

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>345215</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>12/09/2015</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>RIVER TRACE NURSING AND REHABILITATION CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>250 LOVERS LANE</b><br><b>WASHINGTON, NC 27889</b>                  |   |
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| F 000  | INITIAL COMMENTS<br><br>Pertinent staff interviews were conducted on 12/9/15. Therefore, the exit date was changed to 12/9/15.   | F 000   |   |   |
| F 333<br>SS=G  | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on facility record review, hospital record review and staff interview, the facility failed to administer an antibiotic as ordered resulting in a worsening of a urinary tract infection and hospitalization for 1 of 3 residents (Resident #1) reviewed for medication errors.<br>The findings included:<br>Resident #1 was readmitted to the facility on 10/30/14. Diagnoses included bipolar disorder, thyroid disorder, heart failure and chronic obstructive pulmonary disease (COPD). The annual Minimum Data Set dated 9/4/15 revealed the resident was moderately cognitively impaired, rejected care 1-3 days, had verbal behavioral symptoms directed towards others 1-3 days, required extensive assistance of 2 with toileting and was always incontinent of bowel and bladder. Physician orders dated 10/26/15 included an order for a catheterized urine specimen for urinalysis and culture and sensitivity (C&S). On 10/29/15 a final report of the urine culture revealed greater than 100,000 colony forming units (CFU) of Escherichia coli, indicating a urinary tract infection (UTI). A nurse's note written by Nurse #1 dated 10/29/15 at 6:29 PM included, | F 333   | Past noncompliance: no plan of correction required.   | 12/10/15  |

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

TITLE

(X6) DATE

Electronically Signed

12/10/2015

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 333  | <p>Continued From page 1</p> <p>"Notified (name of nurse practitioner) of urine C&amp;S results. New order for Doxycycline (an antibiotic) 100 mg (milligrams) BID (twice a day) X (for) 7 days for UTI. RP (Responsible Party) aware." Review of physician orders revealed no order was written for the Doxycycline. Review of the October and November Medication Administration Record (MAR) revealed no entry for Doxycycline.</p> <p>Laboratory results dated 10/30/15 included a white blood cell (WBC) count of 10.8 k/uL (thousands per cubic milliliter) (reference range was 4.5 - 11.1 k/uL), serum creatinine 1.02 mg/dL (milligram per deciliter) (reference range (0.57 - 1.00) and blood urea nitrogen (BUN) 20 mg/dL (reference range 8 - 27).</p> <p>A nurse's note dated 11/3/15 at 11:06 AM read, "Resident lying in bed with HOB (head of bed) elevated. Alert and verbal. Unable to communicate thoughts clearly. Poor intake thus far. VS (vital signs) (temperature) 97.5 (degrees Fahrenheit), (pulse) 60, (respirations) 18, (blood pressure) 125/83, O2 (oxygen) sats (saturation) 94% on 2LPM (2 liters per minute of oxygen). Fluids encouraged. Will continue to monitor." A note at 5:15 PM read, "Resident lying in bed with flushed skin. Hard to arouse, resident not alert enough to take meds by mouth. Vitals (temperature) 101.2 (degrees F), (pulse) 68, (respirations) 25, (blood pressure) 119/66. Resident respirations labored, sats 89% on 2 LPM. Med provided for fever via suppository. Call bell in reach, will continue to monitor."</p> <p>A physician order dated 11/3/15 read, "Permission to transport to (initials of hospital) - 911."</p> <p>A nurse's note on 11/3/15 indicated the resident was sent to the hospital via EMS (emergency medical services) at 7:45 PM. Her temperature</p> | F 333   |   |                      |   |

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| F 333  | <p>Continued From page 2</p> <p>was 97.9 degrees F, pulse 70, respirations 20, blood pressure 125/64 and O2 sat 88% on 4 LPM.</p> <p>A hospital laboratory report dated 11/3/15 for blood drawn at 8:10 PM revealed a WBC of 15.02 k/uL, serum creatinine of 1.54 mg/dL, BUN of 29 mg/dL and serum sodium of 154 mEq/L (milliequivalents per liter) (reference 136 - 145). A chest x-ray was done in the Emergency Room (ER) at 8:35 PM and was clear. A clean catch urinalysis and culture of 11/3/15 revealed the following indicators of a urinary tract infection: positive for nitrites (normal is negative), large value for leukocyte esterase (normal is negative) and 11-20 white blood cells per high power field (normal range is 0-5). The culture was contaminated.</p> <p>The hospital History and Physical (H&amp;P) dated 11/3/15 at 11:32 PM noted that Resident #1's urine showed findings compatible with a UTI, had an elevated white (blood cell) count and an elevated temperature. She has been somnolent and difficult to arouse and has had a slight worsening of her kidney function. The plan was to admit to the hospital with systemic inflammatory response syndrome probably related to urinary tract infection, further complicated by dehydration. The Discharge Summary dated 11/13/15 included a primary diagnosis of UTI treated and resolved and sepsis secondary to UTI, resolved. The Discharge Summary indicated the resident was discharged to another skilled nursing facility.</p> <p>During an interview on 11/23/15 at 1:05 PM, Nurse #1 stated she called the results of Resident #1's urine culture to the nurse practitioner and received an order for an antibiotic for Resident #1. The nurse said she had written the order in the nurse's notes and called the responsible party</p> | F 333   |   |                      |   |

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| F 333  | <p>Continued From page 3</p> <p>but should have also written the order on the physician order sheet, sent the order to the pharmacy and entered the order on the MAR. Nurse #1 indicated that it had been extremely busy that day and she overlooked writing the order. She added that she normally did not have to call lab results because the physician or nurse practitioner was in the facility 4 days a week. Nurse #1 explained the facility had since implemented a new process that included when lab results had to be called and an order was given, the order was to be written on the lab report.</p> <p>On 11/23/15 at 3:18 PM the Director of Nursing (DON) was interviewed. She stated she was present when Resident #1 was sent to the hospital on 11/3/15. The DON stated the hall nurse reviewed the record when the resident's condition had changed and discovered that an antibiotic had been ordered on 10/29/15 but never given. The DON indicated the hall nurse informed the Emergency Room triage nurse of this oversight when she called the report to the Emergency Room at the time of transfer. (The hall nurse was unavailable for interview during the survey.) The DON stated she immediately began a corrective plan. She explained her expectation of nurses when they receive a telephone order was to write the order, enter it on the MAR and make sure the resident gets the first dose.</p> <p>On 11/23/15, the facility provided the following plan of correction that was begun on 11/3/15 and included worksheets and monitoring/auditing tools:</p> <p>Nurse #1 was suspended pending investigation. A 24 hour report was completed and faxed to the HCPR (Health Care Personnel Registry) on 11/4/15 for the allegation of neglect by the DON. The 5 day report was completed and faxed on</p> | F 333   |   |                      |   |

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| F 333  | Continued From page 4<br>11/6/15.<br>All residents were assessed for change in condition with no acute changes found. Laboratory results including urinalysis, culture and sensitivity and consults in the past 30 days was completed on 11/4/15 to ensure all have been addressed and physician's orders received, transcribed correctly and carried out. A 30-day review of all nurse progress notes was completed on 11/5/15 by the DON, ADON (Assistant Director of Nursing) and Nurse Consultant to ensure any acute episodes have been addressed with an assessment, intervention, MD/RP notification and any new orders were carried out. A 100% audit of physician orders for the past 30 days was completed on 11/6/15 by the DON and ADON to ensure orders given have been transcribed correctly to the MARs/TARs (Treatment Administration Records) and carried out. All areas of concern were addressed by the DON on 11/6/15. Multiple audit sheets were provided revealing audits for laboratory monitoring from October through present for orders received, written and carried out; audit for 30 days of physician orders, 30 days of consults (10/3/15 - 11/4/15) and review for acute changes (10/4 - 11/4/15).<br>An in-service to all licensed nurses was initiated by the DON and Staff Facilitator on 11/4/15 to include: when receiving verbal orders from any MD's: writing the order, taking off the order, putting the order on the MAR and calling the Responsible Party (RP) for notification; and all abnormal labs will be addressed immediately upon receipt. The In-Service Training Report with sign in sheet revealed 22 licensed nurses from all shifts attended the training for "when receiving a verbal order from a physician, #1 write the order, #2 take the order off, #3 put the order on the | F 333   |   |                      |   |

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| F 333  | <p>Continued From page 5</p> <p>MAR and #4 call the RP and inform them of all orders. All abnormal labs will be addressed immediately on receipt."</p> <p>Using an "Acute Change in Condition" audit tool, the DON, ADON, Staff Facilitator and weekend Supervisor will audit the Nursing Progress Notes and 24 hour summary daily for four weeks, then Monday through Friday for 4 weeks, then weekly for 8 weeks to ensure any resident change in condition has been addressed with an assessment, intervention, MD/RP notification, and all new orders carried out. Using the QI (Quality Improvement) Tool for physician order pink copies, the QI Nurse will audit the physician order pink slip copies Monday through Friday to ensure all new orders are transcribed to MAR/TAR correctly and carried out, and RP notification correctly for 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks. The ADON/Weekend Supervisor will complete the Laboratory Monitoring Log daily for 4 weeks, the weekly for 8 weeks to assure labs have been collected, results received, physician was notified, orders written, and transcribed correctly and carried out. The DON will review and sign the audit tools weekly for 12 weeks for completion and to ensure all areas of concern have been addressed. The DON will present the results of the Acute Change in Condition audit tool, QI Tool for physician order pink copies and the Laboratory Monitoring Log to the Executive Quality Assurance Committee Meeting monthly for 3 months for trends and the need for continued monitoring.</p> <p>The corrective action plan was validated. On 11/23/15 at 2:51 PM, Nurse #2 indicated during an interview that all new orders must be written on the physician order sheet as a telephone</p> | F 333   |   |                      |   |

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| F 333  | Continued From page 6<br>order, faxed to the pharmacy, documented in the progress notes and put on the MAR. On 11/23/15 at 3:03 PM, Nurse #3 indicated during an interview that telephone orders must be written on the order sheet, read back, written on the chart, faxed to the pharmacy, called to RP and written on the MAR. The nurse indicated the 11-7 shift nurse gathered the pink slips for the QA nurse. Laboratory monitoring logs were reviewed from 11/8/15 - 11/20/15 which included physician notification, order received, order written and carried out.<br>A telephone interview was conducted with the Administrator on 12/9/15. The Administrator indicated the facility made the decision to incorporate the corrective action measures into the QA system on 11/3/15 when the plan was developed. The Administrator also indicated the decision to monitor/audit acute conditions, lab and pink slips was made on 11/3/15 and implemented on 11/4/15, and nurse training was begun on 11/3/15 and 100% completed on 11/6/15. | F 333   |   |                      |   |