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	345473	A. BUILDING _____ B. WING _____	C 07/17/2015

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WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

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F 000	INITIAL COMMENTS On 07/14/15 through 07/17/15 a complaint investigation survey was conducted. On 07/17/15 an extended survey was conducted. 483.15 (F242) at a scope and severity (J) Immediate Jeopardy began on 02/02/15 when a resident with an advance directive to be a DNR was resuscitated and placed on ventilator support due to the facility staff not obtaining a physician order after receiving the written advance directive from the legal guardian. The Administrator was informed of immediate jeopardy on 07/16/15 at 12:37 PM amd immediate jeopardy was removed on 07/17/15 at 6:30 PM when the facility implements a credible allegation of compliance. The faciltiy remained out of compliance at the lower scope and severity of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for examples 2, 3, 4, and 5 and to complete education and to ensure monitoring systems put into place are effective.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on family, and staff interviews, and medical record review, the facility failed to	F 166	On 7/17/15, the Regional Director of Clinical Services assigned Resident #10	8/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/07/2015

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F 166	Continued From page 1 monitor and effectively resolve a pattern of grievances regarding a resident having to wait extended periods of time for care for 1 of 12 sample residents (Resident #10). The findings included: Resident #10 was admitted to the facility on 06/06/13. Resident #10 was assessed on the most recent Minimum Data Set (MDS) dated 02/26/15 as severely impaired for decision making, requiring extensive assistance with 1 person for most activities of daily living (ADL). Record review of the facility's Grievance file dated 05/28/15 through 07/13/15 revealed Resident #10's family member had voiced several concerns to the facility. The family member voiced these concerns during a meeting with the current administrator. In the file, there were 2 grievances. The first grievance dated 05/28/15 stated Resident #10 missed her doctor's appointment because she was not ready in time. The second grievances dated 07/13/15 stated the resident was not cleaned well by staff after a clothing change. Interview with the family member of Resident #10 on 07/17/15 at 2:05 PM revealed she had kept a notebook with multiple pages about her concerns about Resident #10. She stated she had spoken to the administrator on four different occasions about her concerns. She further stated she had filed a grievance with the facility about the call light being left on for hours and staff would come into the room and turn the call light off without addressing the concerns of the residents. The administrator could not provide a copy of this grievance. She stated the administrator told her	F 166	to the Executive Director and the Social Service Coordinator to visit daily to be aware of any concerns. On 8/5/15, the Executive Director placed the resident into the facility¿s ¿Adopt -a -Resident¿ Program, a program that affords the resident a 1:1 visit from an assigned manager/employee to address any needs. Resident #10¿s Family Member was placed on the facility¿s ¿Adopt-a-Family¿ Program, a program that affords the family member to meet with an assigned department head to address issues or concerns, on 8/5/15 by the Executive Director. The Executive Director will be the designated department head for the resident¿s family member and meet with or speak to 3 times a week to address concerns. Concerns are documented on a grievance form and addressed according to the facility policy and procedure. Current residents and responsible parties have the potential to be affected by this practice. The Executive Director conducted a Resident Council meeting on 8/5/15 to discuss the Grievance Process. The Social Services Professional and the Executive Director will review the process at a family meeting scheduled for 8/17/15 to discuss the Grievance Process. The Executive Director will reeducate staff currently working for the facility by 8/10/15 on the Grievance Process to include reporting and resolution.	

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F 166	Continued From page 2 the staff had been counseled, but all she knew was the staff were no longer working at the facility. An interview was conducted on 07/17/15 at 5:00 PM with the Director of Nursing (DON). She said she was not aware of the current grievances filed by the family member of Resident #10. She further stated the administrator was handling any grievances the families of the residents were filing. She stated she expected her staff to answer call lights as soon as possible and no longer than 10 minutes. She stated she was not aware the staff were going into rooms and turning lights off without assisting the residents and not returning later. An interview on 07/17/15 at 5:15 PM revealed the Administrator was aware of grievances filed by the family member of Resident #10. He stated he had on several occasions talked in depth with the family member of Resident #10 regarding the time it took the staff to answer the call lights and the staff coming into the resident's rooms and cutting the light off without taking care of the needs of the residents. He stated he had counseled the staff members and thought the response time had improved in answering the call lights, but could not provide any paperwork the staff had been counseled or that the response time had improved. He further stated he gave his business card to the family of Resident #10 and explained to the family to call him day or night. He stated he made rounds every morning and talked to all the families of the residents that were present during his morning rounds. Follow up interview with the family member of Resident #10 on 07/18/15 at 11:30 AM revealed	F 166	The Executive Director, Director of Clinical Services, Regional Director of Clinical Services, and/or Social Service Professional will conduct Quality Improvement (QI) monitoring of the Grievance Forms for completeness and documentation of resolution to include follow up with the resident or responsible party 3 times a week for 4 weeks, 2 times a week for 4 weeks, and then 1 time a week for 4 weeks. The QI monitoring will be documented on a Quality Assurance and Performance Improvement Audit Tool. The Executive Director will report the findings of the QI monitoring to the Quality Assurance and Performance Improvement Committee monthly until the committee determines substantial compliance has been achieved.	

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F 166	Continued From page 3 she was not happy with the responses to her grievances from the Administer or the DON. She stated the new social worker came to see her this morning and ask if she had any problems.	F 166		
F 242 SS=J	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, interview with the legal guardian, interviews with the Nurse Practittioner, and the staff the facility failed to follow through with obtaining a physician order for Do Not Resuscitate (DNR) after receiving advance directive information from a resident's legal guardian for 5 of 5 resident records reviewed (Resident #2, #14, #15, #13, and #16). Immediate Jeopardy began on 02/02/15 at 7:15 PM when a resident with an advance directive to be a DNR was resuscitated and placed on ventilator support due to the facility staff not obtaining a physician order after receiving the written advance directive from the legal guardian. Immediate Jeopardy was removed on 07/17/15 at 6:30 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of	F 242	Residents #2, 15, and 16 no longer reside in the facility. The records of residents #14 and 13 were audited by the Director of Clinical Services, the Executive Director, and the Social Services Person on 7/17/15 and any necessary corrections were made to assure the chosen advanced directives are present in the records. Current residents have the potential to be affected by this practice. On July 16 and July 17, 2015, the Executive Director, Director of Clinical Services, and the Social Services Director immediately completed a review of current resident records to assure the presence of advanced directives from the resident or legal representative, telephone orders	8/12/15

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F 242	Continued From page 4 compliance at a lower scope and severity of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for examples 2, 3, 4, and 5 and to complete education and to ensure monitoring systems put into place are effective. The findings included: 1) Resident #2 was admitted to the facility on 12/02/14 with diagnoses that included Alzheimer's disease, failure to thrive, and high blood pressure. The resident expired on 02/09/15 at 10:30 AM. A review of the medical record revealed Resident #2 was admitted to the facility on 12/02/14 from an acute hospital with the hospital discharge summary dated 12/02/14 at 2:48 PM, which indicated Resident #2 was to be a Do Not Resuscitate (DNR). The resident's legal guardian had indicated on the discharge summary that the resident's code status was DNR and the resident had continued to not do well with feedings and to not consider any feeding tube placement. Further review of Resident #2's medical record revealed there was no admission orders and/or advance directive paperwork in the resident's medical record. The facility could not provide the admission orders and/or advance directive paperwork upon request during the survey. A review of the nurse's notes dated 12/02/14 through 01/13/15 revealed no other nurse's notes in Resident #2's medical record after the date of 01/13/15. A physician order dated 12/03/14 in Resident #2's	F 242	for code status, SS 121 forms (form for documentation of do not resuscitate status), Golden Rod (a North Carolina state specific form to document advanced directives) or MOST (newer form to document do not resuscitate). The interdisciplinary team also compared the physician orders to the Medication Administration Record. Any noted discrepancies were corrected immediately. System to assure continued compliance: On 7/17/15 the Director of Clinical Services retrained current Nurses and the Social Service person currently working for the facility on the policies and procedures for advanced directives to include: The necessity of determining the `Do Not Resuscitate¿ status of all newly and readmitted residents to assess if this status has changed and actions to take if a code status cannot be established. The requirement of a physician¿s telephone order for code status upon admission. The proper location of the advanced directive information in the resident record. What forms are accepted as indicators of advanced directives. Action to take if a code status cannot be	

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F 242	Continued From page 5 medical record under the tab "Admission Records" indicated Full Code until Guardian/Facility Discussion. A review of the admission Minimum Data Set (MDS) dated 12/09/14 indicated Resident #2 had impairment in short term and long term memory and was moderately impaired in cognition for daily decision making and required extensive assistance from staff for activities of daily living. A review of a physician progress note dated 12/09/14 had the word "Full" circled for Resident #2's code status and an order for the resident to have a Palliative Care Consult. A review of a care plan dated 12/19/14 indicated Advanced Directives and under the heading problem: resident has advanced directives of: DNR was indicated by a check mark, under the heading of goal: DNR was indicated by a check mark, and under the heading of approaches/interventions indicated a check mark by "physician order for DNR." A review of the Palliative Consultants evaluation/initial consultation dated 12/19/14 indicated on page 1 of 2 the document under the area of Advance Directives: an "X" was marked inside of the DNR checkbox and above the DNR check was a handwritten note "no golden rod." In the consultant's notes was written "seen by palliative care, discussed code status with guardian and resident was made a Do Not Resuscitate (DNR) and the guardian had also indicated to not proceed with feeding tube, and no golden rod DNR form in the chart." Further review of the consultation on page 2 of 2 read "resident was a DNR in the hospital, no	F 242	determined ¿ notify the Director of Clinical Services and or the Executive Director. No nurse will be allowed to work until receiving this training prior to the start of their next scheduled shift. Newly hired nurses will receive training on the ¿Red Light/Green Light¿ policies and procedures on advanced directives in orientation including the above. The Director of Clinical Services or other management nurse will review each admission or readmission to assure the presence of documentation of advanced directives supporting the resident¿s wishes and the physician¿s order. The Executive Director, Director of Clinical Services, and Social Services Person will conduct Quality Improvement (QI) of advanced directive information 2 times a week for 3 months then 1 time a week for 3 months to assure the systems are in place and that required documentation is present on the residents¿ records. The Quality Improvement monitoring will be documented on a Quality Assurance and Performance Improvement Audit Tool. The Director of Clinical Services reports discrepancies, trends, and patterns to the Quality Assurance and Improvement Committee monthly. The QI monitoring will continue until the committee decides substantial compliance has been met.	

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documentation on skilled nursing facility chart, and feeding tube would not be pursued." The Palliative Care Consultant had hand-written "recommend Do Not Resuscitate (DNR) as resuscitation at this stage would likely be over-burdensome and offer little benefit to the resident, and feeding tube would not be recommended secondary to lack of benefit in advanced dementia."

A review of a physician progress note dated 12/30/14 had DNR circled as to indicate Resident #2's code status. Further review of the record revealed there was no physician's order to match the resident's DNR code status as indicated in the physician progress note. The physician was out of town and was unable to be contacted for an interview.

Further review a physician's progress note dated 01/13/15 had DNR circled as to indicate Resident #2's code status. Further review of the record revealed there was no physician's order to match the resident's DNR code status as indicated in the physician progress note. The physician was out of town and was unable to be contacted for an interview.

During a telephone interview on 07/15/15 at 3:43 PM, Resident #2's legal guardian stated 3 days after the resident was admitted to the facility she had met with the former Admissions Director (AD) and the former Administrator related to Resident #2's code status and the resident's wishes to be a DNR. She indicated on that day she provided to the AD and the Administrator, a letter on Department of Social Services letterhead which indicated she was the guardian of Resident #2, the facility's admission paperwork advance

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directive which also had the DNR code status information, and the DNR golden rod form. She further indicated she was advised on 02/03/15 by the local hospital's physician that she was needed at the hospital to make the decision as to continue Resident #2 on life support or to remove the resident from life support. During the interview she indicated that she advised the hospital physician that Resident #2 had a DNR code status and was not supposed to be on life support. She revealed the hospital physician indicated to her that he was aware Resident #2 was a Do Not Resuscitate code status back in December 2014 but the guardian would need to come to the hospital to make the determination as to continue or withdraw the life support from Resident #2. The guardian stated she advised the hospital physician to withdraw the life support as to honor the wish of Resident #2. The guardian indicated she went to the facility after she left the hospital and spoke with the current Administrator in regards to Resident #2's wishes not being honored by the facility and CPR being started by the facility staff. She indicated during their conversation/meeting the Administrator reviewed Resident #2's medical record and explained to her that a mistake was made, all of the paperwork was not in the medical record, and he was aware the resident was supposed to be that of a DNR code status, that CPR should not have been started.

During an interview on 07/15/15 at 5:30 PM the Director of Nursing (DON) stated she expected a resident's code status to be honored as either a full code with CPR initiated or a no code which indicated Do Not Resuscitate (DNR) and no CPR to be initiated. The DON further indicated every resident was considered a full code status until

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the resident, family, or legal representative signed the paperwork regarding the resident's code status choice. The DON stated she expected all the admission paperwork, code status documents, DNR golden rod form, and nurse's notes to be part of the resident ' s medical record. The DON reviewed and confirmed Resident #2's medical record was incomplete and did not contain that information. She further stated she would have expected CPR to not have been started on Resident #2 regarding the resident ' s code status to be that of Do Not Resuscitate (DNR).

During an interview on 07/15/15 at 7:21 PM, the former Admissions Nurse/Director stated she was responsible to obtain, check, and compare the admission orders, the admission paperwork, and the physician's order for the code status. She indicated she remembered the guardian coming to the facility on or around 12/05/14 and had all of Resident #2's admission paperwork, the letter which indicated Resident #2's legal guardian, the golden rod DNR form, which was on the very top of the stack of papers, and a yellow colored sticky note which obtained the legal guardian's name and her phone number. The Admissions Nurse/Director indicated she escorted the guardian to the Administrator's office at which time she obtained all of the papers from Resident #2's guardian. The former Admissions Nurse/Director further indicated she was unable to recall if she had obtained a physician's order as to indicate Resident #2 was to be a DNR on 12/05/14 when the legal guardian brought in the advance directive information.

During an interview on 07/16/15 at 3:23 PM, the Nurse Practitioner (NP) stated she was aware

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Resident #2 was supposed to be a DNR code status. She indicated her expectation of the facility nursing staff was to not initiate CPR on a resident with a code status of Do Not Resuscitate (DNR). The NP stated the physician was out of town and was unavailable for an interview. She indicated she was unable to recall if a physician's order as to indicate Resident #2 was a code status of DNR was in the resident's medical record.

During an interview on 07/16/15 at 5:15 PM, the former Unit Manager stated Resident #2 was being returned to her room after dinner on 02/02/15 when he observed the resident to be pale, with irregular breathing, and to be lifeless. He indicated he looked in the resident's medical record under the tab labeled advanced directives and there was a physician's order that indicated Resident #2 was a full code. He stated upon his return to the resident's room she was unresponsive, not breathing, and had no pulse, and he and a nurse aide immediately started CPR and the hall nurse called 911 for the Medics/Emergency Medical Services (EMS). The Unit Manager indicated the day after the resident was sent out to the hospital he had spoken with the resident's guardian by telephone on 02/03/15 at which time the guardian made him aware that Resident #2 was supposed to have a code status of DNR. He further indicated he immediately went and spoke with the DON and Administrator and they started looking for the code status paperwork and the DNR form. He stated they found the admission advance directive paperwork, the letter which indicated the resident's guardian, the golden rod DNR form, and the physician's order which indicated Resident #2 was to be a DNR code status in a

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drawer in the business office. He stated had the DNR form and physician's order for DNR had of been in the resident ' s medical record then CPR would not have been started.

During an interview on 07/17/15 at 11:40 AM with the Regional Director of Clinical Services (RDCN) stated they had identified a problem on 02/05/15 when it was brought to their attention by the legal guardian that Resident #2 was supposed to be a DNR. The RDCN stated under her direction, the Director of Nursing (DON) was to re-educate all of the nursing staff, newly admitted residents were to have a chart audit completed within 36 hours of admission for verification of advance directive code status, and weekly chart audits were to be done on the in-house resident's. She further indicated the DON and the Administrator had put together a plan of correction to ensure the resident's medical desires would be honored related to their advanced directive and the physician's order would match. The facilities monitoring tools, training records, and audits were provided for review.

During the review of the facility provided records the following information was identified:
a) There was documented training of 13 out of approximately 60 employed nursing staff relating to the advance directive code status and upon request of the training records for the other nursing staff the facility was unable to provide the training records.
b) The 3 nurses working on 07/17/15 from 7:00 AM until 3:00 PM were interviewed and confirmed they had in-service training in February 2015 in regards to obtaining a physician's order to match the advance directive of a resident's choice which included full code status and DNR.

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F 242	Continued From page 11 During a follow-up interview on 07/17/15 at 1:45 PM with the RDCS, DON, and Administrator confirmed that all nursing staff were not trained and no other training records could be found and/or provided, and the resident charts had not been audited as to ensure the physician's order and the advance directive code status paperwork matched. The Administrator was informed of Immediate Jeopardy on 07/16/15 at 12:37 PM for Resident #2. The following Credible Allegation of Compliance was accepted on 07/17/15 at 6:30 PM. Credible allegation of compliance Resident Choice 1) On February 2, 2015, resident #2 experienced an episode of respiratory arrest. The nurse in charge and another nurse checked the medical record and did not find any documentation regarding an advance directive or "Do Not Resuscitate (DNR)," so the nurses initiated Cardiopulmonary Resuscitation, according to policy, and the resident was transported to the hospital for emergency care and was admitted. Thereafter, the Guardian notified the Executive Director on February 3, 2015 that Resident #2 was to have an advance directive in the medical record for "Do Not Resuscitate." She stated she had brought the papers into the building and had given them to the admissions director. An investigation was initiated immediately by the Executive Director	F 242		

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and the Director of Clinical Services at the direction of the Regional Director of Clinical Services. The Executive Director interviewed the Admissions Director who confirmed that the Do Not Resuscitate papers had been brought to the facility by the Guardian but she did not recall where she placed the papers. All files regarding the resident and other resident's records were audited to find the papers. The papers were found in the resident's business office file by the 4th of February.

2) All residents in the facility have the potential to be affected.
On July 16 and 17, 2015, the Executive Director, Director of Clinical Services, and the Social Services Director immediately completed a review of all resident records to assure the presence of advanced directives from the resident or guardian, telephone orders for code status, SS 121 forms (Consulate form for documentation of do not resuscitate status which is part of the admission packet to be completed upon admission), the North Carolina Department of Health and Human Services Golden Rod Form (universally accepted form to document advanced directives - do not resuscitate orders) or MOST (Medical Orders for Scope of Treatment form to document do not resuscitate and other advanced directives including hospitalization, IV, tube feeding). The team compared the physician orders to the above forms present in the records and to the Medication Administration Records. Any noted discrepancies were corrected at this time.

3) System to assure continued compliance
On 07/17/15, the Director of Clinical Services retrained all nurses, the admission coordinator,

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F 242	Continued From page 13 and the social service person currently working for the facility on the policies and procedures for advanced directives to include: · The necessity of determining the "Do Not Resuscitate" status of all newly and readmitted residents to assess if this status has changed and actions to take if a code status cannot be established. · The requirement of a physician's telephone order for code status upon admission · The proper location of the advanced directive information · What forms are accepted as indicators of advanced directives · Action to take if no code status can be determined - notify the Director of Nursing Services and or the Executive Director. · No nurse will be allowed to work until receiving this training prior to the start of their next scheduled shift. · Newly hired nurses will receive training on the "Red Light/Green Light" - the Consulate policies and procedures on advanced directives and do not resuscitate orders in orientation including the above. · The Director of Clinical Services or other management nurse will review each admission to assure the presence of documentation of advanced directives supporting the resident's wishes and the physician's order during the next morning following admission. Immediate jeopardy was removed on 07/17/15 at 6:30 PM when interviews of nursing staff, nurse aides, and the Admissions Coordinator confirmed they had received in-service training on obtaining a physician's order to match the advance	F 242		

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directive of a resident's choice which included full code status and DNR. The nursing staff explained they were taught that it was a resident's choice to make decisions regarding their advanced directives and code status and if they were not able to make the decision, a legal guardian/responsible party could make the decision for them. Nursing staff explained they were expected to always check the resident's chart for a physician's order and advance directive code status first when they found a resident unresponsive so that they would provide CPR if the resident was a full code and they should not start CPR on a resident who had DNR orders.

Record reviews were also made to verify accurate code status was available in the front of the resident's medical record. The Admissions Coordinator and Interim Director of Nursing verified all new admissions would have chart audits completed and documented to ensure the correct advanced directives, code status forms, and the physician's order matched and were present on the resident's chart.

2) Resident #14 was re-admitted to the facility on 04/18/15 with diagnoses which included heart disease, coronary artery disease, Parkinson's disease, and dementia. The MDS dated 04/18/15 revealed Resident #14 was moderately cognitively impaired and required extensive assistance with activities of daily living (ADLs). A random review of the resident's medical record indicated the DNR (golden rod form) was dated 06/19/15 and the physician's order for the resident to be a DNR code status was dated

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07/08/15. The admission advance directive paperwork was not available in the resident's chart.

During an interview on 07/17/15 at 11:40 AM with the Regional Director of Clinical Services (RDCN) stated they had identified a problem on 02/05/15 when it was brought to their attention. The RDCN stated under her direction, the Director of Nursing (DON) was to re-educate all of the nursing staff, newly admitted residents were to have a chart audit completed within 36 hours of admission for verification of advance directive code status, and weekly chart audits were to be done on the in-house resident's. She further indicated the DON and the Administrator had put together a plan of correction to ensure the resident's medical desires would be honored related to their advanced directive and the physician's order would match. The facilities monitoring tools, training records, and audits were provided for review.

During the review of the facility provided records the following information was identified:
a) There was documented training of 13 out of approximately 60 employed nursing staff relating to the advance directive code status and upon request of the training records for the other nursing staff the facility was unable to provide the training records.
b) The 3 nurses working on 07/17/15 from 7:00 AM until 3:00 PM were interviewed and confirmed they had in-service training in February 2015 in regards to obtaining a physician's order to match the advance directive of a resident's choice which included full code status and DNR.

During a follow-up interview on 07/17/15 at 1:45

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PM with the RDCS, DON, and Administrator confirmed that all nursing staff were not trained and no other training records could be found and/or provided, and the resident charts had not been audited as to ensure the physician's order and the advance directive code status paperwork matched.

3) Resident #15 was admitted to the facility on 07/02/15 with diagnoses which included cancer, anemia, high blood pressure, diabetes mellitus, and thyroid disease. The MDS dated 07/09/15 revealed Resident #15 was cognitively intact and required limited assistance with ADLs. Resident #15's admission advance directive paperwork was in the chart and was dated 07/02/15 which indicated the resident was a full code status, with a physician's order dated 07/17/15.

During an interview on 07/17/15 at 11:40 AM with the Regional Director of Clinical Services (RDCN) stated they had identified a problem on 02/05/15 when it was brought to their attention. The RDCN stated under her direction, the Director of Nursing (DON) was to re-educate all of the nursing staff, newly admitted residents were to have a chart audit completed within 36 hours of admission for verification of advance directive code status, and weekly chart audits were to be done on the in-house resident's. She further indicated the DON and the Administrator had put together a plan of correction to ensure the resident's medical desires would be honored related to their advanced directive and the physician's order would match. The facilities monitoring tools, training records, and audits were provided for review.

During the review of the facility provided records

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the following information was identified:
a) There was documented training of 13 out of approximately 60 employed nursing staff relating to the advance directive code status and upon request of the training records for the other nursing staff the facility was unable to provide the training records.
b) The 3 nurses working on 07/17/15 from 7:00 AM until 3:00 PM were interviewed and confirmed they had in-service training in February 2015 in regards to obtaining a physician's order to match the advance directive of a resident's choice which included full code status and DNR.

During a follow-up interview on 07/17/15 at 1:45 PM with the RDCS, DON, and Administrator confirmed that all nursing staff were not trained and no other training records could be found and/or provided, and the resident charts had not been audited as to ensure the physician's order and the advance directive code status paperwork matched.

4) Resident #13 was admitted to the facility on 06/29/15 with diagnoses which included dementia, chronic obstructive pulmonary disease, and malnutrition. The MDS dated 07/06/15 indicated Resident #13 was severely cognitively impaired and required extensive assistance with ADLs. Further review of the resident's chart revealed a physician's order for the resident to be a full code dated 07/09/15. The admission advance directive paperwork was not available in the resident's chart.

During an interview on 07/17/15 at 11:40 AM with the Regional Director of Clinical Services (RDCN) stated they had identified a problem on 02/05/15 when it was brought to their attention. The RDCN

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stated under her direction, the Director of Nursing (DON) was to re-educate all of the nursing staff, newly admitted residents were to have a chart audit completed within 36 hours of admission for verification of advance directive code status, and weekly chart audits were to be done on the in-house resident's. She further indicated the DON and the Administrator had put together a plan of correction to ensure the resident's medical desires would be honored related to their advanced directive and the physician's order would match. The facilities monitoring tools, training records, and audits were provided for review.

During the review of the facility provided records the following information was identified:
a) There was documented training of 13 out of approximately 60 employed nursing staff relating to the advance directive code status and upon request of the training records for the other nursing staff the facility was unable to provide the training records.
b) The 3 nurses working on 07/17/15 from 7:00 AM until 3:00 PM were interviewed and confirmed they had in-service training in February 2015 in regards to obtaining a physician's order to match the advance directive of a resident's choice which included full code status and DNR.

During a follow-up interview on 07/17/15 at 1:45 PM with the RDCS, DON, and Administrator confirmed that all nursing staff were not trained and no other training records could be found and/or provided, and the resident charts had not been audited as to ensure the physician's order and the advance directive code status paperwork matched.

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5) Resident #16 was admitted to the facility on 07/07/15. The resident's MOST form was dated 07/09/15 and a physician's order was dated 07/17/15. The admission advance directive paperwork was not available in the resident's chart.

During an interview on 07/17/15 at 11:40 AM with the Regional Director of Clinical Services (RDCN) stated they had identified a problem on 02/05/15 when it was brought to their attention. The RDCN stated under her direction, the Director of Nursing (DON) was to re-educate all of the nursing staff, newly admitted residents were to have a chart audit completed within 36 hours of admission for verification of advance directive code status, and weekly chart audits were to be done on the in-house resident's. She further indicated the DON and the Administrator had put together a plan of correction to ensure the resident's medical desires would be honored related to their advanced directive and the physician's order would match. The facilities monitoring tools, training records, and audits were provided for review.

During the review of the facility provided records the following information was identified:
a) There was documented training of 13 out of approximately 60 employed nursing staff relating to the advance directive code status and upon request of the training records for the other nursing staff the facility was unable to provide the training records.
b) The 3 nurses working on 07/17/15 from 7:00 AM until 3:00 PM were interviewed and confirmed they had in-service training in February 2015 in regards to obtaining a physician's order to match the advance directive of a resident's choice which

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F 242	Continued From page 20 included full code status and DNR. During a follow-up interview on 07/17/15 at 1:45 PM with the RDCS, DON, and Administrator confirmed that all nursing staff were not trained and no other training records could be found and/or provided, and the resident charts had not been audited as to ensure the physician's order and the advance directive code status paperwork matched.	F 242		
F 309 SS=G	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 observation, resident and staff interviews, and record review the facility failed to administer a scheduled pain mediation as prescribed for a resident with chronic pain for 1 of 4 sampled residents reviewed for well-being (Resident #4). The findings included: Resident #4 was re-admitted to the facility on 07/02/15 with diagnoses which included chronic pain, heart failure, respiratory failure, and lung cancer.	F 309	Resident #4 was provided pain medication according to physician orders after the medication was received from the pharmacy by Nurse #2 at 1:30 pm. Current residents have the potential to be affected by this practice. The Director of Clinical Services and Consulate Healthcare Nurses completed a review of each current medical record and the current medication administration record for any discrepancies by 8/10/15. Any discrepancies were corrected	8/12/15

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F 309	Continued From page 21 Review of Resident #4's admission Minimum Data Set (MDS) dated 07/06/15 revealed the resident was cognitively intact, independent for activities of daily living (ADLs), frequently with pain, and rating the pain intensity as a 5 on a scale of 1 to 10 (zero being no pain and ten as the worst pain imaginable). Review of a physician's order dated 07/06/15 revealed Morphine Sulfate Extended Release (ER) 20 milligrams (mg) (a narcotic analgesic) by mouth (PO) every 12 hours at 9:00 AM and 9:00 PM. Further review of the physician's orders revealed an increase in the pain medication dated 07/15/15 for Morphine Sulfate ER 30 mg PO twice daily (BID) at 9:00 AM and 9:00 PM. Review of the Medication Administration Record (MAR) dated 07/02/15 through 07/31/15 revealed Nurse #2 administered the Morphine Sulfate ER 20 milligrams (mg) at 9:00 AM on 07/14/15. Resident #4 was observed on 07/17/15 at 12:20 PM lying in her bed, awake, and turning from side to side the resident stated "I have not had my pain medication in 3 days and I am miserable can you please help me." The resident indicated her pain was an 8 or 9 on a scale of 1 to 10. Further review of the MAR dated 07/02/15 through 07/31/15 revealed Nurse #2 administered the Morphine Sulfate ER 30 mg at 1:20 PM on 07/17/15. Nurse #2 was interviewed on 07/17/15 at 1:30 PM. Nurse #2 confirmed she had administered Resident #4's pain medication, Morphine Sulfate	F 309	immediately by the Licensed Nurse. The Director of Clinical Services and Consulate Healthcare Nurses completed an audit of each current medical record for needed areas to provide care to assure each area has appropriate orders, meds, and supplies to treat and that Nursing is providing necessary care. Any discrepancy was corrected immediately. A medication cart review was completed by the Director of Clinical Services/Licensed Nurse on 8/5/15 and any discovered discrepancies were reported to the physician for new orders and/or the pharmacy to obtain any missing residents¿ medications. The Director of Clinical Services and Consulate Healthcare Nurses reeducated the nurses currently working for the facility on 7/23/15 on the need to follow up on resident issues affecting their wellbeing such as pain. The Director of Clinical Services or Unit Manager will conduct Quality Improvement (QI) monitoring of 5 resident records for compliance with following up on identified issues and providing care to promote wellbeing 3 times a week for 4 weeks, then 3 resident records 3 times a week for 4 weeks, then 3 resident records 1 time a week for 4 weeks. The QI monitoring will be documented on a Quality Assurance and Performance Improvement Audit Tool. The Director of Clinical Services reports	

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F 309	Continued From page 22 ER 20 mg on 07/14/15 at 9:00 AM, which was the last pill in the packet, and the resident had indicated to the nurse her pain to be a 5 on a scale of 1 to 10. Nurse #2 confirmed Resident #4 had not had any pain medication on 07/14/15 at 9:00 PM, 07/15/15 at 9:00 AM, 07/15/15 at 9:00 PM, 07/16/15 at 9:00 AM, 07/16/15 at 9:00 PM, or 07/17/15 at 9:00 AM. Nurse #2 further confirmed she had administered Morphine Sulfate ER 30 mg on 07/17/15 at 1:20 PM and the resident had reported to the nurse that her pain was an 8 on a scale of 1 to 10. Nurse #2 indicated when a resident ran out of a narcotic medication the nurse practitioner or physician had to write a new order and the new order had to be faxed to the pharmacy. She further indicated the Nurse Practitioner (NP) had increased the dosage of the resident's pain medication from 20 mg to 30 mg and had written the new order on 07/15/15. Nurse #2 indicated she had faxed the new order to the pharmacy on 07/15/15 but she had not kept the faxed confirmation to the pharmacy and there was no documentation which indicated the pharmacy had received the order. Nurse #2 stated she was going to call the pharmacy on 07/16/15 but she had gotten too busy and had forgotten to call. Nurse #2 further stated she called the pharmacy on 07/17/15 at 10:30 AM, the pharmacy had requested a clarification of the order and after she clarified the order with the pharmacist the pain medication was sent to the facility. Nurse #2 confirmed she had administered the pain medication to Resident #4 on 07/17/15 at 1:20 PM. Nurse #2 stated she should have called the pharmacy on 07/15/15 to ensure that Resident #4's pain medication was available but had no answer as to why she failed to do so. A telephone interview was conducted with the	F 309	discrepancies, trends, and patterns to the Quality Assurance and Improvement Committee monthly. The Quality Improvement monitoring will continue until the committee decides substantial compliance has been met.	

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F 309	Continued From page 23 Pharmacist on 07/17/15 at 3:15 PM. The pharmacist stated they had received the faxed physician's order for Resident #4 on 07/15/15 at 7:00 PM for Morphine Sulfate 30 mg. The pharmacist stated she had called the facility on 07/16/15 at 9:30 AM for clarification of the physician's order and was placed on hold for greater than 10 minutes. She stated she called back to the facility on 07/16/15 at 4:30 PM and no one answered the telephone at the facility. The pharmacist further stated Nurse #2 called on 07/17/15 at 10:27 AM, clarified the physician's order, and the pain medication was sent out to the facility at that time. An interview was conducted with the Director of Nursing (DON) on 07/17/15 at 5:30 PM. She stated she expected the nurses to fax orders to the pharmacy and obtain the medications as quickly as possible. She further stated she was unaware Resident #4 had gone 3 days without her pain medication.	F 309		
F 514 SS=E	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.	F 514		8/12/15

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WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

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F 514	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to maintain accurate medical records for 3 of 9 sampled residents (Resident #2, #4, and #7). The findings included: 1) Resident #2 was admitted to the facility on 12/02/14 with diagnoses including Alzheimer's disease, failure to thrive, and high blood pressure. The admission Minimum Data Set (MDS) dated 12/09/14 assessed the resident's long and short term memory as a problem and cognitive skills for daily decision making was moderately impaired. During a review of Resident #2's medical record revealed 2 documents titled "Advanced Directives Discussion Document" form SS 121 (a Consulate Corporation document regarding the resident's wishes on specific life support decisions) a part of the facility's admission packet required to be completed by the Admissions Director/Nurse on the day of the resident's admission to the facility). a) Resident #1's SS 121 form with no date indicated was found in Resident #2's closed medical record with the following information: resident's name, attending physician's name, resident's date of birth, the facility name, and 2 check marks beside the words Cardiopulmonary Resuscitation, Artificial Respiration (including respirator), and Artificial means of providing nutrition or hydration. b) Resident #7's SS 121 form dated 04/15/15 was found in Resident #2's record, which was a	F 514	Residents #2 and #7 no longer reside in the facility. The Executive Director, the Social Services Person, and the Business Office Manager completed an audit of the DNR (Do Not Resuscitate) documentation of Resident #4 for accuracy of the records on 7/17/15 and made any necessary corrections. Current residents have the potential to be affected by this practice. Consulate Healthcare Nurses completed a review of all current medical records to assure completeness and accuracy. Any discrepancies were corrected by the Licensed Nurse or Interdisciplinary Team Member as applicable. This was completed on 8/10/15. A Consulate Healthcare Medical Records Coordinator completed an audit and assembled recent discharge records. This was completed on 7/29/15. The Regional Director of Clinical Services and Consulate Healthcare Nurses retrained nurses currently working in the facility on the need to maintain medical records accurately and completely on 7/23/15. Any nurses not trained as of 7/23/15, will be trained prior to reporting to work for their next scheduled shift. The Regional Director of Clinical Services	

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F 514	Continued From page 25 closed record after Resident #2 had expired, with the following information: resident's name, initials of the resident's responsible party as to indicate the resident's wishes would be for Cardiopulmonary Resuscitation (CPR), and the responsible party's signature. During an interview on 07/17/15 at 10:30 AM the Medical Record Director (MRD) stated she was aware there were records with the wrong resident's documents/forms in other resident's charts. She verified the SS 121 forms should not have been in or a part of Resident #2's medical record. She further stated since she had taken the position of MRD she had been going through the resident's medical records and removing the papers for which was in the wrong resident charts. During an interview on 07/17/15 at 1:45 PM with the Regional Director of Clinical Services (RDCS) and the Director of Nursing (DON) stated they were aware of a systems problem in regards to the accuracy of the medical records. The DON indicated they had recently hired a new medical records coordinator. The DON verified the SS 121 forms should not have been in Resident #2's medical record. She stated she would have expected the papers to have been in the named resident's medical record and not in Resident #2's medical chart. 2) Resident #4 was admitted to the facility on 07/02/15 with diagnoses including chronic pain, heart failure, respiratory failure, and lung cancer. The admission MDS dated 07/06/15 revealed the resident was cognitively intact and no problem with long and short term memory.	F 514	reeducated the Medical Records Person on 8/3/15 on the proper filing, and proper order of the current medical record and the discharge medical record. The Executive Director, Director of Clinical Services, Consulate Healthcare Medical Records Person or a Consulate Healthcare Nurse will conduct Quality Improvement monitoring of medical records for completeness and appropriate order on 5 medical records a week for 4 weeks, 3 medical records a week for 4 weeks then 1 medical record a week for 4 weeks. The Quality Improvement monitoring will be documented on a Quality Assurance and Performance Improvement Audit Tool. The Director of Clinical Services reports discrepancies, trends, and patterns to the Quality Assurance and Improvement Committee monthly. The Quality Improvement monitoring will continue until the committee decides substantial compliance has been met.	

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During a review of Resident #4's medical record revealed 1 document in the resident's medical chart for which did not have her name on the papers and was not a part of Resident #4's record.
a) Further review of Resident #4's medical record revealed a document titled "Wound Physician Progress Note" dated 02/05/15 with Resident #19's name indicated on the progress note and under the chart tab for progress note.

During an interview on 07/17/15 at 10:30 AM the Medical Record Director (MRD) stated she was aware there were records with the wrong resident's documents/forms in other resident's charts. She verified the discharge summary and the 1 document titled wound physician progress notes should not have been in or a part of Resident #4's medical record. She further stated since she had taken the position of MRD she had been going through the resident's medical records and removing the papers for which was in the wrong resident charts.

During an interview on 07/17/15 at 1:45 PM with the Regional Director of Clinical Services (RDCS) and the Director of Nursing (DON) stated they were aware of a systems problem in regards to the accuracy of the medical records. The DON indicated they had recently hired a new medical records coordinator. The DON verified the document should not have been in Resident #4's medical record. She stated she would have expected the papers to have been in the named resident's medical record and not in Resident #4's medical record/chart.

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3. Resident #7 was admitted to the facility on 04/13/15 with diagnoses which included cancer, chronic respiratory failure, chronic airway obstruction and iron deficiency anemia. Resident #7 was discharged on 06/04/15. An admission Minimum Data Set (MDS) dated 04/20/15 indicated the resident was able to make his needs known, but with periods of confusion. The MDS specified the resident required extensive assistance to total dependence on staff for activities of daily living.
A review of Resident #7's closed medical record revealed two documents entitled Physical Therapy Treatment Encounter Note dated 05/25/15 and 06/04/15 belonging to two different residents. One document entitled Speech Therapy Treatment Encounter Note dated 05/26/15 for a different resident. One document entitled Occupational Therapy Treatment Encounter Note dated 05/26/15 for a different resident.
An interview on 07/15/15 at 5:00 PM was conducted with the administrator. He revealed he was aware there was a problem with the medical records. He further stated, "We are trying to correct all the medical records and it takes time."
An interview on 07/15/15 at 5:15 PM with the Director of Nursing (DON) revealed there was a problem with the resident's medical records. She stated she was aware the medical records were "a mess." She stated the facility was in the process of going through all the medical records, but it takes time to check each medical record.

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L 076	.2305(A) QUALITY OF CARE 10A-13D.2305 (a) The facility shall provide necessary care and services in accordance with medical orders, the patient's comprehensive assessment and on-going plan of care. This Rule is not met as evidenced by: Based on record reviews, resident, and staff interviews, the facility failed to follow physician orders for administering insulin and a steroid medication for 2 of 2 residents (Resident #6 and #3). The findings included: 1. Resident #6 was admitted to the facility on 01/30/15 with diagnoses including post traumatic stress disorder, chronic pain, Addison's disease, depressive disorder and anxiety state. A. Review of the medical record for Resident #6 revealed a physician's order dated 03/24/15 for administration of Prednisone for 14 days in decreasing dosages as follows: Prednisone 40 milligrams (mg) once daily for 3 days, Prednisone 30 mg once daily for 3 days, Prednisone 20 mg once daily for 3 days, Prednisone 10 mg once daily for 3 days, Prednisone 5 mg daily for 2 days, then stop. Hold Cortef while taking Prednisone, then resume Cortef 30 mg every morning and 20 mg every night. A physician's order dated 04/01/15 read "Cortef to restart when Prednisone dose drops to 10 mg so they are given the same day for 5 days." Review of the March 2015 and April 2015	L 076	Resident #6 no longer resides in the facility. Resident #3 had no negative outcomes as a result of the medication discrepancy. The medical record was audited by a licensed Consulate Healthcare nurse for any other discrepancies on 8/10/15 and any corrections required were completed. Current residents have the potential to be affected. A review was completed by Consulate Healthcare Licensed Nurses on 8/10/15 to assure all orders and prescribed treatments/medications are correctly transcribed. Any discrepancies noted were corrected and appropriate reporting of discrepancies completed. The Regional Director of Clinical Services and Consulate Healthcare Licensed Nurses reeducated Licensed Nurses currently working at the facility on accurate transcription, reviewing consult documentation and Physician progress notes for orders, and proper documentation of medications and treatments on 7/23/15. The Regional Director of Clinical Services trained Licensed nurses currently working at the facility on and implemented a ¿Red	8/12/15

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L 076	Continued From page 1 Medication Administration Records (MARs) revealed documentation that Prednisone 40 mg was administered March 25 - 29, 2015 and April 1 - 2, 2015 for a total of 7 doses instead of the 3 doses that were ordered. Further review of the March 2015 MAR revealed documentation that Cortef (Hydrocortisone) 30 mg was given at 9:00 AM on 03/26/15, 03/27/15 and 03/30/15 instead of being held as ordered. Also, the March 2015 MAR indicated Cortef 20 mg was given at 9:00 PM on 03/25/15 and 03/26/15 instead of being held as ordered. Further review of the April 2015 MAR revealed Cortef was resumed on 04/11/15 instead of on 04/09/15 as ordered. In an interview with Nurse Practitioner (NP) #1 on 07/16/15 at 3:15 PM about the Prednisone and Cortef not being administered as ordered, NP #1 stated any medication error was a cause for concern. NP #1 stated she didn't think receiving the Prednisone and Cortef simultaneously at the beginning of the Prednisone taper would have had an adverse effect on Resident #6. NP #1 stated her expectation was for staff to administer the medications as ordered by the pulmonologist, a physician specializing in disorders of the lungs. In an interview with the Director of Nursing (DON) on 07/17/15 at 6:49 PM about the facility's process for transcription of medication orders, the DON stated the nurse receiving the order writes it on the MAR and the night shift nurse checks all new orders with the MAR to verify they were transcribed correctly. The DON reviewed the March 2015 MAR for Resident #6 and confirmed that the Prednisone order was not transcribed correctly and the Cortef was not placed on hold as ordered. The DON offered no explanation for the error. When asked to review the April 2015 MAR, the DON stated she entered the	L 076	Line¿ system (a system where the night shift audits each record for accurate transcription of orders and missed orders) on 7/23/15. Any Nurse who missed the training will receive the training prior to the next shift scheduled. The Director of Clinical Services or Unit Manager will conduct Quality Improvement monitoring of 5 resident records, MARs, and TARs for compliance with appropriate transcription and documentation of physician orders and medication/treatment documentation and the presence of the Red Line documentation 3 times a week for 4 weeks, then 3 records 3 times a week for 4 weeks, then 3 records 1 time a week for 4 weeks. The quality monitoring will be documented on a Quality Assurance and Performance Improvement Monitoring Tool. The Director of Clinical Services reports discrepancies, trends, and patterns to the Quality Assurance and Improvement Committee monthly. The monitoring will continue until the committee decides substantial compliance has been met.	

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Prednisone on the MAR and missed seeing that Prednisone 40 mg had been administered 5 days in March 2015. The DON stated the Prednisone should have been started on the April 2015 MAR at 30 mg for 3 days then decreased as ordered. The DON also stated the Cortef should have been resumed on 04/09/15 instead of on 04/11/15. The DON stated the facility's system for doing MARs for the next month at the end of each month was that one nurse completed the new MAR and another checked it for accuracy. The DON reviewed the April 2015 recapitulation of physician's orders and stated they didn't indicated the orders were verified with the MAR by the second nurse.

B. Further review of Resident #6's medical record revealed a physician's progress note by the pulmonologist dated 04/07/15 which indicated the physician recommended nasal saline irrigation twice daily using distilled water. The recommendation was listed in the text of the progress note and not in the list of medications recommended.

Review of physician's orders revealed the other medications were listed and approved by Resident #6's physician at the facility. The nasal saline irrigation twice daily was not written as a telephone order for approval by Resident #6's physician at the facility.

Review of the April 2015 MAR revealed the nasal saline irrigation was not listed on the MAR.

In an interview with the DON on 07/17/15 at 6:49 PM, the DON was asked about the facility's process for verifying orders received from consulting medical specialists. The DON stated the nurse who received the orders and progress

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L 076	Continued From page 3	L 076		

note, should have called the pulmonologist and clarified whether he wanted to order the nasal saline irrigation.

2) Resident #3 was re-admitted to the facility on 11/26/14 with diagnoses which included diabetes mellitus, congestive heart failure, dementia, and high blood pressure.

Review of the medical record for Resident #3 revealed a physician's order dated 12/23/14 for administration of Lantus Insulin 42 units subcutaneously at bedtime (8:30 PM) and Novolog Insulin low dose sliding scale at 6:30 AM every morning and to check a blood sugar prior to administration.

Review of the June 2015 Medication Administration Records (MARs) revealed no documentation of Novolog Insulin low dose sliding scale as being administered on Saturday 06/27/15 at 6:30 AM and no documentation of Lantus Insulin 42 units as being administered on Sunday 06/28/15 at 8:30 PM. Further review of the June 2015 MAR revealed there were no blood sugars checked and/or documented on 06/23/15 or 06/27/15.

Review of the nurse's notes for June 2015 revealed no documentation of blood sugar checks/readings and no documentation as to indicate why the resident was not administered the insulin as per the physician's order.

An interview with Nurse #2 on 07/15/15 at 11:27 AM revealed she could not recall if she checked Resident #3 blood sugar on Friday night 06/26/15

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or if she had administered insulin to the resident. Nurse #2 reviewed the MAR and confirmed her initials as having administered insulin on 06/26/15. She stated she recalls giving Resident #3 Novolog 2 Units between 8:00 PM and 9:00 PM and 30 minutes later she stated she administered 42 units of Lantus Insulin. She further stated she did not check the resident's blood sugar prior to administering the insulins. She stated she was unware of the facility's process for reporting a medication error and once she realized she had made an error she was afraid to document that she had administered the Novolog 2 units without checking a blood sugar first and administering the Lantus 30 minutes later. She further stated she administered the Lantus 42 units because it was the medication that was ordered.

An interview with Nurse #3 on 07/15/15 at 3:36 PM about the facility's process for checking and recording of blood sugars and documentation of the administration of medications as ordered. Nurse #3 stated each nurse assigned to the resident was responsible for the administration of the medications as ordered by the physician and documentation of that medication on the resident's MAR. Nurse #3 confirmed he had not documented a blood sugar and/or the administration of the Novolog insulin on 06/23/15 and 06/27/15. Nurse #3 stated if his initials were not on the MAR then he didn't administer and/or check the resident's blood sugar.

An interview on 07/16/15 at 3:23 PM with the Nurse Practitioner (NP) about the Lantus not being administered as ordered, no blood sugar checks, and the Novolog and Lantus being administered simultaneously. The NP stated any medication error was a cause for concern. The

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L 076	Continued From page 5 NP stated she would have expected to have been notified of the medication error and that her expectation was for staff to administer the medications as ordered. An interview was conducted on 07/17/15 at 1:45 PM with the Director of Nursing. She stated it was her expectation for nurses to give medications as ordered by the physician and look at the MARs to make sure they didn't miss giving medications as ordered. She further stated it was her expectation for blood sugar checks/readings to be recorded on the MAR before the administration of insulin.	L 076		
L 091	.2306(D)(1) MEDICATION ADMINISTRATION 10A-13D.2306 (d) The facility shall ensure that procedures aimed at minimizing medication error rates include the following: (1) All medications or drugs and treatments shall be administered and discontinued in accordance with signed medical orders which are recorded in the patient's medical record. Such orders shall be complete and include drug name, strength, quantity to be administered, route of administration, frequency and, if ordered on an as-needed basis, a stated indication for use. This Rule is not met as evidenced by: Based on record reviews, resident, and staff interviews the facility failed to prevent a significant medication error by administering Novolog and Lantus insulins closely together and not following the physician's orders in 1 of 2 sampled residents reviewed for medication errors (Resident #3). The findings included:	L 091	Resident #3 had no negative outcomes as a result of the medication discrepancy. The medical record was audited by a licensed Consulate Healthcare Nurse for any other discrepancies on 8/10/15 and any corrections required were completed. Current residents have the potential to be affected.	8/12/15

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L 091	Continued From page 6 Resident #3 was re-admitted to the facility on 11/26/14 with diagnoses which included diabetes mellitus, congestive heart failure, dementia, and high blood pressure. A review of a nursing admission data collection form dated 11/26/14 indicated Resident #3 was alert and oriented to person, place, and time and had no short or long term memory impairment. The assessment also indicated Resident #3 needed supervision with activities of daily living (ADLs). A review of a physician's order dated 12/23/14 indicated Lantus Insulin 42 units subcutaneously at bedtime (8:30 PM) and Novolog Insulin low dose sliding scale insulin at 6:30 AM every morning according to blood sugar reading. Further review of the physician's orders dated 06/30/15 indicated magic mouthwash 10 milliliters (ml) to swish and spit out, use every 6 hours for 5 days related to tongue injury. A physician order dated 07/07/15 indicated the following: 1) Lidocaine 2.5 ml apply to tongue every 4 hours as needed for pain. (Resident may apply). 2) Warm salt water gargles every 2 hours as needed for pain. A review of the monthly Medication Administration Records (MARs) for June 2015 indicated the following: a) Lantus Insulin 42 units was indicated as being administered by Nurse #2 on Friday, 06/26/15 at 8:30 PM. b) Novolog Insulin low dose sliding scale had no documentation as being administered or a blood sugar was checked on Saturday 06/27/15 at 6:30 AM.	L 091	An review was completed by Consulate Healthcare Licensed Nurses on 8/10/15 to assure all orders and prescribed treatments/medications are correctly transcribed. Any discrepancies noted were corrected and appropriate reporting of discrepancies completed. The Regional Director of Clinical Services and Consulate Healthcare Nurses reeducated the Licensed Nurses currently working at the facility on Insulin administration and the need to administer medications/treatments according to the physicians¿ orders and document that it was done on 7/23/15. Any Nurse who missed the training will receive the training prior to the next shift scheduled. The Director of Clinical Services or Unit Manager will conduct Quality Improvement monitoring of 5 resident records, MARs, and TARs for compliance with appropriate transcription and documentation of physician orders and medication/treatment documentation 3 times a week for 4 weeks, then 3 records 3 times a week for 4 weeks, then 3 records 1 time a week for 4 weeks. The audits will be documented on a Quality Assurance and Performance Improvement Monitoring Tool. The Director of Clinical Services reports discrepancies, trends, and patterns to the Quality Assurance and Improvement Committee monthly. The monitoring will continue until the committee decides substantial compliance has been met.	

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L 091	Continued From page 7 c) Lantus Insulin pen 42 units was indicated as being administered by Nurse #2 on Saturday 06/27/15 at 8:30 PM. d) Novolog Insulin low dose sliding scale revealed a blood sugar reading of 146 on Sunday 06/28/15 at 6:30 AM and no insulin was administered due to blood sugar being within the range of 70 to 150 which indicated no insulin was to be administered. e) On Sunday 06/28/15 at 8:30 PM there was no documentation of the administration of Lantus Insulin 42 units. A review of nurse's notes dated for the months of June and July 2015 revealed the following nurse entries: 06/05/15-Resident complaining of left sided neck pain 07/03/15-Resident continues to swish and spit without any complaints and area to posterior right side of tongue remains open, resident able to drink and eat with no change in diet. 07/04/15-Resident alert and stated "tongue is a little sore" resident continues magic mouth wash swish and spit. There was no documentation indicated related to the timeframe of 06/26/15 through 07/02/15. Further review of the nurse's notes revealed no blood sugar checks were recorded on 06/26/15 or 06/27/15, the next recorded blood sugar of 146 was dated 06/28/15 at 6:30 AM. During an interview on 07/15/15 at 8:45 AM, Resident #3 stated Nurse #2 came into her room on Friday night 06/26/15 at 9:00 PM and stated to her "I am going to give you your Novolog Insulin." Resident #3 indicated she was setting on the side of her bed and stated to Nurse #2 "I do not take Novolog Insulin at night, the Novolog is only for	L 091		

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	NH0572	A. BUILDING: _____ B. WING _____	C 07/17/2015

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the mornings, and after my blood sugar is checked to see if I need the Novolog. I only take Lantus at night." Resident #3 indicated Nurse #2 stated to her "well I have your insulin and I need to give it to you." Resident #3 further stated she again advised Nurse #2 that she did not take Novolog at night and she was not going to take the insulin until Nurse #2 had checked her blood sugar. Resident #3 indicated during the time she had leaned over to get her blood sugar monitor out of the top drawer of her night stand Nurse #2 injected the insulin into her left upper arm while her head was turned. Resident #3 stated she told Nurse #2 to get out of her room & to never come back. She further stated approximately 30 to 45 minutes after Nurse #2 had given her the insulin she became sweaty, pale, cold, and dizzy and nauseated. Resident #3 indicated later in the night she started vomiting and had diarrhea. She indicated Nurse #2 did not return to her room the rest of the evening and she was seen by the 3rd shift nurse around 12:30 AM after she had rang her call bell for assistance. The resident stated she had told Nurse #4 that Nurse #2 had given her the wrong insulin and that she was very sick. The resident further stated Nurse #4 had checked her blood sugar and the reading was 53 and the nurse was going to give her orange juice (OJ) but was unable to find OJ in the nourishment room so she had given her a thick honey liquid sugar mixture to drink. The resident further indicated that sometime during that night she had bit a hole in her tongue and on Tuesday 06/30/15 the physician's assistant (PA) assessed her and had prescribed her a swish and spit medication called magic mouth wash. She stated the magic mouth wash had not helped and the PA had prescribed a numbing medication called Lidocaine and it had helped. The resident indicated Nurse #4 checked her blood sugar the next morning at 6:00 AM, at

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the time it was supposed to be checked, and her blood sugar was in the 40's and Nurse #4 gave the resident 2 containers of OJ to drink before her breakfast meal. Resident #3 stated Nurse #4 did not administer any insulin on Saturday morning and she was not administered any more insulin until Monday night at 9:00 PM when she was given her regular 42 units of Lantus Insulin. She stated she had advised Nurse #4 of her symptoms and Nurse #4 had told her she would just monitor her throughout the night and should she not be feeling better by the morning she would then send her to the hospital.

During an interview on 07/15/15 at 11:27 AM, Nurse #2 stated she could not recall if she had checked Resident #3's blood sugar on Friday night 06/26/15 or if she had administered insulin to the resident. Nurse #2 reviewed the MAR and confirmed her initials as having administered insulin on 06/26/15. She stated she had given Resident #3 Novolog 2 Units between 8:00 PM and 9:00 PM and 30 minutes later she had administered Lantus Insulin 42 Units to Resident #3. She further stated she had not checked the resident's blood sugar prior to administering the insulins. Nurse #2 further stated she made an error in administering the Novolog and she was aware she should have checked the resident's blood sugar before she administered the Novolog. She indicated she had no explanation as to why she had made the errors and she also failed to report the error to anyone.

During an interview on 07/15/15 at 3:36 PM Nurse #3 stated he was made aware of the medication error on Saturday night after he had talked with the resident and she had advised him of what had happened. He further stated he had talked with Nurse #2 about the incident but he

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had not reported the error to the Director of Nursing (DON). He indicated he had advised Nurse #2 that she was expected to report the error and he was unware she had not reported it. Nurse #3 indicated during his shift on Saturday evening 06/27/15 from 11:00 PM until 7:00 AM Resident #3 did not voice any complaints and/or problems. He further indicated he had checked the resident's blood sugar on Sunday morning 06/28/15 at 6:30 AM and the reading was 146 and no insulin was needed.

During an interview on 07/15/15 at 9:50 PM Nurse #4 confirmed she had worked the night shift from 11:00 PM until 7:00 AM on 06/26/15. She stated she had kept all of her report sheets and confirmed that Nurse #2 had not reported a medication error and/or any concerns with Resident #3 during the shift report on 06/26/15. Nurse #4 did recall her assessment of Resident #3 on the evening of 06/26/15 at 12:30 AM and that the resident was very sweaty, pale, and was vomiting. Nurse #3 indicated the resident had told her that Nurse #2 had given her Novolog and Lantus that evening and when she checked her blood sugar she did not feel the resident's symptoms were related to her blood sugar. Nurse #4 stated she had thought the resident's symptoms were related to something the resident had ate. She further indicated she was unable to recall what the blood sugar reading was and she also confirmed she had not documented the blood sugar reading on the MAR or in the nurse's notes. Nurse #4 stated it was the expectation for all blood sugar readings to be documented on the MAR or in the nurse's notes. Nurse #4 had no answer as to why she had not documented the blood sugar readings. She further stated she did not contact the physician on the night of 06/26/15. She indicated she checked on the resident before

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L 091	Continued From page 11 her shift ended on Saturday morning 06/27/15 and the resident was doing some better. She stated she did not report the resident's condition to the oncoming 1st shift nurse. During an interview on 07/16/15 at 3:23 PM the Nurse Practitioner stated she was unaware that Resident #3 had been administered Novolog and Lantus insulins on 06/26/15. She further stated it was her expectation for the nurses to give medications as ordered by the physician and to look at the MARs closely to ensure they didn't administer the wrong medications and/or at the wrong times. The facility physician was out of town and was unavailable to be interviewed. During an interview on 07/17/15 at 1:45 PM with the Director of Nursing (DON) stated the administration of both insulins was a medication error and she would have expected the error to have been reported. She further stated she expected the nursing staff to follow and administer medications according to the physician's orders.	L 091		
L 102	.2401(A) MAINTENANCE OF MEDICAL RECORDS 10A-13D.2401 (a) The facility shall establish a medical records service. it shall be directed, staffed and equipped to ensure: (1) records are processed, indexed and filed accurately; (2) records are stored in such a manner as to provide protection from loss, damage or unauthorized use; (3) records contain sufficient	L 102		8/12/15

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L 102	Continued From page 12 information to identify the patient plus a record of all assessments; plan of care; pre-admission screening, if applicable; records of implementation of plan of care; progress notes; and record of discharge, including a discharge summary signed by the physician; and (4) records are readily accessible by authorized personnel. This Rule is not met as evidenced by: Based on record review and staff interview the facility failed to file a Medication Administration Record (MAR) in the correct resident's closed record and failed to label all pages of the MAR with the month and year for 1 of 2 residents reviewed (Resident #6). The findings included: During review of Resident #6's closed medical record on 07/16/15, the April 2015 MAR was not included in the record. In an interview on 07/16/15 at 11:35 AM the Medical Records Coordinator (MRC) was asked if she had any additional files for Resident #6. The MRC stated she didn't have any other files but would try to locate the missing April 2015 MAR. The MRC provided Resident #6's April 2015 MAR to the surveyor on 07/16/15 at 3:55 PM. In an interview on 07/17/15 at 6:49 PM, the DON was asked if she knew where Resident #6's April 2015 MAR was located and the DON stated it was on another resident's chart. Further review of Resident #6's medical record revealed there were 4 of the MARs included with Resident #6's February 2015 MARs that were not labeled with a month or year. There was 1 MAR	L 102	Resident #6 no longer resides in the facility. Current residents have the potential to be affected. Consulate Healthcare Nurses completed a review of all current medical records to assure completeness and accuracy. Any discrepancies were corrected by the Licensed Nurse or Interdisciplinary Team Member as applicable. This was completed on 8/10/15. A Consulate Healthcare Medical Records Coordinator completed an audit and assembled recent discharge records. This was completed on 7/29/15. The Regional Director of Clinical Services and Consulate Healthcare Nurses reeducated Licensed nurses currently working in the facility on the need to maintain medical records accurately and completely on 7/23/15 Any Nurse who missed the training will receive the training prior to the next shift scheduled. The Regional Director of Clinical Services reeducated the Medical Records Person on 8/3/15 on the proper filing, and proper order of the current medical record and	

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L 102	Continued From page 13 included with Resident #6's March 2015 MARs that was not labeled with a month or year. There was 1 MAR included with Resident #6's April 2015 MARS that was not labeled with a month or year. During an interview on 07/17/15 at 8:34 AM the DON stated the facility was aware there was a problem with residents' medical records and had hired a new MRC on 04/08/15 who was working on correcting the problems but she had not gotten all the records corrected yet. The DON stated all the MARs should indicate the month and year.	L 102	the discharge medical record. The Executive Director, Director of Clinical Services, Consulate Healthcare Medical Records Person or a Consulate Healthcare Nurse will conduct Quality Improvement monitoring of medical records for completeness and appropriate order on 5 medical records a week for 4 weeks, 3 medical records a week for 4 weeks then 1 medical record a week for 4 weeks. The Quality Improvement monitoring will be documented on a Quality Assurance and Performance Improvement Audit Tool. The Director of Clinical Services reports discrepancies, trends, and patterns to the Quality Assurance and Improvement Committee monthly. The Quality Improvement monitoring will continue until the committee decides substantial compliance has been met.	