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

PRINTED: 10/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 10/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157	*This plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law.*	

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, physician and nurse practitioner interview the facility failed to notify the physician/nurse

F157-notification of changes

1. The Director of Clinical Services notified the Nurse Practitioner on 10/6/15 of the lab results that were not reported and the x-ray that was recommended by the wound physician for resident #7, which was not completed. The Nurse Practitioner did not choose to re-order the X-ray, at that time, and no new orders were received as related to the lab results.
2. Residents residing at the facility are potentially at risk for the alleged deficient practice.
   The Director of Nursing Services and Nurse Managers completed a review of all residents' records to determine if there were any other lab results and/or x-ray results that were not called to the physician by 10/30/15. The Director of Clinical Services called and reported any missed labs and/or x-rays to the physician by 10/30/15.
3. The Director of Clinical Services/Nurse Manager will bring abnormal lab and x-ray reports to the morning meeting for review to assure the physician is notified of abnormal results and it is documented in the medical record. Nurse Manager/Licensed Nurse will review consult reports and will notify the primary physician to obtain orders for any recommended

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/29/15

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.

email DF EB CM Per note

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F 157	Continued From page 1 practitioner of the lab results for a wound culture requiring medication changes for treatment of a wound infection, failed to notify the nurse practitioner of urinalysis results that required further orders and failed to notify the wound physician an XRay to rule out osteomyelitis was not obtained for one of one sampled residents (Resident #7) The findings included: Resident #7 was admitted to facility on 6/13/14 with diagnosis of dysphagia, dementia, subarachnoid hemorrhage and diabetes type 2. The Minimum Data Set (MDS) a quarterly dated 7/31/15 assessed the pressure wound as necrotic with no wound infection. The MDS indicated Resident #7 required extensive assistance with bed mobility, transfers, eating and personal hygiene. Resident #7 had short and long term memory impairment. The care plan dated 8/7/15 indicated a problem for potential for an infection related to coccyx pressure ulcer. The stated goal included the resident would not develop infection secondary to sacral wound. The goal was updated 9/9/15 for the infection to resolve by completion of the antibiotic therapy, and she would experience decreased symptoms of infection. Approaches included treatment as ordered, lab work as ordered and report to physician. The care plan dated 8/7/15 indicated a problem of an indwelling catheter due to a pressure ulcer on the coccyx. The approaches included lab work as ordered and report to physician.	F 157	labs or diagnostic tests, as applicable. The Director of Clinical Services (DCS) re-educated Nurse Managers/Licensed Nurses by 10-30-15 to review lab and diagnostic testing, and to notify the primary physician/nurse practitioner of any abnormal labs and/or diagnostic test results for further interventions. Licensed Nurses, not receiving this training, will have the training prior to working their next scheduled shift. 4. The Director of Clinical Services/Nurse Manager will complete Quality Assurance Monitoring 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then 2 times per week for 4 weeks, and then 1 time monthly for 2 months, using a sample size of 5 residents. The monitoring will be documented on a Quality Assurance and Performance Improvement Monitor Form. The Director of Clinical Services/Nurse Manager will report the results of the monitors to the Quality Assurance and Improvement Committee monthly or until the committee determines the facility has reached substantial compliance.	

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F 157	Continued From page 2	F 157		

Review of the wound physician progress note dated 9/9/15 revealed Resident #7 had a worsening of a chronic pressure wound on the coccyx. The wound measured 5 centimeters (cm) length (L) by 5 cm width (W) by 2.8 cm depth (D). There was undermining at 9 oclock of 1.5 cm. The wound was assessed as 80% necrosis. Treatment included use surgical debridement, Dakins solution, and PICC (central intravenous line) for antibiotic administration for 6 weeks. " Wound has accumulated a large amount of necrotic tissue over the past week, high suspicion for osteomyelitis. Will start vancomycin (antibiotic) and order blood work and XRay. Recommendation: CBC,(complete blood count) place PICC line, Vancomycin 1 gram IV every 12 hours for 6 weeks for osteomyelitis XRay of the sacrum. " After surgical debridement the wound was assessed as a stage 4 pressure ulcer.

Review of the telephone order dated 9/9/15 the nurse practitioner had ordered a wound culture to be obtained when the wound vac was changed. A telephone order dated 9/9/15 for UA (urinalysis) with C&S (culture and sensitivity) to r/o UTI (rule out urinary tract infection).

Telephone order dated 9/9/15 for Cipro (antibiotic) 400 mg (milligrams) intravenous every 12 hours for 7 days for UTI.

Review of the medical record revealed no information that indicated the lab work was obtained, received or reported to the nurse practitioner. The medical record did not indicate the XRay had been obtained.
Upon request, a copy of the lab results for the

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F 157	Continued From page 3	F 157		

wound culture was obtained by the unit manager from the lab. The results indicated 3+ Gram Positive Cocci pairs, 3+ Gram positive rods and 3+ Gram negative rods. The sensitivity report (details what antibiotics would be effective against the organism) indicated the following antibiotics could be used to treat the infection: Gentamycin, Trimeth-Sulfa, Piperacillin/Tazobactam and Tetracycline. The antibiotic used to treat Resident #7, Clindamycin, was not listed on the culture sensitivity report.

The urinalysis report dated 9/8/15 indicated the culture grew " mixed bacterial flora, probable contamination. "

Interview on 10/5/15 at 1:00 PM with the nurse practitioner revealed she could not be sure if the lab results were reported to her. She explained her usual process was to sign the lab result report and make a note about the results. She confirmed there were no results in the chart and a progress note had not been written regarding the culture report. In reviewing the lab report she noted the organism that grew and the drug sensitive and circled Gentamycin.
Interview on 10/5/15 at 1:15 PM with the nurse practitioner revealed Resident #7 required another PICC line placement and treatment with Gentamycin (antibiotic) that was sensitive to the organisms in the wound culture report. She would have expected the nurse to report the lab results to her.
Interview on 10/6/15 with Nurse #1 at 9:15 AM revealed the lab results are faxed to the facility from the lab. The fax machine would be checked by the floor nurse on each shift for possible lab results. The nurse receiving the lab results would notify the physician. There was also a physician '

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F 157	Continued From page 4	F 157		

s notebook lab results were filed for physician/nurse practitioner review Interview with the interim DON on 10/6/15 at 1:44 PM revealed the process for obtaining lab work included putting lab orders into the computer and the lab book with the date the order wo be done. The night nurse checks for routine labs in the lab book. That nurse would get those labs (i.e. urine) or have the lab service get them. The facility had a lab service that came to the building on a scheduled basis for blood draws. Lab slips would be put back in the lab book and flagged for the pending results. The nurses would be alerted to the lab slip being pulled up that a lab had been obtained and results were pending. The nurse manager, unit coordinator or nurse on the unit was supposed to look at the book for labs/exams to be done on that day. When a lab was done, the nurse would report to next shift. Each shift received report and would expect the results. The lab results were sent to the facility via a fax. There were certain times the faxes come thru for the lab results. Each shift would be expected to check the fax machine for lab results. No explanation was provided as to what happened to the lab results for Resident #7 ' s wound culture. Interview with the interim DON on 10/6/15 at 1:46 PM revealed she would expect the nurse to report results of lab work to the physician or nurse practitioner. Lab results are reported in the following manner: 1. If abnormal labs return, the physicians have given parameters for notification, i.e. if way high/low call the physician the results. 2. If the nurse practitioner was coming into the facility, the lab results were put in physician ' s book for review. And 3. If after hours, and abnormal the nurse would call the physician. The interim DON was not aware the results had not been reported to the nurse practitioner or

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F 157	Continued From page 5 physician. Interview with the wound physician on 10/6/15 at 2:05 PM revealed she would expect the nursing staff to implement the recommendations on her note. If there were any problems with the wound orders, she would expect the nursing staff to communicate that as well. She was not aware if the nurses had to have the primary physician review orders and agree with the orders. She had not been informed the XRay had not been obtained.	F 157		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews the facility failed to provide wound treatment, obtain XRay and report lab results to the physician as ordered for one of three sampled residents with pressure ulcers. Resident #7. The findings included: Resident #7 was admitted to facility on 6/13/14 with diagnosis of dysphagia, dementia,	F 314	f314 –pressure ulcers 1. The Director of Clinical Services reviewed the medical record of Resident #7 to assure all orders pertaining to the pressure ulcer were properly and completely transcribed on 10/7/15. The Director of Clinical Services discussed the X-ray, recommended by the wound physician, with the nurse practitioner; and, the nurse practitioner did not choose to re-order the x-ray, at that time. 2. The Director of Clinical Services and Nurse Mangers completed a review of current residents' records by 10-30-15 to assure treatment orders and diagnostic testing orders were transcribed and completed as prescribed, along with a review of physician consults for recommended diagnostic testing and treatment orders. The Director of Clinical Services notified the primary physician of the issues found and new orders were obtained and implemented on 10/30/15.	

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F 314	Continued From page 6 subarachnoid hemorrhage and diabetes type 2. The Minimum Data Set (MDS) a quarterly dated 7/31/15 assessed the pressure wound as necrotic with no wound infection. The MDS indicated Resident #7 required extensive assistance with bed mobility, transfers, eating and personal hygiene. Resident #7 had short and long term memory impairment. The care plan dated 8/7/15 indicated a problem for potential for an infection related to coccyx pressure ulcer. The stated goal included the resident would not develop infection secondary to sacral wound. The goal was updated 9/9/15 for the infection to resolve by completion of the antibiotic therapy, and she would experience decreased symptoms of infection. Approaches included treatment as ordered. Review of the wound physician progress note dated 9/9/15 revealed Resident #7 had a worsening of a chronic pressure wound on the coccyx. The wound measured 5 centimeters (cm) length (L) by 5 cm width (W) by 2.8 cm depth (D). There was undermining at 9 oclock of 1.5 cm. The wound was assessed as 80% necrosis. Treatment included use surgical debridement, Dakins solution, and PICC (central intravenous line) for antibiotic administration for 6 weeks. " Wound has accumulated a large amount of necrotic tissue over the past week, high suspicion for osteomyelitis. Will start vancomycin (antibiotic) and order blood work and XRay. Recommendation: CBC,(complete blood count) place PICC line. Vancomycin 1 gram IV every 12 hours for 6 weeks for osteomyelitis XRay of the sacrum. " After surgical debridement the wound was assessed as a stage 4 pressure	F 314	3. The DCS re-educated Nurse Managers/Licensed Nurses by 10-30-15 to review consult reports and notify the primary physician of recommendations made by the resident's consulting physician to obtain any further orders/interventions. Nurse Managers/Licensed Nurses were also re-educated to report abnormal lab and/or diagnostic results to the primary physician for further orders/interventions. The Director of Clinical Services re-educated Licensed Nurses regarding the need to properly address lab and x-ray reports, as it pertains to wound treatment, and to transcribe wound treatment orders completely and properly by 10-30-15. Licensed Nurses, not receiving this training, will be trained prior to working their next scheduled shift. 4. The Director of Clinical Services/Nurse Manager will complete Quality Improvement monitoring to assure treatment orders and diagnostic testing are transcribed and implemented, as well as to assure that recommendations from consulting physicians are communicated to the primary physician for orders. Quality Improvement monitoring will be conducted 5 times per week for 4 weeks, then 3 times per week for 4	

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F 314	Continued From page 7 ulcer. Record review revealed the recommendations were written as physician orders and followed except for the XRay of the sacrum. The medical record did not have the XRay results and the nurse's notes did not address if the XRay was obtained. Review of a subsequent wound physician progress note dated 9/20/15 indicated there was " No Change " in the wound progress. Surgical debridement had been provided with removal of " muscle along with necrotic tissue. " The telephone order dated 9/9/15 indicated " picc please send coccyx wound for C&S when change wound VAC. " Review of the wound physician progress note dated 9/30/15 indicated the wound size was 6.0 cm L by 6.6 cm W by 3.0 CM D. There was undermining of 2.5 cm at 12 o ' clock. Drainage was moderate with 40% necrotic tissue. Wound progress was assessed as " no change. " The " Assessment & Plan " included " continue: Dakins Solution - once daily, Santyl - once daily, Dry Protective Dressing - once daily. Add: Calcium Alginate - once daily. Recommendation: Cleanse with dakins. " Review of the medical record revealed no orders had been transcribed to include the use of the Calcium Alginate. Review of the Treatment Administration Record revealed the Calcium Alginate was not being used in the treatment of the wound. Record review revealed no culture results and no physician documentation regarding the culture results. Interview with Nurse #1 on 10/6/15 at 9:30 AM	F 314	weeks, then 2 times per week for 4 weeks, and then 1 time per month for 2 months, using a sample size of 5 residents. The monitoring will be documented on a Quality Assurance and Performance Improvement Monitor Form. The Director of Clinical Services/Nurse Manager will report the results of the monitors to the Quality Assurance and Improvement Committee monthly or until the committee determines the facility has reached substantial compliance.	

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F 314	Continued From page 8	F 314		

revealed he had already completed the dressing change for Resident #7. He had provided the treatment as written on the Treatment Administration Record.

Interview with Nurse #2 on 10/6/15 at 9:42 AM revealed the progress note by the wound physician would be considered an order for treatment of the wound. Continued interview with Nurse #2 revealed the culture report was not located and she would request the lab results for the wound culture.

Interview with Nurse #3 on 10/6/15 at 10:46 AM revealed the unit manager or treatment nurse made rounds with the wound physician. Nurse #3 explained she made rounds with the physician on 9/30/15. In reviewing the progress note by the wound physician on 9/30/15 nurse #3 explained she would add the calcium alginate to the new treatment. Further interview revealed the process included to discontinue the old order and write the new order and update the TAR. Nurse #3 explained she was on a medication cart on a hall and made rounds with the wound physician for the building on 9/30/15. After making wound rounds she went back to the cart to pass medications. The supervisors would have reviewed the progress notes for orders and written the orders and updated the treatment record. Nurse #3 explained the supervisors had access to the computer to print the MD ' s notes and would have written the orders.

Interview with the interim DON on 10/6/15 at 1:20 PM revealed her expectations for follow up after the wound physician made rounds included review by the primary physician of the orders the wound physician ordered. The physician of

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F 314	Continued From page 9	F 314		

record (primary physician) for that resident had the final say. During the interview the interim DON explained she would ask the unit manager who was doing the orders.

Interview with the unit manager (Nurse #2) and the interim DON on 10/6/15 at 1:44 PM revealed she had not made rounds with the wound physician on 9/30/15. Nurse #2 explained her process included writing telephone orders as the wound physician made rounds. The wound physician would sign the orders at that time. Further explanation indicated the primary physician would sign any orders not signed by the wound physician. Nurse #2 indicated she was not aware she was supposed to print off of wound notes and review them. She did not have access to the computer and had not reviewed the 9/30/15 notes for orders.

Interview with the interim DON on 10/6/15 at 1:46 PM revealed the treatment nurse or unit managers were to make rounds with the wound physician. It would be the next day before the wound physician ' s note were in the computer. The unit manager would print the notes and review them the day after the visit. The interim DON explained she was not aware the unit manager did not have access to the computer to review the notes. The interim DON explained the XRay was not obtained due to it was not considered an order, but a recommendation. Further interview revealed she did not know if the primary had been contacted regarding the recommendation.

Interview with the wound physician on 10/6/15 at 2:05 PM revealed she would expect the nursing staff to implement the recommendations on her

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F 314	Continued From page 10 note. If there were any problems with the wound orders, she would expect the nursing staff to communicate that as well. She was not aware if the nurses had to have the primary physician review orders and agree with the orders. She further explained she was not aware the Calcium Alginate had not been used since her visit on 9/30/15. That had not been communicated to her. The purpose of the Calcium Alginate was to absorb the drainage from the wound to prevent maceration of the wound.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and nurse practitioner interview the facility failed to obtain a repeat urinalysis to rule out a possible urinary tract infection for one of three residents with an indwelling catheter. Resident #7. . The findings included: Resident #7 was admitted to facility on 6/13/14 with diagnosis of dysphagia, and Dementia.	F 315	F315- No catheter to prevent UTI/Restore Bladder Function 1. Resident # 7 had repeat Urinalysis and Culture completed on 10/6/15 by the Licensed Nurse. The results were reviewed by the nurse practitioner on 10/9/15 and no new orders were given, at that time, as the resident was asymptomatic. 2. Residents residing at the facility with catheters have the potential to be affected. The Director of Clinical Services and Unit Managers reviewed the records of current residents with catheters to assure orders for care and services were implemented as prescribed on 10/27/15 and any corrections implemented. 3. The Director of Clinical Services re-educated licensed nurses currently employed by 10/30/15 concerning the need to review all lab results and to notify the physician if any specimen is contaminated to repeat the test or if the there were abnormal results. The Director of	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345258	A. BUILDING _____ B. WING _____	C 10/06/2015

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TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083

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F 315	Continued From page 11 The Minimum Data Set (MDS) a quarterly dated 7/31/15 indicated Resident #7 required extensive assistance with bed mobility, transfers, eating and personal hygiene. Resident #7 had short and long term memory impairment. Resident #7 was incontinent of bowel and bladder. A telephone order dated 8/2/15 for an indwelling catheter due to a coccyx pressure wound. The care plan dated 8/7/15 indicated a problem of an indwelling catheter due to an unstageable pressure ulcer on the coccyx. The approaches included lab work as ordered and report to physician. Review of a nurse ' s note dated 9/6/15 the urine in the catheter drainage tubing was " cloudy. " A telephone order dated 9/9/15 for UA (urinalysis) with C&S (culture and sensitivity) to r/o UTI (rule out urinary tract infection). Telephone order dated 9/9/15 for Cipro (antibiotic) 400 mg (milligram) intravenous every 12 hours for 7 days for UTI. Observations on 10/5/15 at 7:00 AM revealed Resident #7 had an indwelling catheter to straight drainage with the bag on the bedframe. The urine was yellow in color. Lab results were not present in the medical record for review. Upon request, the lab results for the urinalysis were obtained from the facility ' s lab. The urinalysis report dated 9/8/15 indicated the	F 315	Clinical Services/Nurse Manager will bring abnormal lab results including contaminated specimen results to the morning meeting for review to assure the physician is notified of a contaminated specimen to obtain orders to repeat the test. 4. The Director of Clinical Services/Nurse Manager will conduct Quality Improvement monitoring of residents to assure catheter orders, to include lab testing, are transcribed and implemented appropriately and results are addressed. Quality Improvement monitoring will be conducted 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then 1 time per week for 4 weeks, and then 1 time monthly for 2 months using a sample size of 5 residents. The monitoring will be documented on a Quality Assurance and Performance Improvement Monitor Form. The Director of Clinical Services/Nurse Manager will report the results of the monitors to the Quality Assurance and Improvement Committee monthly or until the committee determines the facility has reached substantial compliance.	

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F 315	Continued From page 12 culture grew " mixed bacterial flora, probable contamination. " Interview on 10/5/15 at 1:15 PM with the nurse practitioner revealed she had not been informed the urinalysis report indicated it was contaminated. She would expect the nurse to report the results to her. She would expect the nurse to have obtained another specimen for testing. Review of the medical record revealed an order dated 10/5/15 for a UA with C&S to r/t UTI. Interview with the interim DON on 10/ 6/15 at 1:44 PM revealed she would expect the nurse to report a contaminated urinalysis to the physician/nurse practitioner and obtained another specimen.	F 315		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, physician and nurse practitioner interview the facility failed to notify the physician/nurse practitioner of the lab results for a wound culture requiring medication changes for treatment of a wound infection for one of one sampled residents (Resident #7) The findings included: Resident #7 was admitted to facility on 6/13/14 with diagnosis of dysphagia, dementia,	F 505	F505 1. The Director of Clinical Services notified the Nurse Practitioner on 10/7/15 of the missed lab results for Resident #7. The resident received an appropriate course of antibiotic for the wound infection which was completed on 10/22/15. 2. The Director of Clinical Services/Nurse Manager completed a review of current resident records by 10-30-15, to assure that the physician was notified of abnormal/missed lab or diagnostic test results. The Director of Clinical Services/Nurse Manager notified the physician of missed/abnormal labs and/or diagnostic tests by 10/30/15. 3. The Director of Clinical Services or Nurse Managers will bring abnormal	

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F 505 Continued From page 13

subarachnoid hemorrhage and diabetes type 2.

The Minimum Data Set (MDS) a quarterly dated 7/31/15 assessed the pressure wound as necrotic with no wound infection. The MDS indicated Resident #7 required extensive assistance with bed mobility, transfers, eating and personal hygiene. Resident #7 had short and long term memory impairment.

The care plan dated 8/7/15 indicated a problem for potential for an infection related to coccyx pressure ulcer. The stated goal included the resident would not develop infection secondary to sacral wound. The goal was updated 9/9/15 for the infection to resolve by completion of the antibiotic therapy, and she would experience decreased symptoms of infection. Approaches included treatment as ordered, labwork as ordered and report to physician.

Review of the wound physician progress note dated 9/9/15 revealed Resident #7 had a worsening of a chronic pressure wound on the coccyx. The wound measured 5 centimeters (cm) length (L) by 5 cm width (W) by 2.8 cm depth (D). There was undermining at 9 oclock of 1.5 cm. The wound was assessed as 80% necrosis. Treatment included use surgical debridement, Dakins solution, and PICC (central intravenous line) for antibiotic administration for 6 weeks. " Wound has accumulated a large amount of necrotic tissue over the past week, high suspicion for osteomyelitis. Will start vancomycin (antibiotic) and order blood work and XRay. Recommendation: CBC,(complete blood count) place PICC line. Vancomycin 1 gram IV every 12 hours for 6 weeks for osteomyelitis XRay of the sacrum. " After surgical debridement

F 505

lab and diagnostic test reports to the morning meeting for review to assure the physician is notified, and it is documented in the medical record. Nurse Managers/Licensed Nurses will review consult reports and will notify the primary physician to obtain orders for any recommended testing. Nurse Managers/Licensed Nurses were re-educated to report abnormal lab and/or diagnostic results to the primary physician for further orders/interventions. Licensed Nurses not receiving this training be trained prior to working their next scheduled shift.

4. The Director of Clinical Services/Nurse Manager will complete Quality Improvement monitoring to assure that all abnormal lab results are called to the resident's physician. Quality Improvement monitoring will be conducted 5 times per week for 4 weeks, then 3 times per week 4 weeks, then 2 times per week for 4 weeks, then 1 time per week for 4 weeks, and then 1 time monthly for 2 months, using a sample size of 5 residents. The monitoring will be documented on a Quality Assurance and Performance Improvement Monitor Form.

The Director of Clinical Services/Nurse Manager will report the results of the monitors to the Quality Assurance and Improvement Committee monthly or until the committee determines the facility has reached substantial compliance.

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F 505	Continued From page 14	F 505		

the wound was assessed as a stage 4 pressure ulcer.

Review of the telephone order dated 9/9/15 the nurse practioner had ordered a wound culture to be obtained when the wound vac was changed. Review of the medical record revealed no information that indicated the lab work was obtained, received or reported to the nurse practioner.
Upon request, a copy of the lab results for the wound culture was obtained by the unit manager from the lab. The results indicated 3+ Gram Positive Cocci pairs, 3+ Gram positive rods and 3+ Gram negative rods. The sensitivity report (details what antibiotics would be effective against the organism) indicated the following antibiotics could be used to treat the infection: Gentamycin, Trimeth-Sulfa, Piperacillin/Tazobactam and Tetracycline. The antibiotic used to treat Resident #7, Clindamycin, was not listed on the culture sensitivity report.
Interview on 10/5/15 at 1:00 PM with the nurse practioner revealed she could not be sure if the lab results were reported to her. She explained her usual process was to sign the lab result report and make a note about the results. She confirmed there were no results in the chart and a progress note had not been written regarding the culture report. In reviewing the lab report she noted the organism that grew and the drug sensitive and circled Gentamycin.
Interview on 10/5/15 at 1:15 PM with the nurse practitioner revealed Resident #7 required another PICC line placement and treatment with Gentamycin (antibiotic) that was sensitive to the organisms in the wound culture report. She would have expected the nurse to report the lab results to her.

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F 505	Continued From page 15	F 505		

Interview on 10/6/15 with Nurse #1 at 9:15 AM revealed the lab results are faxed to the facility from the lab. The fax machine would be checked by the floor nurse on each shift for possible lab results. The nurse receiving the lab results would notify the physician. There was also a physician ' s notebook lab results were filed for physician/nurse practioner review
Interview with the interim DON on 10/6/15 at 1:44 PM revealed the process for obtaining lab work included putting lab orders into the computer and the lab book with the date the order wo be done. The night nurse checks for routine labs in the lab book. That nurse would get those labs (i.e. urine) or have the lab service get them. The facility had a lab service that came to the building on a scheduled basis for blood draws. Lab slips would be put back in the lab book and flagged for the pending results. The nurses would be alerted to the lab slip being pulled up that a lab had been obtained and results were pending. The nurse manager, unit coordinator or nurse on the unit was supposed to look at the book for labs/exams to be done on that day. When a lab was done, the nurse would report to next shift. Each shift received report and would expect the results. The lab results were sent to the facility via a fax. There were certain times the faxes come thru for the lab results. Each shift would be expected to check the fax machine for lab results. No explanation was provided as to what happened to the lab results for Resident #7 ' s wound culture.
Interview with the interim DON on 10/6/15 at 1:46 PM revealed she would expect the nurse to report results of lab work to the physician or nurse practioner. Lab results are reported in the following manner: 1. If abnormal labs return, the physicians have given parameters for notification, i.e. if way high/low call the physician the results.

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F 505	Continued From page 16 2. If the nurse practioner was coming into the facility, the lab results were put in physician ' s book for review. And 3. If after hours, and abnormal the nurse would call the physician. The interim DON was not aware the results had not been reported to the nurse practioner or physician.	F 505		