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| HILLSIDE NURSING CENTER OF WAK | 968 EAST WAIT AVENUE WAKE FOREST, NC 27588 |

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| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). | F 580 | | 4/20/18 |

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

Electronically Signed | 04/13/2018

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| F 580 | Continued From page 1<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and physician interviews and record reviews, the facility failed to notify the physician of a resident ' s repeated low oxygen saturation levels and need to provide a higher concentration of supplemental oxygen than ordered for 1 of 1 residents (Resident #4) with chronic obstructive pulmonary disease (COPD) reviewed for physician notification.<br><br>The findings included:<br><br>Resident #4 was admitted to the facility on 11/6/17 from a hospital. Her cumulative diagnoses included chronic obstructive pulmonary disease (COPD) and hypoxemia (an abnormally low level of oxygen in the blood).<br><br>Resident #4 ' s admission orders dated 11/6/17 included the following: Oxygen (O2) running continuously at 2 liters (L) per minute via nasal cannula; and, check O2 every shift and document results. Additional orders were received from the physician on 11/7/17 to evaluate the resident and provide Occupational Therapy (OT) and Physical Therapy (PT) services as indicated.<br><br>Resident #4 ' s admission Minimum Data Set | F 580 | This plan of correction constitutes a written allegation of compliance, preparation, and submission of the plan of correction does not constitute admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under state and federal law.<br><br>Corrective Action for those residents that have been affected.<br><br>On 3-22-18 a review of the Medical Record for resident #4 for the Month of November the resident has several episodes of a reduced oxygen saturation level that was brought back up to normal range, but the M.D. was not notified.<br><br>Resident #4 was no longer in the facility when survey arrived.<br><br>Corrective action will be accomplished for those residents to be affected by the same deficient practice. | |

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| F 580 | Continued From page 2<br>(MDS) assessment was not completed nor due prior to the resident ' s discharge. The facility ' s Nursing Admission Assessment notes revealed the resident required the assistance of one staff member for her Activities of Daily Living (ADLs). A review of the resident ' s electronic medical record also included Nursing Notes dated 11/7/17 at 5:03 PM which described the resident as alert and verbal with some confusion.<br><br>A review of Resident #4 ' s November 2017 Medication Administration Record (MAR) revealed her oxygen saturation level (O2 sats) measured by a pulse oximeter (a medical device used to measure oxygen levels of the blood) on 11/7/17 1st shift was 96%. Normal pulse oximeter readings usually range from 95 to 100 percent. Values under 90 percent are considered low.<br><br>A review of Resident #4 ' s electronic progress notes included a Therapy Note dated 11/7/17 at 12:56 PM which read, in part: " ...Pt (patient) on 2 LPM (liters per minute oxygen) at start of session with O2 of 99%. With exertion of ADLs (Activities of Daily Living) bathing and dressing pt desated (oxygen saturation level decreased) to 86% after 5 mins (minutes) still at 86%. OT conferred with unit manager who OK pt supplemental O2 to 3 LPM. O2 levels increased to 94% after 3 mins on increased O2 ..." No documentation was found to indicate how long the resident ' s supplemental oxygen remained at 3 LPM (a concentration higher than the 2 LPM ordered by her physician). There was no documentation to indicate the resident ' s physician was notified of the low oxygen saturation levels or need to increase the concentration of her supplemental oxygen. | F 580 | On 3-26-18 the Standing Order Policy was revised by the Medical Director, DON, & Administrator, to include notification to the Physician when the concentration of the supplemental Oxygen provided had to be titrated, staff is to notify the physician in writing.See Exhibit D. This exhibit states the following for respiratory distress: "Check pulse oximetry. If oxygen saturation is below 90%, start oxygen 2L/M nasal cannula. If still unable to reach 90% notify PEC(MD) Triage. If Saturation of Oxygen rises above 90% and the resident is not longer in distress, notify the physician in writing in the PEC book."<br><br>Unit Managers, Unit Coordinators, Supervisors & DON reviewed all residents with current oxygen orders to ensure physician notification when oxygen saturation had to be titrated and recovered to 90% oxygen saturation for that baseline if it was appropriate for that resident.<br><br>Of the 36-nursing staff, 27 have been in-serviced as of 3-28-18. By 4-20-18 100% of all nurses will have been in-serviced. Any nurse that has not been in-serviced will be in-serviced prior to the start of their next scheduled shift.<br><br>This will be part of the orientation process for all nurses.<br>Measures put into place or systemic changes made to ensure that the deficient | |

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| F 580 | Continued From page 3<br><br>A review of the resident ' s MAR revealed her O2 sats were recorded on 11/7/17 as 94% on 2nd shift and 95% on 3rd shift. On 11/8/17, Resident #4 ' s O2 sats were 95% on 1st shift.<br><br>A review of Resident #4 ' s electronic progress notes included a Therapy Note dated 11/8/17 at 12:19 PM which indicated the resident was on 3 L O2 during the therapy session, with O2 sats ranging from 82%-94%. The note revealed the patient required verbal cues for pursed lip breathing when her oxygen levels dropped. A Nursing Note dated 11/8/17 at 10:37 PM indicated the resident, "continues on 3 L of O2 via nc (nasal cannula), O2 sat 92%." No documentation was found to indicate how long the resident ' s supplemental oxygen remained at 3 LPM. There was no documentation to indicate the resident ' s physician was notified of the low oxygen saturation levels or need to increase the concentration of her supplemental oxygen.<br><br>A review of the resident ' s MAR revealed her O2 sats were recorded on 11/8/17 as 93% on 2nd shift and 95% on 3rd shift. On 11/9/17, Resident #4 ' s O2 sats were 96% on 1st shift.<br><br>Further review of Resident #4 ' s electronic progress notes included a Therapy Note dated 11/9/17 at 1:04 PM. The note reported the resident was on 3 L O2. A second Therapy Note dated 11/9/17 at 1:57 PM read, in part: "Pt on 3L O2 with sats 82-83%, nursing alerted and planned to give breathing treatment." No documentation was found to indicate how long the resident ' s supplemental oxygen remained at 3 LPM. There was no documentation to indicate the resident ' s physician was notified of the low | F 580 | practice will not occur.<br><br>The DON, Unit Managers, Supervisors & Unit Coordinators are reviewing 100% of daily orders of residents receiving oxygen, to ensure physicians written notification of concentration was required to be titrated to keep oxygen level above the base line of 90% oxygen concentration.<br><br>The DON or Administrator and/or their designee will review the sheets for accuracy and address discrepancies with the appropriate staff. This will be logged on the audit tool that reviews 100% of residents receiving supplemental oxygen to determine if the physician was notified in written notification of concentration was required to be titrated to keep oxygen level above the baseline of 90% oxygen Saturation. This will be done for 30 days for 5 days a week, then three times weekly for the next thirty days, and then one time weekly for the next thirty days or substantial compliance is maintained. See Exhibit E audit tool. This audit tool reviews all residents receiving oxygen, if MD needed to be notified regarding issues, a not section for actions taken, and initial for staff conducting the audit.<br><br>The Facility Plans to Monitor its performance to make sure the solutions are sustained.<br><br>The Administrator and/or DON will observe the audit tool weekly and will present the findings to the Quality Assurance Performance Improvement | |

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| F 580 | Continued From page 4<br>oxygen saturation levels or need to increase the concentration of her supplemental oxygen.<br><br>A review of the resident ' s MAR revealed her O2 sats on 11/9/17 were recorded as 88% on 2nd shift and 94% on 3rd shift. An O2 sat was not recorded on the 11/10/17 1st shift.<br><br>Review of an electronic Therapy Note dated 11/10/17 at 2:39 PM reported Resident #4 required increased rest breaks with verbal cues for deep breathing techniques while on 3 L O2. Her O2 sats were documented to range from 76%-99% during the session. No documentation was found to indicate how long the resident ' s supplemental oxygen remained at 3 LPM. There was no documentation to indicate the resident ' s physician was notified of the low oxygen saturation levels or need to increase the concentration of her supplemental oxygen.<br><br>Another Therapy Note dated 11/10/17 at 2:52 PM reported the resident was out of bed and being pushed in a wheelchair by family. The note indicated Resident #4 ' s portable O2 tank was found to be empty at that time, she was placed on an O2 concentrator and a new portable tank was obtained for her. Resident #4 ' s O2 levels were reported to be 66% and slowly increased to 86% with verbal cues for deep breathing. The note indicated a member of the nursing staff was informed. There was no documentation to indicate the resident ' s physician was notified of the low oxygen saturation levels.<br><br>A review of Resident #4 ' s MAR revealed her O2 sats were recorded on 11/10/17 as 92% on 2nd shift and 97% on 3rd shift. On 11/11/17, Resident #4 ' s O2 sats were 96% on 1st shift. | F 580 | Committee monthly for three months or until a pattern of compliance is obtained. | |

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Review of an electronic Therapy Note dated 11/11/17 at 12:22 PM reported Resident #4 was on 2 LPM O2 with her O2 sats ranging from 80-91%. The note indicated it was difficult to get an accurate reading from the pulse oximeter due to the resident having cold fingers. The resident was placed on 3 LPM O2 to reduce her shortness of breath and to maintain her O2 sat levels. No documentation was found to indicate how long the resident ' s supplemental oxygen remained at 3 LPM. There was no documentation to indicate the resident ' s physician was notified of the low oxygen saturation levels or need to increase the concentration of her supplemental oxygen.

A review of Resident #4 ' s MAR revealed her O2 sats were recorded on 11/11/17 as 93% on 2nd shift and 91% on 3rd shift. On 11/12/17, her O2 sats were 98% on 1st shift, 95% on 2nd shift, and 93% on 3rd shift. On 11/13/17, Resident #4 ' s O2 sats were 98% on 1st shift, 94% on 2nd shift, and 93% on 3rd shift. And, on 11/14/17, her O2 sats were recorded as 96% on 1st shift.

Review of an electronic Therapy Note dated 11/14/17 at 11:00 AM reported Resident #4 was up in a wheelchair on supplemental O2 at 3 LPM via nasal cannula prior to the initiation of her therapy session. Her O2 sat was reported to be 94% on 3 LPM at the end of the session. No documentation was found to indicate how long the resident ' s supplemental oxygen remained at 3 LPM. There was no documentation to indicate the resident ' s physician was notified of the low oxygen saturation levels or need to increase the concentration of her supplemental oxygen.

A Nursing Note dated 11/14/17 at 8:43 PM

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reported the resident ' s O2 sat was 93%. However, the resident was reported as feeling short of breath so the nurse titrated her O2 concentration up to 3.5 LPM. The resident reported she felt better, she was positioned upright in bed, and her O2 sat was then reported as 95%. No documentation was found to indicate how long the resident ' s supplemental oxygen remained at a concentration higher than the 2 LPM ordered by her physician. There was no documentation to indicate the resident ' s physician was notified of the need to increase the concentration of her supplemental oxygen.

A review of Resident #4 ' s MAR revealed her O2 sats were recorded on 11/14/17 as 95% on 2nd shift and 98% on 3rd shift. On 11/15/17, her O2 sats were documented as 93% on 1st shift.

On 11/15/17 at 11:41 AM, an electronic Therapy Note reported Resident #4 was found sitting up in a wheelchair on supplemental O2 at 3 LPM via nasal cannula prior to initiation of the therapy session. Her O2 sat was taken and verified by nursing as 95%. There was no documentation found to indicate how long the resident ' s supplemental oxygen remained at 3 LPM.

A Nursing Note dated 11/15/17 at 10:01 PM. The note read: "Patient O2 was found to be not working properly by CNA (Certified Nursing Assistant) as patient O2 sat was 60%, patient was assessed by Nurse, HOB (head of bed) elevated to 90%, lung sounds assessed, PRN (as needed) albuterol given for SOB/wheezing, patient O2 titrated to 4 L via nc (nasal cannula), patient sat began to rise, last O2 sat 93%, patient vitals stable, denies any further discomfort, staff to continue to monitor, daughter present in room."

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No documentation was found to indicate how long the resident ' s supplemental oxygen remained at 4 LPM. There was no documentation to indicate the resident ' s physician was notified of the low oxygen saturation levels or need to increase the concentration of her supplemental oxygen.

A review of Resident #4 ' s MAR revealed her O2 sats were not recorded on 11/15/17 2nd shift. Her O2 sat on 3rd shift was noted to be 93%.

A Nursing Note dated 11/16/17 at 5:13 AM reported the resident was resting in bed with even and non-labored respirations noted. Her O2 sat was noted to be 93%. Resident #4 expired at the facility on 11/16/17 at approximately 9:25 AM.

A telephone interview was conducted on 3/21/18 at 5:22 PM with the physician who was assigned to care for Resident #4 during her stay at the facility. Upon inquiry, the physician reported he recalled the situation with Resident #4 and had made notes at his office in regards to it. He stated the facility did not notify him at all with any concerns about the resident ' s O2 sats or her supplemental oxygen. The physician reported if the resident ' s O2 sat was below 90 and she was having respiratory problems, "They (the facility) should have told me. I never got a phone call." The physician further elaborated by saying that if the O2 sat had gone down to the mid- to low-80s (even without obvious respiratory distress), he definitely should have been called. "They didn ' t give me a chance to try to do something for her ...She obviously was having a problem." Upon inquiry, the physician also reported the facility should also have notified him if they were making changes to the supplemental oxygen concentration provided to Resident #4. He

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stated, "I would have wanted to fix the problem ...the O2 saturation was going down for some reason that needed to be addressed."

An interview was conducted on 3/22/18 at 1:49 PM with Certified Occupational Therapy Assistant (COTA) #1. COTA #1 reported she recalled Resident #4 and had worked with the resident on 11/8/17, 11/9/17, 11/10/17 and 11/13/17. Upon inquiry, the COTA recalled the resident ' s O2 sats would go down to the lower 80 ' s, but did increase with some breathing techniques and rest breaks. She described one session on 11/9/17 when Resident #4 ' s O2 sats were low and would not increase. She stated nursing was alerted to the situation, therapy was stopped, and nursing came in to do a breathing treatment for her. When asked if she herself would have adjusted the resident ' s supplemental oxygen concentration, COTA #1 stated, "I would not do that." The COTA reported she would have consulted nursing staff and only adjusted the oxygen concentration if given instruction to do so by the nursing staff.

An interview was conducted on 3/22/18 at 2:04 PM with Physical Therapist (PT) #1. PT #1 reported she did Resident #4 ' s initial evaluation on 11/7/17 and then wrote the PT discharge summary based on the therapy notes. After reviewing her notes, the PT stated she had documented in her evaluation the resident ' s O2 sat levels went from 97% on 2 L of oxygen down to 86% after transfers, then went back up. Her O2 sat went down to 81% after walking and then increased after rest. The PT reported a decrease of O2 sats with activity was "not atypical" with COPD, as long as it went back to baseline and depending on the length of time it took to get

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there. When asked about the increase in the supplemental oxygen concentration provided to a resident, PT #1 indicated there would need to be a physician ' s order to indicate if staff was allowed to increase the concentration of oxygen with exertion.

An interview was conducted on 3/22/18 at 2:55 PM with Nurse #1. Nurse #1 was the hall nurse who helped care for Resident #4 on 11/7/17, 11/8/17, 11/11/17, 11/12/17, 11/14/17, 11/15/17, and 11/16/17 (1st shift). Upon inquiry, Nurse #1 reported she did not recall whether or not she had paged Resident #4 ' s physician about her low O2 sats or need for an increase in the concentration of her supplemental oxygen. The nurse was asked what oxygen saturation level would prompt her to notify a resident ' s physician. The nurse responded by saying she would definitely call the physician if an O2 sat was below 90%, and stated this would have applied to Resident #4. Upon inquiry, Nurse #1 reported, "You have to have an order to increase the oxygen concentration."

An interview was conducted on 3/22/18 at 3:19 PM with the Rehab Unit Coordinator. Upon inquiry, the Coordinator described the protocol utilized by the facility at the time of Resident #4 ' s stay at the facility. She reported that if a resident came in and was desaturating (O2 sats were declining), nursing staff would call the physician with any O2 sat below 90. She added that if a resident who was already on oxygen had an O2 sat less than 90% and was in distress, nursing would bump up the O2 concentration to get them at 90% or above. Nursing staff would then notify the physician.

An interview was conducted on 3/22/18 at 4:08

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| F 580 | Continued From page 10 | F 580 | | |

PM with Nurse #2. Nurse #2 was the hall nurse who helped care for Resident #4 on 11/13/17 (1st shift), 11/14/17 and 11/15/17 (2nd shift). Upon inquiry, Nurse #2 reported she thought she may have paged Resident #4 ' s physician about her low O2 sats or need for an increase in the concentration of her supplemental oxygen, but she was not sure. The nurse stated, however, she did remember notifying her immediate supervisor of the resident ' s low O2 sats. Nurse #2 reported if a resident ' s O2 sats would not come up, she would notify the physician, tell him she had titrated the O2 concentration up without getting the O2 sats over 90%, then would get orders from the physician at that point.

An interview was conducted on 3/22/18 at 4:30 PM with the Director of Therapy. During the interview, the protocol used when therapy worked with a resident who was oxygen-dependent was discussed. The Director stated the goal was for a resident ' s O2 sat to always be greater than 90%. She reported the rehab staff would monitor and check O2 sats throughout the therapy session and may even have the resident keep a pulse oximeter on the resident during the session. If a resident ' s O2 sats went down, the staff would implement a therapeutic rest or give verbal cues for purse lip breathing. The Director reported nursing staff would need to be alerted by therapy if a resident ' s O2 sat started to go below 90% and was not bouncing back, if the O2 sat dropped with less exertion than previous sessions, or if the O2 sat dropped faster and was not recovering. When asked if therapy staff could increase a resident ' s supplemental oxygen concentration, the Director stated they could if nursing staff instructed them to do so. The Director stated it was her understanding that nursing would obtain

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| F 580 | Continued From page 11<br>a physician ' s order for the increase in oxygen concentration if there was not already one for the resident.<br><br>An interview was conducted on 3/23/18 at 8:30 AM with the facility ' s Director of Nursing (DON). During the interview, the facility ' s standing orders at the time of Resident #4 ' s admission were reviewed and confirmed as correct by the DON. Standing orders on the Physician ' s Order Sheet for Shortness of Breath read as follows: "Raise the head of bed, check O2 sats, obtain vital signs, assess lung sounds, and administer O2 at 2 LPM, notify MD (Medical Doctor)." The DON stated, "I do remember having that conversation (with the nursing staff) of who was supposed to notify the doctor." The DON reported her expectation would have been for nursing staff to notify the physician if a resident ' s O2 sats were less than 90%. The DON stated she would have expected staff to titrate the oxygen concentration based on the clinical presentation of the resident at that moment or the frequency of the low O2 sats occurring. The DON also indicated she would have expected the physician to be notified (unless the resident ' s O2 sats immediately improved).<br><br>A follow-up interview was conducted on 3/23/18 at 11:40 AM with the DON. At that time, the DON stated her expectation for the nursing staff was to follow the physician notification as listed on the standing orders. She added the nursing staff were expected to take it up the chain of command and page the Medical Director, if needed. | F 580 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2) | F 677 | | 4/20/18 |

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| F 677 | Continued From page 12<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interviews and record reviews the facility failed to remove chin hairs on Resident #5 in 1 of 4 residents reviewed for activities of daily living.<br>Findings included:<br>Resident #5 was admitted to the facility on 8/12/11 with cumulative diagnoses which included cerebral vascular accident (stroke) and diabetes.<br>Review of the Resident Council Meeting Minutes dated 11/9/17 revealed a concern that nursing needed weekly nail checks and chin hair shaved as needed.<br>Review of the quarterly Minimum Data Set assessment tool dated 2/23/18 revealed in part resident was alert and oriented, not coded for behaviors or rejection of care. Resident # 5 was coded as requiring extensive assistance from 1 (one) staff member for personal hygiene.<br>Review of the revised care plan dated 2/27/18 revealed a problem of resistant to activities of daily living care on occasions. Displays verbal abusive behavior. To address this problem some of the approaches included approaching resident slowly and calm and If I become verbally inappropriate leave and try to approach later. An additional intervention included staff to monitor and record behaviors.<br>Record review revealed no recent issues with behaviors or refusing care since 2/27/18 at 10:45 PM.<br>On 3/21/18 at 10:00 AM an observation revealed considerably longer gray hairs. | F 677 | This plan of correction constitutes a written allegation of compliance, preparation, and submission of the plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under state and federal law.<br><br>Corrective action for those residents that have been affected.<br><br>On 3-22-18 it was observed that resident #5 was not shaved. Staff states she refuses grooming often. Upon reviewing documentation to support this behavior. There was not any documented behaviors regarding refusal of care. On 3-22-18 resident allowed staff to shave her chin hair but not her mustache. This has been documented in the chart.<br><br>Corrective action will be accomplished for those residents to be affected by the same deficient practice.<br><br>On 3-26-18 all clinical staff was educated on grooming residents and refusals of care procedure. Of the 102 Staff | |

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| F 677 | Continued From page 13<br>On 3/22/18 at 8:37 AM an observation of resident revealed the long hairs were still on her chin.<br>On 3/22/18 at 10:15 AM an observation revealed Resident #5 continued to have gray colored hairs at multiple lengths which covered the entire width of her chin. The length of some of the hairs measured approximately 1-1/2 inch to 2 inches.<br>Interview with Resident #5 at the time of the observation stated that the staff usually will shave my chin hairs. "I must ask them otherwise they do not offer. I had care already this morning and they did not shave me."<br>On 3/22/18 at 12:09 PM an inquiry was made about the presence of the chin hair with Nursing Assistant (NA) #1. NA #1 indicated that the resident will not let you shave hair on her chin. "I did not ask her today if she wanted the chin hair removed." At 12:13 PM the resident was asked if she wanted the hair removed from her chin and responded, "would love it."<br>Interview on 3/22/18 at 4 PM with the administrator revealed an expectation that personal care be provided. | F 677 | employed 66 have completed the In-service 100% in-service will be completed by 4/20/18. This will be part of the new orientation for clinical staff. The in-service outlines the policy for refusal of grooming: Staff to reapproach after refusal, if refusal persists notify nurse, nurse will educate resident and if resident still refuses, the nurse will document the refusal in the chart. See Exhibit C<br><br>On 3-24-18 all residents were observed to ensure facial hair was shaved. It was documented if residents refused multiple attempts to shave.<br><br>Measures put into place or systemic changes made to ensure that the deficient practice will not occur.<br><br>Manager/Coordinators/Supervisors or their designees will observer residents four times a week for thirty days and then two times a week for thirty days and then 1 time weekly for thirty days. Upon refusal this will documented in the chart. This will be documented on the Audit tool. This tool documents resident room number, resident initials, if resident required a shave, refused a shave, did not require a shave, and a note section describing actions regarding the refusal of care. See Exhibit C.<br><br>The DON or designee will be responsible inspecting the audit tool weekly<br><br>The facility plans to monitor its performance to make sure solutions are | |

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| F 677 | Continued From page 14 | F 677 | sustained.<br><br>The DON/Administrator will observe the audit tool weekly to ensure compliance. The findings will be brought to the Quality Assurance Performance Committee monthly for three months or until a pattern of compliance is obtained. | |
| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or | F 732 | | 4/25/18 |

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| F 732 | Continued From page 15<br>written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to 1. posted staffing information that was complete, accurate and not missing information 2. retain minimum of 18 months of daily posted data. This was evident in 4 of 5 months of posted staffing data reviewed. (September 2017, October2017, November 2017 and December 2017).<br>Findings included:<br>Record review revealed the facility was certified for 130 skilled beds.<br>Review of the Daily Posted Staffing revealed: There were no daily posted staffing data for September 2017 and October 2017.<br>Review of the November 2017 daily posted staffing data revealed on: 11/4/17 no census recorded for all shifts.<br>11/5/17 no census recorded for all shifts.<br>11/9/17 a facility census of 143 for all shifts was recorded. The facility only had 130 dually certified beds.<br>11/10/17 a facility census of 143 for all shifts was recorded.<br>11/12/17 no census data recorded for all shifts<br>11/14/17 data recorded for a facility census of 143 for 1st and 2nd shift. No census was recorded for the 3rd shift<br>11/17/17 no recorded data for the 1st and 2nd | F 732 | This plan of correction constitutes a written allegation of compliance, preparation, and submission of the plan of correction does not constitute admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under state and federal law.<br><br>Corrective Action for those residents that have not been affected.<br><br>On 3/22/18 the Complaint Survey team requested to observe the Daily Census and Staffing sheets for the month of November 2017. It was observed that Daily Census & Staffing numbers were not accurate for the month of November 2017. Several staff included the census from the Assisted Living Facility, as well as Supervisor names and census totals not completed. The Daily Staffing Data sheets have been inspected and are accurate beginning January 1, 2018. October, November, & December Sheets have been recovered and verified for the | |

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| F 732 | Continued From page 16<br>shifts<br>11/23/17 no facility census recorded for all shifts<br>12/2/18 a census of 141 for 1st-2nd was recorded and 3rd shift was recorded for 140 census.<br>12/3/17 a census of 141 was recorded.<br>12/9/17 no census recorded for the 1st and second shifts<br>12/14/17 no census recorded for all shifts<br>12/18/17 no census recorded for all shifts<br><br>Interview on 3/22/17at 5 PM with the Administrator revealed staff must have combined the non- certified beds (licensed only) with the certified beds. The Administrator indicated the night shift nurse usually will complete the form. At the time of the survey the night nurse was unavailable.<br>Interview on 3/22/17 at 5:18 PM with the Unit coordinator revealed various staff complete the posted staffing form.<br>A second interview on 3/22/18 at 6:35 pm with the Administrator revealed he expected the census be updated each shift, use number of certified beds only and retained. | F 732 | year 2017.<br><br>Corrective action will be accomplished for those residents to be affected by the same deficient practice.<br><br>Beginning on 4-3-18 all Nurses were in-serviced by the DON or the Second Shift supervisor on the procedure for reporting the daily Census and Staffing. See Exhibit A. This exhibit outlines the policy for documenting the daily skilled nursing census changes and clinical staffing per shift. This is to be done in pencil.<br><br>Of the 36-nursing staff, 27 have been in-serviced. 100% of Nurses will be in-serviced by 4/25/18. Any nurse that has not been in-serviced will be in-serviced prior to the start of their next scheduled shift.<br>This will be part of the orientation process for all nurses.<br><br>Measures put into place or systemic changes made to ensure that the deficient practice will not occur.<br><br>The Third Shift Supervisor or the DON□S designee will be responsible for updating the Daily Census and Staffing Sheets.<br><br>The DON or Administrator and/or their designee will review the sheets for accuracy and address discrepancies with the appropriate staff. This will be done for thirty days for five days a week. Then | |

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| F 732 | Continued From page 17 | F 732 | three times weekly for the next thirty days. Then one time weekly for the next thirty days. This will be logged on the audit tool. See Exhibit B<br>This audit tool reviews the posted skilled nursing census as well as the clinical staffing for projected for the day. To ensure accuracy, discrepancies are documented and corrected and the note sections explains the procedure. This is initialed by the Administrator or his designee.<br><br>The Facility Plans to Monitor its performance to make sure the solutions are sustained.<br><br>The Administrator and/or DON will observe the Daily Census and Staffing sheets audit tool weekly and will present the findings to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained. | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(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.<br><br>§483.70(i) Medical records. | F 842 | | 4/20/18 |

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| F 842 | Continued From page 18<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§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-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(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.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches | F 842 | | |

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| F 842 | Continued From page 19<br>legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record reviews, the facility failed to accurately document information in the medical record for 1 of 7 sample residents (Resident #4) whose records were reviewed.<br><br>The findings included:<br><br>1) Resident #4 was admitted to the facility on 11/6/17 from a hospital with a cumulative diagnoses which included chronic obstructive pulmonary disease (COPD) and anxiety. Her hospital discharge medication list included 0.5 milligrams (mg) alprazolam (an antianxiety medication) to be given as ½ tablet (0.25 mg total dose) by mouth two times daily as needed for sleep or anxiety.<br><br>A review of the resident ' s admission orders dated 11/6/17 included a Physician ' s Telephone Order for 0.5 mg alprazolam to be given as ½ (one-half) tablet by mouth every 12 hours as needed for sleep or anxiety. The telephone order was written by Nurse #3. Further review of the | F 842 | This plan of correction constitutes a written allegation of compliance, preparation, and submission of the plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under state and federal law.<br><br>Corrective action for those residents that have been affected.<br><br>On 3-23-18 it was observed in the Medical record for resident #4 an admission order dated 11/6/17 was 0.5 mg alprazolam to be administered as a one half tablet by mouth every twelve hours as needed. Review of the MAR dated 11-6-17 the order was transcribed for 0.5 mg alprazolam tab to be administered as two | |

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| F 842 | Continued From page 20<br>admission orders revealed the order for alprazolam on the Physician Order Summary (dated 11/6/17) and the November 2017 Medication Administration Record (MAR) was written for 0.5 mg alprazolam tab to be given as 2 tablets by mouth twice daily as needed for anxiety (which would provide a total dose of 1 mg alprazolam).<br><br>A review of Resident #4 ' s November 2017 MAR revealed the resident received one dose of alprazolam on 11/6/17, one dose on 11/7/17, and one dose on 11/8/17. On 11/8/17, the order for alprazolam on the MAR was re-written for 0.5 mg alprazolam to be given as 0.5 tab (0.25 mg total dose) by mouth twice daily as needed for anxiety.<br><br>A review of the resident ' s Controlled Drug Receipt/Record/Disposition Form revealed the facility ' s contracted pharmacy had sent out 0.25 mg alprazolam tablets for Resident #4, with instructions to take 1 tablet by mouth every 12 hours as needed for anxiety or insomnia. The Controlled Drug Record served as a declining inventory of the alprazolam tablets and indicated the correct dose (0.25 mg total dose) was administered to the resident once each day on 11/6/17, 11/7/17, and 11/8/17 prior to the dosage instructions being corrected on the MAR.<br><br>A telephone interview was conducted on 3/21/18 at 3:18 PM with Nurse #3. Nurse #3 was identified by her signature as the nurse who wrote the telephone order for alprazolam (with the correct dosage) and who also checked the admission orders on the 11/6/17 Physician Order Summary (with the incorrect dosage). Upon inquiry, the nurse confirmed a resident ' s admission orders were based on the hospital | F 842 | tablets by mouth twice daily as needed for anxiety.<br><br>This was a transcription error as the resident did receive the correct medication and dosage per the admission order.<br><br>Corrective action will be accomplished for those residents to be affected by the same deficient practice.<br><br>On 3-26-18 nurse educated was initiated on orders transcription and medication error policy. The Medication Administration Record (MAR) must match the Medication Label, prior to administering the medication. If a discrepancy is discovered, staff must do the following: Check the chart for the most current order, complete the medication incident report, follow policy related to medication error report. Of the 36 nurses 27 have completed the In-service. 100% completion will be completed by 4/20/18 Any nurse that has not completed this in-service must complete prior to the start of their next shift. See Exhibit F<br><br>This will be part of the new orientation for clinical staff.<br>Measures put into place or systemic changes made to ensure that the deficient practice will not occur.<br><br>The DON, Unit Managers, Supervisors & Unit Coordinators are reviewing 100% of new orders daily to ensure medication orders are transcribed accurately to the | |

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| | 345417 | A. BUILDING _____ B. WING _____ | C 03/23/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HILLSIDE NURSING CENTER OF WAK | 968 EAST WAIT AVENUE WAKE FOREST, NC 27588 |

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| F 842 | Continued From page 21<br>discharge medication list. She discussed the process of obtaining physician approval of the hospital discharge medications and transcribing the resident ' s admission orders onto the Physician Order Summary and the MAR. The nurse did not recall any issues or concerns in regards to Resident #4 ' s admission orders.<br><br>An interview was conducted on 3/23/18 at 8:30 AM with the facility ' s Director of Nursing (DON). During the interview, the DON was asked to identify the signature of the nurse who transcribed the order for Resident #4 ' s alprazolam on the Physician Order Summary and MAR. The DON reported the nurse no longer worked at the facility. No contact information for this nurse was available.<br><br>Upon request, an interview was conducted with Nurse #1 in the presence of the DON on 3/23/18 at 10:30 AM. Nurse #1 recalled when a Medication Aide brought to her attention the discrepancy between the dosage instructions on Resident #4 ' s alprazolam medication card (from the pharmacy) and the MAR. Nurse #1 reported after talking with her supervisor, she just re-wrote the order on the MAR to indicate the correct dosage of 0.25 mg alprazolam. Upon inquiry, the nurse stated she did not recall whether or not a med error report was completed. The DON stated this was a med error (due to the dosage discrepancy) but it was not flagged as such when it was simply re-written on the MAR. The DON stated the incorrect order should have been discontinued and the physician called for a new order or order clarification.<br><br>A follow-up interview was conducted on 3/23/18 at 11:40 AM with the DON. When asked, the | F 842 | MAR. This will be done daily for thirty days. Then three times weekly for the next thirty days. Then one time weekly for the next thirty days. This will be logged on the audit tool. This audit tool references each resident's new order were transcribed correctly, if not transcribed correctly what interventions were put in place to correct the issue. See Exhibit G<br><br>The facility plans to monitor its performance to make sure solutions are sustained.<br><br>The DON/Administrator will observe the audit tool weekly to ensure compliance. The findings will be brought to the Quality Assurance Performance Committee monthly for three months or until a pattern of compliance is obtained. | |

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| F 842 | Continued From page 22 | F 842 | | |

DON reported she would expect a medication to be transcribed correctly according to the original order. She stated the nurse should have double checked the original order and fixed it. The DON also reported she would expect the nursing staff to follow the 6 rights (right individual, right medication, right dose, right time, right route, and right documentation) at all times when documenting on the MAR.

2) Resident #4 was admitted to the facility on 11/6/17 from a hospital. Her cumulative diagnoses included chronic obstructive pulmonary disease (COPD).

The resident ' s admission orders dated 11/6/17 included the following: Oxygen (O2) running continuously at 2 liters (L) per minute via nasal cannula; check O2 every shift and document results; and, change O2 filter and tubing every week and as needed.

Resident #4 ' s admission Minimum Data Set (MDS) assessment was not completed nor due prior to the resident ' s discharge. The resident expired at the facility on 11/16/17 at approximately 9:25 AM.

A review of the resident ' s November 2017 Medication Administration Record (MAR) revealed the oxygen tubing, humidified water bottle, and nebulizer mask were scheduled to be changed every Thursday on the 11:00 PM to 7:00 AM 3rd shift. The MAR showed a rectangular block was initialed to indicate the task was completed on 11/2/17, 11/9/17 and 11/16/17. However, the resident was not admitted to the facility until 11/6/17 and she had expired the morning of 11/16/17.

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| F 842 | Continued From page 23<br><br>An interview was conducted with the facility ' s Director of Nursing (DON) on 3/23/18 at 8:30 AM. During the interview, the documentation on the MAR for the changing of the oxygen tubing, humidified water bottle, and nebulizer mask was reviewed. The DON confirmed a task documented as completed by the 3rd shift nursing staff on 11/16/17 indicated the task would have been completed between 11:00 PM on 11/16/17 and 7:00 AM on 11/17/17. Upon review, the DON stated, "That is a problem."<br><br>A follow-up interview was conducted on 3/23/18 at 11:40 AM with the DON. When asked, the DON reported she would expect the nursing staff to follow the 6 rights (right individual, right medication, right dose, right time, right route, and right documentation) at all times when documenting on the MAR. The DON indicated she did not understand why this task had been documented on the MAR as having been completed on 11/2/17 and 11/16/17. | F 842 | | |