STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. BUILDING ______ B. WING ______	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	**106 CAMERON STREET** **LAKE WACCAMAW, NC 28450**

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to develop a care plan to maintain fluid restrictions for one of two residents reviewed for fluid restriction (Res. #79). Findings included: Resident #79 was admitted to the facility on 6/17/2010 and readmitted on 8/24/2015 with diagnoses which included congestive heart failure and pulmonary hypertension. A review of the most recent Minimum Data Set (MDS) dated 11/15/2015, indicated the resident	F 279	This plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that changes to the areas cited have been made and that the facility is in compliance with participation requirements established by stated and federal law. The care plan and kardex for resident #79 were reviewed and revised immediately to	3/4/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/03/2016

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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was moderately impaired for cognition and independent with most Activities of Daily Living (ADLs). Resident # 79 needed set up help for eating.

A review of a nursing note dated 10/17/2015 indicated resident #79 was seen by a Pulmonologist (breathing specialist) who recommended a cardiac, 2400 milligram (mg) low sodium, 2000 milliliter (ml) fluid restriction meal plan.

The care plan dated 9/10/2015 indicated " Keep water pitcher at bedside " and " Offer extra liquids during each shift. "

An observation on 2/9/2016 at 12:36 PM noted one water pitcher and one ice pitcher in Resident #79 ' s room, with ice and water in them.

An observation on 2/10/2016 at 4:46 PM noted one water pitcher and one ice pitcher in Resident #79 ' s room, with ice and water in them.

An observation on 2/11/2016 at 12:04 PM noted one water pitcher and one ice pitcher in Resident #79 ' s room, with ice and water in them.

An interview with Resident #79 on 2/11/2016 at 12:04 PM was conducted, and the Resident stated the staff was filling up ice and water in her pitchers every day and as needed.

In an interview with a Nursing Assistant (NA) #1, on 2/11/2016 at 12:06 PM, NA#1 reported water pitchers were filled up for each resident at least once per shift. NA #1 further stated according to Resident # 79 ' s care plan, fluid intake was encouraged with meals and between meals.

F 279

include appropriate interventions regarding fluid restrictions. After resident education was provided regarding her disease process and physician orders for fluid restriction, permission was obtained from resident and the water pitchers were removed from the resident's room. Amount of Intake consumed daily was added to the MAR to accurately track resident□s fluid intake. (2/11/2016)

Because all residents with physician orders for fluid restrictions are potentially affected by the cited deficiency, on 2/11/16, the director of nursing and QA Nurse conducted an audit on 100% of residents□ current orders to ensure that there were no fluid restriction orders that were not care planned. Care plans and kardexes were reviewed by the MDS coordinator for all other residents who did have orders for fluid restrictions to ensure that the care plans accurately reflected the interventions provided regarding the fluid restriction. These same residents□ rooms were inspected to ensure that water pitchers were not at the bedside. (2/12/16)

Nursing staff meetings were held and nurses and CNAs were reminded of importance of adhering to the care plans and kardexes, specifically pertaining to fluid restrictions. Nursing staff were educated that they must record the amount of the fluid consumed by residents with restrictive orders and that continued education of the residents may be required. Nurses were also told that if

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F 279	Continued From page 2 The Director of Nursing was interviewed on 2/11/2016 at 4:47 PM, and stated the care plan should be updated when changes are made. On 2/11/2016 at 5:27 PM, in an interview, the Administrator stated the care plan should be updated according to the resident ' s physician ' s order.	F 279	a resident does not adhere to the fluid restriction as ordered by the physician, the MD must be made aware. It was explained to all nursing staff that fluids are provided by dietary and nursing per diet card and MAR and that no additional fluids are made readily available. Therefore, water pitchers have been removed from these residents□ rooms and are not to be replaced. To enhance current compliant operations, the DON or designee along with the interdisciplinary team now reviews all the previous day□s physician□s orders in the morning clinical meeting. Care plans and kardexes are updated by MDS coordinator or designee as indicated during this process. In the event that any fluid restriction orders are noted, the DON or designee also updates the MAR to reflect the specific fluid restrictions and to ensure intake is documented daily. (3/2/2016) A performance improvement program was initiated under the supervision of the director of nursing to monitor the process of care planning all applicable physician orders that pertain to the direct care of the resident, which would include fluid restrictions. The QA nurse or designee will audit 100% of resident charts each quarter to review physician orders and ensure the new process of care planning during the daily order review has been effective. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted monthly to the QAPI Committee meeting for further review or corrective	

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F 279	Continued From page 3	F 279	action. This audit will continue until a compliance level of 100% is reached for two quarters and then may be reduced per the QAPI Committee recommendations.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to identify and assess one of one hemodialysis resident ' s vital signs (Res. #20); and failed to maintain a fluid restriction for two of two residents reviewed for fluid restriction (Res. #20 and Res. #79). Findings included: 1. Resident #20 was admitted on 7/2/2014 with diagnoses of End Stage Renal Disease (ESRD) and Diabetes. The annual Minimum Data Set (MDS) dated 9/8/2015 noted Resident #20 was moderately impaired for cognition and was independent for eating. The care plan dated 11/3/2015 noted a focus of hemodialysis with ESRD and fluid restriction, and	F 309	Davita dialysis center was contacted immediately to request vital signs that had been obtained on resident #20 during dialysis treatments as requested by state surveyor. Faxed communication of vital signs for dialysis treatments from January 2016 through February 10, 2016 were received and shared with state surveyor. (2/11/2016) The care plans and kardexs for resident #79 and resident #20 were reviewed and revised to include appropriate interventions regarding fluid restrictions. After individualized resident education was provided regarding the disease process and physician orders for fluid restriction, permission was obtained from both residents to remove the water	3/4/16

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F 309	Continued From page 4 a goal that Resident #20 would have no adverse side effects. Interventions were: Communicate with dialysis via consult sheet and when necessary. Encourage Resident to be compliant with 1500 milliliters (ml) of fluid (per 24 hours) restriction. Monitor dialysis site for thrill (vibration feeling) and bruit (sound of blood flow) and bleeding. Diet and medications as ordered. Provide transport to dialysis. Remove dressing from dialysis site as ordered. A review of the physician order sheet for January and February 2016 revealed diet orders which included: Give 1000 ml on 7A - 7P shift. Give 500 ml on 7P - 7A shift. 1500 ml / 24 hour fluid restriction due to diagnosis: ESRD. The January 2016 and February 2016 Medication Administration Records (MAR) were reviewed and indicated the dialysis access site was checked for thrill and bruit every day. A review of vital signs for January 2016 and February 2016 revealed the vital signs were taken and documented weekly and after a fall. A review of the Long Term Care / Dialysis Communication Sheets from January 4, 2016 through January 29, 2016 revealed the sheets had Resident #20s name, the date and a current dry weight. A dialysis workers signature was also on the sheet. On 2/11/2016 at 10:25 AM, in an interview Nurse #2, who regularly took care of Resident #20 stated the dialysis communication sheet was only for weight. Nurse #2 stated vital signs were not done before Resident #20 left for dialysis, because he got up at 4:30 AM. Nurse #2	F 309	pitchers from the residents rooms. Director of nursing ensured each resident s MAR unmistakably incorporated accurate tracking of daily fluid intake. (2/12/16) All residents who receive hemodialysis may be affected; therefore, the existing dialysis communication sheet was updated to include pertinent vital signs before and after each dialysis treatment. This sheet will be sent with each dialysis resident as a communication tool to make our facility aware of: new orders, lab reports, current dry weight and pertinent vital signs before and after each dialysis treatment. When the residents return from dialysis, the communication sheet will be given to the primary nurse. Pertinent vital signs along with the dry weight and any other new orders will then be charted in Point Click Care under the communication with dialysis tab (3/1/16). Nurses were educated by the staff development nurse on the updated dialysis communication tool and the new documentation process/guidelines that are now required. Nursing staff were also educated regarding the fact that care plans and kardexes must be followed specifically relating to residents with fluid restrictions. This includes not placing water pitchers in these residents rooms so that we can accurately monitor their fluid intake (2/12/16). An audit tool was initiated by the QA nurse on 2/24/16 for the hall nurses to complete each shift to inspect the room of each resident with orders for fluid restriction to	

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F 309	Continued From page 5 indicated vital signs were not on the communication sheets when Resident #20 returned from dialysis. Nurse #2 stated there was no order for vital signs post dialysis. In an interview on 2/11/2016 at 10:46 AM, the charge nurse at Resident #20 ' s dialysis center stated Resident #20 had vital signs taken and documented prior to starting dialysis and every 30 minutes during dialysis, and also when dialysis was finished. The charge nurse indicated if there was any problem or change, she called the facility. An observation was made on 2/11/2016 at 11:54 AM of a pink plastic water pitcher in Resident # 20 ' s room on the bedside table. The pitcher contained ice and water. On 2/11/2016 at 11:55 AM, in an interview, Nursing Assistant (NA) #2 indicated she worked wherever she was needed. NA #2 stated she looked in the care guide in a resident ' s chart to find if a resident had a fluid restriction. On 2/11/2016 at 11:56 AM, in an interview, NA #3 stated the fluid restriction is in the care guide in the computer, or the nurses told you. NA #3 stated all residents on dialysis are on fluid restriction. On 2/11/16 at 2:40 PM, Resident #20 stated the staff sometimes put a pitcher of ice and water at his bedside. In an interview on 2/11/2016 at 2:57 PM, Nurse #2 stated the facility sent the Communication	F 309	ensure no water pitchers are at bedside and to verify the fluid intake is being documented on the resident□s MAR. Deficiencies will be corrected on the spot. This audit will be completed every shift, daily for 3 weeks or until 100% compliance is reached. It will then be reduced to each shift on 3 random days per week for an additional 3 weeks and if the compliance remains at 100%, it may then be reduced further by selecting two random residents with fluid restrictions to be audited once weekly for four weeks to ensure continued compliance. The findings of the audits will be documented and submitted to the QAPI committee for further review or corrective action. The dialysis communication tools are being audited as of 3/3/2016 by the QA nurse or designee to ensure that documentation process/guidelines are being followed by our nursing staff as directed per in-service. A report will be generated by the QA nurse or designee in Point Click Care to indicate each time a nursing note was documented under the communication with dialysis tab. The nursing notes will then be audited to validate the required information of resident blood pressure upon arrival and departure to dialysis center, resident□s dry weight & time of return to facility are all included. Audits will be completed 3 times weekly for four weeks on all dialysis residents or until found to be 100% compliant, then, the medical records of 2 random hemodialysis residents will be audited three times weekly for two weeks	

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Sheet to have Resident #20 ' s weight. Nurse #2 stated there had been a problem in the past getting Resident #20 ' s weight, therefore the Communication Sheet was created by the facility. Nurse #2 stated she had never called the dialysis center for anything except the weight. Nurse #2 stated Resident #20 never goes over his fluid limit.

An interview was conducted on 2/11/2016 at 3:25 PM, with the Registered Dietician (RD) who stated Resident #20 was on a fluid restriction and he should not have had a filled water pitcher in his room.

On 2/11/2016 at 4:48 PM in an interview, the Director of Nursing (DON) stated the water pitcher should not be in Resident #20 ' s room. The DON indicated the NAs knew by what was in the care guide. The DON stated the expectation was vital signs were taken on long term stable residents weekly, and that had been in place in the facility since 2009.

2) Record review indicated Resident #79 was admitted to the facility on 6/17/2010 and readmitted on 8/24/2015 with diagnoses which included congestive heart failure and pulmonary hypertension.

A review of the most recent Minimum Data Set (MDS) dated 11/15/2015, indicated the resident was moderately impaired and independent with most Activities of Daily Living (ADLs) except needed set up help for eating.

Review of a nursing note dated 10/17/2015 indicated a resident #79 was seen by a Pulmonologist and recommended a cardiac, 2400

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to ensure continued compliance. The findings of the audits will be documented and submitted to the QAPI committee for further review or corrective action.

A performance improvement program was initiated under the supervision of the director of nursing to monitor the process of care planning all applicable physician orders that pertain to the direct care of the resident. The QA nurse or designee will audit 100% of resident charts each quarter to review physician orders and ensure the new process of care planning during the daily order review has been effective. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted monthly to the QAPI Committee meeting for further review or corrective action. This audit will continue until a compliance level of 100% is reached for two quarters.

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F 309	Continued From page 7 mg low sodium, 2000 milliliter fluid restriction meal plan. An observation on 2/9/2016 at 12:36 PM noted one water pitcher and one ice pitcher in Resident #79 ' s room, with ice and water in them. An observation on 2/10/2016 at 4:46 PM noted one water pitcher and one ice pitcher in Resident #79 ' s room, with ice and water in them. An observation on 2/11/2016 at 12:04 PM noted one water pitcher and one ice pitcher in Resident #79 ' s room, with ice and water in them. An interview with resident #79 on 2/11/2016 at 12:04 PM was conducted, and the resident stated staff was filling up ice and water in her pitchers every day and as needed. In an interview with a Nurse Aid (NA) #1, on 2/11/2016 at 12:04 PM, the NA reported water pitchers were filled up for each residents at least once per shift. The NA #1 further stated according to Resident # 79 ' s care plan, fluid intake was encouraged with meals and between meals. On 2/11/2016 at 2: 42 PM, in an interview with a Nurse #1, Nurse #1 stated Resident #79 was put on fluid restriction after pulmonologist ' s visit on 10/17/2015, due to diagnosis of pulmonary hypertension, and fluid was being divided between dietary with meals and nursing to give between meals. On 2/11/2016 at 3:13 PM, in an interview with a Registered Dietitian (RD), who stated the Resident #79 was on 2000 milliliter (ml), should get 1380 ml water with meals, and the rest should be provided by nursing with medication and throughout the day as needed.	F 309		

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F 309	Continued From page 8 In an interview with a Director of Nursing on 2/11/2016at 4:47 PM, who stated the expectation was monitor residents ' fluid intake if they had physician ' s order for fluid restriction and water or ice pitcher should not be kept in the resident ' s room without monitoring fluid intake.	F 309		