STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING ______ B. WING ______	C 02/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	**111 HARRILSON STREET CHERRYVILLE, NC 28021**

(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 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to inform a nurse aide of a Physician ordered stool sample which resulted in the specimen not being collected for 1 of 1 sampled resident (Resident #1). The findings included: Resident #1 was admitted on 02/01/17 with diagnoses including chronic lymphocytic leukemia (type of cancer of the blood and bone marrow),	F 309	F309 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and	3/16/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/15/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 secondary thrombocytopenia (low blood platelet count), and anemia. Review of a admission nursing evaluation dated 02/01/17 revealed Resident #1 was alert and oriented and able to make his needs known. The admission nursing evaluation noted Resident #1 was continent of bowel and bladder and required supervision with toileting, transfers, and walking. Review of an history and physical revealed Resident #1 was examined by the physician on 02/01/17. The Physician noted Resident #1 was admitted to the facility following a hospital stay where he was treated for a significant worsening of his chronic lymphocytic leukemia (CLL). The history and physical further revealed Resident #1 received 1 unit of packed red blood cells and 1 unit of platelets while he was in the hospital which did not significantly change his blood counts. The Physician documented Resident #1 was due to return to the hospital on 02/02/17 for a repeat transfusion. Review of a nurse's note dated 02/07/17 revealed Resident #1 told Nurse #1 he had a large, black, liquid stool at the hospital after his infusion on 02/06/17 but had not had bowel movement since. Review of the medical record revealed a Physician's order dated 02/08/17 to collect a stool sample and discontinue the order when the sample was obtained. Review of Resident #1's Medication Administration Record (MAR) from 02/08/17 through 02/11/17 revealed nurses on all three shifts initialed the MAR and documented he had not had a bowel movement.	F 309	Federal law. Resident #1 was discharged to the hospital on February 11, 2017 and did not readmit to the facility following discharge. Between February 25, 2017 and February 28, 2017 the Director of Nursing audited all active physician orders to ensure any ordered stool samples within the past (30) days had been collected. Between February 25, 2017 and March 15, 2017 all nursing staff, including LPN□s, RN□s, and C.N.A.□s were in-serviced by the Director of Nursing and Assistant Director of Nursing regarding the procedure for collection of stool samples. Physician orders for a stool sample collection will be written on the daily assignment sheet in addition to a verbal notification between nurse and nurse aides. To ensure quality assurance, all new physician orders are reviewed by a member of nurse management Monday thru Friday. If a new order is written for a stool sample, this is reviewed daily in the clinical meeting Monday thru Friday until completion or discontinuation of the order. Orders will be reviewed and monitored on Saturday and Sunday by the Weekend Nurse Supervisor or a designee. Results of these audits and reviews will be reported in the facility Quality Assurance Meeting for a minimum of three consecutive meetings. All corrective action will be complete on or before March 16, 2017.	

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Review of Resident #1's bowel movement record revealed Nurse Aide (NA) #1 documented Resident #1 had a bowel movement on 02/10/17.

Review of the emergency room documentation dated 02/11/17 noted Resident #1 had a history of CLL and was currently undergoing chemotherapy. The Physician noted Resident #1 was being evaluated for dark stool and decreased by mouth intake. The Physician's examination revealed dark tarry stool in the rectal vault but no bright red bleeding. The Physician documented Resident #1 was ill-appearing but no acute distress was noted. His hemoglobin was 8.2 g/dL (grams per deciliter) but appeared to be stable. Resident #1 was transferred to another hospital for further management because the hospital did not have a bed.

Review of a grievance dated 02/13/17 revealed Resident #1's family member came to the facility on 02/13/17 and spoke with the Administrator and the Director of Nursing (DON). The family member reported his father was moaning in pain when he arrived and he told the staff Resident #1 needed to go to the hospital. The family member stated there was a black bowel movement in the toilet when he arrived and he flushed the toilet and did not show it to the nurse.

During a telephone interview on 02/25/16 at 1:12 PM Nurse #2 confirmed she worked from 7:00 AM to 7:00 PM on 02/11/17 and cared for Resident #1. Nurse #2 recalled he had orders to collect a stool specimen and she instructed the nurse aide (NA) to report to her if Resident #1 had a bowel movement. Nurse #2 stated Resident #1 did not report a bowel movement

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that day and the NA did not observe one either. The interview further revealed a family member came to see Resident #1 around supper time and wanted his father sent to the hospital due to uncontrollable pain. Nurse #2 recalled when she checked Resident #1's blood sugar around 4:30 PM he denied complaints. Nurse #2 stated she checked Resident #1's vital signs and they were stable and Resident #1 commented to her that maybe he was just anxious. Nurse #1 explained she eventually got an order from the Physician for the family member to take Resident #1 to the hospital.

An interview with Nurse #1 on 02/25/17 at 1:50 PM revealed she cared for Resident #1 on 02/10/17 and recalled he went out for a doctor's appointment after breakfast. Nurse #1 stated she was aware of the order to collect a stool specimen and had clarified the order with the doctor's office. Nurse #1 further stated there was a collection pan in the bathroom and Resident #1 was able to put it on the toilet. The interview revealed nurses told the NAs when a resident needed a stool sample collected but she did not recall if she told NA #1 Resident #1 needed a stool specimen on 02/10/17.

During a telephone interview on 02/25/17 at 3:36 PM NA #1 confirmed she cared for Resident #1 on 02/10/17 before he went out for an appointment that morning. NA #1 stated Resident #1 did not like them helping him and she was checking on him that morning and he was having a little trouble getting cleaned up after a bowel movement. NA #1 described the bowel movement as soft and formed and did not recall the bowel movement being dark or seeing any blood. The interview further revealed NA #1 was

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not aware Resident #1 needed a stool sample collected and did not recall seeing a collection pan in the bathroom.

An interview was conducted with the Physician on 02/25/17 at 5:56 PM. The Physician stated Resident #1 was being treated for a known bleeding disorder and the hematology reports were not very positive. The Physician was informed Resident #1 had a bowel movement on 02/10/17 but the staff did not collect the sample. The Physician stated he did not believe that would have changed the outcome for the resident.

An interview with the DON on 02/25/17 at 6:48 PM revealed when a resident had an order for a stool specimen it comes up on the electronic MAR at the beginning of each shift. The DON stated the nurses were expected to tell the NAs when a resident needs a stool sample collected.