### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 157</td>
<td>463.10(b)(11) NOTIF OR CHANGES</td>
<td>SS=0</td>
<td>INJURY/DECLINE/ROOM. ETC</td>
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**A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.16(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on record review, staff interview, physician and nurse practitioner interview the facility failed to notify the physician/nurse.

Laboratory Director or Provider/Suppliers Representative's Signature: [Signature]

Title: Administrator

Date: 10/29/15

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 patient. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 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 required to continued program participation.
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<td>labs or diagnostic tests, as applicable. The Director of Clinical Services (OCS) re-educated Nurse Managers/Licensed Nurses by 10-30-15 to review lab and diagnostic testing, and to notify the primary physician/nurse practitioner of any abnormal labs and/or diagnostic test results for further interventions. Licensed Nurses, not receiving this training, will have the training prior to working their next scheduled shift.</td>
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<td>4. The Director of Clinical Services/Nurse Manager will complete Quality Assurance Monitoring 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then 2 times per week for 4 weeks, and then 1 time monthly for 2 months, using a sample size of 5 residents. The monitoring will be documented on a Quality Assurance and Performance Improvement Monitor Form.</td>
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<td>Resident #7 was admitted to facility on 6/13/14 with diagnosis of dysphagia, dementia, subarachnoid hemorrhage and diabetes type 2.</td>
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<td>The Minimum Data Set (MDS) a quarterly dated 7/1/15 assessed the pressure wound as necrotic with no wound infection. The MDS indicated Resident #7 required extensive assistance with bed mobility, transfers, eating and personal hygiene. Resident #7 had short and long term memory impairment.</td>
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<td>The care plan dated 8/7/15 indicated a problem for potential for an infection related to coccyx pressure ulcer. The stated goal included the resident would not develop infection secondary to sacral wound. The goal was updated 9/9/15 for the infection to resolve by completion of the antibiotic therapy, and she would experience decreased symptoms of infection. Approaches included treatment as ordered, lab work as ordered and report to physician.</td>
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<td>The care plan dated 8/7/15 indicated a problem of an indwelling catheter due to a pressure ulcer on the coccyx. The approaches included lab work as ordered and report to physician.</td>
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**F 157 Continued From page 2**

Review of the wound physician progress note dated 9/9/15 revealed Resident #7 had a worsening of a chronic pressure wound on the coccyx. The wound measured 5 centimeters (cm) length (L) by 5 cm width (W) by 2.8 cm depth (D). There was undermining at 9 o'clock of 1.5 cm. The wound was assessed as 80% necrosis. Treatment included use surgical debridement, Dakins solution, and PICC (central intravenous line) for antibiotic administration for 6 weeks. "Wound has accumulated a large amount of necrotic tissue over the past week, high suspicion for osteomyelitis. Will start vancomycin (antibiotic) and order blood work and XRay. Recommendation: CBC, complete blood count, place PICC line, Vancomycin 1 gram IV every 12 hours for 6 weeks for osteomyelitis XRay of the sacrum." After surgical debridement the wound was assessed as a stage 4 pressure ulcer.

Review of the telephone order dated 9/9/15 the nurse practitioner had ordered a wound culture to be obtained when the wound vac was changed. A telephone order dated 9/9/15 for UA (urinalysis) with C&S (culture and sensitivity) to rule out UTI (urinary tract infection).

Telephone order dated 9/9/15 for Cipro (antibiotic) 400 mg (milligrams) intravenous every 12 hours for 7 days for UTI.

Review of the medical record revealed no information that indicated the lab work was obtained, received or reported to the nurse practitioner. The medical record did not indicate the XRay had been obtained.

Upon request, a copy of the lab results for the
wound culture was obtained by the unit manager from the lab. The results indicated 3+ Gram Positive Cocci pairs, 3+ Gram positive rods and 3+ Gram negative rods. The sensitivity report (details what antibiotics would be effective against the organism) indicated the following antibiotics could be used to treat the infection: Gentamycin, Trimeth-Sulfa, Piperacillin/Tazobactam and Tetracycline. The antibiotic used to treat Resident #7, Clindamycin, was not listed on the culture sensitivity report.

The urinalysis report dated 9/8/16 indicated the culture grew "mixed bacterial flora, probable contamination."

Interview on 10/6/15 at 1:00 PM with the nurse practitioner revealed she could not be sure if the lab results were reported to her. She explained her usual process was to sign the lab result report and make a note about the results. She confirmed there were no results in the chart and a progress note had not been written regarding the culture report. In reviewing the lab report she noted the organism that grew and the drug sensitive and circled Gentamycin.

Interview on 10/8/15 at 1:15 PM with the nurse practitioner revealed Resident #7 (required another PICC line placement and treatment with Gentamycin (antibiotic) that was sensitive to the organisms in the wound culture report. She would have expected the nurse to report the lab results to her.

Interview on 10/8/15 with Nurse #1 at 9:15 AM revealed the lab results are faxed to the facility from the lab. The fax machine would be checked by the floor nurse on each shift for possible lab results. The nurse receiving the lab results would notify the physician. There was also a physician...
F 157  Continued From page 4

A notebook lab results were filed for physician/nurse practitioner review.

Interview with the interim DON on 10/6/15 at 1:44 PM revealed the process for obtaining lab work included putting lab orders into the computer and the lab book with the date the order was done. The night nurse checks for routine labs in the lab book. That nurse would get those labs (i.e., urine) or have the lab service get them. The facility had a lab service that came to the building on a scheduled basis for blood draws. Lab slips would be put back in the lab book and flagged for the pending results. The nurses would be alerted to the lab slip being pulled up that a lab had been obtained and results were pending. The nurse manager, unit coordinator or nurse on the unit was supposed to look at the book for labs/exams to be done on that day. When a lab was done, the nurse would report to next shift. Each shift received report and would expect the results. The lab results were sent to the facility via a fax. There were certain times the faxes come thru for the lab results. Each shift would be expected to check the fax machine for lab results. No explanation was provided as to what happened to the lab results for Resident #1’s wound culture.

Interview with the interim DON on 10/6/15 at 1:48 PM revealed she would expect the nurse to report results of lab work to the physician or nurse practitioner. Lab results are reported in the following manner: 1. If abnormal labs return, the physicians have given parameters for notification, i.e., if way high/low call the physician the results. 2. If the nurse practitioner was coming into the facility, the lab results were put in physician’s book for review. And 3. If after hours, and abnormal the nurse would call the physician. The interim DON was not aware the results had not been reported to the nurse practitioner or
F 157  Continued From page 5

Interview with the wound physician on 10/8/15 at 2:05 PM revealed she would expect the nursing staff to implement the recommendations on her note. If there were any problems with the wound orders, she would expect the nursing staff to communicate that as well. She was not aware if the nurses had to have the primary physician review orders and agree with the orders. She had not been informed the x-ray had not been obtained.

F 314  483.25(c) TREATMENTS/IVCS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:

Based on record review, staff and physician interviews the facility failed to provide wound treatment, obtain x-ray and report lab results to the physician as ordered for one of three sampled residents with pressure ulcers. Resident #7.

The findings included:

Residents #7 was admitted to facility on 6/12/14 with diagnosis of dysphagia, demente,
Continued From page 6

subarachnoid hemorrhage and diabetes type 2.

The Minimum Data Set (MDS) a quarterly dated 7/11/15 assessed the pressure wound as necrotic with no wound infection. The MDS indicated Resident #7 required extensive assistance with bed mobility, transfers, eating and personal hygiene. Resident #7 had short and long term memory impairment.

The care plan dated 8/7/15 indicated a problem for potential for an infection related to coccyx pressure ulcer. The stated goal included the resident would not develop infection secondary to sacral wound. The goal was updated 9/8/15 for the infection to resolve by completion of the antibiotic therapy, and she would experience decreased symptoms of infection. Approaches included treatment as ordered.

Review of the wound physician progress note dated 9/9/15 revealed Resident #7 had a worsening of a chronic pressure wound on the coccyx. The wound measured 5 centimeters (cm) length (L) by 5 cm width (W) by 2.8 cm depth (D). There was undermining at 9 o'clock of 1.5 cm. The wound was assessed as 80% necrosis. Treatment included use surgical debridement, Dakins solution, and PICC (cannula intravenous line) for antibiotic administration for 6 weeks. "Wound has accumulated a large amount of necrotic tissue over the past week, high suspicion for osteomyelitis. Will start vancomycin (antibiotic) and order blood work and XRay. Recommendation: CBC (complete blood count) place PICC line, Vancomycin 1 gram IV every 12 hours for 6 weeks for osteomyelitis XRay of the sacrum." After surgical debridement the wound was assessed as a stage 4 pressure
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ulcer.

Record review revealed the recommendations were written as physician orders and followed except for the XRay of the sacrum. The medical record did not have the XRay results and the nurse's notes did not address if the XRay was obtained.

Review of a subsequent wound physician progress note dated 9/20/15 indicated there was "No Change" in the wound progress. Surgical debridement had been provided with removal of "muscle along with necrotic tissue."

The telephone order dated 9/9/15 indicated "picc please send coccyx wound for C&S when change wound VAC." Review of the wound physician progress note dated 9/30/15 indicated the wound size was 6.0 cm L by 6.8 cm W by 3.0 CM D. There was undermining of 2.5 cm at 12 o'clock. Drainage was moderate with 40% necrotic tissue. Wound progress was assessed as "no change." The "Assessment & Plan " included "continue: Dakins Solution - once daily, Sanyyl - once daily, Dry Protective Dressing - once daily. Add: Calcium Alginate - once daily. Recommendation: Cleanse with Dakins." The

Review of the medical record revealed no orders had been transcribed to include the use of the Calcium Alginate. Review of the Treatment Administration Record revealed the Calcium Alginate was not being used in the treatment of the wound. Record review revealed no culture results and no physician documentation regarding the culture results.

Interview with Nurse #1 on 10/6/15 at 9:30 AM

F 314 weeks, then 2 times per week for 4 weeks, and then 1 time per month for 2 months, using a sample size of 5 residents. The monitoring will be documented on a Quality Assurance and Performance Improvement Monitor Form.

The Director of Clinical Services/Nurse Manager will report the results of the monitors to the Quality Assurance and Improvement Committee monthly or until the committee determines the facility has reached substantial compliance,
F 314  Continued From page 8

revealed he had already completed the dressing change for Resident #7. He had provided the treatment as written on the Treatment Administration Record.

Interview with Nurse #2 on 10/6/15 at 9:42 AM revealed the progress note by the wound physician would be considered an order for treatment of the wound. Continued interview with Nurse #2 revealed the culture report was not located and she would request the lab results for the wound culture.

Interview with Nurse #3 on 10/6/15 at 10:46 AM revealed the unit manager or treatment nurse made rounds with the wound physician. Nurse #3 explained she made rounds with the physician on 9/30/15. In reviewing the progress note by the wound physician on 9/30/15 nurse #3 explained she would add the calcium alginate to the new treatment. Further interview revealed the process included to discontinue the old order and write the new order and update the TAR. Nurse #3 explained she was on a medication cart on a hall and made rounds with the wound physician for the building on 9/30/16. After making wound rounds she went back to the cart to pass medications. The supervisors would have reviewed the progress notes for the orders and written the orders and updated the treatment record. Nurse #3 explained the supervisors had access to the computer to print the MD's notes and would have written the orders.

Interview with the interim DON on 10/6/15 at 1:20 PM revealed her expectations for follow up after the wound physician made rounds included review by the primary physician of the orders the wound physician ordered. The physician of
F 314 Continued From page 9

record (primary physician) for that resident had
the final say. During the interview the Interim
DON explained she would ask the unit manager
who was doing the orders.

Interview with the unit manager (Nurse #2) and
the Interim DON on 10/6/15 at 1:44 PM revealed
she had not made rounds with the wound
physician on 9/30/15. Nurse #2 explained her
process included writing telephone orders as the
wound physician made rounds. The wound
physician would sign the orders at that time.
Further explanation indicated the primary
physician would sign any orders not signed by the
wound physician. Nurse #2 indicated she was
not aware she was supposed to print off of wound
notes and review them. She did not have access
to the computer and had not reviewed the 9/30/15
notes for orders.

Interview with the Interim DON on 10/6/15 at 1:46
PM revealed the treatment nurse or unit
managers were to make rounds with the wound
physician. It would be the next day before the
wound physician’s note were in the computer.
The unit manager would print the notes and
review them the day after the visit. The Interim
DON explained she was not aware the unit
manager did not have access to the computer to
review the notes. The Interim DON explained the
XRay was not obtained due to it was not
considered an order, but a recommendation.
Further interview revealed she did not know if the
primary had been contacted regarding the
recommendation.

Interview with the wound physician on 10/6/15 at
2:05 PM revealed she would expect the nursing
staff to implement the recommendations on her
Continued From page 10

Note. If there were any problems with the wound orders, she would expect the nursing staff to communicate that as well. She was not aware if the nurses had to have the primary physician review orders and agree with the orders. She further explained she was not aware the Calcium Alginate had not been used since her visit on 9/30/15. That had not been communicated to her. The purpose of the Calcium Alginate was to absorb the drainage from the wound to prevent maceration of the wound.

F 314: F 314

483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on observations, record review, staff and nurse practitioner interview the facility failed to obtain a repeat urine analysis to rule out a possible urinary tract infection for one of three residents with an indwelling catheter. Resident #7.

The findings included:

Resident #7 was admitted to facility on 6/13/14 with diagnosis of dysphagia, and Dementia.

1. Resident #7 had repeat Urinalysis and culture completed on 10/6/15 by the licensed Nurse. The results were reviewed by the nurse practitioner on 10/6/15 and no new orders were given, at that time, as the resident was asymptomatic.

2. Residents residing at the facility with catheters have the potential to be affected. The Director of Clinical Services and Unit Managers reviewed the records of current residents with catheters to assure orders for care and services were implemented as prescribed on 10/27/15 and any corrections implemented.

3. The Director of Clinical Services re-educated licensed nurses currently employed by 10/30/15 concerning the need to review all lab results and to notify the physician if any specimen is contaminated to repeat the test or if there were abnormal results. The Director of
Continued From page 11

The Minimum Data Set (MDS) a quarterly dated 7/1/15 indicated Resident #7 required extensive assistance with bed mobility, transfers, eating and personal hygiene. Resident #7 had short and long term memory impairment. Resident #7 was incontinent of bowel and bladder.

A telephone order dated 8/2/15 for an indwelling catheter due to a coccyx pressure wound.

The care plan dated 8/7/15 indicated a problem of an indwelling catheter due to an unstageable pressure ulcer on the coccyx. The approaches included lab work as ordered and report to physician.

Review of a nurse’s note dated 9/6/15 the urine in the catheter drainage tubing was "cloudy."

A telephone order dated 9/9/15 for UA (urinalysis) with C&S (culture and sensitivity) to /o UTI (rule out urinary tract infection).

Telephone order dated 9/9/15 for Claro (antibiotic) 400 mg (milligram) Intravenous every 12 hours for 7 days for UTI.

Observations on 10/5/15 at 7:00 AM revealed Resident #7 had an indwelling catheter to straight drainage with the bag on the bedframe. The urine was yellow in color.

Lab results were not present in the medical record for review. Upon request, the lab results for the urinalysis were obtained from the facility’s lab.

The urinalysis report dated 9/8/15 indicated the
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES 
(X) PROVIDER/SUPPLIER/CLE IDENTIFICATION NUMBER:

(X) MULTIPLE CONSTRUCTION
A. BUILDING
B. VIMO

(X) DATE SURVEY COMPLETED
C
10/06/2015

NAME OF PROVIDER OR SUPPLIER

TRANITIONAL HEALTH SERVICES OF KANAPOLIS

STREET ADDRESS, CITY, STATE, ZIP CODE
1810 CONCORD LAKE ROAD
KANAPOLIS, NC 28083

1441 ID PREFIX
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TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX
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TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

2315 COMPLETION DATE

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culture grew "mixed bacterial flora, probable contamination."

Interview on 10/9/15 at 1:15 PM with the nurse practitioner revealed she had not been informed the urinalysis report indicated it was contaminated. She would expect the nurse to report the results to her. She would expect the nurse to have obtained another specimen for testing.

Review of the medical record revealed an order dated 10/9/15 for a UA with C&S to r/r UTI. Interview with the interim DON on 10/6/15 at 1:44 PM revealed she would expect the nurse to report a contaminated urinalysis to the physician/nurse practitioner and obtained another specimen.

F 505 483.75ji(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS

The facility must promptly notify the attending physician of the findings.

This REQUIREMENT is not met as evidenced by:

Based on record review, staff interview, physician and nurse practitioner interview the facility failed to notify the physician/nurse practitioner of the lab results for a wound culture requiring medication changes for treatment of a wound infection for one of one sampled residents (Resident #7)

The findings included;

Resident #7 was admitted to facility on 6/13/14 with diagnosis of dysphagia, dementia.

1. The Director of Clinical Services notified the Nurse Practitioner on 10/7/15 of the missed lab results for Resident #7. The resident received an appropriate course of antibiotic for the wound infection which was completed on 10/23/15.

2. The Director of Clinical Services/Nurse Manager completed a review of current resident records by 10-30-15, to assure that the physician was notified of abnormal/missed lab or diagnostic test results. The Director of Clinical Services/Nurse Manager notified the physician of missed/abnormal labs and/or diagnostic tests by 10/30/15.

3. The Director of Clinical Services or Nurse Managers will bring abnormal
F 505 Continued from page 13

subarachnoid hemorrhage and diabetes type 2.

The Minimum Data Set (MDS) a quarterly dated 7/31/15 assessed the pressure wound as necrotic with no wound infection. The MDS indicated Resident #7 required extensive assistance with bed mobility, transfers, eating and personal hygiene. Resident #7 had short and long term memory impairment.

The care plan dated 8/7/15 indicated a problem for potential for an infection related to coccyx pressure ulcer. The stated goal included the resident would not develop infection secondary to sacral wound. The goal was updated 9/9/15 for the infection to resolve by completion of the antibiotic therapy, and she would experience decreased symptoms of infection. Approaches included treatment as ordered, labwork as ordered and report to physician.

Review of the wound physician progress note dated 9/9/15 revealed Resident #7 had a worsening of a chronic pressure wound on the coccyx. The wound measured 5 centimeters (cm) length (L) by 5 cm width (W) by 2.8 cm depth (D). There was undermining at 9 o'clock of 1.5 cm. The wound was assessed as 80% necrosis. Treatment included use surgical debridement, Dakins solution, and PICC (central intravenous line) for antibiotic administration for 6 weeks. "Wound has accumulated a large amount of necrotic tissue over the past week, high suspicion for osteomyelitis. Will start vancomycin (antibiotic) and order blood work and XRay. Recommendation: CBC, complete blood count, platelet PICC line, Vancomycin 1 gram IV every 12 hours for 6 weeks for osteomyelitis XRay of the sacrum." After surgical debridement lab and diagnostic test reports to the morning meeting for review to assure the physician is notified, and it is documented in the medical record. Nurse Managers Licensed Nurses will review consult reports and will notify the primary physician to obtain orders for any recommended testing. Nurse Managers Licensed Nurses were re-educated to report abnormal lab and/or diagnostic results to the primary physician for further orders/interventions. Licensed Nurses not receiving this training be trained prior to working their next scheduled shift.

4. The Director of Clinical Services/Nurse Manager will complete Quality Improvement monitoring to assure that all abnormal lab results are called to the resident's physician. Quality Improvement monitoring will be conducted 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then 1 time per week for 4 weeks, and then 1 time monthly for 2 months, using a sample size of 5 residents. The monitoring will be documented on a Quality Assurance and Performance Improvement Monitor Form.

The Director of Clinical Services/Nurse Manager will report the results of the monitors to the Quality Assurance and Improvement Committee monthly or until the committee determines the facility has reached substantial compliance.
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the wound was assessed as a stage 4 pressure ulcer.

Review of the telephone order dated 9/9/15 the nurse practitioner had ordered a wound culture to be obtained when the wound vac was changed. Review of the medical record revealed no information that indicated the lab work was obtained, received or reported to the nurse practitioner.

Upon request, a copy of the lab results for the wound culture was obtained by the unit manager from the lab. The results indicated 3+ Gram Positive Cocci pairs, 3+ Gram positive rods and 3+ Gram negative rods. The sensitivity report (details what antibiotics would be effective against the organism) indicated the following antibiotics could be used to treat the infection: Gentamycin, Trimeth-Sulf, Piperacillin/Tazobactam and Tetracycline. The antibiotic used to treat Resident #7, Clindamycin, was not listed on the culture sensitivity report.

Interview on 10/5/15 at 1:00 PM with the nurse practitioner revealed she could not be sure if the lab results were reported to her. She explained her usual process was to sign the lab result report and make a note about the results. She confirmed there were no results in the chart and a progress note had not been written regarding the culture report. In reviewing the lab report she noted the organism that grew and the drug sensitive and circled Gentamycin.

Interview on 10/5/15 at 1:15 PM with the nurse practitioner revealed Resident #7 required another PICC line placement and treatment with Gentamycin (antibiotic) that was sensitive to the organisms in the wound culture report. She would have expected the nurse to report the lab results to her.
F 605  Continued From page 15
Interview on 10/6/15 with Nurse #1 at 9:15 AM revealed the lab results are faxed to the facility from the lab. The fax machine would be checked by the floor nurse on each shift for possible lab results. The nurse receiving the lab results would notify the physician. There was also a physician/nurse practitioner review interview with the interim DON on 10/6/15 at 1:44 PM revealed the process for obtaining lab work included putting lab orders into the computer and the lab book with the date the order was done. The right nurse checks for routine labs in the lab book. That nurse would get those labs (e.g., urine) or have the lab service get them. The facility had a lab service that came to the building on a scheduled basis for blood draws. Lab slips would be put back in the lab book and flagged for the pending results. The nurses would be alerted to the lab slip being pulled up that a lab had been obtained and results were pending. The nurse manager, unit coordinator or nurse on the unit was supposed to look at the book for labs/exams to be done on that day. When a lab was done, the nurse would report to next shift. Each shift received report and would expect the results. The lab results were sent to the facility via a fax. There were certain times the faxes come thru for the lab results. Each shift would be expected to check the fax machine for lab results. No explanation was provided as to what happened to the lab results for Resident #7's wound culture. Interview with the interim DON on 10/6/15 at 1:46 PM revealed she would expect the nurse to report results of lab work to the physician or nurse practitioner. Lab results are reported in the following manner: 1. If abnormal labs return, the physicians have given parameters for notification, i.e. if way high/flow call the physician the results.
2. If the nurse practitioner was coming into the facility, the lab results were put in physician’s book for review. And 3. If after hours, and abnormal the nurse would call the physician. The interim DON was not aware the results had not been reported to the nurse practitioner or physician.