STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345559	A. BUILDING _____ B. WING _____	C 01/30/2018

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HOMESTEAD HILLS	2105 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a physician order for oxygen administration for one of one resident reviewed for oxygen use (Resident #1). Findings included: Resident #1 was admitted 08/18/17 with diagnoses that included fracture of an unspecified part, chronic obstructive pulmonary disease, pulmonary mycobacterium and severe protein malnutrition. The MDS dated 09/02/17 indicated that the resident was cognitively intact. During her re-admission of 08/26/18, the resident used oxygen by nasal cannula. Documentation of oxygen use was present in the following notes: An entry on the nursing care plan dated 08/23/17 noted that resident "receives oxygen at 3 L/min." A nursing progress note dated 08/28/17 at 11:19 a.m. noted " ...O2 at 2LPM continues." A physician note dated 08/29/18 noted that "	F 658	F658 Facility failed to provide a physician order for oxygen for patient #1. A Root cause analysis was conducted by the interdisciplinary team and determined the clinical team failed to follow the facility procedure of transcribing physician orders and a second review of new physician orders to assure accuracy. Patient #1 no longer resides in health care center. An audit of all current resident's orders will be provided by the Director of Nursing or designee to assure orders are in patients' medical record. The Director of Nursing or designee will educate all licensed nurses on order transcription and the second review of new physician orders to be completed by an additional nurse. The Director of Nursing or designee will audit all new admission physician orders for accuracy for one month. Then, he/she will audit three new admissions a week for and additional month. Then, he/she will audit one new admission physician orders weekly for two months.	3/10/18

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

Electronically Signed | 02/25/2018

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F 658	Continued From page 1 ...nasal cannula oxygen [is] in place..." A nurse practitioner note dated 08/31/17 noted that " ...nasal cannula oxygen [is] in place ..." A nursing progress note dated 09/03/17 at 2:13 a.m. noted that " ...O2 at 2 LPM [liters per minute] continues ..." A nursing progress note dated 09/03/17 at 11:36 a.m. noted "pox [pulse ox] 79% on 4 L NC [nasal cannula] ..." There was no physician order for oxygen present in the medical record. In an interview on 1/29/18 at 3:20 p.m., the Director of Nursing (DON) confirmed that there was no physician order for oxygen present in the Medication Administration Record (MAR) or Treatment Administration Record (TAR). She indicated that oxygen is usually ordered with liters per minute specified, frequency of oxygen saturation checks, and parameters for notifying the physician. In an interview on 01/30/18 at 10:00 a.m., the Attending Physician acknowledged that he did remember the resident. He did not recall writing an order for the oxygen and indicated that the resident may have been discharged by the hospital with oxygen in use. He considered the use of oxygen to be a nursing order. In an interview on 01/31/18 at 1:55 p.m., Nurse #4 indicated that the resident was on oxygen when readmitted to the facility. Unless specified by the physician, Nurse #4 stated she continued	F 658	Audit results of the transcription of new admission orders will be presented, by the Director of Nursing at the monthly Quality Assurance Performance Improvement (QAPI) meeting for the review of the QAPI Committee for four months. The QAPI Committee will determine the effectiveness of the audits and make changes as necessary, to assure ongoing compliance.	

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F 658	Continued From page 2 providing oxygen at the same concentration as admission and then determined if the resident could tolerate "weaning several days later." She confirmed that no orders to use oxygen and to assess oxygen saturation were present on the TAR. In an interview on 01/31/18 at 2:30 p.m., Nurse Practitioner #2 confirmed that oxygen was not present in the list of medical orders for the resident ' s re-admission on 08/26/17. In an interview on 01/31/18 at 6:15 p.m., the DON shared her expectation that oxygen use by residents was covered by a medical order and monitored for effectiveness.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, the facility failed to monitor temperature and pulse ox and to provide a nursing assessment immediately for 1 of 3 residents reviewed for a significant change in condition (Resident #1). Findings included:	F 684	F684 The facility failed to monitor temperature and pulse oxygen saturation rate and to provide a nursing assessment immediately for patient #1. A root cause analysis was conducted by the interdisciplinary team and determined nurse #3 failed conduct a timely assessment identifying the resident's	3/10/18

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F 684	Continued From page 3 Resident #1 was initially admitted to the facility 08/18/17 with diagnoses that included rheumatoid arthritis, chronic obstructive pulmonary disease (COPD), pulmonary mycobacterium avium complex or MAC (a non-tuberculous lung infection), and severe protein malnutrition. She was re-admitted 08/26/17 following a brief hospitalization for an infected left wrist. The care plan dated 08/23/17 identified resident at risk for infection related to pyogenic arthritis (a joint infection). Nursing orders listed on the care plan were not followed: "assess and document temperature every 12 hours" to start on admission (08/18/17) and "check/record oxygen saturation every 8 hours...starting 09/02/17." A single temperature was documented each day for Resident #1 on re-admission and one pulse ox reading was recorded for 09/02/17. The Minimum Data Set (MDS) dated 09/02/17 noted that Resident #1 was cognitively intact. Relevant medical orders included the following medications: 1) Zithromax 500 milligrams (mg) by mouth 3 times a week, start date 08/18/17, for pulmonary MAC 2) Nystatin 500,000 units by mouth two times a day, start date 08/18/17, indication unknown 3) Ipratropium - albuterol 0.5 mg/3.0 mg ampule via inhalation every 6 hours as needed (PRN), start date 08/18/17, for COPD 4) Ceftriaxone 2 grams (GM) IV daily at 8:00 p.m., start date 08/27/17, for septic arthritis	F 684	change in condition and transport patient to the hospital timely. The facility also failed follow the resident's Plan of Care by not implementing orders for oxygen and obtaining resident's vital signs. Patient #1 no longer resides in the health care center. The Director of Nursing or designee will conduct an audit of all residents who have had a change in condition in the month of February. He/she will also, review the nursing assessments related to the change and the outcome of the change, to assure timely interventions were conducted. The Director of Nursing or Designee will review all patient care plans and assure there are orders implemented for vital signs and oxygen if indicated in the care plan. The Director of Nursing or designee will educate all licensed nurses timely patient assessments, timely interventions and the implementation of the SBAR tool to assist with accurate documentation. He/She will also educate licensed nurses on following and documenting vital signs/Oxygen saturation according to the resident's Care Plan. Education will be conducted by March 8, 2018. The Director of Nursing or Designee will review all SBAR tools/ change in condition, patient assessment documentation and the timely interventions for those patients, to assure patient needs are met timely and proper interventions are achieved for one month. He/She will also review all vital sign care plans and audit nursing documentation to assure nursing staff are following	

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F 684	Continued From page 4 5) Vancomycin 500 ml IV daily for 13 days, start date 08/30/17, for septic arthritis Resident #1 received supplemental oxygen via nasal cannula (NC) at 3 liters per minute (LPM). In an interview on 01/29/18 at 7:30 p.m., a family member related that when she visited on 09/01 and 09/02/17, she observed Resident #1 with shaking hands and slightly labored breathing on oxygen at 2 LPM. She questioned the facility thermometer ' s accuracy in registering a normal temperature even though the resident had complained of feeling chilled (09/01/17) and feverish (09/02/17). During the interview, she indicated that bought her own monitoring equipment to track vital signs. On 09/03/17 she recorded a heart rate of 113 and a pulse ox of 78% at 9:04 a.m. She relayed her concerns that morning to Nurse #2 who was on duty at the time and asked her to take vital signs as well but there was a delay in the nurse ' s assessment. She stated she waited 10 to 15 minutes for the nurse and then went to search. When she couldn ' t find locate her, she placed a call to Emergency Medical Services (EMS) to request transfer of the resident without waiting for the nurse ' s assessment. A review of the EMS report revealed that a call was received at 10:25 a.m. on 09/03/17. Vital signs were obtained on arrival at 10:51 a.m. by EMS workers: oxygen saturation 77%, heart rate (HR) 130, respirations 30, blood pressure (BP) 110/70, and temperature 101.7 degrees F. The resident ' s heart rate fluctuated as high as 166 beats per minute in the moments following EMS arrival. The EMS narrative described "SOB (shortness of breath) getting worse over past 3	F 684	resident's plan of care. Then he/she will review patient change of Care Plans, Vital sign documentation Condition/SBAR' documentation and interventions 3 days a week for one month. Then he or she will review Care Plans, vital sign documentation, change in condition/SBAR documentation and interventions 1 day a week for two additional months. Audit results for the Care Plans, vital signs, SBAR/change of condition, documentation and timely interventions will be presented by the Director of Nursing at the monthly Quality Assurance Performance Improvement (QAPI) meeting for the review of the QAPI committee for four months. The QAPI Committee will determine the effectiveness of the audits and make changes as necessary, to assure ongoing compliance.	

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F 684	Continued From page 5	F 684		

days ...l/s (lung sounds) diminished in lower lobes and expiratory wheezes noted in upper lobes. Pt placed on 6 LPM O2 ..."

Resident #1 left the facility at 11:01 a.m. with EMS for the emergency department of a local hospital where she was diagnosed with "severe sepsis" and "bilateral multifocal pneumonia" and admitted to the TICU (Trauma Intensive Care Unit).

In an interview on 01/30/18 at 11:45 a.m., Nurse Aide #1 confirmed that she was working on 09/03/17, the day Resident #1 was discharged to the hospital. The resident ' s family member came to the break room in search of a nurse. She and another aide followed her back to the room. Her first impression of the resident was that she was "breathing funny." Both Aide #1 and Aide #2 measured vital signs with the family member ' s equipment. Neither aide charted the vital signs. She indicated that only nurses entered them in the medical record.

Nurse Aide #1 stated she could not locate a nurse on the unit to notify about the abnormal vital signs. She indicated that there was a meal being served at the clubhouse that morning (a separate building on campus) and she stated the nurses had walked up there together to pick up their meals. She stated that "there should have been nurses here [facility]." She confirmed that the family member had phoned EMS prior to the arrival of the nurse to the room.

In an interview on 01/30/18 at 1:00 p.m., Nurse #2 stated that she and Nurse #3 were on the Assisted Living side of the facility earlier that day and then they were in Room 509 together. Aide

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#3 saw and asked them to come to the room of Resident #1. Her impression was that the resident was breathing "just fine" and was able to talk. The family member had already phoned EMS. When asked, she stated that she personally had not noticed any respiratory changes in the resident in the days leading up to 09/03. She confirmed there was a free buffet at the clubhouse that morning but she and Nurse #3 had gone separately.

In an interview on 01/30/18 at 1:30 p.m., Nurse #3 confirmed she was the nurse assigned to Resident #1 on 09/03/17 when the resident had a decline. She stated she worked at the facility every other weekend and was not as familiar with the residents as others might be, especially if the residents were not here that long. She acknowledged that a family member had approached her that morning and asked her to check the resident ' s vital signs. She chose to return when the resident had finished toileting. She stated she went to care for other residents and was not gone from the hall for more than 5 or 10 minutes. With regard to the family member or nurse aides ' claim of not being able to find a nurse, she stated that she was in the building.

Aide #4 told her that Resident #1 was worsening. The family member had already called EMS before she arrived to the room. She stated that she took vital signs and gave the resident oxycodone by mouth and started a nebulizer treatment.

Nurse #3 stated that she did not share much of the family member ' s concern about the resident ' s condition. She described her as alert, oriented and "talkative." She did notice shallow

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F 684	Continued From page 7 respirations and the pulse ox of 79% was concerning but that the blood pressure "was not a ' septic ' blood pressure." She stated the resident #1 denied have chest pain. In an interview on 01/31/18 at 6:15 p.m., the Director of Nursing (DON) shared her expectation that nurses be available on the unit for assessments and to promptly stop what they are doing when asked to observe or examine a resident. Nurses should tell at least one other nurse when leaving the unit and arrange for an available nurse to help monitor residents and to guide the care provided by nurse aides. When a resident had a change in clinical condition, the DON expected the licensed nurse to do a timely assessment and contact a medical staff member or the Physician Elder Care (PEC) triage system after hours. If the nurse disagreed with a family member ' s wish for emergency transport, as in the case of Resident #1, the family ' s preference for an outside evaluation should be honored, as Nurse #3 did.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		3/10/18

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professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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F 842	Continued From page 9 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to accurately document effectiveness of medications for 1 of 1 resident reviewed for medication administration (Resident #1). The findings included: Resident #1 was admitted 08/18/17 after hip surgery and then readmitted 08/26/17 after a three-day hospitalization for pyogenic arthritis of the left wrist. Diagnoses included fracture of an unspecified part, rheumatoid arthritis, chronic obstructive pulmonary disease (COPD), and pulmonary mycobacterium (a lung infection). The Minimum Data Set (MDS) dated 09/02/17 noted the resident was cognitively intact. She needed limited assistance for most activities of daily living. An entry on the September 2017 Medication Administration Record (MAR) shows that one ipratropium-albuterol 0.5/3.0 mg ampule	F 842	F842 The facility failed to document timely administration of medication/treatment and the effectiveness of the medication/treatment. A Root cause analysis was conducted by the interdisciplinary team and determined nurse #3 dispensed medication without documenting immediately. She also, documented a treatment of a PRN was affective after the patient had left the facility and had been admitted to the hospital. Patient #1 no longer resides in the health care center. An audit of all patient who have discharged from the healthcare center to the hospital February 2018 to determine if patients who received PRN medications/treatments if nurses accurately and if the documentation clarified the patient's condition. Then determine a timely discharge from the healthcare center. The audit will also identify if the documentation of the PRN's	

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F 842	Continued From page 10 prescribed for COPD was administered to Resident #1 via inhalation on 09/03/17 at 11:35 a.m. by Nurse #3. Results were assessed as "effective" at 12:35 p.m. The resident was not present in the facility at the time. She had been transported to a local hospital by Emergency Medical Services (EMS) earlier that day at 11:01 a.m. An additional entry on the September 2017 MAR indicated that oxycodone 5 mg PRN (as needed) for pain was administered by mouth to Resident #1 on 09/03/17 at 10:55 a.m. by Nurse #3. Results were assessed as "effective" at 11:55 a.m. The resident was not present in the facility at that time. In an interview on 01/30/18 at 1:30 p.m., Nurse #3 stated that she "must have been on autopilot" with regard to charting after the resident had departed. She admitted that she could not have assessed the resident for the effectiveness of the oxycodone and the nebulizer treatment because the resident was not in the facility at the time. She was aware that she could have entered notes in the MAR to explain that the resident was not present for an assessment of effectiveness but she did not do this. In an interview on 01/31/18 at 6:15 p.m., the Director of Nursing shared her expectation that any PRN (as needed) medication administered was followed by an assessment of effectiveness and that this assessment was documented accurately. She explained that the MAR software program automatically entered a time for the assessment that is exactly one hour later than the time of administration. If it was not possible for the nurse to follow up at this time or if the resident	F 842	given are effective while the patient remained in the healthcare center of if the patient was sent to the hospital prior to being able to assess the patient. The Director of Nursing or designee will educate all licensed nurses on timely documentation of PRN medication/treatment administration, timely assessments on effectiveness of the PRN medication/treatment and the importance of timely discharge of emergent changes of condition. Education completed by March 8, 2018. The Director of Nursing or designee will audit patients discharged to the hospital, PRN medication/treatment administration, documentation accuracy of assessments of effectiveness of PRN medications and timeliness of the discharge to the hospital for one month. Then he/she will audit 3 patient discharges weekly to the hospital PRN medication/treatment administration, documentation accuracy of assessments of effectiveness of PRN's, change in condition/SBAR documentation, assessment documentation and the timeliness of discharge accuracy for one month. The 1 patient a week for two months. Audit results on timely PRN medication/treatment administration documentation, accurate assessment documentation, and timely discharge of emergent patients will be presented by the Director of Nursing or designee at the monthly Quality Assurance Performance Improvement (QAPI), meeting for the review of the QAPI committee for four months. The QAPI Committee will	

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F 842	Continued From page 11 was off site, the DON stated that the nurse should enter a note in the medical record to provide clarification.	F 842	determine the effectiveness of the audits and make changes a necessary.	