

MAY 16 2013

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345538	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2013
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST-ACUTE CARE-RALEIGH			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	
(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 309 SS=D	<p>403.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow physician 's orders to administer scheduled pain medications for 2 (Resident #4 and #5) of 3 sampled residents and failed to monitor bowel movements and initiate standing physician 's orders for 2 (Resident #5 and #9) of 3 sampled residents who had not had a bowel movement in 3 days.</p> <p>The findings included:</p> <p>1. Resident #4 was admitted to the facility on 4/5/13 and had diagnoses that included Compression Fractures of the Thoracic Spine.</p> <p>The hospital Discharge Summary for Resident #4 dated 4/5/13 under Discharge Medications revealed that the resident was to receive Norco 5/325 milligrams (mg) one tablet in the morning and one tablet at bedtime. Norco is a narcotic medication used to treat moderate to severe pain.</p> <p>An initial pain assessment dated 4/5/13 showed that the resident had severe pain with movement and increased physical activity due to</p>	F 309	<p>F-309 PROVIDING CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Immediate action taken for residents Identified:</p> <ol style="list-style-type: none"> 1. Resident # 4 no longer resides in the facility. 2. Resident #5 pain medication was applied on 04/14/13 and laxative was given per protocol. 3. Resident #9 was given laxative as ordered. <p>Identification of other residents with potential to be affected:</p> <ol style="list-style-type: none"> 1. Licensed Nurses completed a Pain audit on 100% of the residents in the facility on 04/25/13. 2. The Licensed Nurse is completing a Pain observation on all new Residents upon admission.. 3. Nurse #1 have been counseled and re-educated on ensuring Physician's orders are carried out to include pain medication administration. 4. The Bowel Movement records were reviewed to ensure the resident have had a BM within 3 days and/or that the BM protocol has been followed per physician order. 	5-14-13

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

Daniel Taylor

TITLE

Administrator

(X6) DATE

5/14/13

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 309	<p>Continued From page 1</p> <p>musculoskeletal problems, arthritis and spinal stenosis. The form showed that the resident was to receive Norco 5/325 mg BID (twice a day) and Norco 7.5/325mg every 4 hours PRN (as needed) for pain.</p> <p>The Admission Minimum Data Set (MDS) Assessment dated 4/10/13 revealed that the resident had short term memory loss and was moderately cognitively impaired and had frequent pain.</p> <p>The Care Area Assessments and Care Plan were not completed prior to the resident leaving the facility on 4/10/13.</p> <p>The Medication Administration Record (MAR) for April 2013 revealed an entry dated 4/5/13 for Resident #4 to receive Norco 5/325mg 1 tablet by mouth at 8:00 AM and 8:00 PM daily.</p> <p>The Director of Nursing Service (DNS) stated in an interview on 4/25/13 at 4:23 PM that Resident #4 was admitted on Friday (4/5/13) afternoon. The DNS stated that on Monday evening (4/7/13) it was brought to her attention that Resident #4 did not receive her scheduled pain medication over the weekend. The DNS stated that she spoke with Nurse #1 that worked on the weekend and the nurse told her that she thought that the pain medication was PRN. The DNS stated that the Nurse told her that the resident was offered pain medication several times on the weekend and the resident stated that she did not need pain medication at that time and that she gave the pain medication when the resident complained of pain. The DNS stated that education was provided for the nurse about giving scheduled</p>	F 309	<p>5. Nurses education has been Provided for assessment of Resident pain and the Bowel Movement Protocol to current staff and will be provided to new hires during their general orientation to the facility.</p> <p>6. CNA Education has been provided to current staff on immediate reporting of pain and documentation of the Bowel-Movements and will be provided to new hires during their general orientation to the facility</p> <p>Systemic Changes</p> <p>1. Education related to Medication administration, Administration of Pain medications and the Bowel Movement protocol has been included in the general orientation for all Licensed Nurses.</p> <p>2. Education related to reporting of residents in pain and documentation of the Bowel Movements every shift has been added to general orientation for the Certified Nursing Assistance.</p> <p>3. The DHS/ADHS/CCC or Designee will audit all MARS for documentation of administration of Medications,</p>		

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F 309	<p>Continued From page 2</p> <p>pain medication per physician 's orders. The DNS stated that the facility initiated a plan of correction on 4/10/13 that included staff education and an audit of pain medications for new admissions. The DNS stated that they initiated chart audits of pain medications for residents that were not new admissions on 4/25/13.</p> <p>A telephone interview was conducted with Nurse #1 on 4/26/13 at 11:45 AM. The Nurse stated that she was unable to recall much about Resident #4 and did not recall an issue with the resident 's pain medication.</p> <p>The DNS stated in an interview on 4/26/13 at 5:19 PM that the nurse that worked on the weekend (Nurse #1) told her that she did not see the scheduled pain medication on the MAR and thought that the pain medication was PRN.</p> <p>2. Resident #5 was admitted to the facility on 4/7/13 and had diagnoses that included Left Hip Fracture and Dementia.</p> <p>A review of the Physician 's Orders revealed an order dated 4/8/13 for Fentanyl 12 micrograms (mcg) patch and to change the patch every 72 hours. Fentanyl is a narcotic medication used to treat pain. The Medication Administration Record (MAR) revealed an entry for the Fentanyl 12 mcg patch to be given every 3rd day at 9:00 PM and a box was marked off every 3rd day indicating that the medication was due to be given on that day. The MAR revealed that the medication was given on 4/8/13 and was due to be given on April 11, 2013. There were no initials in the box to indicate that the medication had been given on 4/11/13. A</p>	F 309	<p>3x per week for 3weeks; then weekly x4; then monthly x 4 months.</p> <p>4. The DHS / ADHS / CCC or Nursing Supervisor will audit the Bowel Movement records to ensure the Bowel Protocol has been initiated if necessary. This is conducted 2X per week for 3 weeks, then weekly X 4 weeks, then monthly X 4 months.</p> <p>Performance Improvement</p> <ol style="list-style-type: none"> 1. The DHS will present the tracking and trending of the MAR administration audit to QAPI committee for revisions if applicable monthly for review and appropriate actions. 2. The DHS will present the tracking and trending of the Bowel Movement audits to the QAPI committee monthly for review and appropriate ations. 		

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F 309	<p>Continued From page 3</p> <p>review of the Controlled Drug Record for Fentanyl for Resident #5 revealed there was not a Fentanyl patch signed out for the resident on 4/11/13. The MAR and the Controlled Drug Record revealed that the Fentanyl patch was not administered until 4/14/13.</p> <p>The Admission Minimum Data Set (MDS) Assessment dated 4/12/13 revealed that Resident #5 had short and long term memory loss and was severely cognitively impaired and had pain constantly.</p> <p>The Care Area Assessment for Pain dated 4/16/13 revealed that the resident had scheduled and PRN (as needed) pain medications related to recent left hip fracture and that the pain medications were effective.</p> <p>The Care Plan for Resident #5 dated 4/16/13 for Pain related to left hip fracture directed the staff to administer PRN and scheduled pain medications as ordered.</p> <p>On 4/25/13 at 1:50 PM an interview was conducted with the nurse (Nurse #2) that worked on the evening shift on 4/11/13. Nurse #2 stated that she did not administer the Fentanyl patch on 4/11/13 because she thought the time on the MAR was 9:00 AM instead of 9:00 PM.</p> <p>The Director of Nursing Service (DNS) stated in an interview on 4/25/13 at 2:10 PM that a medication error report had been written regarding the omitted Fentanyl patch on 4/11/13 and that nursing education had been initiated.</p> <p>3. Resident #5 was admitted to the facility on</p>	F 309			

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F 309	<p>Continued From page 4 4/7/13 and had diagnoses that included Left Hip Fracture and Dementia.</p> <p>The Admission Minimum Data Set (MDS) Assessment dated 4/12/13 showed that the resident had short and long term memory loss and was severely cognitively impaired. The MDS revealed that the resident required extensive assistance with bed mobility and was dependent on staff for transfers and was not ambulatory. The MDS revealed that the resident required extensive assistance for toileting and personal hygiene. The MDS showed that bowel incontinence was not rated.</p> <p>The Care Area Assessment for Urinary Incontinence dated 4/16/13 showed that the resident was frequently incontinent and received regular and frequent incontinence care by the staff.</p> <p>The Care Plan dated 4/16/13 showed the resident received pain medications due to fracture of the left hip. The Care Plan directed staff to check and provide incontinent care as needed.</p> <p>The MDS Nurse stated in an interview on 4/25/13 at 2:25 PM that the BM (bowel movement) Report showed that the resident did not have a bowel movement during the 4/7/13 to 4/12/13 assessment period so bowel status could not be rated on the MDS. The MDS Nurse provided a copy of the BM report showing that the resident did not have a bowel movement for 4/9/13 through 4/12/13. There was not an entry on the bowel movement record for 4/7/13 or 4/8/13.</p> <p>A review of the resident's medical record</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>revealed that the resident was taking narcotic medications for pain due to a fractured hip. Narcotic pain medications are known to cause constipation.</p> <p>The Assistant Director of Nursing (ADON) stated in an interview on 4/26/13 at 4:50 PM that the standing orders for the bowel protocol should be initiated when a resident had not had a bowel movement in 3 days.</p> <p>The physician ' s standing orders for the bowel protocol was as follows: If no BM times 3 days, give MOM (milk of magnesia) 30 ml (milliliters) by mouth. If no results, give Bisacodyl 1 suppository rectally. If no results, give enema of choice rectally.</p> <p>The Medication Administration Record (MAR) for April 2013 for Resident #5 showed an entry that read: " BM Protocol. " There was no documentation on the MAR that the bowel protocol had been initiated.</p> <p>On 4/26/13 at 5:38 PM the Unit Coordinator stated that the nursing assistants (NAs) document on each resident in the computer that the resident did or did not have a BM during their shift. The Unit Coordinator stated that the nursing assistants sometimes document BMs on the ADL (activities of daily living) Care Plan Signature Sheet. The Unit Coordinator stated that the 11PM to 7AM Nurse was supposed to complete a BM audit for all residents every night using the BM Audit Sheet and was suppose to initiate the BM Protocol for residents who had not had a BM in 3 days. The Unit Coordinator stated that she was only able to find 2 BM Audit sheets for the month</p>	F 309		

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F 309	<p>Continued From page 6</p> <p>of April 2013 and provided BM Audit Sheets dated 4/10/13 and 4/20/13. The sheet dated 4/10/13 contained the name of Resident #5 and under the column " Last BM " read: " unknown. " There was a column titled " MOM given (started on nights) " that contained no information regarding Resident #5.</p> <p>The BM Report for Resident #5 for April 2013 did not include an entry that the resident did or did not have a BM on 4/7/13 or 4/8/13 and revealed that the resident did not have a bowel movement from 4/9/13 through 4/14/13. There was no entry on the report for 4/15/13 or 4/16/13 to indicate that the resident did or did not have a BM. On 4/17/13 at 12:43 PM, a medium sized, soft, formed bowel movement was documented on the BM Report for Resident #5. The ADL Care Plan Signature Sheet for April 2013 showed no documentation that the resident had a bowel movement until 4/17/13 when a small bowel movement was documented on the 7AM to 3 PM shift. The resident ' s MAR for April 2013 showed no documentation that the bowel protocol was initiated or that other medications were given for constipation. A review of the nurse ' s notes for April 2013 for Resident #5 revealed no information regarding bowel movements or interventions provided due to the lack of bowel movements.</p> <p>Nurse #3 stated in a telephone interview on 4/26/13 at 5:54 PM that she worked 7PM to 7AM 3 nights per week on the unit where the resident resided. The Nurse stated that she completed the BM Audit Sheets on the nights that she worked from the ADL sheet that the NAs fill out.</p>	F 309		

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F 309	<p>Continued From page 7</p> <p>Nurse #4 stated in a telephone interview on 4/26/13 at 5:58 PM that she worked 7PM to 7AM 3 nights per week on the unit where the resident resided. The Nurse stated that she filled out the BM Audit Sheet on the nights that she worked from information that the NAs gave her and put the audit sheets in the report book. The Unit Coordinator was present during the interview and stated that she did not think to look in the report book. The Unit Coordinator stated that she would look to see if she could find the additional audit sheets.</p> <p>The DNS stated in an interview on 4/26/13 at 7:07 PM that the NAs let the nurses know on each shift if the resident had a bowel movement. The DNS stated that according to the BM Report, the bowel protocol should have been initiated on 4/11/13. The DNS was observed to review the resident's MAR for April 2013 and stated that the staff did not initiate the bowel protocol. The DNS stated that the staff was unable to find any more of the BM Audit Sheets.</p> <p>4. Resident #9 was admitted to the facility on 4/2/13 with diagnoses including Acute Cerebrovascular Accident (Stroke).</p> <p>The Admission Minimum Data Set (MDS) Assessment dated 4/9/13 showed that the resident was cognitively intact and required extensive assistance with bed mobility, transfers, toileting and personal hygiene. The MDS revealed that the resident was frequently incontinent of urine and occasionally incontinent of bowel.</p> <p>The Care Area Assessment (CAA) for ADL</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>(activities of daily living) Functional/Rehabilitation Potential dated 4/12/13 revealed that the resident required extensive assistance from staff with ADLs and continued episodes of incontinence of bowel and bladder with regular and frequent incontinence care.</p> <p>A review of the BM Report and the ADL Care Plan Signature Sheet Form for April 2013 for Resident #9 revealed that the resident did not have a bowel movement on 4/18/13 through 4/21/13.</p> <p>On 4/26/13 at 5:38 PM the Unit Coordinator stated that the nursing assistants (NAs) document in the computer on each resident that the resident did or did not have a bowel movement (BM) during their shift and sometimes document BMs on the ADL Care Plan Signature Sheet. The Unit Coordinator stated in an interview that the 11PM to 7AM Nurse was supposed to complete a BM audit for all residents every night using the BM Audit Sheet and was suppose to initiate the BM Protocol for residents who had not had a BM in 3 days. The Unit Coordinator stated that she was only able to find 2 BM Audit sheets for the month of April 2013 and provided BM Audit Sheets dated 4/10/13 and 4/20/13. The BM Audit sheet dated 4/20/13 revealed that Resident #9 last had a BM on 4/17/13. There was no additional information on the Audit sheet regarding interventions for Resident #9.</p> <p>A review of the resident 's Medication Administration Record (MAR) for April 2013 revealed an entry for the bowel movement (BM) protocol PRN (as needed). The facility 's standing orders for the BM protocol were to</p>	F 309	

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F 309	<p>Continued From page 9</p> <p>administer Milk of Magnesia 30 milliliters by mouth if no BM in 3 days. If no results, give Bisacodyl 1 suppository rectally. If no results, give enema of choice. There was no documentation on the MAR showing that the bowel protocol had been initiated.</p> <p>A review of the Nurse ' s Notes for Resident #9 for 4/18/13 through 4/21/13 did not include information regarding Interventions provided due to the resident not having a bowel movement.</p> <p>Nurse #3 stated in a telephone interview on 4/26/13 at 5:54 PM that she worked 7PM to 7AM 3 nights per week on the unit where the resident resided. The Nurse stated that she completed the BM Audit Sheets on the nights that she worked from the ADL sheet that the NAs fill out.</p> <p>Nurse #4 stated in a telephone interview on 4/26/13 at 5:58 PM that she worked 7PM to 7AM 3 nights per week on the unit where the resident resided. The Nurse stated that she filled out the BM Audit Sheet on the nights that she worked from information that the NAs give her and put the audit sheets in the report book. The Unit Coordinator was present during the interview and stated that she did not think to look in the report book. The Unit Coordinator stated that she would look to see if she could find the additional audit sheets.</p> <p>The DNS (Director of Nursing Service) stated in an interview on 4/26/13 at 7:07 PM that the NAs let the nurses know every shift if the resident has had a bowel movement during their shift. The DNS stated that according to the BM Report the bowel protocol should have been initiated for</p>	F 309			

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F 309	Continued From page 10 Resident #9 on 4/21/13. The DNS was observed to review the resident 's MAR and stated that the bowel protocol was not initiated. The DNS stated that the staff was unable to find any more of the BM Audit Sheets for the month of April 2013.	F 309			