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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING ______ B. WING ______	C 04/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF CLEMMONS	**3905 CLEMMONS ROAD CLEMMONS, NC 27012**

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 4/30/15. Event ID# E1QC11.	F 000		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to document the assessment of the significant change in condition of 1 of 2 sampled residents receiving dialysis. Resident #41. Findings included: Resident #41 was admitted to the facility on 12/8/14 with diagnoses which included: End-Stage Renal Disease, septic arthritis of knee, cirrhosis of the liver and diabetes mellitus. The review of the 30-day assessment dated	F 514	On 5/14/2015 the DON completed a 100% audit of resident #41's nursing assessment documentation of transfers out to the hospital. Results of the audit showed that the nurses assessment documentation was completed since exit of the Survey Team. All residents with a significant change in condition have a potential to be affected by the deficient practice. On 5/18/2015 the DON completed a 100% audit of all resident who may have a	6/1/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/22/2015

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 514

Continued From page 1

4/3/15 indicated Resident #41 was cognitively intact and received dialysis treatment. The hemodialysis Care Plan included the resident was to receive dialysis on Monday, Wednesday, and Friday; monitoring the resident's diagnostic reports; and monitor/document/report when necessary, for signs/symptoms of bleeding, hemorrhaging, bacteremia, and septic shock.

Review of the clinical records revealed an order from the Physician's Assistant dated 3/27/15 at 4:55pm, for Resident #41 to be transported to the hospital's emergency room for evaluation. There was no documentation in the resident's clinical records indicating the resident was in distress or any documentation of the nurse conducting an assessment of the resident's condition on 3/27/15. There was a Nurse's Note in the clinical record documenting that Resident #41 returned from the hospital on 3/27/15 at 2:30am with hospital records indicating a diagnosis of cellulitis.

During an interview on 4/30/15 at 11:08am, SN#1 (Staff Nurse) revealed that in the past month, Resident #41 had been in and out of the hospital due to high ammonia levels.

During an interview on 4/30/15 at 12:59pm, SN#2 revealed that upon Resident #41's return from dialysis, one of the nursing assistants reported to her that the resident was not "acting his normal self". She (SN#2) assessed the resident, then reported her assessment to the resident's nurse (SN#3). SN#2 indicated that SN#3 also conducted an assessment of Resident #41 and notified physician services. A telephone order was given to send the resident to the emergency room for evaluation.

F 514

significant change in condition. Results of the audit showed that the nurses assessment documentation was completed since exit of the Survey Team.

In-servicing to all current licensed Nurses began on 5/14/15 instructing all nurses that:
1. Any change in condition observed by any staff member is to be reported to the Charge Nurse responsible for that resident immediately.
2. The resident is to be assessed immediately by the Charge Nurse once reported.
3. Once assessed, if a standing order cannot be initiated, the Charge Nurse is to notify the MD/PA, for further instructions and/or orders.
4. Documentation of the resident¿s assessment will be completed under the SBAR communication form tab located in Assessments in PCC.
5. The Charge Nurse who completes the assessment of a resident is responsible for completing the documentation of the assessment in the SBAR assessment in PCC.

All new hired licensed Nurses will be in-serviced on and instructed that:
1. Any change in condition observed by any staff member is to be reported to the Charge Nurse responsible for that resident immediately.
2. The resident is to be assessed immediately by the Charge Nurse once reported.
3. Once assessed, if a standing order

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F 514	Continued From page 2 During a telephone interview on 4/30/15 at 3:08pm, SN#3 indicated that on 3/27/15 during the nurses' shift change, it was reported to her that the dialysis staff had called earlier, wanting to know what medication Resident #41 had taken due to he was behaving oddly at the dialysis center (unable to follow commands). SN#3 also revealed that on 3/27/15, she received a phone call from the facility's transport driver (en route to facility from dialysis) stating that Resident #41 was behaving oddly on the van. SN#3 further revealed that once the resident arrived at the facility, SN#2 accompanied her (SN#2) to the resident's room where NA#2 showed her how to do the assessment of the resident. NA#3 stated that the resident was very disoriented and confused, could not follow simple commands. As a result of the assessment, SN#3 notified the physician services and obtained an order to send the resident to the hospital. Emergency Medical Services arrived to the facility 5-10 minutes after the phone call. SN#3 revealed she was responsible for documenting this assessment in the Progress Note in the computer; but, SN#2 told her not to worry about putting anything in computer, because she (SN#2) had taken care of it. During an interview on 4/30/15 at 4:21pm, the Director of Nursing revealed her expectation of the facility's nurses is that the nurse who conducted the actual assessment of a resident, would be responsible for documenting it in the resident's medical record.	F 514	cannot be initiated, the Charge Nurse is to notify the MD/PA, for further instructions and/or orders. 4. Documentation of the resident¿s assessment will be completed under the SBAR communication form tab located in Assessments in PCC. 5. The Charge Nurse who completes the assessment of a resident is responsible for completing the documentation of the assessment in the SBAR assessment in PCC. DON/ADON and or Unit Coordinator will audit for nurses SBAR assessment for any resident with a significant change of condition daily x 1 month, weekly x 4 weeks, and monthly x 2 months and will report to QA committee x 3months. All in-servicing will be complete by 6/1/2015.	