| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345263 | A. BUILDING _____ B. WING _____ | C 08/05/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MACON VALLEY NURSING AND REHABILITATION CENTER | 245 OLD MURPHY ROAD FRANKLIN, NC 28734 |

| (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 |
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| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interviews the facility failed to monitor bowel records and address one of three sampled residents that went an extended time without a documented bowel movement. In addition, the facility failed to ensure medication orders on readmission were consistent with hospital discharge medication orders for one of one sampled resident.<br>(Resident #5)<br><br>The findings included:<br><br>1.a. The facility standing orders for constipation included: Milk of Magnesium 30 cubic centimeters orally or per tube if no bowel movement in three days. If no results by next day, give Dulcolax suppository; if no results from Dulcolax in 24 hours, give fleet enema. If no results from enema in 24 hours call physician.<br><br>Resident #5 was originally admitted to the facility 4/20/13 and readmitted 07/18/14 after hospitalization for acute respiratory failure. Additional medical diagnoses for Resident #5 included chronic obstructive pulmonary disease, | F 309 | Macon Valley Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiences and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.<br>Macon Valley Nursing and Rehabilitation Center response to the statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate.<br>Further, Macon Valley Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies through informal dispute resolution or formal appeals procedure and or any other administrative or legal proceeding.<br><br>Current physician orders were reviewed for resident #5 and found to be current/accurate. Current bowel | 9/2/14 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 08/29/2014 |

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| F 309 | Continued From page 1<br>osteoarthrosis, hypertension, spinal cord injury and dementia.<br><br>Physician orders for Resident #5 on readmission 07/18/14 included Lasix (a diuretic) 20 milligrams (mg) every day, Miralax (a laxative) 17 grams every day and Senna (a laxative) 8.6 mg every day.<br><br>The latest Minimum Data Set dated 7/25/14 assessed Resident #5 with severe cognitive impairement, always incontinent and requiring extensive assistance of staff for toileting.<br><br>On 08/05/14 at 11:45 AM Nurse #1 (identified as the nurse in charge at the time of the survey) reported that residents' bowel movements are monitored via the electronic medical record. Nurse #1 stated nursing assistants document bowel movements on a daily basis for residents in the electronic medical record. Nurse #1 explained alerts displayed every day via the electronic record and indicated any residents that did not have a bowel movement in three days. Nurse #1 stated these alerts went to all nurses as well as management nursing staff. Nurse #1 stated nursing staff were expected to review the alerts and 1) identify any residents they were responsible for, 2) implement facility standing orders for constipation, 3) document on the Medication Administration Record what medication was given (from the standing orders for constipation) with results and 4) to "turn off" the alert. Nurse #1 stated nursing staff would note any assigned residents they had implemented standing orders for constipation on the 24 hour nursing report so subsequent nursing staff would be aware.<br>Bowel records for Resident #5 were reviewed and | F 309 | movement documentation was reviewed on resident #5, and found to be in compliance with bowel movement protocol.<br><br>Nursing has completed a 100% review of all other resident physician orders compared to the Medication Administration Record (MAR) for omissions. Nursing has conducted 100% audit of all other residents, BM (bowel movement)records to ensure that facility protocol is being followed.<br><br>The Director of Nursing completed an in-service on August 7, 2014, for the Licensed Staff, i.e., RN/LPN on the new protocol for reviewing the admission orders to ensure all medications are noted and carried over properly. The Director of Nursing in-serviced the licensed staff, medication aides, and nursing assistants on the facility bowel protocol and the appropriate interventions required. The facility protocol has been placed in front of the MAR's for reference.<br><br>New monitoring tools, including an "Admission Orders" audit,have been established. This requires the licensed staff to review new admission and re-entry orders with a second nurse, as well as third/final review by an Administrative Nurse, i.e., QI, MDS, SFC, to ensure orders upon admission have been transcribed appropriately upon admission or re-entry of every resident for the next 90 days. New monitoring tools have been established to review bowel movement | |

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| F 309 | Continued From page 2<br>noted "no bowe movementl" from readmission on 07/18/14 until discharge to the hospital on 07/28/14. Review of nurses notes in the electronic medical record of Resident #5 did not include any documentation specific to bowels. Review of the July 2014 Medication Administration Record (MAR) for Resident #5 noted Milk of Magnesium was given to Resident #5 on 07/25/14 (seven days after readmission and without a documented bowel movement). Documentation on the back of the MAR by Nurse #2 noted the Milk of Magnesium was effective. On 08/05/14 at 3:50 PM Nurse #2 recalled she gave the Milk of Magnesium to Resident #5 because of an alert on the electronic medical record. Nurse #2 stated when she recorded "effective" it meant Resident #5 had a bowel movement. Review of nursing 24 hour reports from 07/18/14-07/28/14 included documentation 07/25/14 of administration of Milk of Magnesium to Resident #5. There were no other notations regarding bowel movements for Resident #5 on the 24 hour nursing reports from 07/18/14-07/25/14.<br>In a follow-up interview on 08/05/14 at 2:20 PM Nurse #1 stated she was not aware of the extended time frame Resident #5 went without a bowel movement until the documentation was printed and provided to the survey team. Nurse #1 stated staff should have implemented the standing orders for constipation prior to 07/25/14 for Resident #5. On 08/05/14 at 4:20 PM the facility administrator stated he reviewed the electronic record and noted "no bowel movement" alerts had been sent for Resident #5 via the electronic record and had been "turned off." The facility administrator could not explain why the alerts would have been "turned off" without implementation of the standing orders for | F 309 | results to ensure facility protocol is being followed. The monitoring is started with the licensed staff, and then reviewed by the Administrative Nurse, i.e., QI, MDS, SFC, to ensure the protocol is being followed.<br><br>The bowel movement audits will be completed daily for 30 days, then three times per week for 30 days, then once weekly for 30 days, with results being reports to the QAPI Committee. The DON or Designee, i.e., QI, MDS, SFC, will be responsible to ensure these audits are completed. The findings of the audits will be reported monthly to the QAPI committee to reflect identification of patterns, additional concerns, and analysis of the progress of training and tools to ensure admission orders are noted and carried out properly and bowel movement protocol is being followed. The LNHA is responsible to ensure communication and implementation of any Quality Assurance and Performance Improvement Committee recommendations. | |

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| F 309 | Continued From page 3 | F 309 | | |

constipation for Resident #5 from 07/18/14-07/25/14.
Resident #5 was hospitalized 07/28/14-07/30/14 for respiratory distress. Review of bowel records after readmission 07/30/14 noted regular bowel movements for Resident #5.
1b. Resident #5 was originally admitted to the facility 4/20/13 and readmitted 07/18/14 after hospitalization for acute respiratory failure. Additional medical diagnoses for Resident #5 included chronic obstructive pulmonary disease, osteoarthrosis, hypertension, spinal cord injury and dementia.

Multiple copies of the hospital discharge records from the 07/16/14-07/18/14 stay for Resident #5 were located in the medical record. These records discussed the course of treatment as well as medications to continue upon discharge. These hospital records all listed the same medications which included Flovent 2 puffs twice a day, Duoneb scheduled four times a day as well as Albuterol four times a day PRN (as needed) for wheezing. The Duoneb and Allbuterol were to be administered by hand held nebulizer (HHN), which allows the medication to be inhaled passively without any active participation of the resident. Review of the handwritten readmission orders on 07/18/14 for Resident #5 noted an omission of the Duoneb four times a day and PRN Albuterol. Readmission orders included a handwritten note that Resident #5 was readmitted on 07/18/14 at 12:37 PM.

In an interview on 08/05/14 at 2:45 PM Nurse #3 (the nurse that wrote the readmission orders for Resident #5 on 07/18/14) recalled the circumstances of the readmission. Nurse #3 stated admission orders were provided to nurses

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| F 309 | Continued From page 4 | F 309 | | |

prior to the residents arrival in order to begin paperwork, including physician orders. Nurse #3 reviewed the hospital discharge papers sent for Resident #5 and stated she did not recall there being two separate pages of orders. Nurse #3 noted hospital discharge orders for Resident #5 with a time stamp of 07/18/14 at 8:46 AM (which would be before the 07/18/14 readmission at 12:37 PM) and noted these were most likely the hospital discharge records she would have had available and used to write physician orders prior to the arrival of Resident #5 to the facility. Nurse #3 stated typically the hospital will send additional discharge orders and nursing staff would compare those to earlier written physician orders. Nurse #3 stated she must have missed the scheduled Duoneb and PRN Albuterol on the additional discharge records sent at the time of readmission which included both as part of the resident's medication regimen. Nurse #3 reviewed the readmission physician order sheet and noted another nurse had initialed the orders. Nurse #3 explained before physician orders are Faxed they are always reviewed by another nurse for accuracy. Nurse #3 stated Nurse #4 had initialed the readmission orders for Resident #5 and stated the initials would mean the readmission orders had been reviewed and confirmed accurate. Nurse #3 stated Nurse #4 was not available for interview at the time of the survey.

Physician orders for Resident #5 after readmission on 07/18/14 included an order dated 07/19/14 for Duoneb by HHN every four hours as well as Albuterol by HHN every four hours PRN. The Albuterol and Duoneb were written on the July 2014 Medication Administration Record (MAR) 07/19/14 but were not signed as

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| F 309 | Continued From page 5 | F 309 | | |

administered until 07/20/14. Nurse #5, that wrote the 07/19/14 order for Resident #5 recalled the circumstances of the order during an interview on 08/05 14 at 3:13 PM. Nurse #5 stated she noted Resident #5 was having difficulty using the Flovent inhaler; specifically not having the physical or cogntive ability to inhale the contents of the Flovent inhaler for full benefit. Nurse #5 stated when the resident's physician was in the facility late in the day on 07/19/14 she spoke to him about an alternative medication to the inhaler for Resident #5. Nurse #5 stated the physician ordered the aerosolized Albuterol and Duoneb at that time. Nurse #5 stated she recalled setting up equipment for the nebulizer and most likely administered it that night to Resident #5 and forgot to sign the MAR. Review of a physician's note dated 07/20/14 included: "Patient has also come back without nebulizers and has been on this for years. We will re-order."

On 08/05/14 Nurse #1 (who was identified as the nurse in charge at the time of the survey) stated she could not explain why the scheduled Duoneb and PRN Albuterol would have been left off the readmission orders for Resident #5 which resulted in a delay of aerosolized nebulizer treatments.