STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345563	A. BUILDING _____ B. WING _____	C 12/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION HEALTH CENTER AT BRIGHTMORE	10011 PROVIDENCE ROAD WEST CHARLOTTE, NC 28277

(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) 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 staff and resident interview the facility failed to inform 1 of 1 (#1) alert and oriented residents of a change in medication. Findings	F 157	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the	1/8/16

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

Electronically Signed | 01/07/2016

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F 157	Continued From page 1 included: Medical record review revealed a hospital discharge summary 11/25/15 which stated, "Of other concern is that she has had a left septic elbow joint removal. She has spiculated (lump of tissue with spikes on the surface) humerus, and one of the spicules of bone eroded through her skin (resident's elbow was removed previously) She was seen by staff orthopaedic here, and the area was oversewn with a superficial suture. She is scheduled to see Dr. at _____ for follow up. Discharge medications included Keflex 500 mg by mouth two times a day." The Minimum Data Set Assessment completed 11/29/15 revealed that the resident was assessed as being alert and oriented with okay long and short term memory. Interview with Resident #1 at 6:25 pm on 12/11/15 revealed that she was taking the antibiotic Keflex when admitted to the facility to treat her elbow area. The resident reported that the antibiotic was discontinued by the facility physician "without asking me". The resident stated that two nights ago she could not sleep because of a bad smell. The resident stated that the nurse came in and sniffed everywhere and thought that she had a bowel movement in the bed. The nurse could not find the smell. Resident #1 further stated that when she woke up the next morning with her face turned to the left she realized that the smell was coming from her elbow (the resident's elbow had been removed). The resident stated that she was told by the social worker that the Keflex had been	F 157	alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date of dates indicated. F157 Corrective Action for Resident Affected For resident # 1: Resident was discharged 12/12/2015. Corrective Action for Resident Potentially Affected All alert and oriented residents who have had a medication order change have the potential to be affected by this practice. On 01/05/2016 the nurse managers began reviewing the order list report from the electronic health record. All current and discontinued medication orders written in the last 60 days for active alert and oriented patients were reviewed. Once medication changes were identified, the nurse managers ten went to each patient and explained to the patient what medications were changed. If the patient had any questions or concerns the physician was notified and corrective actions identified and implemented. This was completed on 01/06/2016.	

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F 157	Continued From page 2 discontinued by the facility physician. The resident stated that she went to see her orthopaedic physican earlier that day and that she was supposed to have surgery to get a new elbow in January of 2016. Resident #1 said that her orthopaedic physician told her that the surgery would have to be delayed now that her elbow is infected, maybe for as long as 6-9 months. The resident stated, "It's taken away all my hope for the future. I was hoping to live alone again." Review of the resident's medication administration record revealed that the facility stopped the Keflex on 12/5/15. Interview with the Director of Nurses on 12/11/15 at 8:30 pm revealed that the no one talked to the resident about stopping the Keflex.	F 157	Systematic Changes On 01/04/2016 the Director of Nursing began inserviceing the full the full time, part time and prn nurses. Topics included: Notification of the patient when medications are changed or discontinued and documentation of the notification in the patient's medical record. Any in-house staff member who did not receive in-service training by 01/08/2016 will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the QA Survey Tool. A medication order list report will be generated weekly that includes current and discontinued medications in the last7 days. The medications will be reviewed for any changes and the nursing notes will be checked to ensure that there is documentation of the notification. Any issues will be reported to the Administrator. This will be done weekly for one month then a sample of 10 residents will be reviewed monthly times two months or until resolved by Quality Assurance Committee. Reports will be	

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F 157	Continued From page 3	F 157	presented to the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 309 SS=D	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 medical record review, resident interview and staff interview the facility failed to communicate or coordinate the plan of care with the resident's orthopaedic physician before discontinuing an antibiotic for 1 of 1 residents (#1). The facility failed to clarify parameters of normal blood pressure for a resident with orders to start diuretics when blood was normal for 1 of 1 residents (#2). Findings included: Medical record review revealed a discharge summary 11/25/15 from the hospital which stated, "Of other concern is that she has had a left septic elbow joint removal. She has spiculated (lump of	F 309	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	1/8/16

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F 309	Continued From page 4 tissue with spikes or points on the surface) humerus, and one of the spicules of bone eroded through her skin. She was seen by staff orthopaedic here, and the area was oversewn with a superficial suture. She is scheduled to see Dr. at _____ for follow up." Discharge medications included Keflex 500 mg by mouth two times a day. The Minimum Data Set Assessment completed 11/29/15 revealed that the resident was assessed as being alert and oriented with okay long and short term memory. Interview with Resident #1 at 6:25 pm on 12/11/15 revealed that she was taking the antibiotic Keflex when admitted to the facility to treat her elbow area. The resident reported that the antibiotic was discontinued by the facility physician "without asking me". The resident stated that two nights ago she could not sleep because of a bad smell. The resident stated that the nurse came in and sniffed everywhere and thought that she had a bowel movement in the bed. The nurse could not find the smell. Resident #1 further stated that when she woke up the next morning with her face turned to the left she realized that the smell was coming from her elbow (the resident's elbow had been removed.) The resident stated that she was told by the social worker that the Keflex had been discontinued by the facility physician. The resident stated that she went to see her orthopaedic physican earlier that day. Resident #1 stated that she was supposed to have surgery to get a new elbow in January of 2016. The resident stated that her orthopaedic physician said that the surgery would have to be delayed	F 309	F 309 Corrective Action for Resident Affected For resident #1: The resident was discharged on 12/12/2015. For resident #2: The resident was discharged on 11/29/2015. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this practice. On 01/05/2016 the nurse managers reviewed all current patients to identify those with active orthopedic consults. All orders for the last 60 day were reviewed for those identified patients. If the patient had a medication discontinued that pertained to the orthopedic procedure the chart was reviewed to verify that the orthopedic physician was aware of the change. If they were not notified of the change the orthopedic physician was notified via fax notification. This was completed on 01/05/2016. On 01/05/2016 the nurse managers began reviewing all current resident□s orders for orders requiring Blood Pressure parameters to identify any that required parameters for administrations that were not clear or were missing. Specific measurable parameters were obtained from the physician as needed. This will be completed by 01/07/2016.	

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F 309	Continued From page 5 now that her elbow was infected, maybe for as long as 6-9 months. The resident stated, "It's taken away all my hope for the future. I was hoping to live alone again." Review of the resident's medication administration record revealed that the facility stopped the Keflex on 12/5/15. Interview with the Director of Nurses on 12/11/15 at 8:30 pm revealed that the no one talked to the resident about stopping the Keflex. Resident #2 was admitted to the facility on 11/26/15 at 3:54 with diagnosis including artificial hip, hypertension, paroxysmal atrial fibrillation, hypothyroidism, major depressive disorder and hyperlipidemia. Medical record review revealed a nursing discharge summary which stated, "Please check blood pressure twice daily. Resume Lasix (prior home dose 40mg by mouth twice a day) and Aldactone (25mg by mouth daily) once blood pressure can tolerate. Also resume potassium chloride 20 meq by mouth twice a day when started back on her Lasix)." Medical record review revealed that on 11/26/15 the resident's blood pressures was recorded as 110/69 and her weight recorded at 207 lbs. The resident's blood pressure was recorded as 111/66 on 11/27/15. The facility recorded blood pressures of 110/72 and 104/62 on 11/28/15. Review of nurses notes 11/28/15 at 6:34 pm revealed that the resident had a blister on her left leg. Nurses note 11/28/15 11:45 pm state, blister bigger earlier 3 cm reassessed 7 cm. The daily clinical review note 11/28/15 in the section labeled Medicare covered diagnosis state: "CHF (congestive heart failure)/Cardiac Disease	F 309	Systemic Changes On 01/04/2016 the Director of Nursing began inservicing the full time, part time and prn nurses. Topics included: ensuring that orders entered into the electronic health record have clearly defined measurable parameters for administration when required; ensuring that orthopedics are notified when orders related to the orthopedics care are changed or discontinued. Inserviceing was completed Any in-house staff member who did not receive in-service training by 01/08/2016 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the QA Survey Tool. Order listing reports will be generated from the electronic health records. Order listing reports will be generated from the electronic health records. Orders with Blood Pressure monitoring will be reviewed for any missing or vague parameters and orders that required notification of the orthopedic physician. Corrective actions will be initaitied if clarifications are needed. Any issues will	

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F 309	Continued From page 6 Surgical." Review of the closed record revealed that the resident was ordered Potassium chloride 20 meq, Aldactone tab 25 mg and Lasix 40 mg on 11/28/15. The resident received her first dose of Lasix on 11/28/15 at 5pm. Resident #2 received her first dose of Aldactone on 11/29/15 at 8am. The residents weight was documented at 234 pounds and her blood pressure as 89/54 on 11/29/15. Per nurses notes 11/29/15, Resident #2 was taken to the hospital by her family member. Interview with the Director of Nurses on 12/11/15 at 7:49 pm revealed that the charge nurse stated that the resident's blood pressure needed to be above 110 to start the Lasix.	F 309	be reported to the Administrator. This will be done weekly for one month then a sample of 10 residents will be reviewed monthly times two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. Compliance date: 01/08/2016	