

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

PRINTED: 03/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345222	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/02/2015
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF DREXEL			STREET ADDRESS, CITY, STATE, ZIP CODE 307 OAKLAND AVENUE DREXEL, NC 28619		
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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administer an intravenous infusion ordered by the physician for 1 of 3 residents reviewed for highest practical well-being. (Resident #99).</p> <p>The findings included:</p> <p>Resident #99 was readmitted to the facility 04/06/12 with diagnoses which included anemia and diabetes. Recent diagnoses included an infected cyst in the resident's groin and pneumonia. A quarterly Minimum Data Set (MDS) dated 01/02/15 indicated Resident #99's cognition was intact. The MDS specified the resident understood others and could be understood, required limited staff assistance for toilet use, transfers, and bed mobility. Resident #99 was assessed as independent with all other activities of daily living.</p> <p>A review of Resident #99's medical record revealed a physician's order dated 02/04/15 to initiate Doxycycline (an antibiotic) 100 milligrams (mg) twice a day related to an infected groin cyst. Additional physician's orders specified Levaquin</p>	F 309	<p>This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.</p> <p>It is the policy of this facility that each resident receives and this facility will provide the necessary care and the services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Resident #99 was discharged from the facility 2/18/15.</p> <p>Under the direction of the Director of Nursing, licensed staff involved in this alleged deficient practice has been in-serviced for their responsibility for</p>	3/6/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/10/2015

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	<p>Continued From page 1</p> <p>(an antibiotic) 500 mg daily was to be initiated 02/13/15 related to a diagnosis of pneumonia. A physician's order dated 02/14/15 increased the dosage of Levaquin to 750 mg daily.</p> <p>Additional review of Resident #99 s medical record revealed a physician's progress note dated 02/17/15 at 8:30 PM. The note specified the resident appeared to be declining related to a diagnosis of lower respiratory infection. The note further specified the physician's plan was to start intravenous (IV) fluids, continue antibiotics, and consider transferring to the emergency department if not improving.</p> <p>Further medical record review revealed no documentation to indicate a physician's order to administer IV fluids had been noted. Additional medical record review revealed no documentation to indicate IV fluids were administered to Resident #99 before leaving the facility at 4:10 AM on 02/18/15.</p> <p>Continued medical record review revealed a nurse's progress note written at 4:10 AM on 02/18/15 and signed by Nurse #2. The nurse documented she was called to Resident #99' room by the nurse aides at 2:00 AM. The nurse aides reported the resident had a fever. She found the resident shaking and jerking of the entire body, hallucinations, and a temperature of 102.6 Fahrenheit (F) 45 minutes after fever reducing medication was administered. Further documentation review revealed the on call physician was notified and provided instructions to send Resident #99 to the hospital. The documentation specified the resident left the facility at 4:10 AM via ambulance with EMS (emergency medical services) in attendance.</p>	F 309	<p>accepting, transcribing and following physician orders, importance of prioritizing orders, such as starting IV therapy when ordered, scope of practice for IV therapy using the North Carolina Board of Nursing position statements and nurse practice act. For Nurse #2 involved with this alleged deficient practice, an investigation was completed by the Administrator related to the events of the night of 2/17/15, and nurse #2 was re-educated for critical thinking and decision-making, prioritizing Physician orders and documentation for residents who have an acute onset change of condition or who have an order for IV fluids.</p> <p>Because all residents are potentially affected by the alleged cited deficiency, and to enhance the facilities current compliant operations, under the direction of the Director of Nursing, all licensed nurses received training on facility policy for their individual responsibility for accepting, transcribing and following physician orders, importance of prioritizing orders, such as starting IV therapy when ordered, scope of practice for IV therapy using the North Carolina Board of Nursing position statements and Nurse Practice Act.</p> <p>Effective 03/02/15, under the direction of the Director of Nursing a Quality Assurance program was begun to re-educate licensed nurses for critical thinking, establishing priorities for transcribing and following physician orders to initiate delivery of immediate</p>		

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F 309	<p>Continued From page 2</p> <p>An interview was conducted via phone with Nurse #1 on 03/02/15 at 11:38 AM. Nurse #1 stated she worked on Resident #99's hall the evening shift of 02/17/15. She stated the MD made rounds late that evening. Nurse #1 stated it was not unusual for the MD to make rounds late in the evening. Nurse #1 explained it was around 10:15 PM when she found an order to initiate IV fluids for Resident #99. She added it was so late, she did not note the order nor did she start the IV fluids. She stated she passed the order on to Nurse #2 who relieved her at 11:00 PM. Nurse #1 stated during the evening shift Resident #99 appeared weak but ate all his supper. She added the resident was up in his wheelchair and visiting with his family. Nurse #1 stated the last time she saw the resident, he was lying in his bed quietly sleeping. She stated she had no reports of shaking from the nurse aides and did not observe any signs of a fever.</p> <p>An interview was conducted via phone with Nurse #2 on 03/02/15 at 12:25 PM. She stated she worked the 11:00 PM to 7:00 AM shift that started 02/17/15. She stated Nurse #1 did report that Resident #99's ordered IV fluids had not been started. Nurse #2 stated the resident was shaking so badly, she could not start an IV. She stated she thought the resident needed to go to the hospital so she called the on call physician. Nurse #2 stated without the resident's chart, she was unable to provide a time the resident began shaking or what time the resident left the building.</p> <p>An additional interview via phone with Nurse #2 at 1:28 PM on 03/02/15 revealed the nurse aides found Resident #99 on rounds and reported to the nurse the resident had a fever and behaviors.</p>	F 309	<p>care including starting IVs as ordered. If nurse is unable to start IV then the RN supervisor is to be informed. If RN supervisor is unable to start IV then the Physician must be informed for additional orders. All IVs must be attempted to be started within 1 hour of the nurse receiving the order unless the order is specified as Stat. All attempts to start IV must be documented in the resident's medical record for the time of each event. Also a documented record of the resident condition and response must be recorded in the electronic health record for the timeline of the events, including documentation that the family/responsible party is aware of the events.</p> <p>The Director of Nursing or designated Quality Assurance representative will perform the following systematic changes: daily checks of physician orders to track IV therapy orders 5 days weekly for 4 weeks, ensuring timeliness of initiating the Physician order to start the IV and to ensure follow up with transcribing the order into the electronic health record, attempts to start IV, documentation for IV therapy, and resident condition and response, physician informed for concerns if unable to start IV, follow-up orders from Physician, family/responsible party informed. Then the Director of Nursing or designated Quality Assurance representative will perform random weekly checks of IV orders to monitor and ensure continued compliance.</p> <p>Any deficiencies will be corrected on the spot, and findings will be documented and</p>		

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F 309	<p>Continued From page 3</p> <p>Nurse #2 stated since the resident had complained of pain and the ordered pain medication provided fever reducing properties, she thought the resident's fever would come down. Nurse #2 was unable to recall how high Resident #99's fever was.</p> <p>An interview was conducted via phone with Nurse #3 on 03/02/15 at 2:47 PM. Nurse #3 stated she worked the night Resident #99 left for the emergency department but was not the nurse on the resident's hall. She explained the facility had a 3 check system to ensure physician's orders were noted and carried out correctly. Nurse #3 stated she found the MD's handwritten telephone order to initiate IV fluids for Resident #99. She added the resident had already left for the emergency department when she found the order and had not returned to the facility. Nurse #3 stated if she found a physician's order that had not been noted she would note it. Since Resident #99 had left the building, she placed the order in the Director of Nursing's (DON) mailbox at the end of her shift on the morning of 02/18/15. She added her intent was to let the DON know the physician's order had not been initiated.</p> <p>An interview was conducted via phone on 03/02/15 at 2:45 PM with the Staff Development Coordinator (SDC) who was the DON on 02/18/15. The SDC stated she did remember seeing the physician's order dated 02/17/15 instructing the initiation of IV fluids for Resident #99. She added Nurse #2 reported to her on the morning of 02/18/15 that she was unable to start the IV because the resident was shaking so much.</p> <p>An interview with the Administrator on 03/03/15 at</p>	F 309	submitted at the quarterly quality assurance committee meeting for further review or corrective action.		

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F 309	Continued From page 4 5:19 PM revealed she expected a physician's order for IV fluid administration to be a priority. The Administrator acknowledged the evening shift nurse should have asked for help to start the IV and both nurses should have made an IV a priority.	F 309			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to maintain a complete and accurate medical record regarding a physician's order to initiate intravenous fluids and document a temperature reading for 1 of 1 resident reviewed for accuracy of the medical record. (Resident #99). The findings included: Resident #99 was readmitted to the facility 04/06/12 with diagnoses which included anemia	F 514	It is facility policy to maintain electronic clinical records on each resident in accordance with accepted professional standards and practices which are: complete, accurately documented, readily accessible and systematically organized. Our facility policy states that each resident's clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	3/10/15	

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F 514	<p>Continued From page 5</p> <p>and diabetes. Recent diagnoses included an infected cyst in the resident's groin and pneumonia. A quarterly Minimum Data Set (MDS) dated 01/02/15 indicated Resident #99's cognition was intact. The MDS specified the resident understood others and could be understood, required limited staff assistance for toilet use, transfers, and bed mobility. Resident #99 was assessed as independent with all other activities of daily living.</p> <p>A review of Resident #99's medical record revealed a physician's progress note dated 02/17/15 at 8:30 PM. The note specified the resident appeared to be declining related to a diagnosis of lower respiratory infection. The note further specified the physician's plan was to start intravenous (IV) fluids, continue antibiotics, and consider transferring to the emergency department if not improving.</p> <p>Further medical record review revealed no documentation to indicate a physician's order to administer IV fluids had been noted. Additional medical record review revealed no documentation to indicate IV fluids were administered to Resident #99 before leaving the facility at 4:10 AM on 02/18/15.</p> <p>Additional medical record review revealed a nurse's progress note written at 4:10 AM on 02/18/15 and signed by Nurse #2. The nurse documented she was called to Resident #99's room by the nurse aides at 2:00 AM. The nurse aides reported the resident had a fever. She found the resident shaking and jerking of the entire body and with hallucinations. Continued documentation review revealed, 45 minutes after fever reducing medication was administered a</p>	F 514	<p>preadmission screening conducted by the State; and progress notes.</p> <p>Resident # 99 was discharged from the facility 2/18/15.</p> <p>Under the direction of the Director of Nursing, licensed staff involved in this alleged deficient practice has been in-serviced on facility policy to maintain a complete and accurate medical record including Physician's orders, assessment of resident condition including vital signs, and for their responsibility for accepting, transcribing and following Physician orders including IV fluids.</p> <p>Because all residents are potentially affected by the alleged deficiency, effective 3/2/15, under the direction of the Director of Nursing, a quality assurance program was begun to re-educate licensed nurses on facility policy to maintain a complete and accurate medical record including Physician's orders, assessment of resident condition including vital signs, the plan of care and services provided, response to treatment, documentation that the resident and/or family/responsible party is aware of the events, and for their responsibility for accepting, transcribing and following Physician orders including IV fluids.</p> <p>The Director of Nursing/designee performs the following systematic changes: daily checks of Physician orders and resident progress notes five days weekly for 4 weeks then random</p>		

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F 514	<p>Continued From page 6</p> <p>temperature of 102.6 Fahrenheit (F) was noted .</p> <p>An interview was conducted via phone with Nurse #1 on 03/02/15 at 11:38 AM. Nurse #1 stated she worked on Resident #99's hall the evening shift of 02/17/15. She stated the MD made rounds late that evening. Nurse #1 stated it was not unusual for the MD to make rounds late in the evening. Nurse #1 explained it was around 10:15 PM when she found an order to initiate IV fluids for Resident #99. She added it was so late, she did not note the order nor did she start the IV fluids. She stated she passed the order on to Nurse #2 who relieved her at 11:00 PM.</p> <p>An interview was conducted via phone with Nurse #2 on 03/02/15 at 12:25 PM. She stated she worked the 11:00 PM to 7:00 AM shift that started 02/17/15. She stated Nurse #1 did report that Resident #99's ordered IV fluids had not been started. Continued interview at 1:28 PM revealed Nurse #2 stated the nurse aides found Resident #99 with a fever on rounds. She was unable to recall the temperature reading.</p> <p>An interview was conducted with the Director of Nursing (DON) on 03/02/15 at 2:27 PM. The DON stated Nurse #2 should have documented the temperature reading the nurse aides reported to her at 2:00 AM.</p> <p>An interview was conducted via phone with Nurse #3 on 03/02/15 at 2:47 PM. Nurse #3 stated she worked the night Resident #99 left for the emergency department but was not the nurse on the resident's hall. She explained the facility had a 3 check system to ensure physician's orders were noted and carried out correctly. Nurse #3 stated she found the MD's handwritten telephone</p>	F 514	<p>weekly checks to ensure all required documentation related to resident condition including vital signs, is in accordance with accepted professional standards of practice as well as entry of Physician order into the electronic health record. Any concerns will be corrected immediately and the results documented and submitted to the quality assurance committee quarterly for further review or corrective action.</p>		

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F 514	<p>Continued From page 7</p> <p>order to initiate IV fluids for Resident #99. She added the resident had already left for the emergency department when she found the order and had not returned to the facility. Nurse #3 stated if she found a physician's order that had not been noted she would note it. Since Resident #99 had left the building, she stated at the end of her shift on the morning of 02/18/15, she placed the order in the DON's mailbox. She added her intent was to let the DON know the physician's order had not been initiated.</p> <p>An interview was conducted via phone on 03/02/15 at 2:45 PM with the Staff Development Coordinator (SDC) who was the DON on 02/18/15. The SDC stated she did remember seeing the physician's order dated 02/17/15 instructing the initiation of IV fluids for Resident #99. She added Nurse #2 reported to her on the morning of 02/18/15 that she was unable to start the IV because the resident was shaking so much. She was unable to recall what happened to the hand written physician's order.</p>	F 514			