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record reviews, the facility failed to immediately implement emergency medical interventions and initiate Cardiopulmonary Resuscitation (CPR) as specified by the Advanced Directives for one (1) of six (6) residents. (Resident #1) Immediate jeopardy began on 12/26/10 when Resident #1 did not receive immediate emergency medical interventions including CPR and calling 911 for a resident who had a full code status. Immediate Jeopardy was removed on 4/28/11 following staff education. The facility remains out of compliance at a lower scope and severity of D, an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy, while the facility monitors the effectiveness of the staff education. The findings are: An undated facility policy titled "Cardiopulmonary Resuscitation (CPR)" included the following: - CPR is provided when the resident's Advanced Directive specifies such, or when there is NO Advance Directive to contraindicate CPR administration..	F 309	findings of the audit to the Administrator weekly x one year. The Administrator will evaluate the audit results to ensure that the plan is effective and report to the QA&A Committee monthly x one year. Resident # 1 has expired. Nurse # 1 no longer works at facility. An audit of all residents' clinical records was completed by the Resident Care Coordinators and the MDS Coordinators on 4/27/11 and 4/28/11 to ensure that each residents' CODE status is clearly defined in the medical record. A list of all residents with a FULL CODE status was placed in front of the Medication Administration Record as of 4/28/11 and will be updated as changes occur. All newly admitted residents' CODE status is obtained by the Admissions Coordinator and placed in the admission packet and given to the admitting nurse. Admitting nurse is verifying the CODE status with the resident/family and is contacting the physician for verification prior to placing in the clinical record. The admitting nurse is updating the CODE status list in the MAR to include new residents CODE information.	5/20/11

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F 309	Continued From page 3 - Upon finding the resident, call for help. Certified personnel should attend to the resident while other staff make emergency calls and retrieve resuscitation equipment. - Observe for symptoms of cardiac arrest: loss of consciousness, absence of carotid or femoral pulses, absence of audible heart sounds, absence of breath sounds. - If no pulse is observed, tilt head back and give two (2) quick, full, long inflations. - Check for pulses again. - If pulses are absent, begin cardiopulmonary resuscitation. Resident #1 was admitted 12/21/10 with diagnoses including End-Stage Dementia, Failure to Thrive, Cachexia and Chronic Wounds. The Interdisciplinary Assessment completed during admission indicated impairment of memory and cognition and dependence on staff assistance for all daily care. The nursing admission note indicated the resident was scheduled for feeding tube placement 12/30/10. Medical record review revealed a document titled "Full Code Agreement," which included text as follows: "This is to acknowledge that this resident is a full code. If the resident is found to have no heart rhythm or respirations, then full measures will be implemented." The document was signed 12/21/10 by the Guardian for Resident #1. The admission note written 12/21/10 by the Social Worker noted, "Full code is in effect." The History and Physical signed by the physician 12/23/10 indicated the resident's code status was full code. Review of nursing documentation of 12/26/10 revealed the following note written at 6:39 a.m. by	F 309	In-services were conducted on 4/27/11 and 4/28/11 by the Director of Nurses, Assistant Director of Nurses/Staff Development Coordinator and the Vice President of Clinical Services and included the following: a. If a resident is found unresponsive, pull emergency call light and summon a Nurse STAT. b. The nurse will assess the resident while another nurse checks the medical record for the code status. If the code status is FULL CODE, immediately page "code blue" via the overhead page and initiate CPR. a. Call 911. b. Call the MD c. Call the family. d. If the resident is determined to be a DNR status, call the MD and the family. e. The Charge Nurse and/or the assigned nurse will notify The Director of Nursing immediately if a resident with a FULL CODE status has been resuscitated or has expired to allow her to de-	

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F 309 Continued From page 4

Licensed Nurse #1:

"Resdt (resident) observed not to be breathing. 0 (No) resp (respirations). 0 pulse. On call physician paged. Awaiting him to call back. Guardian notified by leaving message with the answering services. CPR initiated. 911 notified. Resdt pronounced dead by EMS (Emergency Medical Services)."

During an interview on 4/26/11 at 1:20 p.m., the Director of Nursing (DON) stated the policy and procedure for medical emergencies included overhead page of code blue, call to 911, and call to the physician. The nurse is responsible for verifying the code status in the chart. If a resident is full code status, CPR should be started immediately. The DON stated the resident's code status is considered a physician's order and should be followed by nursing staff. The DON stated the nurse responsible for the resident's care on 12/26/10 was CPR certified, but did not page the emergency overhead and did not immediately start CPR, and his actions were based on his assessment that the resident was deceased. The DON stated nurses are not qualified to pronounce the death of a resident.

On 4/27/11 at 9:55 a.m., interview with Licensed Nurse (LN) #1 revealed he was responsible for the resident's care 12/26/10. LN #1 stated he was passing medications and found the resident without pulse and respirations when he entered her room at 6:39 a.m. LN #1 stated he thought the resident's death was "expected," and he left the room and reported to the supervisor (LN #3) the resident had expired. LN #1 stated the supervisor told him to go and check the chart to

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termine that appropriate procedures were followed.

f. Residents who are FULL CODE are listed in front of the MAR.

All facility staff have been in-serviced regarding the CODE Blue policy as of 5/9/11.

All newly hired facility staff will be educated regarding the CODE status and the initiation of CPR during orientation to include the following:

a. If a resident is found unresponsive, pull emergency call light and summon a Nurse STAT.
b. The nurse will assess the resident while another nurse checks the medical record for the code status. If the code status is FULL CODE, immediately page "code blue" via the overhead page and initiate CPR.
c. Call 911.
d. Call the MD
e. Call the family.
f. If the resident is determined to be a DNR status, call the MD and the family.

g. The Charge Nurse and/or the assigned Nurse will notify The Director of Nursing immediately if a resident

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verify code status, and he went to the nurse's station to check the chart. LN #1 stated he saw the full code status, called to notify the physician, and called the guardian to notify of the resident's death. He stated the on-call physician returned the call and directed him to follow the order for code status, and start CPR and call 911. When questioned about his actions, LN #1 stated he did not start CPR immediately because she was cold and had no pulse and respirations. LN #1 stated, " She was dead." LN #1 stated pronouncing death was not in his scope of practice as a Licensed Practical Nurse. LN #1 said after making the calls, LN #3 and NA (Nursing Assistant) #3 were in the room to help him with the code.

On 4/27/11 at 11:00 a.m., the resident's physician was interviewed. The physician stated once the nurse determined full code status for Resident #1, he/she should have immediately started CPR and called 911. The physician stated his expectation is for nursing staff to, without exception, follow orders for code status. The physician stated determination of death is not the responsibility of the nurse.

On 4/27/11 at 1:30 p.m., interview with LN #2 revealed she arrived late to work on 12/26/11, at approximately 7:30 a.m. LN #2 stated EMS arrived after she arrived at work.

During an interview on 4/27/11 at 2:50 p.m., LN #3 stated she received the report the next night during the 7:00 p.m.-7:00 a.m. shift that Resident #1 had expired.

Review of call and arrival times for EMS revealed

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with a FULL CODE status has been resuscitated or has expired to allow her to determine that appropriate procedures were followed.

h. Residents who are FULL CODE are listed on the front of the MAR.

Additionally, All newly hired licensed nurses and certified nursing assistants will be educated regarding the following:

Nurses will monitor residents with noted decline in condition with a terminal diagnosis and with possible or expected death. The resident will be assessed every hour for signs and symptoms of decline and imminent death with findings of assessment documented in clinical record and the 24 hour report sheet. The Charge Nurse will participate in the evaluation and decisions regarding the care of the resident. Findings of assessment will be documented on the 24 hour report and the physician notified as indicated by code status and directives related to hospitalization, medication, and life sustaining measures.

Certified Nursing Assistants will be educated to notify the charge nurse when a residents' condition changes.

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F 309	Continued From page 6 the call was received by EMS at 7:44 a.m., and EMS personnel arrived in the facility at 7:47 a.m. Review of the facility's investigation of the incident revealed statements were taken only from LN #1 and NA #3. The written statements included the following: NA #3 noted the resident was last seen on 12/26/10 at approximately 5:15 a.m. during rounds. The NA reported the resident was alive, and was turned and repositioned at that time. LN #1 documented on 12/26/10 at approximately 6:40 a.m., he went into the resident's room to give medications and found the resident had expired. LN #1 stated he went to notify his supervisor (LN #3) and informed her that the resident's death was expected, then proceeded to call the on-call physician. During the call to notify the physician, LN #1 noted he realized the resident's full code status and informed the on-call service. The Nurse Practitioner on-call for the physician returned the call within a few minutes and directed LN #1 to call 911 and initiate CPR based on the resident's code status. EMS was in the resident's room within a few minutes, and pronounced death. Review of the facility's staff education provided 12/28/10 following the event revealed an inservice was provided to approximately 25 licensed staff. No provision was made to include staff members unavailable at the time of the inservice or prn (as needed) employees not scheduled for work, or for new employees to receive the education. Unlicensed staff (NAs) were not included in the inservice. The content of	F 309	The newly admitted residents' chart is audited within 24 hours by nursing administration (Director of Nurses, Assistant Director of Nurses/Staff Development Coordinator, Resident Care Coordinator (LPN), MDS Coordinator, Weekend Supervisor-Saturday and Sunday. R.N. assigned for holidays) to ensure that the advanced directives are clear and accurate. The Director of Nurses will be notified immediately of any variance from the procedure and inform her of the corrections that were made. A complete audit is reported to the Director of Nurses weekly x one year. Any CODE status changes will be written on the 24 hour report by the nurse transcribing the order, the clinical record will be updated and the MAR FULL CODE list will be updated by that nurse at that time. Nurses will monitor residents with noted decline in condition with a terminal diagnosis and with possible or expected death. The resident will be assessed every hour for signs and symptoms of decline and imminent death with findings of assessment documented in clinical record and the 24 hour report sheet. The Charge Nurse will participate in the evaluation and decisions regarding the care of the resident. Findings of assessment will be documented on the 24 hour report and the physician notified as indicated by code status and directives related to hospitalization, medication,	

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F 309	Continued From page 7	F 309	and life sustaining measures.	

the inservice included the following:
"It is imperative that as a licensed nurse you do rounds on your patients. Your rounds should be opposite of your C.N.A.'s rounds so your patients will be checked on hourly (night shift nurses especially). If a patient is found in your opinion without signs of life and he/she is a FULL CODE you must immediately begin CPR until EMS or Fire Dept arrives and takes over the situation no matter what the patient's condition is (Rigor mortis, cold, blue, vomited, etc ...). This is because you are not qualified to pronounce a patient as being deceased."

The DON was interviewed on 4/27/11 at 3:25 p.m. No explanation was offered for the nurse's failure to immediately intervene in the resident's medical emergency. The DON stated that nurses should follow the resident's Advanced Directive for code status, and based on this resident's designated code status, the facility procedures for code blue should have been initiated when the resident was discovered without a pulse and respirations.

The survey was extended on April 27, 2011, and the Administrator was informed of Immediate Jeopardy (IJ) on April 27, 2011 at 3:00 p.m. for Resident #1.

The facility presented a credible allegation of compliance which included:

1. Correction for Resident #1
Resident #1 has expired.

2. Correction for current residents at risk 4/27/11 and 4/28/11.

The 24 hour report and all physicians' orders will be reviewed by nursing administration (Director of Nurses, Assistant Director of Nurses, Resident Care Coordinators (LPN), MDS Coordinators and Weekend Supervisor-Saturday and Sunday. R.N. assigned for holidays) during morning clinical rounds to identify any clinical status changes and to verify that CODE status was followed going forward.

The chart will be audited and updated at that time as needed by nursing administration (Director of Nurses, Assistant Director of Nurses, Resident Care Coordinators (LPN), MDS Coordinators and Weekend Supervisor-Saturday and Sunday. R.N. assigned for holidays) to ensure that CODE status has been updated where necessary within the residents' clinical record and the MAR.

The Resident Care Coordinator (LPN) for each unit will audit the MAR FULL CODE list weekly to ensure that it is updated and correct with a report to the Director of Nurses weekly x one year.

The Charge nurse or the assigned nurse will notify the Director of Nurses immediately if a resident with a Full CODE status has been resuscitated or has expired to allow her to determine that the appropriate procedures were followed.

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F 309	Continued From page 8 · An audit of all resident charts was conducted on 4/27/11 and 4/28/11 by the Resident Care Coordinators and the MDS Coordinators to ensure that each resident's code status is clearly defined in the Medical Record. A list of residents with a FULL CODE status was placed in the front of each Medication Administration Record on 4/28/11 so that licensed staff has been made aware of all residents with a FULL CODE status. · All newly admitted resident's code status is obtained by the Admissions Coordinator and placed in the admissions packet and given to the admitting nurse. Admitting nurse is verifying the code status with the resident/family and is contacting the physician for verification prior to placing in the clinical record. The admitting nurse is updating the CODE status list in the MAR to include new resident CODE information. · The newly admitted resident's chart is audited within 24 hours by nursing administration to ensure that the Advanced Directives are clear and accurate. The Director of Nurses will be notified immediately of any variance from the procedure and inform her of the corrections that were made. A complete audit is reported to the Director of Nurses weekly. · Nurse involved with Resident #1 is no longer employed by facility. 3. In-service: In-service was conducted on 4/27/11 and 4/28/11 by the Director of Nurses, Assistant Director of Nurses/Staff Development Coordinator and the Vice President of Clinical Services and included the following: 88% of Full time, 68% of Part time and 22% of PRN staff that have direct access to residents (Nursing, housekeeping, maintenance, medical	F 309	The Director of Nursing will audit 10 charts weekly to ensure that the Advance Directives remain in place and are correct x 1 year. In the absence/unavailability of the Director of Nurses the Assistant Director of Nurses will complete audits. The Resident Care Director (Social Worker) will audit 100% of residents' CODE status quarterly for changes in CODE status and to ensure that documentation is present and correct. The Resident Care Director will provide a report of the findings of these audits weekly to the Administrator x 1 year. The Administrator will evaluate these Audits and report to the QA&A Committee monthly x one year. The Director of Nurses or the Assistant Director of Nurses/Staff Development Coordinator will evaluate the results of the Nursing Administration audits to ensure that the plan is effective with report to the QA& A Committee one x monthly x one year.	

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F 309	Continued From page 9	F 309		

records, Administrator, Dietary manager, business office personnel) were re-educated on 4/27/11 and 4/28/11 regarding the initiation of CPR and have been notified of residents with FULL CODE status. The remaining 12% of Full Time, 32% of Part time and 78% of PRN staff will be re-educated prior to working.

Education includes:
a. If a resident is found unresponsive, pull emergency call light and summon a Nurse STAT.
b. The nurse will assess the resident while another nurse checks the medical record for the code status. If the code status is FULL CODE, immediately page "code blue" via the overhead page and initiate CPR.
c. Call 911.
d. Call the MD
e. Call the family.
f. If the resident is determined to be a DNR status, call the MD and the family.
g. The Charge Nurse and/or the assigned Nurse will notify The Director of Nursing immediately if a resident with a FULL CODE status has been resuscitated or has expired to allow her to determine that appropriate procedures were followed.

Nurses have been educated additionally on 4/27/11 and 4/28/11 by the Director of Nurses, Assistant Director of Nurses/Staff Development Coordinator and the Vice President of Clinical Services and included the following:

Residents who are FULL CODE are listed in front of the MAR books for each unit.

Nurses will monitor residents with noted decline

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING REHAB CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

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F 309	Continued From page 10 in condition with a terminal diagnosis and with possible or expected death. The resident will be assessed every hour for signs and symptoms of decline and imminent death with findings of assessment documented in clinical record and the 24 hour report sheet. The Charge Nurse will participate in the evaluation and decisions regarding the care of the resident. Findings of assessment will be documented on the 24 hour report and the physician notified as indicated by code status and directives related to hospitalization, medication, and life sustaining measures. Certified Nursing Assistants have been educated on 4/27/11 and 4/28/11 by the Director of Nurses, Assistant Director of Nurses/Staff Development Coordinator and the Vice President of Clinical Services additionally on the following: C.N.As will notify the nurse of any difference in the residents' appearance or behavior. All newly hired employees will be in-serviced by the Assistant Director of Nurses/Staff Development Coordinator regarding determination of resident's CODE status and initiation of CPR to include the following: Education includes: a. If a resident is found unresponsive, pull emergency call light and summon a Nurse STAT. b. The nurse will assess the resident while another nurse checks the medical record for the code status. If the code status is FULL CODE, immediately page "code blue" via the overhead page and initiate CPR. c. Call 911 d. Call the MD	F 309		

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F 309	Continued From page 11 e. Call the family. f. If the resident is determined to be a DNR status, call the MD and the family. g. The Charge Nurse and/or the assigned Nurse will notify The Director of Nursing immediately if a resident with a FULL CODE status has been resuscitated or has expired to allow her to determine that appropriate procedures were followed. Newly hired Nurses will be educated by the Assistant Director of Nurses/Staff Development Coordinator during the orientation process prior to being assigned to the unit additionally on the following: Residents who are FULL CODE are listed in front of the MAR. Nurses will monitor residents with noted decline in condition with a terminal diagnosis and with possible or expected death will be assessed every hour for signs and symptoms of decline and imminent death. The Charge Nurse will participate in the evaluation and decisions regarding the care of the resident. Findings of assessment will be documented on the 24 hour report and the physician notified as indicated by code status and directives related to hospitalization, medication, and life sustaining measures. The Charge Nurse and/or the assigned Nurse will notify The Director of Nursing immediately if a resident with a FULL CODE status has been resuscitated or has expired to allow her to determine that appropriate procedures were followed. The Charge Nurse will review the	F 309		

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F 309	Continued From page 12 residents' clinical record at that time to ensure that the CODE status is being followed as well as evaluate the procedure. The Charge Nurse will report to the Director of Nurses any variances to the procedure. Newly Hired Certified Nursing Assistants will be educated additionally during orientation and prior to working on the unit by the Assistant Director of Nurses/Staff Development Coordinator additionally on the following: C.N.As will notify the nurse of any difference in the residents' appearance or behavior. 4. Monitoring: 4/27/11 Residents with noted decline in condition with a terminal diagnosis and with possible or expected death will be assessed every hour for signs and symptoms of decline and imminent death. The Charge Nurse will participate in the evaluation and decisions regarding the care of the resident. Findings of assessment will be documented on the 24 hour report, and in the clinical record and the physician notified as indicated by code status and directives related to hospitalization, medication, and life sustaining measures. The Charge Nurse and/or the assigned Nurse will notify the Director of Nursing immediately if a resident with a FULL CODE status has been resuscitated or has expired to allow her to determine that appropriate procedures were followed. The Charge Nurse will review the residents' clinical record at that time to ensure	F 309		

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F 309	Continued From page 13 that the CODE status is being followed as well as evaluate the procedure. The Charge Nurse will report to the Director of Nurses any variances to the procedure. Any CODE status changes will be written on the 24 hour report by the nurse transcribing the order, the clinical record will be updated and the MAR FULL CODE list will be updated by that nurse at that time. The 24 hour report and all physicians' orders are being reviewed by nursing administration (Director of Nurses, Assistant Director of Nursing, Resident Care Coordinator and MDS Coordinators) during morning clinical rounds to identify any clinical status changes and to verify that CODE status was followed. The chart will be audited and updated as needed at that time by nursing administration to ensure that CODE status has been updated where necessary within the residents' clinical record and the MAR. The Resident Care Coordinator for each unit will audit the MAR FULL CODE list weekly to ensure that it is updated and correct with a report to the director of nurses weekly. The Director of Nursing will audit 10 charts weekly to ensure that the Advance Directives remain in place and are correct x 1 year. In the absence/unavailability of the Director of Nurses the Assistant Director of Nurses will complete audits. The Director of Nurses or Assistant Director of Nurses will report findings of the chart and MAR	F 309		

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

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F 309	Continued From page 14 FULL CODE list audits to the QA& A Committee monthly x 12 months. The QA&A Committee will evaluate findings and determine if changes to the plan are needed to assure continued compliance. The Resident Care Director (Social Worker) will audit 100% of residents' CODE status quarterly for changes in CODE status and to ensure that documentation is present and correct. Immediate jeopardy was removed on 4/28/11 at 4:30 p.m. with interviews of direct care staff and licensed nursing staff confirming that they had received inservice training on the unresponsive resident and code blue initiation. Interviews with nursing staff revealed awareness of how to respond and implement measures for an unresponsive resident without pulse or respiration. Reassessment of residents' code status was completed by administrative nursing staff and social services. Code listings for residents designated full code status were updated and placed in the front of the Medication Administration Records (MARs). Observations were made to ensure accurate full code status listings were available in the MARs.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	Resident # 3s PT/INR was completed on 3/21/11 and the residents' physician notified of the results. Licensed nurse #4 was educated regarding necessity of obtaining labs as ordered and that lab orders should not be changed without physician's consent. If lab orders are unable to be obtained the Director of Nurses and the resident's physician must be notified immediately.	5/20/11

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F 329	Continued From page 15 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to obtain lab work as ordered by the physician for 1 of 18 sampled residents on Coumadin medication. (Resident #3) The findings are: Resident #3 was admitted 2/18/08 with diagnoses including Atrial Fibrillation and Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 3/1/11 indicated independence with most activities of daily living but severe cognitive impairment. Review of the medical record revealed the resident was on daily Coumadin (an anticoagulant medication) and required PT/INR testing (blood test to determine accuracy of Coumadin dosing). Review of the resident's "PT/INR Anticoagulation	F 329	An audit for residents on anticoagulant therapy was completed on 5/16/11 by the Resident Care Coordinator and Assistant Director of Nurses/Staff Development Coordinator and Nursing Supervisor to ensure that all ordered labs were drawn timely and the results reported to the physician. All administrative nurses were in-serviced on 5/18/11 by the Director of Nurses regarding the PT/INR policy and the need to obtain labs timely. All newly hired licensed nurses will be educated regarding the PT/INR policy and the need to obtain labs timely. The PT/INR log book will be reviewed daily by the administrative nursing team (Director of Nurses, Assistant Director of Nurses/Staff Development Coordinator, Resident Care Coordinator, MDS Coordinator and/or Nursing Supervisor, Weekend Supervisor Saturday and Sunday, R.N. assigned for holidays) during morning clinical rounds to ensure that all labs were obtained as ordered going forward. The Resident Care Coordinator will report to the Director of Nurses the findings of the PT/INR log book audit weekly x one year.	

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F 329	Continued From page 16 Log Sheet" revealed a notation that the resident had a PT/INR drawn 3/9/11 and was to have a repeat INR on 3/16/11. The record revealed the physician was notified on 3/9/11 that the resident's PT was 21.7, the INR was 1.8, and the Coumadin dose was adjusted to 5.5 milligrams (mg) for Saturday and Sunday and 4.5 mg Monday-Friday. Review of the Physician's Telephone Orders dated 3/9/11 revealed the following: "PT/INR 1 wk [week] 3/16/11." Further review of the resident's medical record revealed no documentation that a PT/INR was drawn 3/16/11. Continued review of the log sheet revealed a notation that the resident's next PT/INR was drawn on 3/21/11; the PT was 18.1, the INR was 1.5, and the physician adjusted the Coumadin to 5mg daily. Review of the Physician's Telephone Orders revealed the following order dated 3/21/11: "Order clarification:-change PT/INR from 3/16/21 [sic] - to 3/21/11." The order was signed by the physician's nurse practitioner 3/23/11. Review of the lab calendar revealed entries were previously written in the 3/16/11 and 3/21/11 blocks but were covered with correction fluid and no longer readable. On 4/26/11 at 4:10 p.m., LN #4 stated she wrote the 3/21/11 PT/INR order for Resident #3. She said she was responsible for obtaining the lab work, notifying the doctor of the results, and writing the new orders for the next PT/INR. LN #4 stated, "I make the orders according to how many [other PT/INRs] I have to do in a day and I'll sometimes swing them to even them out." When asked about the 3/21/11 clarification order, LN #4 stated she did not recall why the order was	F 329	The Director of Nurses or Assistant Director of Nurses/Staff Development Coordinator will review the findings from the weekly report to ensure that the plan is effective and report to the QA&A Committee monthly x 1 year.	

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F 329	Continued From page 17 changed. During an interview on 4/26/11 at 5:00 p.m. with LN #4 and the Director of Nursing (DON present, the DON stated she expected blood to be drawn as ordered unless the physician made changes or gave an order to get it on a different day. Telephone interview with the physician on 4/27/11 at 11:05 a.m. revealed he did not know why the PT/INR ordered to be completed 3/16/11 was not completed until 3/21/11.	F 329		