SEP 0 9 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. BUILDING ______ B. WING ______	C 08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHCHASE NURSING AND REHABILITATION CENTER	3015 ENTERPRISE DR WILMINGTON, NC 28405

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 record review and staff interviews, the facility failed to initiate physician ' s orders for a bowel protocol for 2 (Resident #1 and Resident #4) of 3 sampled residents who did not have a bowel movement in 3 days. The findings included: The physician ' s standing orders included orders to give milk of magnesia 30 ccs (cubic centimeters) by mouth times 1 dose if no bowel movement in 3 days. If no results, give a dulcalox suppository per rectum. If no results, give fleets enema times 1 per rectum. If no results, notify the physician for further orders. 1. Resident #1 was admitted to the facility on 07/25/13 and had diagnoses that included Pneumonia, Generalized Muscle Weakness, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. The Resident Care Guide dated 7/25/13 revealed that the resident used an incontinent brief for protection. The Admission Minimum Data Set (MDS)	F 309	Northchase Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and remains committed to providing quality of care to the residents which we serve. The plan of correction is submitted as a written allegation of compliance. 1. Resident #1 is expired. Resident #4 had no negative outcome as a result of not following bowel protocol from 8/6/13-8/10/13 as she had a bowel movement on 8/11/13. 2. All residents were checked in the computer for outstanding No BM in 3 days. No other residents were found to be out of the no BM in 3 day perameter to warrant implementing the bowel protocol. 100% of licensed nurses	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa K [signature]
TITLE: Administrator
(X6) DATE: 9.5.13

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	Continued From page 1 Assessment dated 8/1/13 revealed that the resident had a Brief Interview for Mental Status (BIMS) of 15 indicating that the resident was cognitively intact. The MDS revealed that the resident required the assistance of 2 persons for bed mobility and transfers and was occasionally incontinent of bowel and bladder. The Care Area Assessment (CAA) for Activities of Daily Living (ADLs) dated 8/7/13 revealed that the resident had generalized weakness and required extensive assistance for ADLs, transfers and mobility. The Resident ' s Care Plan was not completed prior to the resident ' s discharge from the facility on 8/7/13. A review of nurse ' s notes revealed that the resident had intermittent confusion. A review of the Bowel Movement record for Resident #1 showed documentation that the resident had not had a bowel movement from 7/26/13 through 8/3/13. A review of the Medication Administration Record for July and August 2013 revealed no documentation that the bowel protocol had been initiated. The nursing progress notes for Resident #1 revealed no information regarding bowel movements until 8/6/13 at 1:55 PM. The progress note read: " Noted resident with distended abdomen today. + (positive) bowel sounds x (times) 4 quadrants. Resident has had 2 small bowel movements in last 2 days. NP (nurse practitioner) in to see resident today. New orders	F 309	were inserviced on checking computer at the beginning of each shift for residents that may alert for no BM for 3 days, place on 24 hour report and implement bowel protocol and if resident is continent of bowel to speak with resident to inquire if BM took place and document. 3. Administrative nurses will check computer alert to assure no BM's in 3 days are properly documented, bowel protocol implemented. This will occur a minimum of 5 times per week for one month; 3 times per week ongoing. (Attachment #1) 4. The QI committee will review the results of the audits to identify any	

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F 309	Continued From page 2 received for abdominal flat plate, IV (intravenous) ½ NS (normal saline) at 75 cc (cubic centimers)/hr (hour), NPO (nothing by mouth) with ice chips only, and SSE (soap suds enema) until clear. " A Radiology Report for Resident #1 dated 8/6/13 for 1 view of the abdomen showed that bowel gas pattern was normal with nondistended loops of small bowel and colon seen. The conclusion was that there were no acute findings. A nursing progress notes revealed that the resident was given soap suds enemas with a large amount of stool returned. Nurse #1 stated in an interview on 8/23/13 at 10:22 AM that the nursing assistants (NAs) document in the computer system whether or not the resident had a bowel movement (BM). The Nurse stated that the system showed an alert if the resident did not have a BM in 3 days and the 11PM-7AM nurse was responsible for checking for the alert. The Nurse stated that if the resident had no BM in 3 days the nurses were to initiate the bowel protocol. The Nurse stated that on 8/6/13 she called the nurse practitioner because the resident ' s abdomen was distended and she saw on the bowel record that the resident had gone several days without a BM. An interview was conducted with the Administrator and the acting Director of Nursing (DON) on 8/23/13 at 2:30 PM. The DON stated that the NAs document in the computer system whether or not the resident had a BM on their shift and the computer system would show an alert on the dash board if a resident had not had a BM in 3 days. The DON stated that the night	F 309	trends/concerns. The review will completed monthly for 3 months, then quarterly.	9.6.13

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F 309	Continued From page 3 shift nurse was supposed to look at the dash board and write any alerts on the 24 hour shift report and the day nurse was responsible for initiating the bowel protocol. In an interview with the DON and the Nurse Facilitator on 8/23/13 at 3:00 PM, the DON stated that the night nurse was supposed to write on the 24 hour report under the interdisciplinary communication section any resident that the system showed had not had a BM in 3 days. The DON provided the 24 hour shift reports for 7/26/13 through 8/10/13. There was no information on the 24 hour shift reports that showed that any resident had not had a BM in 3 days. The 24 hour shift report dated 8/6/13 revealed that Resident #1 had abdominal distension with positive bowel sounds and had 2 small BMS in the past 2 days. The DON also provided an Alert Listing Report triggered by the computer system for Resident #1 that showed " No BM in 3 days " on 7/29/13, 7/30/13, 7/31/13, 8/1/13, 8/2/13, 8/3/13, 8/4/13 and 8/5/13. On 8/23/13 at 3:52 PM an interview was conducted with Nurse #2 who stated that she worked some 11PM to 7AM shifts during Resident #1 ' s stay in the facility. The Nurse stated that the night nurse was supposed to look at the computer dash board at the end of the shift. The Nurse stated that she checked the dash board in the mornings when she worked and there were no alerts. The Administrator stated in an interview on 8/23/13 at 4:05 PM that one nurse on the night shift no longer worked in the facility and Nurse #2 was the other nurse that worked the night shift when Resident #1 was in the facility. The	F 309		

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F 309	Continued From page 4	F 309		

Administrator stated that the alert information was not documented on the 24 hour shift report.

2. Resident #4 was admitted to the facility on 06/25/13 and re-admitted on 07/05/13 with diagnoses that included Fractured Lumbar Vertebrae, Senile Dementia and Generalized Muscle Weakness.

The Admission Minimum Data Set (MDS) Assessment dated 7/12/13 revealed that the resident had short and long term memory deficits. The MDS revealed that the resident required extensive assistance for bed mobility and transfers and required extensive assistance for toileting and personal hygiene. The MDS revealed that the resident was incontinent of bowel and bladder.

The Care Area Assessment (CAA) for Cognitive Status dated 7/18/13 showed that the resident was usually understood and usually understood others but had difficulty expressing her needs and emotions at times. The CAA for Activities of Daily Living (ADLs) dated 7/18/13 revealed that the resident was admitted with a L (lumbar) 2 Fracture related to a previous fall and also with a diagnosis of Pneumonia. The CAA revealed that the resident had been on strict bed rest and required extensive staff assistance to perform all of her ADL care. The CAA for Urinary Incontinence dated 7/18/13 revealed that the resident was incontinent of bowel and bladder.

The resident ' s Care Plan dated 7/18/13 showed that Resident #4 required assistance for personal hygiene, transferring, toileting and personal hygiene. The Care Plan revealed that the resident used incontinent products and that resident had

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F 309	Continued From page 5 urinary incontinence related to cognitive impairment and loss of muscle tone. The Care Plan directed staff to provide peri-care after each incontinent episode. A review of the Bowel Record for Resident #4 revealed that the resident did not have a bowel movement on 8/6/13 through 8/10/13. A review of the August 2013 Medication Administration Record for Resident #4 revealed that the bowel protocol had not been initiated. Nurse #1 stated in an interview on 8/23/13 at 10:22 AM that the nursing assistants (NAs) document in the computer system whether or not the resident had a bowel movement (BM). The Nurse stated that the system showed an alert if the resident did not have a BM in 3 days and the 11PM-7AM nurse was responsible for checking for the alert. The Nurse stated that if the resident had no BM in 3 days the nurses were to initiate the bowel protocol. An interview was conducted with the Administrator and the acting Director of Nursing (DON) on 8/23/13 at 2:30 PM. The DON stated that the NAs document in the computer system whether or not the resident had a BM on their shift and the computer system would show an alert on the dash board if a resident had not had a BM in 3 days. The DON stated that the night shift nurse was supposed to look at the dash board and write any alerts on the 24 hour shift report and the day nurse was responsible for initiating the bowel protocol. In an interview with the DON and the Nurse Facilitator on 8/23/13 at 3:00 PM, the DON stated	F 309		

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F 309	Continued From page 6 that the night nurse was supposed to write on the 24 hour report under the interdisciplinary communication section any resident that the system showed had not had a BM in 3 days. The DON provided the 24 hour shift reports for 7/26/13 through 8/10/13. There was no information on the 24 hour shift reports that showed that any resident had not had a BM in 3 days. The DON also provided an Alert Listing Report triggered by the computer system for Resident #4 that showed " No BM in 3 days " for 8/8/13, 8/9/13 and 8/10/13. On 8/23/13 at 3:52 PM an interview was conducted with Nurse #2 who stated that she worked some 11PM to 7AM shifts. The Nurse stated that the night nurse was supposed to look at the computer dash board at the end of the shift. The Nurse stated that she checked the dash board in the mornings when she worked and there were no alerts. The Administrator stated in an interview on 8/23/13 at 4:05 PM that one nurse on the night shift no longer worked in the facility and Nurse #2 was the other nurse that worked the night shift during this period of time. The Administrator stated that the alert information was not documented on the 24 hour shift report.	F 309		