STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345375	A. BUILDING ______ B. WING ______	C 10/30/2014

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SCOTLAND MANOR HEALTH CARE CENTER	**920 JR HIGH SCHOOL ROAD** **SCOTLAND NECK, NC 27874**

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		11/5/14
	This REQUIREMENT is not met as evidenced by: Based on resident, responsible party, facility staff and oncology staff interview and record review, the facility failed to follow the physician's orders in posting a radiation sign, failed to instruct the Responsible Party on radiation precautions, and failed to provide a private room for 12 hours after the resident received radiation therapy in order to reduce the potential for radiation exposure to other residents for 2 of 2 residents (Resident # 52 and Resident # 34). Findings included: Resident # 52 was readmitted on 5/8/14 with diagnoses that included hypertension, congestive heart failure, and diabetes and cancer. Review of the Quarterly Minimum Data Set (MDS) for Resident # 52, dated 10/2/14 indicated he was cognitively intact. There was no rejection of care coded. The resident was coded as only requiring supervision for toilet use and personal hygiene. Resident # 34 shared a room with Resident # 52. Resident # 34 was admitted on 4/27/11 with		F323 Free of Accident Hazards : It is the policy of the this facility to ensure that the resident environment remains as free of accidents hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents 1.Resident #52 returned to the facility on 10/9/14 at 4:30 pm from receiving radiation treatment. Radiation Precautions were schedule to end twelve hours later. Resident # 52 no longer requires Radiation Precaution as of 10/10/14 at 4:30 am. There is no evidence that Resident #34 had a negative outcome from rooming with Resident # 52. 2. There was a complete facility audit to determine others residents at risk for this alleged deficient practice. No other residents were identified as receiving radiation therapy this audit determine that there were no other residents at risk. Ongoing audits are in process by DON,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 11/16/2014

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 323	Continued From page 1 diagnoses that included seizure disorder and depression. Resident # 34's MDS, a quarterly dated 8/15/14, indicated the resident was moderately cognitively impaired. The MDS also indicated Resident # 34 was independent with toilet use and required limited assistance with personal hygiene. A Physician's telephone order dated, 10/7/14 indicated an indwelling foley catheter should be inserted on the evening of 10/8/14 in preparation for Resident # 52's radiation treatment on 10/9/14. Review of nurse's notes for 10/9/14 at 4:30 PM, indicated the resident had returned to the facility after receiving a "liquid radiation". The note further documented Resident # 52 was to have limited exposure to residents and staff. A Report of Consultation form, dated 10/9/14, and signed by the oncologist, listed under Recommendations/New Orders: Place radiation signs on door, return on 10/13/14 at 9:30 AM to remove catheter, staff and visitors to limit exposure to patient, have patient empty catheter in toilet. A Oncologist Physician Verbal Order form, dated 10/9/14 and signed by the oncologist, indicated the 12 hours the following ordered applied: empty catheter bag frequently and do not let it get past half full flush toilet twice after each use/emptying of bag wash hands with soap and water thoroughly after emptying visitors restricted for 30 minute visits for a	F 323	ADON or licensed nurse during daily clinical review to determine an oncology related new admission or oncology consult\appointment. The Medical Director was notified of the radiation treatment for Resident #52. The Medical Director and the Oncologist shared conversation regarding isolation protocols for Resident #52 and the physicians identified no side effects were determined from this conversation. The Medical Director informed this facility of no determined side effects. 3. The Staff Development Nurse was educated immediately by a Signature Care Consultant and the Staff Development Nurse (SDC) began education on 10/31/14, with the Licensed Nurses and Certified Nursing Assistance regarding the facility must ensure that the resident environment remains as free of accidents hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. The Staff Development Nurse additionally had training on SHC Learn, SignatureNs online education system. This included education on following physician orders, and Radiation Precautions. All new staff will receive education during orientation to ensure that all staff will be educated prior to a scheduled shift. 4. Ongoing audits are in process by DON, ADON or licensed nurse during daily	

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F 323	Continued From page 2 maximum of 3 times per day. Children and pregnant women are not to visit If a catheter spill or leak should occur please call (number of oncologist office) and explain what has happened encourage fluids for the next 3 hours If urine gets on clothes, these clothes must be washed separately On return, a physician's telephone order was written that "limit staff and visitor exposure". Other elements of the oncologist's orders were not included. The order was signed by the Director of Nursing (DON). The facility Census Board (a form that indicated which rooms were occupied and which rooms were vacant), dated 10/9/14 was reviewed. On review, it was noted Room 101 was designated as empty and Room 206, beds A and B were empty. Review of the resident's care plan, with a revision date of 10/9/14, indicated the resident had an indwelling catheter. Interventions included emptying when half full, using gloves, flushing the toilet twice and calling the oncologist's number for any spillage or leakage. A telephone interview was held with the Responsible Party (RP) for Resident # 52 on 10/29/14 at 11:00 AM. She stated she was the one to be notified for any problems or changes in treatment or resident condition. The RP stated no one from the facility had called her after the resident's radiation treatment to give her instructions regarding limiting visits or precautions to take during visits. While she was not able to visit often, the RP stated she had been here	F 323	clinical review to determine an oncology related new admission or oncology consult\appointment. Audits will be reviewed weekly x 4 weeks and monthly for three months by Quality Assurance committee and revised as needed to ensure compliance. All data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services.	

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F 323	Continued From page 3 within the month of October. She was unsure of the date of her visit or if it was during the time the resident had received the radiation treatment. A telephone interview was held with the Oncology Nurse on 10/29/14 at 11:17 AM. She stated she had called the facility on 10/9/14 after the resident's radiation and spoken to Nurse # 3, who was working the 7-3 shift. The oncology nurse stated she had requested the resident be placed in a private room, at least overnight, because of his radioactive status. The nurse added placing Resident # 52 in a private room was to limit other resident's exposure to the radiation. The nurse stated Nurse # 3 told her Resident # 52 had a room-mate and the space between beds was limited. The oncology nurse stated she then asked to speak to the DON and explained why a private room was needed. The DON told her she would try, but was unsure if she had any rooms available. The oncology nurse added the danger in such close quarters would be radiation exposure for the room mate. During an interview with the resident, on 10/29/14 at 1:30 PM, he stated after he had his radiation shot, the facility instructed him not to be around a lot of people; adding he stayed in his room for 3 days. He could not recall any other instructions given. On 10/30/14 at 9:46 AM, Nursing Assistant # 2 was interviewed. She stated she knew Resident # 52 pretty good. The NA stated any special instructions for residents were relayed verbally from the nurse. She stated instructions were not written anywhere. On Resident # 52's return from his radiation, instructions taught by the Staff Development Coordinator (SDC) included not	F 323		

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F 323	Continued From page 4 letting the resident's urine splash and if the urine did splash the nurse was to be notified, double glove when emptying the urine collection bag and flush the toilet 3 times. If the resident went out to smoke, he had to go when other residents were not around, but a staff member had to go with him. The NA stated Resident # 52 remained in the same room with his room-mate and was not placed in a private room. An interview was held with Nurse # 2 on 10/30/14 at 10:56 AM. The nurse stated she was familiar with Resident # 52. Nurse # 2 stated she worked the day the resident returned from his radiation treatment. Nurse # 1 recalled Resident # 52 was separated from other residents, ate in his room and went out to smoke when the other residents were not out smoking. She stated, that while he was separated at those times, he remained in the same room and slept in the same room as his room mate. Nurse # 2 stated she was taught to double glove when emptying the catheter drainage bag, but was not taught she had to flush more than once. Nurse # 2 stated she was not instructed to limit contact with the resident, but had worked with radiation patients before so she decided to limit exposure on her own. She added she had worked 3-11 on the day he returned from this treatment. The day shift nurse, Nurse # 3, was the one that told her the resident was not supposed to be around other residents. Nurse # 2 stated she asked Nurse # 3 if Resident # 52 would remain in the room with his room-mate, Resident # 34, and was told yes, because there were no private rooms available. The nurse was unsure if the resident had visitors during the time limited exposure had been ordered. On 10/30/14 at 11:21 AM, an interview was held	F 323		

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F 323	Continued From page 5 with the SDC. She stated after Resident # 52's radiation treatment, staff were received instructions directly from the information received from the Oncology Center. This included emptying the catheter drainage bag frequently, double gloving when emptying the bag, flushing the toilet twice and to avoid splashing the urine. The SDC added a hamper was placed in the resident's room so his clothes could be laundered separately. Staff were also given the emergency number in case splashing occurred. She stated she had not instructed the resident's RP on precautions; adding the resident stated he would do that. The SDC acknowledged it was not the resident's responsibility to instruct others on radiation precautions. The SDC stated Resident # 52 remained in his room with his room mate, Resident # 34. She stated she had been standing by when the DON spoke with the oncology nurse, but only heard half of the conversation. The DON had told her Resident # 52 could remain in his room with his room-mate, although, he was not allowed to smoke when other resident's were outside smoking. The SDC stated she could not guarantee there was no physical contact between Resident # 52 and his room-mate, could not guarantee there was no urine splashed in the bathroom or if housekeeping cleaned the splashes immediately should splashing occurred. The SDC stated Resident # 52's room-mate, Resident # 34 toileted independently. The SDC reviewed her staff roster for the radiation precaution training and acknowledged Nurse # 2, who had worked on 10/9/14 on the 3-11 shift with Resident # 52, had not signed as receiving the training on precautions to minimize radiation exposure. An interview was held with the DON on 10/30/14	F 323		

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F 323	Continued From page 6 at 1:21 PM. She stated after Resident # 52's radiation treatment, staff were told he needed to stay in his room, could not visit other residents, and could not go to the lobby. She stated staff were also instructed to wear double gloves when the catheter drainage bag was emptied and taught to flush the toilet 3 times when emptying the drainage bag. The DON added Resident # 52 was also instructed since he was capable of emptying his own urine drainage bag. The DON stated Resident # 52 remained in the same room with his room mate, Resident # 34. She stated she had spoken to the Oncology Nurse who had requested a private room, but added there were no private rooms available. The DON stated the oncology nurse told her as long as the privacy curtain was pulled, the room-mate should be fine. The DON stated both Resident # 52 and the staff emptied the catheter drainage bag. She added the room-mate, Resident # 34 also toileted independently. The DON acknowledged there was no way to guarantee Resident # 52 did not splash urine while emptying the urine drainage bag, there was no way to guarantee he flushed 3 times, there was no way to guarantee he double gloved and no way to guarantee the room-mate was not exposed. The DON reviewed the Census Board for 10/9/14 and was shown the documented empty rooms. She stated she knew someone was in Room 101, but she could not remember who. The DON added Room 206 was currently used by the therapy department. An interview was held with the Administrator on 10/30/14 at 1:40 PM. She stated the resident was in route back to the facility when the facility was notified he needed a private room. She stated with more notice, Room 206 could have been cleared and used. The Administrator	F 323		

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F 323	Continued From page 7 checked the census for 10/9/14 and acknowledged Room 101 was vacant and able to be used as a private room for Resident # 52. The SDC was interviewed on 10/30/14 at 3:30 PM. She reviewed the 10/9/14 Report of Consultation and acknowledged the form indicated a Radiation sign should be posted on Resident # 52's door. She stated the Oncology Clinic had sent a radiation sign back with the resident, but she had not posted the sign because it was an invasion of privacy. Nurse # 3 no longer worked at the facility and was unavailable for interview.	F 323		