

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

PRINTED: 02/06/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/08/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-NEUSE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1303 HEALTH DRIVE</b> <b>NEW BERN, NC 28560</b>	
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E 000	Initial Comments	E 000		
F 000	INITIAL COMMENTS	F 000		
F 580 SS=J	<p>No deficiencies were cited as a result of complaint investigations for Event ID IFMD11.</p> <p>The survey team entered the facility on 12/09/18 to conduct a recert and complaint survey, and exited on 12/14/18. The survey team returned to the facility on 01/07/19 to obtain additional information and exited on 01/08/19. Therefore, the exit date was changed to 01/08/19.</p> <p>A continuation of a recert and complaint survey was conducted from 01/07/19 through 01/08/19. Immediate Jeopardy was identified at:</p> <p>CFR 483.10 at tag F580 at a scope and severity (J) CFR 483.12 at tag F600 at a scope and severity (J)</p> <p>The tag F600 constituted Substandard Quality of Care.</p> <p>Immediate Jeopardy began on 10/25/18 and was removed on 01/08/19. An extended survey was conducted.</p> <p>Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes.</p>	F 580		1/16/19

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

TITLE

(X6) DATE

Electronically Signed

01/15/2019

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 580	<p>Continued From page 1</p> <p>(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-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(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);</p> <p>(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</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(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.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15)</p>	F 580			

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F 580	<p>Continued From page 2</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, and staff, physician, and Nurse Practitioner interviews the facility failed to notify the physician or Nurse Practitioner of a significant change in condition for 1 of 1 residents (Resident #94) when the resident was found with respiratory difficulty and hypoxia (low oxygen saturation levels). Resident #94 expired on 10/28/18.</p> <p>Immediate Jeopardy began on 10/25/18 when Nurse #1 found Resident #94 with a pulse oximetry reading of 46 percent (%), applied oxygen, suctioned the resident twice, and recorded a repeat pulse oximetry reading of 64% without notification to the physician.</p> <p>Immediate Jeopardy was removed on 1/8/19 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D (no actual harm with a potential for minimal harm which is not immediate jeopardy).</p> <p>Findings included:</p> <p>Resident #94 was admitted to the facility 2/11/2016. Admitting diagnoses included COPD, Cerebrovascular Accident (CVA), Aspiration</p>	F 580	<p>This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.</p> <p>Resident # 94 was admitted to Pruitt Health Neuse on 2/11/2016 from Crystal Coast Hospice Upon admission family revoked 3HC hospice and transferred to Pruitt-Healthcare. Resident admitting diagnosis: Sepsis, Chronic obstructive pulmonary disease, Bipolar, cerebral infarct, TIA, essential hypertension, dementia without behavioral disturbance, Diabetes type 2, dysphagia, UTI, unspecified asthma.</p>		

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F 580	<p>Continued From page 3</p> <p>pneumonia, and acute-on-chronic hypoxemic respiratory failure.</p> <p>A physician progress note dated 9/27/18 read, in part, "No current complaints or concerns." It further revealed she had unlabored respirations and clear lung sounds without wheezes or rhonchi (rattling lung sounds which could indicate obstruction or secretions), and Resident #94 was at high risk for repeat aspiration and pneumonia. The plan included, "Overall stable. Continue current treatment plan and medication regimen. Routine follow up."</p> <p>A Quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 10/2/18 revealed Resident #94 was severely cognitively impaired, had daily behavioral symptoms not directed towards others, and required extensive to total assistance for all Activities of daily Living (ADLs). Active diagnoses included diabetes mellitus (DM), non-Alzheimer's dementia, depression, manic depression, and COPD. There were no assessments related to (r/t) hospice services or oxygen therapy.</p> <p>A care plan last updated 10/2/18 read: "(Resident #94) has Dx (diagnosis) of COPD and is at risk for respiratory distress. Goals included-will maintain ventilation within resident's normal range and without s/s (signs and symptoms) of respiratory distress. Interventions included elevate HOB (head of bed) as tolerated, provide rest periods, O2 (oxygen) per order, auscultate (listen with a stethoscope) lung sounds, monitor O2 sat (saturation) PRN (as needed), monitor respiratory status, notify MD (physician) as warranted."</p>	F 580	<p>7/10/16 Carolina East Health System discharge diagnosis included: Acute and chronic respiratory failure with hypoxia, bipolar disorder, dehydration, unspecified dementia without behavioral disturbance, stupor, pneumonia due to other specified bacteria, sepsis due to anaerobes.</p> <p>2/21/2016 Physician notes indicate resident was being admitted the facility for conservative long-term care.</p> <p>On 7/20/2016 physician visit notes that indicate supportive care and comfort measures were being provided.</p> <p>On 8/13/18 physician visit notes identified that indicate supportive care and comfort measures were being provided.</p> <p>On 9/27/18 physician visit notes identified that indicate supportive care and comfort measures were being provided.</p> <p>On 10/25/18, 12:00am a resident's oxygen saturation dropped to 46%. Oxygen was started at 4 liters per minute per nasal cannula, resident was suctioned X2 with thick white mucus from throat. Resident was dry to touch. Resident was placed in high fowlers position to assist with breathing. Oxygen saturation increased to 64%.</p> <p>On 10/25/18 6:30am condition unchanged no gurgling respirations, non-responsive to tactile stimuli. No further symptoms currently. Resident took morphine sublingually, the off-going nurse did not report resident condition to Physician, Director of Nursing and on-coming nurse at shift change, nor did they document further oxygen saturations during their shift.</p> <p>10/26/18 7am: resident restless in bed</p>		

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F 580	<p>Continued From page 4</p> <p>Physician orders dated 10/1/18 through 10/31/18 read, in part, "May use standing orders: Oxygen at 2l (liters)/ (per) minute prn SOB (shortness of breath), notify MD if not relieved or if SOB is accompanied with other symptoms."</p> <p>A review of the Medication Administration record (MAR) for 10/1/18 through 10/31/18 revealed prn oxygen was administered on 10/24/18. No other entries were revealed.</p> <p>Review of a nursing note dated 10/25/18 at 12:00AM and signed by Nurse #1 read, "During routine rounds resident (JH) observed to be unresponsive to tactile stimuli. O2 sat 46% (percent) (Normal oxygen saturation levels are greater than 90%) on RA (room air). O2 started at 4L/m (liters per minute) per NC (nasal cannula). Suctioned x 2. Thick, white mucus from throat. O2 sats 64% /c (with) O2. Color pale and ashen. Resident put in H (high) fowlers to assist /c breathing." There was no notification to the medical provider.</p> <p>Review of a nursing note dated 10/25/18 at 6:30AM and signed by Nurse #1 read, in part, "Condition unchanged. Non responsive to tactile stimuli. Took Morphine as ordered." There was no notification to the medical provider.</p> <p>An interview was conducted with Nurse #1 on 12/13/18 at 1:02PM. He stated Resident #94 was frequently short of breath, but had not required oxygen in months. He stated she was a DNR (Do Not Resuscitate), but a DNR did not mean you would not treat a resident for shortness of breath or pneumonia. He also stated she received scheduled Morphine for dyspnea since she was admitted to the facility in 2016. He stated, "When</p>	F 580	<p>with signs of dyspnea. SPO2 84% on 4 L/M. Registered Nurse notified physician of condition change and titrated Oxygen to 5 L/M, administered order for DuoNeb, Ativan for restlessness, order for chest X-ray. SPO2 up to 90% on 5 L/M via nasal cannula., Licensed Nurse called family without contact. X-ray ordered and completed on 10/26/2018 with bibasilar pneumonia noted. Licensed nurse will continue to monitor.</p> <p>10/26/18 10pm: <input type="checkbox"/> neb treatment and O2 on going comfort measure in place, ate 25% T 99.2</p> <p>10/27/18 2pm <input type="checkbox"/> O2 90% with nebs. No food, mouth swabbed provided, ABT ongoing DuoNeb<input type="checkbox"/>s as ordered.</p> <p>10/28/18 12:50am: <input type="checkbox"/> Pt found by nurse without pulse or respirations. Pt is a DNR and Death verified by 2 nurses<input type="checkbox"/>.</p> <p>The Facilities Clinical Competency Coordinator began educating the Licensed Nurses on 12/14/18 utilizing the interact change in condition protocol which include clinical pathways of when to contact the physician. Education also began on 12/14/18 by the Clinical Competence Coordinator to the Licensed Nurses regarding placing residents change of conditions on the 24-hour report sheets utilized by the Licensed Nurses for reporting from shift to shift. As of 1/7/2019, 25 of 27 Licensed Nurses have been educated regarding change of condition with notification to the physician. Licensed Nurses whom have not received the education by 12/21/18 will be removed from the schedule until the education is</p>		

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F 580	<p>Continued From page 5</p> <p>I checked on her that night (10/25/18) she was not responsive. I checked her vital signs and her oxygen level was 46%. I sat her all the way up and put oxygen on her. Her oxygen level went to 64%. Usually we would call the doctor, but I didn't because I thought she was a hospice resident. I have no excuse for not calling the doctor other than I thought she was hospice. I don't know why I thought that, but I was wrong and I should've notified the doctor." He stated hospice status and other resident care needs were communicated in report, but he had no recall of hospice information being communicated to him about Resident #94. He stated the staff chart by exception so if there were no nursing notes from July through October for Resident #94 it meant there was nothing out of the ordinary for the resident during that time. He also stated he had not communicated Resident #94's hypoxia to the on-coming shift.</p> <p>Review of a nursing note dated 10/26/18 at 7:00AM read, in part, "Resident restless /c (with sign of dyspnea (respiratory difficulty). Spo2 (oxygen saturation) 84%. SN (staff nurse) received order for Ativan (an anti-anxiety medication)."</p> <p>An interview was conducted with Nurse #2 on 12/14/18 at 8:35AM. She stated, "(Nurse #1) didn't pass any concerns on to me about (Resident #94). I wasn't on the cart (medication cart), but the cart nurses sometimes asked me to assess a resident if they had concerns. A care partner (a staff member who does not provide any patient care) asked me to come have a look at (Resident #94 because she said she wasn't breathing well. I assessed her, increased her oxygen to 5L and called the doctor. He ordered a chest x-ray, steroids (Prednisone), breathing</p>	F 580	<p>completed. The Two Licensed Nurses who have not completed the education have been removed from the schedule until the education is completed.</p> <p>On 1/9/2019, 27 out of 27 Licensed Nurses have been educated regarding change of condition with notification to the physician. This education has been added to the general orientation of newly hired Registered and Licensed Practical Nurses. The Clinical Competency Coordinator began educating all staff (certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration) on the stop and watch cards identifying a resident change in condition with notification to the Licensed Nurse on 12/14/2018. Facility staff will be educated by 12/21/2018. Staff whom has not received the education by 12/21/18 will be removed from the schedule until the education is completed. . As of 1/7/2019, 115 employees out of 126 employees have been educated on stop and watch cards. As of 1/9/2019, 126 out of 126 employees have been educated on stop and watch cards. This education has been added to the general orientation for newly hired certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration. On 1/7/2019 the Clinical Competency Coordinator began educating the Licensed Nurses to contact the physician with resident change in conditions as the change in condition occurred. The Licensed Nurses are not required to contact the Director of Nurses</p>		

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F 580	<p>Continued From page 6</p> <p>treatments and antibiotics. I was not aware of her hypoxia from the night before or that would have changed everything. Her change in condition was not communicated to me in report from (Nurse #1) or the cart nurse (Nurse #5). She had been on Morphine for the almost 2 years I have worked here. We gave her Morphine for her COPD." She also stated a physician order was needed for comfort measures and described comfort measures as a way to keep symptoms at bay without looking for curative measures when a patient is at the end of life. She stated Resident #94 had a slow decline over the last several months, but was not ordered for comfort measures or hospice. She stated she was surprised when Resident #94 expired.</p> <p>On 10/26/18 MD orders included: "DuoNeb-1 vial inh (inhalation) q6hrs (every 6 hours) x (for) 7 days. D/C (discontinue) PRN (as needed) O2 (oxygen). Start oxygen via NC (nasal cannula) titrate for sats (oxygen saturation) &gt; (greater than) 88% (percent); CXR (chest x-ray) 2 views SOB (shortness of breath)/congestion; Ativan 0.25mg (milligrams) 1 tab PO/SL (by mouth or sublingual) q4hr PRN (restlessness/anxiety) x 14 days; Prednisone 20mg PO q day x 3 then Prednisone 10mg PO q day x 3; Levaquin 500mg 1 tab PO q day lower lobe PNA (pneumonia) x 7 days."</p> <p>A review of the death certificate for Resident #94 listed the cause of death as respiratory failure as a result or consequence of pneumonia as a result or consequence of COPD (Chronic Obstructive Pulmonary Disease).</p> <p>An interview was conducted with the Director of Nursing (DON) on 12/13/18 at 1:35PM. She</p>	F 580	<p>prior to physician notification. All Licenses Nurses (27 out of 27) have been in-serviced as of 1/7/2019.</p> <p>2. Monitor: Address how the facility will identify other residents having the potential to be affected by the deficient practice</p> <p>On 12/13/12/14/18 the Nurse management team including (RN Unit Managers, RN Clinical Competency Coordinator, RN Nurse Navigator, RN Case Mix Director, RN Case Mix Coordinator) reviewed all active resident charts nursing notes for the past 90 days to validate that the physician was notified of all change in conditions. 89 resident charts reviewed with 31 changes in conditions noted with 31 physician notifications identified.</p> <p>On 12/13/2018 the Director of Nursing and/or Nurse Managers began reviewing the 24-hour report sheet daily to identify change of conditions and validate that physician notification is documented in the nursing notes. The Director of Health Services, Unit Managers and Nurse Managers utilizes the Notification Review form, to review the 24-hour report sheets weekly for 4 weeks then monthly thereafter.</p> <p>The Director of Nursing and/or Nurse Managers as of 1/7/2019 are reviewing the nursing documentation for residents with change in condition until resident has 72 hours of return to baseline</p>		

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F 580	<p>Continued From page 7</p> <p>stated, "Staff call me or a unit manager for emergencies or a change in status and I contact the MD. That's the way he (the physician) wanted it set up. I was not aware of (Resident #94's) change in condition until we did an x-ray on 10/26/18. Staff didn't notify me of the change. I wasn't aware of her O2 sats being 46% until you, the surveyor, told me today (12/13/18) because nobody notified me of that either. So the MD wasn't notified. I should have been notified when her oxygen saturation was found to be 46%. And again when it went to only 64%. Actually, 911 should've been called when her saturation was 46% and then I should have been notified. I would have called 911, then notified the doctor. (Resident #94) should've been sent out to the hospital when her sats were 46%. My expectation is if there is a significant change in condition of a resident notification should be made to myself and the provider. In her (Resident #94) situation I would have expected 911 to be called, notification to myself and the provider, and then notification of the family. I don't know why I was not notified. I would have sent her to the emergency department. She should have been sent to the emergency room."</p> <p>An interview was conducted with the physician on 12/13/18 at 3:35PM. He stated if a resident had a change in condition the nurses or DON (if she was in the building) were supposed to notify him. He also stated he was not notified of the change in condition for Resident #94 and would have immediately sent the resident to the hospital had he been notified. He stated it sounded like she had an aspiration event, by the time he was notified on 10/26/18 her oxygen saturation was 90%. He stated, "I don't know why I wasn't notified when she became real hypoxic, but she</p>	F 580	<p>documentation. This review has been added to the Notification Review form on 1/8/2018 The Director of Nursing and/or Nurse managers will complete this review daily for 5 days then weekly for 4 weeks then monthly thereafter.</p> <p>On 1/7/2019 the Director of Nursing began tracking and trending the results of the 24-hour report sheet, physician notification regarding resident change in condition, documented in the nursing notes on the Notification review DHS form. The analysis of the tracking and trending will be presented at the monthly Quality Assurance meeting until 3 consecutive months of compliance is sustained then quarterly thereafter.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure the deficient practice does not recur</p> <p>Effective 1/7/2019 the Medical Doctors <input type="checkbox"/> phone number has been posted at both nurse <input type="checkbox"/>s stations to provide Nurses direct contact with the Physician for resident care needs. Prior to 1/7/2019 the nurses <input type="checkbox"/> contacted the Director of Nursing and/or Unit Managers prior to contacting the physician. The audit completed on 12/14/2018 did not reveal a systemic issue with contacting the physician.</p> <p>On 1/8/2018 the facility Nurse Managers began interviewing 3 nurses per day to audit their understanding of the training and change in condition and when to</p>		

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F 580	<p>Continued From page 8</p> <p>would have been better served if she had been immediately sent out to the hospital. By the time they called me (31 hours later) her oxygen saturation was around 90% so I ordered a chest x-ray and antibiotics. They never told me she had been so hypoxic." He also stated he was not aware she had been so hypoxic (46%) until the facility told him today (12/13/18) or he would have sent her immediately out to the emergency department.</p> <p>An additional interview was conducted with the physician on 1/8/19 at 8:35AM. He stated he had no recall of writing a comfort measures order and was not treating Resident #94 as if she was at the end of her life. He stated, "If she was comfort measures or end of life care only I would not have ordered a chest x-ray, breathing treatments, Prednisone, and antibiotics." He also stated the facility normally sent out residents with emergency conditions, but (Resident #94) was not sent out because it was his understanding the nurse mistakenly thought she was a hospice patient. If he had been informed of her severe hypoxia on 10/25/18 he would have immediately transferred her to the emergency department. He also stated the facility now has his number posted at each nursing station, but prior to yesterday the facility staff contacted the DON and she contacted him. He also stated, "We were just as puzzled as you were about why they didn't do anything for her. She had actually bounced back a bit after the orders I gave were initiated."</p> <p>An interview was conducted with the Nurse Practitioner (NP) on 12/14/18 at 9:46AM. She stated, "She (Resident #94) was definitely in bad health. Comfort measures include manage pain, anything to keep the patient comfortable. In her</p>	F 580	<p>contact the physician. This will continue weekly for 12 weeks and results will be brought to the QA Committee monthly.</p> <p>On 1/8/18 the Clinical Competency Coordinator began interviewing 5 ancillary staff members (Certified Nursing Assistants, housekeeping, maintenance, therapy, social services, activities, and administration) per day to audit their understanding of stop and watch cards and how to use them. The Clinical Competency Coordinator will be responsible for bringing the results to the QA committee monthly.</p> <p>The Clinical Competency Coordinator is responsible that all new staff (Certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration) are educated regarding stop and watch (the stop and watch cards identifying a resident change in condition with notification to the Licensed Nurse). The Clinical Competency Coordinator will report the number of staff educated to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly to ensure 100% of employees hired have completed the education.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained:</p> <p>On 12/14/2018 the Administer of the facility met with the Department Managers</p>		

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F 580	<p>Continued From page 9</p> <p>case it meant preventing ulcers, treating her pain, keeping her safe from her severe dementia, treating some of her medical conditions, like pneumonia. She was being treated for pneumonia in October of 2018. The staff should notify the provider of any change in condition for any resident. We may or may not treat, but we should be notified. I was never notified of a pulse ox reading of 46% or 64%. She was a high risk for aspiration pneumonia and already had pneumonia. I became aware of her hypoxia after she had passed away. The provider should have been notified of her hypoxia (46% and 64%) because it's likely her pneumonia was the cause of her hypoxia."</p> <p>On 1/7/19 at 4:30PM, the Administrator and DON were notified of the Immediate Jeopardy.</p> <p>On 1/8/19 the facility provided an acceptable credible allegation of Immediate Jeopardy removal which included:</p> <p>"This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.</p> <p>Resident # 94 was admitted to Pruitt Health Neuse on 2/11/2016 from Crystal Coast Hospice</p>	F 580	<p>regarding pending survey results and began to develop an on-going plan of correction.</p> <p>The Medical Director was notified regarding the survey and facility plan on 12/14/2018 and was updated on 1/7/2019 regarding the plan changes.</p> <p>On 12/13/2018 the Director of Nursing and/or Nurse Managers began reviewing the 24-hour report sheet daily to identify change of conditions and validate that physician notification is documented in the nursing notes. The Director of Health Services, Unit Managers and Nurse Managers utilizes the Notification Review form, to review the 24-hour report sheets weekly for 4 weeks then monthly thereafter. The Director of Nursing will report the analysis of the track and trending of the Notification Review to the Quality Assurance / Performance Improvement Committee monthly until 3 months of sustained compliance is maintained then quarterly thereafter.</p> <p>The Director of Nursing and/or Nurse Managers as of 1/7/2019 are reviewing the nursing documentation for residents with change in condition until resident has 72 hours of return to baseline documentation. This review has been added to the Notification Review form on 1/8/2018 The Director of Nursing and/or Nurse managers will complete this review daily for 5 days then weekly for 4 weeks then monthly thereafter. The Director of Nursing will report the analysis of the track and trending of the Notification Review to the Quality Assurance / Performance</p>		

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F 580	<p>Continued From page 10</p> <p>Upon admission family revoked 3HC hospice and transferred to Pruitt-Healthcare.</p> <p>Resident admitting diagnosis: Sepsis, Chronic obstructive pulmonary disease, Bipolar, cerebral infarct, TIA, essential hypertension, dementia without behavioral disturbance, Diabetes type 2, dysphagia, UTI, unspecified asthma.</p> <p>7/10/16 Carolina East Health System discharge diagnosis included: Acute and chronic respiratory failure with hypoxia, bipolar disorder, dehydration, unspecified dementia without behavioral disturbance, stupor, pneumonia due to other specified bacteria, and sepsis due to anaerobes.</p> <p>2/21/2016 Physician notes indicate resident was being admitted the facility for "conservative long-term care."</p> <p>On 7/20/2016 physician visit notes that indicate supportive care and comfort measures were being provided.</p> <p>On 8/13/18 physician visit notes identified that indicate supportive care and comfort measures were being provided.</p> <p>On 9/27/18 physician visit notes identified that indicate supportive care and comfort measures were being provided.</p> <p>On 10/25/18, 12:00am a resident's oxygen saturation dropped to 46%. Oxygen was started at 4 liters per minute per nasal cannula, resident was suctioned X 2 with thick white mucus from throat. Resident was dry to touch. Resident was placed in high fowler's position to assist with breathing. Oxygen saturation increased to 64%.</p>	F 580	<p>Improvement Committee monthly until 3 months of sustained compliance is maintained then quarterly thereafter.</p> <p>The Clinical Competency Coordinators/Director of Nursing will ensure all staff is educated related to utilization of the interact change in condition (stop and watch, SBAR communication form, MD communication form for non-emergent) will be taken to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly to ensure all employees who have worked have completed and understand the education.</p> <p>The Clinical Competency Coordinator/ Director of Nursing will present the number of new staff educated related to Stop and Watch will be taken to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly until three months of continues compliance is sustained then quarterly thereafter, to ensure all newly hired of employees have completed and understand the education. The Administrator is responsible to ensure the plan of correction is completed.</p> <p>The completion date for this corrective action is 1/16/19.</p>		

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F 580	<p>Continued From page 11</p> <p>On 10/25/18 6:30am condition unchanged no gurgling respirations, non-responsive to tactile stimuli. No further symptoms currently.</p> <p>Resident took morphine sublingually, the off-going nurse did not report resident condition to Physician, Director of Nursing and on-coming nurse at shift change, nor did they document further oxygen saturations during their shift.</p> <p>10/26/18 7am: resident restless in bed with signs of dyspnea. SPO2 84% on 4 L/M. Registered Nurse notified physician of condition change and titrated Oxygen to 5 L/M, administered order for DuoNeb, Ativan for restlessness, order for chest X-ray. SPO2 up to 90% on 5 L/M via nasal cannula. Licensed Nurse called family without contact. X-ray ordered and completed on 10/26/2018 with bibasilar pneumonia noted. Licensed nurse will continue to monitor.</p> <p>10/26/18 10pm: - neb treatment and O2 on going comfort measure in place, ate 25% T 99.2</p> <p>10/27/18 2pm - O2 90% with nebs. No food, mouth swabbed provided, ABT ongoing DuoNeb as ordered.</p> <p>10/28/18 12:50am: - Pt found by nurse without pulse or respirations. Pt is a DNR and Death verified by 2 nurses.</p> <p>The Facilities Clinical Competency Coordinator began educating the Licensed Nurses on 12/14/18 utilizing the interact change in condition protocol which include clinical pathways of when to contact the physician. Education also began on 12/14/18 by the Clinical Competence Coordinator to the Licensed Nurses regarding</p>	F 580			

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F 580	Continued From page 12 placing residents' change of conditions on the 24-hour report sheets utilized by the Licensed Nurses for reporting from shift to shift. As of 1/7/2019, 25 of 27 Licensed Nurses have been educated regarding change of condition with notification to the physician. Licensed Nurses whom have not received the education by 12/21/18 will be removed from the schedule until the education is completed. The Two Licensed Nurses who have not completed the education have been removed from the schedule until the education is completed. This education has been added to the general orientation of newly hired Registered and Licensed Practical Nurses The Clinical Competency Coordinator began educating all staff (certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration) on the stop and watch cards identifying a resident change in condition with notification to the Licensed Nurse on 12/14/2018. Facility staff will be educated be 12/21/2018. Staff whom has not received the education by 12/21/18 will be removed from the schedule until the education is completed. . As of 1/7/2019 115 employees out of 126 employees have been educated on stop and watch cards. This education has been added to the general orientation for newly hired certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration. On 1/7/2019 the Clinical Competency Coordinator began educating the Licensed Nurses to contact the physician with resident change in conditions as the change in condition occurred. The Licensed Nurses are not required to contact the Director of Nurses prior to physician notification.	F 580			

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F 580	<p>Continued From page 13</p> <p>2. Monitor: Address how the facility will identify other residents having the potential to be affected by the deficient practice</p> <p>On 12/13/12/14/18 the Nurse Management team including (RN Unit Managers, RN Clinical Competency Coordinator, RN Nurse Navigator, RN Case Mix Director, and RN Case Mix Coordinator) reviewed all active resident charts nursing notes for the past 90 days to validate that the physician was notified of all change in conditions. 89 resident charts reviewed with 31 changes in conditions noted with 31 physician notifications identified.</p> <p>On 12/13/2018 the Director of Nursing and/or Nurse Managers began reviewing the 24-hour report sheet daily to identify change of conditions and validate that physician notification is documented in the nursing notes. The Director of Health Services, Unit Managers and Nurse Managers utilizes the "Notification Review" form, to review the 24-hour report sheets weekly for 4 weeks then monthly thereafter.</p> <p>The Director of Nursing and/or Nurse Managers as of 1/7/2019 are reviewing the nursing documentation for residents with change in condition until resident has 72 hours of return to baseline documentation. This review has been added to the "Notification Review" form on 1/8/2018 The Director of Nursing and/or Nurse Managers will complete this review daily for 5 days then weekly for 4 weeks then monthly thereafter.</p> <p>On 1/7/2019 the Director of Nursing began tracking and trending the results of the 24-hour report sheet, physician notification regarding</p>	F 580			

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F 580	<p>Continued From page 14</p> <p>resident change in condition, documented in the nursing notes on the "Notification review" DHS form. The analysis of the tracking and trending will be presented at the monthly Quality Assurance meeting until 3 consecutive months of compliance is sustained then quarterly thereafter.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure the deficient practice does not recur Effective 1/7/2019 the Medical Doctors' phone number has been posted at both nurse's stations to provide Nurses direct contact with the Physician for resident care needs. Prior to 1/7/2019 the nurses' contacted the Director of Nursing and/or Unit Managers prior to contacting the physician. The audit completed on 12/14/2018 did not reveal a systemic issue with contacting the physician.</p> <p>On 1/8/2018 the facility Nurse Managers began interviewing 3 nurses per day to audit their understanding of the training and change in condition and when to contact the physician. This will continue weekly for 12 weeks and results will be brought to the QA Committee monthly.</p> <p>On 1/8/18 the Clinical Competency Coordinator began interviewing 5 ancillary staff members (Certified Nursing Assistants, housekeeping, maintenance, therapy, social services, activities, and administration) per day to audit their understanding of stop and watch cards and how to use them. The Clinical Competency Coordinator will be responsible for bringing the results to the QA committee monthly.</p> <p>The Clinical Competency Coordinator is responsible that all new staff (Certified nursing</p>	F 580			

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F 580	<p>Continued From page 15</p> <p>assistance, housekeeping, maintenance, therapy department, social services, activities, and administration) are educated regarding stop and watch (the stop and watch cards identifying a resident change in condition with notification to the Licensed Nurse). The Clinical Competency Coordinator will report the number of staff educated to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly to ensure 100% of employees hired have completed the education.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained:</p> <p>On 12/14/2018 the Administrator of the facility met with the Department Managers regarding pending survey results and began to develop an on-going plan of correction.</p> <p>The Medical Director was notified regarding the survey and facility plan on 12/14/2018 and was updated on 1/7/2019 regarding the plan changes.</p> <p>On 12/13/2018 the Director of Nursing and/or Nurse Managers began reviewing the 24-hour report sheet daily to identify change of conditions and validate that physician notification is documented in the nursing notes. The Director of Health Services, Unit Managers and Nurse Managers utilizes the "Notification Review" form, to review the 24-hour report sheets weekly for 4 weeks then monthly thereafter. The Director of Nursing will report the analysis of the track and trending of the "Notification Review" to the Quality Assurance / Performance Improvement Committee monthly until 3 months of sustained</p>	F 580			

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F 580	<p>Continued From page 16</p> <p>compliance is maintained then quarterly thereafter.</p> <p>The Director of Nursing and/or Nurse Managers as of 1/7/2019 are reviewing the nursing documentation for residents with change in condition until resident has 72 hours of return to baseline documentation. This review has been added to the "Notification Review" form on 1/8/2018 The Director of Nursing and/or Nurse Managers will complete this review daily for 5 days then weekly for 4 weeks then monthly thereafter. The Director of Nursing will report the analysis of the track and trending of the "Notification Review" to the Quality Assurance / Performance Improvement Committee monthly until 3 months of sustained compliance is maintained then quarterly thereafter.</p> <p>The Clinical Competency Coordinators/Director of Nursing will ensure all staff is educated related to utilization of the interact change in condition (stop and watch, SBAR communication form, MD communication form for non-emergent) will be taken to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly to ensure all employees who have worked have completed and understand the education.</p> <p>The Clinical Competency Coordinator/ Director of Nursing will present the number of new staff educated related to Stop and Watch will be taken to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly until three months of continued compliance is sustained then quarterly thereafter, to ensure all newly hired employees have completed and understand the</p>	F 580			

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F 580	Continued From page 17 education.  The Administrator is responsible to ensure the plan of correction is completed.  Completion date 1/8/2019."  Immediate Jeopardy was removed on 1/8/19 at 1:00PM when observations and staff interviews revealed the credible allegation of Immediate Jeopardy removal had been implemented and staff education had been completed.	F 580			
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Physician, and Nurse Practitioner interviews the facility neglected to monitor and/or evaluate a resident response to interventions and/or revise interventions for hypoxia (low oxygen saturation levels) for 1 of 1 residents (Resident #94)	F 600	Resident # 94 was admitted to Pruitt Health Neuse on 2/11/2016 from Crystal Coast Hospice Upon admission family revoked 3HC hospice and transferred to Pruitt-Healthcare.	1/16/19	

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F 600	<p>Continued From page 18 reviewed for death in the facility. Resident #94 expired 10/28/18.</p> <p>Immediate Jeopardy began on 10/25/18 when Resident #94 was in a compromised respiratory situation and was not provided ongoing, effective nursing and/or medical interventions, nor was a medical provider contacted to communicate a significant change in status. Immediate Jeopardy was removed on 1/8/19 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D (no actual harm with a potential for minimal harm which is not immediate jeopardy).</p> <p>Findings included:</p> <p>Resident #94 was admitted to the facility 2/11/2016. Admitting diagnoses included COPD (Chronic Obstructive Pulmonary Disease). Cerebrovascular Accident (CVA), aspiration pneumonia, and acute-on-chronic hypoxemic respiratory failure.</p> <p>A physician progress note dated 9/27/18 read, in part, "No current complaints or concerns." It further revealed she had unlabored respirations and clear lung sounds without wheezes or rhonchi (rattling lung sounds which could indicate obstruction or secretions), and Resident #94 was at high risk for repeat aspiration and pneumonia. The plan included, "Overall stable. Continue current treatment plan and medication regimen. Routine follow up."</p> <p>A Quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 10/2/18 revealed</p>	F 600	<p>Resident admitting diagnosis: Sepsis, Chronic obstructive pulmonary disease, Bipolar, cerebral infarct, TIA, essential hypertension, dementia without behavioral disturbance, Diabetes type 2, dysphagia, UTI, unspecified asthma.</p> <p>7/10/16 Carolina East Health System discharge diagnosis included: Acute and chronic respiratory failure with hypoxia, bipolar disorder, dehydration, unspecified dementia without behavioral disturbance, stupor, pneumonia due to other specified bacteria, sepsis due to anaerobes.</p> <p>2/21/2016 Physician notes indicate resident was being admitted the facility for conservative long-term care.</p> <p>On 7/20/2016 physician visit notes that indicate supportive care and comfort measures were being provided.</p> <p>On 8/13/18 physician visit notes identified that indicate supportive care and comfort measures were being provided.</p> <p>On 9/27/18 physician visit notes identified that indicate supportive care and comfort measures were being provided.</p> <p>On 10/25/18, 12:00am a resident's oxygen saturation dropped to 46%. Oxygen was started at 4 liters per minute per nasal cannula, resident was suctioned X2 with thick white mucus from throat. Resident was dry to touch. Resident was placed in high fowlers position to assist with breathing. Oxygen saturation increased to 64%.</p> <p>On 10/25/18 6:30am condition unchanged no gurgling respirations, non-responsive to tactile stimuli. No further symptoms currently. Resident took morphine sublingually, the off-going nurse did not</p>		

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F 600	<p>Continued From page 19</p> <p>Resident #94 was severely cognitively impaired and required extensive to total assistance for all Activities of Daily Living (ADLs). Active diagnoses included diabetes mellitus (DM), non-Alzheimer's dementia, depression, manic depression, and COPD.</p> <p>A care plan last updated 10/2/18 read: "(Resident #94) has Dx (diagnosis) of COPD and is at risk for respiratory distress." Goals included "will maintain ventilation within resident's normal range and without s/s (signs and symptoms) of respiratory distress." Interventions included "elevate HOB (head of bed) as tolerated, provide rest periods, O2 (oxygen) per order, auscultate (listen with a stethoscope) lung sounds, monitor O2 sat (saturation) PRN (as needed), monitor respiratory status, notify MD (physician) as warranted."</p> <p>Physician orders dated 10/1/18 through 10/31/18 read, in part, "May use standing orders: Oxygen at 2l (liters)/ (per) minute prn SOB (shortness of breath), notify MD if not relieved or if SOB is accompanied with other symptoms, and Morphine Sulfate 100mg/5 mL (100 milligrams in 5 milliliters) 1mL PO (by mouth) q6hrs (every six hours) dyspnea (shortness of breath)."</p> <p>A review of the Medication Administration record (MAR) for 10/1/18 through 10/31/18 revealed prn oxygen was administered on 10/24/18. No other entries related to oxygen administration was revealed.</p> <p>Review of a nursing note dated 10/25/18 at 12:00AM and signed by Nurse #1 read, "During routine rounds resident (Resident #94) observed to be unresponsive to tactile stimuli. O2 sat 46%</p>	F 600	<p>report resident condition to Physician, Director of Nursing and on-coming nurse at shift change, nor did they document further oxygen saturations during their shift.</p> <p>10/26/18 7am: resident restless in bed with signs of dyspnea. SPO2 84% on 4 L/M. Registered Nurse notified physician of condition change and titrated Oxygen to 5 L/M, administered order for DuoNeb, Ativan for restlessness, order for chest X-ray. SPO2 up to 90% on 5 L/M via nasal cannula., Licensed Nurse called family without contact. X-ray ordered and completed on 10/26/2018 with bibasilar pneumonia noted. Licensed nurse will continue to monitor.</p> <p>10/26/18 10pm: <input type="checkbox"/> neb treatment and O2 on going comfort measure in place, ate 25% T 99.2</p> <p>10/27/18 2pm <input type="checkbox"/> O2 90% with nebs. No food, mouth swabbed provided, ABT ongoing DuoNeb<input type="checkbox"/> as ordered.</p> <p>10/28/18 12:50am: <input type="checkbox"/> Pt found by nurse without pulse or respirations. Pt is a DNR and Death verified by 2 nurses<input type="checkbox"/>.</p> <p>The Facilities Clinical Competency Coordinator began educating the Licensed Nurses on 12/14/18 utilizing the interact change in condition protocol which include clinical pathways of when to contact the physician. Education also began on 12/14/18 by the Clinical Competence Coordinator to the Licensed Nurses regarding placing residents change of conditions on the 24-hour report sheets utilized by the Licensed Nurses for reporting from shift to shift. As</p>		

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F 600	<p>Continued From page 20</p> <p>(percent) (Normal oxygen saturation levels are greater than 90%) on RA (room air). O2 started at 4L/m (liters per minute) per NC (nasal cannula). Suctioned x 2. Thick, white mucus from throat. O2 sats 64% /c (with) O2. Color pale and ashen. Resident put in H (high) fowlers to assist /c breathing." This nursing note did not indicate the resident's medical provider was notified of the resident's condition.</p> <p>Review of a nursing note dated 10/25/18 at 6:30AM and signed by Nurse #1 read, in part, "Condition unchanged. Non responsive to tactile stimuli. Took Morphine as ordered." The medical record did not contain the resident's vital signs and/or O2 saturation level as taken by Nurse #1 at this time. This nursing note did not indicate the resident's medical provider was notified of the resident's condition.</p> <p>An interview was conducted with Nurse #1 on 12/13/18 at 1:02PM. He stated Resident #94 was frequently short of breath, but had not required oxygen in months. He stated he had checked Resident #94 during routine rounds and found her oxygen saturation level was 46%. He suctioned her airway, sat her up, and applied oxygen. Her repeat oxygen saturation level was 64%. At no time had he notified the physician because he stated he mistakenly thought Resident #94 was on hospice care. He stated he had not assessed Resident #94's condition again until 6:30AM and her condition remained unchanged.</p> <p>An additional interview was conducted with Nurse #1 on 1/7/19 at 2:55PM. He stated, "My routine rounds start at midnight. She appeared not her normal. She was pale and ashen." He stated Resident #94 had no response to him touching</p>	F 600	<p>of 1/7/2019, 25 of 27 Licensed Nurses have been educated regarding change of condition with notification to the physician. Licensed Nurses whom have not received the education by 12/21/18 will be removed from the schedule until the education is completed. The Two Licensed Nurses who have not completed the education have been removed from the schedule until the education is completed.</p> <p>On 1/9/2019, 27 out of 27 Licensed Nurses have been educated regarding change of condition with notification to the physician. This education has been added to the general orientation of newly hired Registered and Licensed Practical Nurses. The Clinical Competency Coordinator began educating all staff (certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration) on the stop and watch cards identifying a resident change in condition with notification to the Licensed Nurse on 12/14/2018. Facility staff will be educated be 12/21/2018. Staff whom has not received the education by 12/21/18 will be removed from the schedule until the education is completed. . As of 1/7/2019, 115 employees out of 126 employees have been educated on stop and watch cards. As of 1/9/2019, 126 out of 126 employees have been educated on stop and watch cards. This education has been added to the general orientation for newly hired certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration. On 1/7/2019 the Clinical</p>		

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F 600	<p>Continued From page 21</p> <p>her except to moan. He administered her usual dose of Morphine inside her mouth because she was not able to swallow. He stated he repeated her Morphine dose at 6:00AM because she was still having respiratory difficulty. He also stated, "Her oxygen saturation level was around 70% when I left." He also stated he had not notified anyone, the Director of Nursing (DON) or Physician, of Resident #94's condition because he thought she was on hospice care. He stated had she not been on hospice he would have notified the DON and sent Resident #94 to the hospital. No nursing notes were revealed in the medical record from 10/25/18 at 6:30AM through 10/26/18 at 7:00AM.</p> <p>An interview was conducted on 12/13/18 at 5:39PM with Nurse #5, who had cared for Resident #94 on 10/26/18 on the 7:00AM to 3:00PM shift. She stated, "I don't recall (Nurse #1) passing any information on about her being hypoxic during the night."</p> <p>An interview was conducted with Nurse #6 on 12/13/18 at 5:40PM. She stated she cared for Resident #94 on 10/25/18 from 3:00PM-11:00PM. she was not told of anything unusual for Resident #94 during shift report.</p> <p>Review of a nursing note dated 10/26/18 at 7:00AM and signed by Nurse #2, the Unit Manager on the 7:00AM through 3:00PM shift read, in part, "Resident restless in bed /c sign of dyspnea (respiratory difficulty). SpO2 (oxygen saturation) 84% on 4L. SN (staff nurse) titrated O2 up to 5L and administered order for DuoNeb (breathing treatment). SpO2 up to 90% on 5L. SN received order for Ativan for restlessness. SN will continue to monitor."</p>	F 600	<p>Competency Coordinator began educating the Licensed Nurses to contact the physician with resident change in conditions as the change in condition occurred. The Licensed Nurses are not required to contact the Director of Nurses prior to physician notification. All Licenses Nurses (27 out of 27) have been in-serviced as of 1/7/2019.</p> <p>2. Monitor: Address how the facility will identify other residents having the potential to be affected by the deficient practice</p> <p>On 12/13/12/14/18 the Nurse management team including (RN Unit Managers, RN Clinical Competency Coordinator, RN Nurse Navigator, RN Case Mix Director, RN Case Mix Coordinator) reviewed all active resident charts nursing notes for the past 90 days to validate that the physician was notified of all change in conditions. 89 resident charts reviewed with 31 changes in conditions noted with 31 physician notifications identified.</p> <p>On 12/13/2018 the Director of Nursing and/or Nurse Managers began reviewing the 24-hour report sheet daily to identify change of conditions and validate that physician notification is documented in the nursing notes. The Director of Health Services, Unit Managers and Nurse Managers utilizes the Notification Review form, to review the 24-hour report sheets weekly for 4 weeks then monthly thereafter.</p>		

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F 600	<p>Continued From page 22</p> <p>An interview was conducted with Nurse #2 on 12/14/18 at 8:35AM. She stated, "(Nurse #1) didn't pass any concerns on to me about (Resident #94) on 10/25. A care partner (a staff member who does not provide any patient care) asked me to come have a look at (Resident #94) on 10/26/18 because she said she wasn't breathing well. I assessed her, increased her oxygen to 5L and called the doctor. He ordered a chest x-ray, steroids (Prednisone), breathing treatments and antibiotics. I was not aware of her hypoxia from the night before or I would have called the doctor sooner and sent her to the hospital. Her change in condition was not communicated to me in report from (Nurse #1)."</p> <p>On 10/26/18 MD orders included DuoNeb-1 vial inh (inhalation) q6hrs (every 6 hours) x (for) 7 days. D/C (discontinue) PRN (as needed) O2 (oxygen). Start oxygen via NC (nasal cannula) titrate for sats (oxygen saturation) &gt; (greater than) 88% (percent); CXR (chest x-ray) 2 views SOB (shortness of breath)/congestion; Ativan 0.25mg (milligrams) 1 tab PO/SL (by mouth or sublingual) q4hr PRN (restlessness/anxiety) x 14 days; Prednisone 20mg PO q day x 3 then Prednisone 10mg PO q day x 3; Levaquin 500mg 1 tab PO q day lower lobe PNA (pneumonia) x 7 days.</p> <p>Resident #94's chest x-ray results were sent to the facility by fax (facsimile) on 10/26/18 at 11:18AM. The results read, "bi-basilar infiltrates (an indication of pneumonia), worse in right lung." The MD was notified of the results on 10/26/18.</p> <p>Review of the next nursing note was dated 10/26/18 at 10:00PM, signed by Nurse #3 and</p>	F 600	<p>The Director of Nursing and/or Nurse Managers as of 1/7/2019 are reviewing the nursing documentation for residents with change in condition until resident has 72 hours of return to baseline documentation. This review has been added to the Notification Review form on 1/8/2018 The Director of Nursing and/or Nurse managers will complete this review daily for 5 days then weekly for 4 weeks then monthly thereafter.</p> <p>On 1/7/2019 the Director of Nursing began tracking and trending the results of the 24-hour report sheet, physician notification regarding resident change in condition, documented in the nursing notes on the Notification review DHS form. The analysis of the tracking and trending will be presented at the monthly Quality Assurance meeting until 3 consecutive months of compliance is sustained then quarterly thereafter.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure the deficient practice does not recur</p> <p>Effective 1/7/2019 the Medical Doctors ☐ phone number has been posted at both nurse ☐s stations to provide Nurses direct contact with the Physician for resident care needs. Prior to 1/7/2019 the nurses ☐ contacted the Director of Nursing and/or Unit Managers prior to contacting the physician. The audit completed on 12/14/2018 did not reveal a systemic</p>		

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F 600	<p>Continued From page 23</p> <p>read, in part, "Neb treatments and O2 on-going. Comfort measures in place."</p> <p>The next nursing note was dated 10/27/18 at 2:00PM, signed by Nurse #3 and read, in part, "90% /c neb. No food. On-going DuoNeb as ordered."</p> <p>An interview was conducted with Nurse #3 on 12/13/18 at 1:25PM. She stated she had not received information about Resident #94's oxygen saturation levels in shift report.</p> <p>An additional interview was conducted on 1/7/19 at 11:38AM with Nurse #3. She cared for Resident #94 on 10/27/18 on the 7:00AM-3:00PM shift. She stated, "She was declining for about a week to a week and a half. The Unit Manager gave us updates and told us she was dying. I didn't call the doctor because I knew she was dying. 'No food' in my note meant she wasn't eating or swallowing anything. Her MAR read DNR, but did not have comfort measures written on it. I still gave her Morphine when she wasn't responsive because it can be absorbed in her cheek. I gave her Morphine anyway to keep her comfortable. I don't know what her vital signs were. She was on oxygen the last week of her life which was unusual because she didn't typically need oxygen. She was in respiratory distress. She was Cheyne-stoking (periods of not breathing along with periods of breathing). She had periods of apnea throughout my shift. I didn't call the doctor, but told the on-coming shift she didn't look good."</p> <p>An interview was conducted on 12/13/18 at 1:12PM with Nurse #4, who cared for Resident #94 on 10/25/18 on the 11:00PM through 7:00AM</p>	F 600	<p>issue with contacting the physician.</p> <p>On 1/8/2018 the facility Nurse Managers began interviewing 3 nurses per day to audit their understanding of the training and change in condition and when to contact the physician. This will continue weekly for 12 weeks and results will be brought to the QA Committee monthly.</p> <p>On 1/8/18 the Clinical Competency Coordinator began interviewing 5 ancillary staff members (Certified Nursing Assistants, housekeeping, maintenance, therapy, social services, activities, and administration) per day to audit their understanding of stop and watch cards and how to use them. The Clinical Competency Coordinator will be responsible for bringing the results to the QA committee monthly.</p> <p>The Clinical Competency Coordinator is responsible that all new staff (Certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration) are educated regarding stop and watch (the stop and watch cards identifying a resident change in condition with notification to the Licensed Nurse). The Clinical Competency Coordinator will report the number of staff educated to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly to ensure 100% of employees hired have completed the education.</p>		

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F 600	<p>Continued From page 24</p> <p>shift. She stated she had not received any information related to Resident #94's hypoxia during shift report.</p> <p>An additional interview was conducted with Nurse #4 on 1/7/19 at 2:25PM. She stated there was one night in October Resident #94 had a low oxygen saturation. The low oxygen level had concerned her, but she had not called the DON because the oxygen had helped. She stated if Nurse #1 had told her Resident #94 was having saturations in the 40's, 50's or 60's she would have called the DON because oxygen levels so low were considered an emergency. She also could not recall anything concerning being communicated in report.</p> <p>A review of the death certificate for Resident #94 listed the cause of death as respiratory failure as a result or consequence of pneumonia as a result or consequence of COPD (Chronic Obstructive Pulmonary Disease).</p> <p>An interview was conducted with the Director of Nursing (DON) on 12/13/18 at 1:35PM. She stated, "Staff call me or a unit manager for emergencies or a change in status and I contact the MD. That's the way he (the physician) wanted it set up. I was not aware of (Resident #94's) change in condition until we did an x-ray on 10/26/18. Staff didn't notify me of the change. I wasn't aware of her O2 sats being 46% until you, the surveyor, told me today (12/13/18) because nobody notified me of that. I should have been notified when her oxygen saturation was found to be 46%. And again when it went to only 64%. Actually, 911 should've been called when her saturation was 46% and then I should have been notified. I would have called 911, then notified the</p>	F 600	<p>4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained:</p> <p>On 12/14/2018 the Administer of the facility met with the Department Managers regarding pending survey results and began to develop an on-going plan of correction.</p> <p>The Medical Director was notified regarding the survey and facility plan on 12/14/2018 and was updated on 1/7/2019 regarding the plan changes.</p> <p>On 12/13/2018 the Director of Nursing and/or Nurse Managers began reviewing the 24-hour report sheet daily to identify change of conditions and validate that physician notification is documented in the nursing notes. The Director of Health Services, Unit Managers and Nurse Managers utilizes the Notification Review form, to review the 24-hour report sheets weekly for 4 weeks then monthly thereafter. The Director of Nursing will report the analysis of the track and trending of the Notification Review to the Quality Assurance / Performance Improvement Committee monthly until 3 months of sustained compliance is maintained then quarterly thereafter.</p> <p>The Director of Nursing and/or Nurse Managers as of 1/7/2019 are reviewing the nursing documentation for residents with change in condition until resident has 72 hours of return to baseline documentation. This review has been added to the Notification Review form on 1/8/2018 The Director of Nursing and/or</p>		

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F 600	<p>Continued From page 25</p> <p>doctor. (Resident #94) should've been sent out to the hospital when her sats were 46%. My expectation is if there is a significant change in condition of a resident notification should be made to myself and the provider after the assessment was completed. In her (Resident #94) situation I would have expected 911 to be called because of how low her oxygen level, and because she had not responded well to oxygen being applied. I don't know why I was not notified. I would have sent her to the emergency department. She should have been sent to the emergency room." She also stated she would have expected an oxygen saturation level of 64% would have been discussed in shift report, if the resident remained in the facility and was not in the hospital.</p> <p>An interview was conducted with the Physician on 12/13/18 at 3:35PM. He stated if a resident had a change in condition the nurses or DON (if she was in the building) were supposed to notify him. He also stated he was not notified of the change in condition for Resident #94 and would have immediately sent the resident to the hospital. He stated, "I don't know why I wasn't notified when she became real hypoxic, but she would have been better served if she had been immediately sent out to the hospital. By the time they called me (31 hours later) her oxygen saturation was around 90% so I ordered a chest x-ray and antibiotics. They never told me she had been so hypoxic." He also stated he was not aware she had been so hypoxic (46%) until the facility told him today (12/13/18) or he would have sent her immediately out to the emergency department.</p> <p>An additional interview was conducted with the physician on 1/8/19 at 8:35AM. He stated he had</p>	F 600	<p>Nurse managers will complete this review daily for 5 days then weekly for 4 weeks then monthly thereafter. The Director of Nursing will report the analysis of the track and trending of the Notification Review to the Quality Assurance / Performance Improvement Committee monthly until 3 months of sustained compliance is maintained then quarterly thereafter.</p> <p>The Clinical Competency Coordinators/Director of Nursing will ensure all staff is educated related to utilization of the interact change in condition (stop and watch, SBAR communication form, MD communication form for non-emergent) will be taken to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly to ensure all employees who have worked have completed and understand the education.</p> <p>The Clinical Competency Coordinator/ Director of Nursing will present the number of new staff educated related to Stop and Watch will be taken to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly until three months of continues compliance is sustained then quarterly thereafter, to ensure all newly hired of employees have completed and understand the education. The Administrator is responsible to ensure the plan of correction is completed.</p> <p>The completion date for this corrective action is 1/16/19.</p>		

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F 600	<p>Continued From page 26</p> <p>no recall of writing a comfort measures order and was not treating Resident #94 as if she was at the end of her life. He stated, "If she was comfort measures or end of life care only I would not have ordered a chest x-ray, breathing treatments, Prednisone, and antibiotics." He also stated he would not recommend administration of Morphine to an unresponsive patient, unless they were comfort measures only. He also stated the facility normally sent out residents with emergency conditions, but (Resident #94) was not sent out because it was his understanding the nurse mistakenly thought she was a hospice patient. If he had been informed of her severe hypoxia on 10/25/18 he would have immediately transferred her to the emergency department. He also stated the facility now has his number posted at each nursing station, but prior to yesterday the facility staff contacted the DON and she contacted him. He also stated, "We were just as puzzled as you were about why they didn't do anything for her. She had actually bounced back a bit after the orders I gave were initiated."</p> <p>An interview was conducted with the Nurse Practitioner (NP) on 12/14/18 at 9:46AM. She stated, "She (Resident #94) was definitely in bad health. Comfort measures include manage pain, anything to keep the patient comfortable. In her case it meant preventing ulcers, treating her pain, keeping her safe from her severe dementia, treating some of her medical conditions, like pneumonia. She was being treated for pneumonia in October of 2018. The staff should notify the provider of any change in condition for any resident. We may or may not treat, but we should be notified. I was never notified of a pulse ox reading of 46% or 64% on 10/25/18. She was a high risk for aspiration pneumonia and already</p>	F 600			

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F 600	<p>Continued From page 27</p> <p>had pneumonia. I became aware of her hypoxia after she had passed away. The provider should have been notified of her hypoxia (46% and 64%) because it's likely her pneumonia was the cause of her hypoxia."</p> <p>On 1/7/19 at 4:30PM, the Administrator and DON were notified of the Immediate Jeopardy.</p> <p>On 1/8/19 the facility provided an acceptable credible allegation of Immediate Jeopardy removal which included:</p> <p>"This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.</p> <p>Resident # 94 was admitted to Pruitt Health Neuse on 2/11/2016 from Crystal Coast Hospice</p> <p>Upon admission family revoked 3HC hospice and transferred to Pruitt-Healthcare.</p> <p>Resident admitting diagnosis: Sepsis, Chronic obstructive pulmonary disease, Bipolar, cerebral infarct, TIA, essential hypertension, dementia without behavioral disturbance, Diabetes type 2, dysphagia, UTI, unspecified asthma.</p> <p>7/10/16 Carolina East Health System discharge</p>	F 600			

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F 600	<p>Continued From page 28</p> <p>diagnosis included: Acute and chronic respiratory failure with hypoxia, bipolar disorder, dehydration, unspecified dementia without behavioral disturbance, stupor, pneumonia due to other specified bacteria, and sepsis due to anaerobes.</p> <p>2/21/2016 Physician notes indicate resident was being admitted the facility for "conservative long-term care."</p> <p>On 7/20/2016 physician visit notes that indicate supportive care and comfort measures were being provided.</p> <p>On 8/13/18 physician visit notes identified that indicate supportive care and comfort measures were being provided.</p> <p>On 9/27/18 physician visit notes identified that indicate supportive care and comfort measures were being provided.</p> <p>On 10/25/18, 12:00am a resident's oxygen saturation dropped to 46%. Oxygen was started at 4 liters per minute per nasal cannula, resident was suctioned X 2 with thick white mucus from throat. Resident was dry to touch. Resident was placed in high fowler's position to assist with breathing. Oxygen saturation increased to 64%.</p> <p>On 10/25/18 6:30am condition unchanged no gurgling respirations, non-responsive to tactile stimuli. No further symptoms currently.</p> <p>Resident took morphine sublingually, the off-going nurse did not report resident condition to Physician, Director of Nursing and on-coming nurse at shift change, nor did they document further oxygen saturations during their shift.</p>	F 600			

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F 600	<p>Continued From page 29</p> <p>10/26/18 7am: resident restless in bed with signs of dyspnea. SPO2 84% on 4 L/M. Registered Nurse notified physician of condition change and titrated Oxygen to 5 L/M, administered order for DuoNeb, Ativan for restlessness, order for chest X-ray. SPO2 up to 90% on 5 L/M via nasal cannula. Licensed Nurse called family without contact. X-ray ordered and completed on 10/26/2018 with bibasilar pneumonia noted. Licensed nurse will continue to monitor.</p> <p>10/26/18 10pm: - neb treatment and O2 on going comfort measure in place, ate 25% T 99.2</p> <p>10/27/18 2pm - O2 90% with nebs. No food, mouth swabbed provided, ABT ongoing DuoNeb as ordered.</p> <p>10/28/18 12:50am: - Pt found by nurse without pulse or respirations. Pt is a DNR and Death verified by 2 nurses.</p> <p>The Facilities Clinical Competency Coordinator began educating the Licensed Nurses on 12/14/18 utilizing the interact change in condition protocol which include clinical pathways of when to contact the physician. Education also began on 12/14/18 by the Clinical Competence Coordinator to the Licensed Nurses regarding placing residents' change of conditions on the 24-hour report sheets utilized by the Licensed Nurses for reporting from shift to shift. As of 1/7/2019, 25 of 27 Licensed Nurses have been educated regarding change of condition with notification to the physician. Licensed Nurses whom have not received the education by 12/21/18 will be removed from the schedule until the education is completed. The Two Licensed</p>	F 600			

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F 600	<p>Continued From page 30</p> <p>Nurses who have not completed the education have been removed from the schedule until the education is completed. This education has been added to the general orientation of newly hired Registered and Licensed Practical Nurses The Clinical Competency Coordinator began educating all staff (certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration) on the stop and watch cards identifying a resident change in condition with notification to the Licensed Nurse on 12/14/2018. Facility staff will be educated be 12/21/2018. Staff whom has not received the education by 12/21/18 will be removed from the schedule until the education is completed. . As of 1/7/2019 115 employees out of 126 employees have been educated on stop and watch cards. This education has been added to the general orientation for newly hired certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration. On 1/7/2019 the Clinical Competency Coordinator began educating the Licensed Nurses to contact the physician with resident change in conditions as the change in condition occurred.</p> <p>The Licensed Nurses are not required to contact the Director of Nurses prior to physician notification.</p> <p>2. Monitor: Address how the facility will identify other residents having the potential to be affected by the deficient practice</p> <p>On 12/13/12/14/18 the Nurse Management team including (RN Unit Managers, RN Clinical Competency Coordinator, RN Nurse Navigator, RN Case Mix Director, and RN Case Mix</p>	F 600			

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F 600	<p>Continued From page 31</p> <p>Coordinator) reviewed all active resident charts nursing notes for the past 90 days to validate that the physician was notified of all change in conditions. 89 resident charts reviewed with 31 changes in conditions noted with 31 physician notifications identified.</p> <p>On 12/13/2018 the Director of Nursing and/or Nurse Managers began reviewing the 24-hour report sheet daily to identify change of conditions and validate that physician notification is documented in the nursing notes. The Director of Health Services, Unit Managers and Nurse Managers utilizes the "Notification Review" form, to review the 24-hour report sheets weekly for 4 weeks then monthly thereafter.</p> <p>The Director of Nursing and/or Nurse Managers as of 1/7/2019 are reviewing the nursing documentation for residents with change in condition until resident has 72 hours of return to baseline documentation. This review has been added to the "Notification Review" form on 1/8/2018 The Director of Nursing and/or Nurse Managers will complete this review daily for 5 days then weekly for 4 weeks then monthly thereafter.</p> <p>On 1/7/2019 the Director of Nursing began tracking and trending the results of the 24-hour report sheet, physician notification regarding resident change in condition, documented in the nursing notes on the "Notification review" DHS form. The analysis of the tracking and trending will be presented at the monthly Quality Assurance meeting until 3 consecutive months of compliance is sustained then quarterly thereafter.</p> <p>3. Address what measures will be put into place</p>	F 600			

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F 600	<p>Continued From page 32 or systemic changes made to ensure the deficient practice does not recur</p> <p>Effective 1/7/2019 the Medical Doctors' phone number has been posted at both nurse's stations to provide Nurses direct contact with the Physician for resident care needs. Prior to 1/7/2019 the nurses' contacted the Director of Nursing and/or Unit Managers prior to contacting the physician. The audit completed on 12/14/2018 did not reveal a systemic issue with contacting the physician.</p> <p>On 1/8/2018 the facility Nurse Managers began interviewing 3 nurses per day to audit their understanding of the training and change in condition and when to contact the physician. This will continue weekly for 12 weeks and results will be brought to the QA Committee monthly.</p> <p>On 1/8/18 the Clinical Competency Coordinator began interviewing 5 ancillary staff members (Certified Nursing Assistants, housekeeping, maintenance, therapy, social services, activities, and administration) per day to audit their understanding of stop and watch cards and how to use them. The Clinical Competency Coordinator will be responsible for bringing the results to the QA committee monthly.</p> <p>The Clinical Competency Coordinator is responsible that all new staff (Certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration) are educated regarding stop and watch (the stop and watch cards identifying a resident change in condition with notification to the Licensed Nurse). The Clinical Competency Coordinator will report the number of staff</p>	F 600			

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F 600	<p>Continued From page 33</p> <p>educated to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly to ensure 100% of employees hired have completed the education.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained:</p> <p>On 12/14/2018 the Administrator of the facility met with the Department Managers regarding pending survey results and began to develop an on-going plan of correction.</p> <p>The Medical Director was notified regarding the survey and facility plan on 12/14/2018 and was updated on 1/7/2019 regarding the plan changes.</p> <p>On 12/13/2018 the Director of Nursing and/or Nurse Managers began reviewing the 24-hour report sheet daily to identify change of conditions and validate that physician notification is documented in the nursing notes. The Director of Health Services, Unit Managers and Nurse Managers utilizes the "Notification Review" form, to review the 24-hour report sheets weekly for 4 weeks then monthly thereafter. The Director of Nursing will report the analysis of the track and trending of the "Notification Review" to the Quality Assurance / Performance Improvement Committee monthly until 3 months of sustained compliance is maintained then quarterly thereafter.</p> <p>The Director of Nursing and/or Nurse Managers as of 1/7/2019 are reviewing the nursing documentation for residents with change in condition until resident has 72 hours of return to</p>	F 600			

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F 600	<p>Continued From page 34</p> <p>baseline documentation. This review has been added to the "Notification Review" form on 1/8/2018 The Director of Nursing and/or Nurse Managers will complete this review daily for 5 days then weekly for 4 weeks then monthly thereafter. The Director of Nursing will report the analysis of the track and trending of the "Notification Review" to the Quality Assurance / Performance Improvement Committee monthly until 3 months of sustained compliance is maintained then quarterly thereafter.</p> <p>The Clinical Competency Coordinators/Director of Nursing will ensure all staff is educated related to utilization of the interact change in condition (stop and watch, SBAR communication form, MD communication form for non-emergent) will be taken to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly to ensure all employees who have worked have completed and understand the education.</p> <p>The Clinical Competency Coordinator/ Director of Nursing will present the number of new staff educated related to Stop and Watch will be taken to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly until three months of continued compliance is sustained then quarterly thereafter, to ensure all newly hired employees have completed and understand the education.</p> <p>The Administrator is responsible to ensure the plan of correction is completed.</p> <p>Completion date 1/8/2019."</p>	F 600			

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F 600	Continued From page 35 Immediate Jeopardy was removed on 1/8/19 at 1:00PM when observations and staff interviews revealed the credible allegation of  Immediate Jeopardy removal had been implemented and staff education had been completed.	F 600			
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.  §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		1/16/19	

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F 623	<p>Continued From page 36</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p>	F 623			

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NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-NEUSE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1303 HEALTH DRIVE</b> <b>NEW BERN, NC 28560</b>		
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F 623	<p>Continued From page 37</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide written notice of discharge to the resident/resident's representative and Ombudsman for a discharge to the hospital for 3 of 3 residents reviewed for hospitalization (Resident #50, Resident #344, and Resident #39).</p> <p>The findings included:</p> <p>1. Resident #50 was admitted to the facility on 7/24/17. Her diagnoses included: multiple</p>	F 623	<p>1. What corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>Resident #50 was given a copy of the Discharge Notification Letter for the 10/19/18 hospitalization and a copy has been sent to the Ombudsman on 1/15/2019. A copy of the letter has been placed in the resident's chart. Resident #39 was given a copy of the</p>		

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F 623	<p>Continued From page 38</p> <p>sclerosis, anemia and hypertension.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 7/30/18 indicated Resident #50's was cognitively intact. She was totally dependent with one person assist for dressing, bathing, eating toilet use, and personal hygiene. Resident #50 required extensive assistance with bed mobility.</p> <p>Review of a nurse's note dated 10/19/18 revealed Resident #50 was sent to the hospital for evaluation for hypoxia (an oxygen deficiency to the body).</p> <p>A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's transfer to the hospital on 10/19/18. Further review of the medical record revealed no written notice of the resident's discharge to the hospital was provided to the ombudsman.</p> <p>During an interview with the Social Worker on 12/13/18 at 9:36 AM, she stated that she was unaware that written notice of discharge was to be sent to the resident or resident's representative and ombudsman for emergent hospital transfers. She reported nursing contacts the resident or resident representative by telephone when a resident is transferred to the hospital.</p> <p>An interview was conducted with the Administrator on 12/13/18 at 9:44 AM, who indicated it was her expectation written notice of discharge would be sent to the resident or resident's representative with a copy forwarded to the ombudsman as required by regulations for</p>	F 623	<p>Discharge Notification Letter for the 11/17/18 hospitalization and a copy was sent to the Ombudsman on 1/15/2019. A copy of the letter has been placed in the resident's chart.</p> <p>Resident #344 did not return to the facility after a hospitalization on 10/28/18 but a copy of the Discharge Notification letter for the 10/28/18 hospitalization was sent to the responsible party at the address on file. A copy of this letter was also sent to the Ombudsman as of 1/15/2019.</p> <p>2. Monitor: Address how the facility will identify other residents having the potential to be affected by the deficient practice:</p> <p>All residents/responsible parties will be notified in writing on transfer to the hospital through Discharge Notification Letter. The social worker will keep record of these forms and when they are mailed to responsible parties. The social worker will also send a copy of the Discharge Notification Letter to the Ombudsman each time a discharge occurs. The social worker will place a copy of the completed Discharge Notification Letter in each resident's chart that has been sent to the hospital.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure the deficient practice does not recur:</p> <p>The Social Worker, Director of Nursing, and Unit Managers have been In-Serviced</p>		

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F 623	<p>Continued From page 39</p> <p>emergent hospital transfers by the Social Worker. She stated that the facility would begin sending these notices as required.</p> <p>2. Resident #344 was admitted to the facility on 10/24/18. His diagnoses included dementia, hypertension and chronic kidney disease.</p> <p>Review of a nurse's note dated 10/28/18 revealed Resident #344 was sent to the hospital for evaluation for chest pain.</p> <p>A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's transfer to the hospital on 10/28/18. Additionally, no written notice of the resident's discharge to the hospital was provided to the ombudsman.</p> <p>During an interview with the Social Worker on 12/13/18 at 9:36 AM, she stated that she was unaware that written notice of discharge was to be sent to the resident or resident's representative and ombudsman for emergent hospital transfers. She reported nursing contacts the resident or resident representative by telephone when a resident is transferred to the hospital.</p> <p>An interview was conducted with the Administrator on 12/13/18 at 9:44 AM, who indicated it was her expectation written notice of discharge would be sent to the resident or resident's representative with a copy forwarded to the ombudsman as required by regulations for emergent hospital transfers by the Social Worker. She stated that the facility would begin sending these notices as required.</p>	F 623	<p>regarding the use of the Discharge Notification Letter by the Administrator on 12/13/18 as to the correct procedure.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained:</p> <p>The Social Worker will bring a list of residents and/or resident representatives that received the Discharge Notification Letter monthly to the QA Committee for review and monitoring to ensure continued compliance. The Administrator is responsible for ensuring the plan of correction is completed.</p> <p>The date of completion is 1/16/19.</p>		

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F 623	<p>Continued From page 40</p> <p>3. Resident #39 was admitted to the facility on 9/23/16. Her diagnoses included chronic respiratory failure, heart failure and dementia.</p> <p>An annual Minimum Data Set (MDS) assessment dated 7/25/18, indicated Resident #39 was cognitively impaired. She required extensive assistance with one person assist for bed mobility, dressing and personal hygiene. She was dependent with one person assist for eating and bathing.</p> <p>Review of a nurse's note dated 11/17/18 revealed Resident #39 was sent to the hospital for evaluation of chest pain and hypoxia (an oxygen deficiency to the body).</p> <p>A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's transfer to the hospital on 11/17/18. Additionally, no written notice of the resident's discharge to the hospital was forwarded to the ombudsman.</p> <p>During an interview with the Social Worker on 12/13/18 at 9:36 AM, she stated that she was unaware that written notice of discharge was to be sent to the resident or resident's representative and ombudsman for emergent hospital transfers. She reported nursing contacts the resident or resident representative by telephone when a resident is transferred to the hospital.</p> <p>An interview was conducted with the Administrator on 12/13/18 at 9:44 AM, who indicated it was her expectation written notice of discharge would be sent to the resident or resident's representative with a copy forwarded to</p>	F 623			

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F 623	Continued From page 41 the ombudsman as required by regulations for emergent hospital transfers by the Social Worker. She stated that the facility would begin sending these notices as required.	F 623			
F 684 SS=J	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Physician, and Nurse Practitioner interviews the facility failed to monitor and/or evaluate a resident response to interventions and/or revise interventions for hypoxia (low oxygen saturation levels) to prevent a decline in the physical well-being for 1 of 1 residents (Resident #94) reviewed for death in the facility.  Immediate Jeopardy began on 10/25/18 when Resident #94 was in a compromised respiratory situation and was not provided ongoing, effective nursing and/or medical interventions. Immediate Jeopardy was removed on 1/8/19 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D (no actual harm with a potential for minimal harm which is not immediate jeopardy).	F 684	Resident # 94 was admitted to Pruitt Health Neuse on 2/11/2016 from Crystal Coast Hospice Upon admission family revoked 3HC hospice and transferred to Pruitt-Healthcare. Resident admitting diagnosis: Sepsis, Chronic obstructive pulmonary disease, Bipolar, cerebral infarct, TIA, essential hypertension, dementia without behavioral disturbance, Diabetes type 2, dysphagia, UTI, unspecified asthma. 7/10/16 Carolina East Health System discharge diagnosis included: Acute and chronic respiratory failure with hypoxia, bipolar disorder, dehydration, unspecified dementia without behavioral disturbance, stupor, pneumonia due to other specified bacteria, sepsis due to anaerobes. 2/21/2016 Physician notes indicate	1/16/19	

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F 684	<p>Continued From page 42</p> <p>Findings included:</p> <p>Resident #94 was admitted to the facility 2/11/2016. Admitting diagnoses included COPD (Chronic Obstructive Pulmonary Disease). Cerebrovascular Accident (CVA), aspiration pneumonia, and acute-on-chronic hypoxemic respiratory failure.</p> <p>A physician progress note dated 9/27/18 read, in part, "No current complaints or concerns." It further revealed she had unlabored respirations and clear lung sounds without wheezes or rhonchi (rattling lung sounds which could indicate obstruction or secretions), and Resident #94 was at high risk for repeat aspiration and pneumonia. The plan included, "Overall stable. Continue current treatment plan and medication regimen. Routine follow up."</p> <p>A Quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 10/2/18 revealed Resident #94 was severely cognitively impaired and required extensive to total assistance for all Activities of Daily Living (ADLs). Active diagnoses included diabetes mellitus (DM), non-Alzheimer's dementia, depression, manic depression, and COPD.</p> <p>A care plan last updated 10/2/18 read: "(Resident #94) has Dx (diagnosis) of COPD and is at risk for respiratory distress." Goals included "will maintain ventilation within resident's normal range and without s/s (signs and symptoms) of respiratory distress." Interventions included "elevate HOB (head of bed) as tolerated, provide rest periods, O2 (oxygen) per order, auscultate (listen with a stethoscope) lung sounds, monitor</p>	F 684	<p>resident was being admitted the facility for conservative long-term care.</p> <p>On 7/20/2016 physician visit notes that indicate supportive care and comfort measures were being provided.</p> <p>On 8/13/18 physician visit notes identified that indicate supportive care and comfort measures were being provided.</p> <p>On 9/27/18 physician visit notes identified that indicate supportive care and comfort measures were being provided.</p> <p>On 10/25/18, 12:00am a resident's oxygen saturation dropped to 46%. Oxygen was started at 4 liters per minute per nasal cannula, resident was suctioned X2 with thick white mucus from throat. Resident was dry to touch. Resident was placed in high fowlers position to assist with breathing. Oxygen saturation increased to 64%.</p> <p>On 10/25/18 6:30am condition unchanged no gurgling respirations, non-responsive to tactile stimuli. No further symptoms currently. Resident took morphine sublingually, the off-going nurse did not report resident condition to Physician, Director of Nursing and on-coming nurse at shift change, nor did they document further oxygen saturations during their shift.</p> <p>10/26/18 7am: resident restless in bed with signs of dyspnea. SPO2 84% on 4 L/M. Registered Nurse notified physician of condition change and titrated Oxygen to 5 L/M, administered order for DuoNeb, Ativan for restlessness, order for chest X-ray. SPO2 up to 90% on 5 L/M via nasal cannula., Licensed Nurse called family without contact. X-ray ordered and</p>		

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F 684	<p>Continued From page 43</p> <p>O2 sat (saturation) PRN (as needed), monitor respiratory status, notify MD (physician) as warranted."</p> <p>Physician orders dated 10/1/18 through 10/31/18 read, in part, "May use standing orders: Oxygen at 2l (liters)/ (per) minute prn SOB (shortness of breath), notify MD if not relieved or if SOB is accompanied with other symptoms, and Morphine Sulfate 100mg/5 mL (100 milligrams in 5 milliliters) 1mL PO (by mouth) q6hrs (every six hours) dyspnea (shortness of breath)."</p> <p>A review of the Medication Administration record (MAR) for 10/1/18 through 10/31/18 revealed prn oxygen was administered on 10/24/18. No other entries related to oxygen administration was revealed.</p> <p>Review of a nursing note dated 10/25/18 at 12:00AM and signed by Nurse #1 read, "During routine rounds resident (Resident #94) observed to be unresponsive to tactile stimuli. O2 sat 46% (percent) (Normal oxygen saturation levels are greater than 90%) on RA (room air). O2 started at 4L/m (liters per minute) per NC (nasal cannula). Suctioned x 2. Thick, white mucus from throat. O2 sats 64% /c (with) O2. Color pale and ashen. Resident put in H (high) fowlers to assist /c breathing." This nursing note did not indicate the resident's medical provider was notified of the resident's condition.</p> <p>Review of a nursing note dated 10/25/18 at 6:30AM and signed by Nurse #1 read, in part, "Condition unchanged. Non responsive to tactile stimuli. Took Morphine as ordered." The medical record did not contain the resident's vital signs and/or O2 saturation level as taken by Nurse #1</p>	F 684	<p>completed on 10/26/2018 with bibasilar pneumonia noted. Licensed nurse will continue to monitor.</p> <p>10/26/18 10pm: <input type="checkbox"/> neb treatment and O2 on going comfort measure in place, ate 25% T 99.2</p> <p>10/27/18 2pm <input type="checkbox"/> O2 90% with nebs. No food, mouth swabbed provided, ABT ongoing DuoNeb <input type="checkbox"/>s as ordered.</p> <p>10/28/18 12:50am: <input type="checkbox"/> Pt found by nurse without pulse or respirations. Pt is a DNR and Death verified by 2 nurses <input type="checkbox"/>.</p> <p>The Facilities Clinical Competency Coordinator began educating the Licensed Nurses on 12/14/18 utilizing the interact change in condition protocol which include clinical pathways of when to contact the physician. Education also began on 12/14/18 by the Clinical Competence Coordinator to the Licensed Nurses regarding placing residents change of conditions on the 24-hour report sheets utilized by the Licensed Nurses for reporting from shift to shift. As of 1/7/2019, 25 of 27 Licensed Nurses have been educated regarding change of condition with notification to the physician. Licensed Nurses whom have not received the education by 12/21/18 will be removed from the schedule until the education is completed. The Two Licensed Nurses who have not completed the education have been removed from the schedule until the education is completed.</p> <p>On 1/9/2019, 27 out of 27 Licensed Nurses have been educated regarding change of condition with notification to the physician. This education has been added</p>		

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F 684	<p>Continued From page 44</p> <p>at this time. This nursing note did not indicate the resident's medical provider was notified of the resident's condition.</p> <p>An interview was conducted with Nurse #1 on 12/13/18 at 1:02PM. He stated Resident #94 was frequently short of breath, but had not required oxygen in months. He stated, "When I checked on her that night (10/25/18) she was not responsive. I checked her vital signs and her oxygen level was 46%. I sat her all the way up, suctioned her, and put oxygen on her. Her oxygen level went to 64%. He stated he had not assessed Resident #94's condition again until 6:30AM and her condition remained unchanged. He stated he had not repeated her vital signs or called the physician on 10/25/18 between 12:00 AM to 6:30 AM because he mistakenly thought Resident #94 was a hospice resident.</p> <p>An additional interview was conducted with Nurse #1 on 1/7/19 at 2:55PM. He stated, "My routine rounds start at midnight. I don't recall getting any special information in report about (Resident #94). She had been unwell for quite some time. I went to her room and noticed she was not displaying her normal behavior. So I went in and knew she needed to be charted on. She appeared not her normal self. She was pale and ashen. My definition of unresponsive to tactile stimuli would be touching and not getting a normal response (eye opening, moving). When I touched her she had no response. She did move and moaned a little bit, but she didn't respond in her normal pattern. I gave her Morphine to ease her respiratory distress. She had been on long standing Morphine for her COPD. Her O2 sat was telling me she was having difficulty since it was 46%, but I don't recall if she looked short of</p>	F 684	<p>to the general orientation of newly hired Registered and Licensed Practical Nurses. The Clinical Competency Coordinator began educating all staff (certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration) on the stop and watch cards identifying a resident change in condition with notification to the Licensed Nurse on 12/14/2018. Facility staff will be educated by 12/21/2018. Staff whom has not received the education by 12/21/18 will be removed from the schedule until the education is completed. . As of 1/7/2019, 115 employees out of 126 employees have been educated on stop and watch cards. As of 1/9/2019, 126 out of 126 employees have been educated on stop and watch cards. This education has been added to the general orientation for newly hired certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration. On 1/7/2019 the Clinical Competency Coordinator began educating the Licensed Nurses to contact the physician with resident change in conditions as the change in condition occurred. The Licensed Nurses are not required to contact the Director of Nurses prior to physician notification. All Licenses Nurses (27 out of 27) have been in-serviced as of 1/7/2019.</p> <p>2. Monitor: Address how the facility will identify other residents having the potential to be affected by the deficient practice</p>		

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F 684	<p>Continued From page 45</p> <p>breath. So I started oxygen, suctioned her, gave her Morphine and put her in high fowler's (sitting straight up) position to help her breathing. I did not call the DON because I mistakenly thought she was hospice. I frequently checked on her throughout the night but didn't chart on her until 6:30AM. I know I took her vital signs throughout the night, but didn't chart them. I know I should have. Her vitals were stable. I gave her Morphine around 6AM because she was still having respiratory difficulty. Her oxygen saturations were somewhere in the 70's at that point. I don't remember what though. I gave her the Morphine buccaly (in her cheek area within her mouth) because she was not able to swallow. When her O2 sat was 64% I put her in high fowler's. Her oxygen saturation was a little bit over 70% when I left in the morning. I told the on-coming nurse she was not doing well, but it wasn't a brand new condition. I told (Nurse #5) she had been hypoxic throughout the night, but I was wrong in thinking she was Hospice. When someone is in the condition she was in you should check them more frequently. I was mistaken in not charting what I assessed. I checked her throughout the night I just didn't chart it. I know her sats went from 46% to the 50's, 60's and right around 70% when I left in the morning. I should have done a better job of charting because I know if it's not charted it isn't done."</p> <p>No nursing notes were revealed in the medical record from 10/25/18 at 6:30AM through 10/26/18 at 7:00AM.</p> <p>An interview was conducted with Nurse #5 on 12/13/18 at 5:39PM. She stated, "The only thing I noticed on 10/25/18 during my shift (7:00AM through 3:00PM) was she (Resident #94) didn't</p>	F 684	<p>On 12/13/12/14/18 the Nurse management team including (RN Unit Managers, RN Clinical Competency Coordinator, RN Nurse Navigator, RN Case Mix Director, RN Case Mix Coordinator) reviewed all active resident charts nursing notes for the past 90 days to validate that the physician was notified of all change in conditions. 89 resident charts reviewed with 31 changes in conditions noted with 31 physician notifications identified.</p> <p>On 12/13/2018 the Director of Nursing and/or Nurse Managers began reviewing the 24-hour report sheet daily to identify change of conditions and validate that physician notification is documented in the nursing notes. The Director of Health Services, Unit Managers and Nurse Managers utilizes the Notification Review form, to review the 24-hour report sheets weekly for 4 weeks then monthly thereafter.</p> <p>The Director of Nursing and/or Nurse Managers as of 1/7/2019 are reviewing the nursing documentation for residents with change in condition until resident has 72 hours of return to baseline documentation. This review has been added to the Notification Review form on 1/8/2018 The Director of Nursing and/or Nurse managers will complete this review daily for 5 days then weekly for 4 weeks then monthly thereafter.</p> <p>On 1/7/2019 the Director of Nursing</p>		

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F 684	<p>Continued From page 46</p> <p>eat well. She did seem more quiet than normal. I don't recall (Nurse #1) passing any information on about her being hypoxic during the night."</p> <p>An interview was conducted with Nurse #6 on 12/13/18 at 5:40PM. She stated she cared for Resident #94 on 10/25/18 from 3:00PM-11:00PM. She stated, "She seemed a little lethargic so I held her scheduled Morphine and took her vital signs. They seemed to be okay. She took Morphine every 6 hours to help with her COPD. Her pulse oximetry was usually between 92% and 93%. On 10/25/18 she didn't take her Med Pass like she usually did. She loved her Med Pass and would always drink 100% of it. But that day she had not. Everything else was at baseline for her. If a resident was hypoxic I'd start oxygen at 2 liters and text or notify the DON." She stated she was not told of anything unusual for Resident #94 during shift report.</p> <p>Review of a nursing note dated 10/26/18 at 7:00AM and signed by Nurse #2, the Unit Manager on the 7:00AM through 3:00PM shift read, in part, "Resident restless in bed /c sign of dyspnea (respiratory difficulty). SpO2 (oxygen saturation) 84% on 4L. SN (staff nurse) titrated O2 up to 5L and administered order for DuoNeb (breathing treatment). SpO2 up to 90% on 5L. SN received order for Ativan for restlessness. SN will continue to monitor."</p> <p>An interview was conducted with Nurse #2 on 12/14/18 at 8:35AM. She stated, "(Nurse #1) didn't pass any concerns on to me about (Resident #94) on 10/25. I wasn't on the cart (medication cart) because I am the Unit Manager, but the cart nurses sometime asked me to assess a resident if they had concerns. A care</p>	F 684	<p>began tracking and trending the results of the 24-hour report sheet, physician notification regarding resident change in condition, documented in the nursing notes on the Notification review DHS form. The analysis of the tracking and trending will be presented at the monthly Quality Assurance meeting until 3 consecutive months of compliance is sustained then quarterly thereafter.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure the deficient practice does not recur</p> <p>Effective 1/7/2019 the Medical Doctors ☐ phone number has been posted at both nurse ☐s stations to provide Nurses direct contact with the Physician for resident care needs. Prior to 1/7/2019 the nurses ☐ contacted the Director of Nursing and/or Unit Managers prior to contacting the physician. The audit completed on 12/14/2018 did not reveal a systemic issue with contacting the physician.</p> <p>On 1/8/2018 the facility Nurse Managers began interviewing 3 nurses per day to audit their understanding of the training and change in condition and when to contact the physician. This will continue weekly for 12 weeks and results will be brought to the QA Committee monthly.</p> <p>On 1/8/18 the Clinical Competency Coordinator began interviewing 5 ancillary staff members (Certified Nursing Assistants, housekeeping, maintenance,</p>		

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F 684	<p>Continued From page 47</p> <p>partner (a staff member who does not provide any patient care) asked me to come have a look at (Resident #94) on 10/26/18 because she said she wasn't breathing well. I assessed her, increased her oxygen to 5L and called the doctor. He ordered a chest x-ray, steroids (Prednisone), breathing treatments and antibiotics. I was not aware of her hypoxia from the night before or I would have called the doctor sooner and sent her to the hospital. Her change in condition was not communicated to me in report from (Nurse #1) or the cart nurse (Nurse #5) who cared for her on 10/25/18. After the x-ray report came back, (Resident #94) was being treated for pneumonia and was on antibiotics and nebulizer (breathing) treatments." She also stated Resident #94 had been on Morphine for the almost 2 years she had worked there. "We gave her Morphine for her COPD." She stated Resident #94 had a slow decline over the last several months, but had no orders for comfort measures or hospice.</p> <p>An additional interview was conducted on 1/7/19 at 10:00AM with Nurse #2. She stated, "Respiratory difficulty was unusual for her. I was concerned she wasn't at baseline and continuing assessments would have been completed by the hall nurse on 7:00AM through 3:00PM. I wasn't told of any further issues for my shift (7A-3P), but I told the nurse coming in at 3PM to keep an eye on (Resident #94) because of the respiratory issues. (Resident #94) came to us on scheduled Morphine to help with her COPD. With my hospice background, we gave Morphine to help decrease respiratory rates. So for example, if a patient was hyperventilating (breathing fast) we gave Morphine to slow the rate down from say the 30's into the 20's. This helped perfuse them. (Resident #94's) meds were always crushed in</p>	F 684	<p>therapy, social services, activities, and administration) per day to audit their understanding of stop and watch cards and how to use them. The Clinical Competency Coordinator will be responsible for bringing the results to the QA committee monthly.</p> <p>The Clinical Competency Coordinator is responsible that all new staff (Certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration) are educated regarding stop and watch (the stop and watch cards identifying a resident change in condition with notification to the Licensed Nurse). The Clinical Competency Coordinator will report the number of staff educated to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly to ensure 100% of employees hired have completed the education.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained:</p> <p>On 12/14/2018 the Administer of the facility met with the Department Managers regarding pending survey results and began to develop an on-going plan of correction.</p> <p>The Medical Director was notified regarding the survey and facility plan on 12/14/2018 and was updated on 1/7/2019 regarding the plan changes.</p> <p>On 12/13/2018 the Director of Nursing</p>		

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F 684	<p>Continued From page 48</p> <p>apple sauce or liquid, like her Morphine, so the nurse could have given it to her if she unresponsive. Typically, people come to us from hospice after they have improved enough to no longer qualify for hospice care. I believe that's what happened with (Resident #94)."</p> <p>On 10/26/18 MD orders included DuoNebs-1 vial inh (inhalation) q6hrs (every 6 hours) x (for) 7 days. D/C (discontinue) PRN (as needed) O2 (oxygen). Start oxygen via NC (nasal cannula) titrate for sats (oxygen saturation) &gt; (greater than) 88% (percent); CXR (chest x-ray) 2 views SOB (shortness of breath)/congestion; Ativan 0.25mg (milligrams) 1 tab PO/SL (by mouth or sublingual) q4hr PRN (restlessness/anxiety) x 14 days; Prednisone 20mg PO q day x 3 then Prednisone 10mg PO q day x 3; Levaquin 500mg 1 tab PO q day lower lobe PNA (pneumonia) x 7 days.</p> <p>Resident #94's chest x-ray results were sent to the facility by fax (facsimile) on 10/26/18 at 11:18AM. The results read, "bi-basilar infiltrates (an indication of pneumonia), worse in right lung." The MD was notified of the results on 10/26/18.</p> <p>Review of the next nursing note was dated 10/26/18 at 10:00PM, signed by Nurse #3 and read, in part, "Neb treatments and O2 on-going. Comfort measures in place."</p> <p>The next nursing note was dated 10/27/18 at 2:00PM, signed by Nurse #3 and read, in part, "90% /c neb. No food. On-going DuoNeb as ordered."</p> <p>An interview was conducted with Nurse #3 on 12/13/18 at 1:25PM. She stated Resident #94</p>	F 684	<p>and/or Nurse Managers began reviewing the 24-hour report sheet daily to identify change of conditions and validate that physician notification is documented in the nursing notes. The Director of Health Services, Unit Managers and Nurse Managers utilizes the Notification Review form, to review the 24-hour report sheets weekly for 4 weeks then monthly thereafter. The Director of Nursing will report the analysis of the track and trending of the Notification Review to the Quality Assurance / Performance Improvement Committee monthly until 3 months of sustained compliance is maintained then quarterly thereafter.</p> <p>The Director of Nursing and/or Nurse Managers as of 1/7/2019 are reviewing the nursing documentation for residents with change in condition until resident has 72 hours of return to baseline documentation. This review has been added to the Notification Review form on 1/8/2018 The Director of Nursing and/or Nurse managers will complete this review daily for 5 days then weekly for 4 weeks then monthly thereafter. The Director of Nursing will report the analysis of the track and trending of the Notification Review to the Quality Assurance / Performance Improvement Committee monthly until 3 months of sustained compliance is maintained then quarterly thereafter.</p> <p>The Clinical Competency Coordinators/Director of Nursing will ensure all staff is educated related to utilization of the interact change in</p>		

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F 684	<p>Continued From page 49</p> <p>was a total care resident and (Resident #94) had a lot of respiratory issues. Comfort measures include hydration, feeding, assessing for pain, medicating per orders, and providing ADL care. We need an order for comfort measures." She stated she had not received information about Resident #94's oxygen saturation levels in shift report. She also stated charting was completed by exception so if there were no notes it meant nothing happened out of the ordinary for the resident.</p> <p>An additional interview was conducted on 1/7/19 at 11:38AM with Nurse #3. She cared for Resident #94 on 10/27/18 on the 7:00AM-3:00PM shift. She stated, "She was declining for about a week to a week and a half. She was usually gotten out of bed and would play with her blanket, but they weren't getting her up for about the last week of her life. I was concerned, but was being told in report she wasn't doing well. The last 2-3 days of her life she wasn't responding as usual. The Unit Manager gave us updates and told us she was dying. Anything we need to know is on the MAR (Medication Administration Record) or on a clipboard we keep at the nurses' station. If a resident is comfort care that's written on the MAR. Comfort care means you keep feeding, medicating, giving oxygen, complete ADLs, and just do everything to make a resident comfortable. You don't send them to the hospital because that discussion has already taken place. I didn't call the doctor because I knew she was dying. 'No food' in my note meant she wasn't eating or swallowing anything. Her MAR read DNR, but did not have comfort measures written on it. I still gave her Morphine when she wasn't responsive because it can be absorbed in her cheek. She didn't have to swallow it. So she could</p>	F 684	<p>condition (stop and watch, SBAR communication form, MD communication form for non-emergent) will be taken to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly to ensure all employees who have worked have completed and understand the education.</p> <p>The Clinical Competency Coordinator/ Director of Nursing will present the number of new staff educated related to Stop and Watch will be taken to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly until three months of continues compliance is sustained then quarterly thereafter, to ensure all newly hired of employees have completed and understand the education. The Administrator is responsible to ensure the plan of correction is completed.</p> <p>The completion date for this corrective action is 1/16/19.</p>		

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F 684	<p>Continued From page 50</p> <p>have been unresponsive, but I gave her Morphine anyway to keep her comfortable. I don't know what her vital signs were. She was on oxygen the last week of her life which was unusual because she didn't typically need oxygen. She was in respiratory distress. She was breathing hard the last time I took care of her at the end of October. She was Cheyne-stoking (periods of not breathing along with periods of breathing). She had periods of apnea throughout my shift. I didn't call the doctor, but told the on-coming shift she didn't look good." She stated she believed Resident #94 was on hospice care.</p> <p>An interview was conducted on 12/13/18 at 1:12PM with Nurse #4, who cared for Resident #94 on 10/25/18 on the 11:00PM through 7:00AM shift. She stated she had not received any information related to Resident #94's hypoxia during shift report.</p> <p>An additional interview was conducted with Nurse #4 on 1/7/19 at 2:25PM. She stated there was one night in October Resident #94 had a low oxygen saturation. She could not recall the date, but stated she placed her on oxygen and her saturation came up. The low oxygen level had concerned her, but she had not called the DON because the oxygen had helped. She stated if Nurse #1 had told her Resident #94 was having saturations in the 40's, 50's or 60's she would have called the DON because, "That's what we are supposed to do in an emergency." She also could not recall anything concerning being communicated in report.</p> <p>A review of the death certificate for Resident #94 listed the cause of death as respiratory failure as a result or consequence of pneumonia as a result</p>	F 684			

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F 684	<p>Continued From page 51 or consequence of COPD (Chronic Obstructive Pulmonary Disease).</p> <p>An interview was conducted with the Director of Nursing (DON) on 12/13/18 at 1:35PM. She stated, "Staff call me or a unit manager for emergencies or a change in status and I contact the MD. That's the way he (the physician) wanted it set up. I was not aware of (Resident #94's) change in condition until we did an x-ray on 10/26/18. Staff didn't notify me of the change. I wasn't aware of her O2 sats being 46% until you, the surveyor, told me today (12/13/18) because nobody notified me of that. I should have been notified when her oxygen saturation was found to be 46%. And again when it went to only 64%. Actually, 911 should've been called when her saturation was 46% and then I should have been notified. I would have called 911, then notified the doctor. (Resident #94) should've been sent out to the hospital when her sats were 46%. My expectation is if there is a significant change in condition of a resident notification should be made to myself and the provider after the assessment was completed. In her (Resident #94) situation I would have expected 911 to be called because of how low her oxygen level, and because she had not responded well to oxygen being applied. I don't know why I was not notified. I would have sent her to the emergency department. She should have been sent to the emergency room." She also stated she would have expected an oxygen saturation level of 64% would have been discussed in shift report, if the resident remained in the facility and was not in the hospital.</p> <p>An interview was conducted with the physician on 12/13/18 at 3:35PM. He stated if a resident had a</p>	F 684			

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F 684	<p>Continued From page 52</p> <p>change in condition the nurses or DON (if she was in the building) were supposed to notify him. He also stated he was not notified of the change in condition for Resident #94 and would have immediately sent the resident to the hospital. He stated, "I don't know why I wasn't notified when she became real hypoxic, but she would have been better served if she had been immediately sent out to the hospital. By the time they called me (31 hours later) her oxygen saturation was around 90% so I ordered a chest x-ray and antibiotics. They never told me she had been so hypoxic." He also stated he was not aware she had been so hypoxic (46%) until the facility told him today (12/13/18) or he would have sent her immediately out to the emergency department.</p> <p>An additional interview was conducted with the physician on 1/8/19 at 8:35AM. He stated he had no recall of writing a comfort measures order and was not treating Resident #94 as if she was at the end of her life. He stated, "If she was comfort measures or end of life care only I would not have ordered a chest x-ray, breathing treatments, Prednisone, and antibiotics." He also stated he would not recommend administration of Morphine to an unresponsive patient, unless they were comfort measures only. He also stated the facility normally sent out residents with emergency conditions, but (Resident #94) was not sent out because it was his understanding the nurse mistakenly thought she was a hospice patient. If he had been informed of her severe hypoxia on 10/25/18 he would have immediately transferred her to the emergency department. He also stated the facility now has his number posted at each nursing station, but prior to yesterday the facility staff contacted the DON and she contacted him. He also stated, "We were just as puzzled as you</p>	F 684			

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F 684	<p>Continued From page 53</p> <p>were about why they didn't do anything for her. She had actually bounced back a bit after the orders I gave were initiated."</p> <p>An interview was conducted with the Nurse Practitioner (NP) on 12/14/18 at 9:46AM. She stated, "She (Resident #94) was definitely in bad health. Comfort measures include manage pain, anything to keep the patient comfortable. In her case it meant preventing ulcers, treating her pain, keeping her safe from her severe dementia, treating some of her medical conditions, like pneumonia. She was being treated for pneumonia in October of 2018. The staff should notify the provider of any change in condition for any resident. We may or may not treat, but we should be notified. I was never notified of a pulse ox reading of 46% or 64% on 10/25/18. She was a high risk for aspiration pneumonia and already had pneumonia. I became aware of her hypoxia after she had passed away. The provider should have been notified of her hypoxia (46% and 64%) because it's likely her pneumonia was the cause of her hypoxia."</p> <p>On 1/7/19 at 4:30PM, the Administrator and DON were notified of the Immediate Jeopardy.</p> <p>On 1/8/19 the facility provided an acceptable credible allegation of Immediate Jeopardy removal which included:</p> <p>"This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is</p>	F 684			

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F 684	<p>Continued From page 54</p> <p>prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.</p> <p>Resident # 94 was admitted to Pruitt Health Neuse on 2/11/2016 from Crystal Coast Hospice</p> <p>Upon admission family revoked 3HC hospice and transferred to Pruitt-Healthcare.</p> <p>Resident admitting diagnosis: Sepsis, Chronic obstructive pulmonary disease, Bipolar, cerebral infarct, TIA, essential hypertension, dementia without behavioral disturbance, Diabetes type 2, dysphagia, UTI, unspecified asthma.</p> <p>7/10/16 Carolina East Health System discharge diagnosis included: Acute and chronic respiratory failure with hypoxia, bipolar disorder, dehydration, unspecified dementia without behavioral disturbance, stupor, pneumonia due to other specified bacteria, and sepsis due to anaerobes.</p> <p>2/21/2016 Physician notes indicate resident was being admitted the facility for "conservative long-term care."</p> <p>On 7/20/2016 physician visit notes that indicate supportive care and comfort measures were being provided.</p> <p>On 8/13/18 physician visit notes identified that indicate supportive care and comfort measures were being provided.</p> <p>On 9/27/18 physician visit notes identified that indicate supportive care and comfort measures</p>	F 684			

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F 684	<p>Continued From page 55 were being provided.</p> <p>On 10/25/18, 12:00am a resident's oxygen saturation dropped to 46%. Oxygen was started at 4 liters per minute per nasal cannula, resident was suctioned X 2 with thick white mucus from throat. Resident was dry to touch. Resident was placed in high fowler's position to assist with breathing. Oxygen saturation increased to 64%.</p> <p>On 10/25/18 6:30am condition unchanged no gurgling respirations, non-responsive to tactile stimuli. No further symptoms currently. Resident took morphine sublingually, the off-going nurse did not report resident condition to Physician, Director of Nursing and on-coming nurse at shift change, nor did they document further oxygen saturations during their shift.</p> <p>10/26/18 7am: resident restless in bed with signs of dyspnea. SPO2 84% on 4 L/M. Registered Nurse notified physician of condition change and titrated Oxygen to 5 L/M, administered order for DuoNeb, Ativan for restlessness, order for chest X-ray. SPO2 up to 90% on 5 L/M via nasal cannula. Licensed Nurse called family without contact. X-ray ordered and completed on 10/26/2018 with bibasilar pneumonia noted. Licensed nurse will continue to monitor.</p> <p>10/26/18 10pm: - neb treatment and O2 on going comfort measure in place, ate 25% T 99.2</p> <p>10/27/18 2pm - O2 90% with nebs. No food, mouth swabbed provided, ABT ongoing DuoNeb as ordered.</p> <p>10/28/18 12:50am: - Pt found by nurse without pulse or respirations. Pt is a DNR and Death</p>	F 684			

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F 684	Continued From page 56 verified by 2 nurses.  The Facilities Clinical Competency Coordinator began educating the Licensed Nurses on 12/14/18 utilizing the interact change in condition protocol which include clinical pathways of when to contact the physician. Education also began on 12/14/18 by the Clinical Competence Coordinator to the Licensed Nurses regarding placing residents' change of conditions on the 24-hour report sheets utilized by the Licensed Nurses for reporting from shift to shift. As of 1/7/2019, 25 of 27 Licensed Nurses have been educated regarding change of condition with notification to the physician. Licensed Nurses whom have not received the education by 12/21/18 will be removed from the schedule until the education is completed. The Two Licensed Nurses who have not completed the education have been removed from the schedule until the education is completed. This education has been added to the general orientation of newly hired Registered and Licensed Practical Nurses The Clinical Competency Coordinator began educating all staff (certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration) on the stop and watch cards identifying a resident change in condition with notification to the Licensed Nurse on 12/14/2018. Facility staff will be educated be 12/21/2018. Staff whom has not received the education by 12/21/18 will be removed from the schedule until the education is completed. . As of 1/7/2019 115 employees out of 126 employees have been educated on stop and watch cards. This education has been added to the general orientation for newly hired certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities,	F 684			

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F 684	<p>Continued From page 57 and administration. On 1/7/2019 the Clinical Competency Coordinator began educating the Licensed Nurses to contact the physician with resident change in conditions as the change in condition occurred.</p> <p>The Licensed Nurses are not required to contact the Director of Nurses prior to physician notification.</p> <p>2. Monitor: Address how the facility will identify other residents having the potential to be affected by the deficient practice</p> <p>On 12/13/12/14/18 the Nurse Management team including (RN Unit Managers, RN Clinical Competency Coordinator, RN Nurse Navigator, RN Case Mix Director, and RN Case Mix Coordinator) reviewed all active resident charts nursing notes for the past 90 days to validate that the physician was notified of all change in conditions. 89 resident charts reviewed with 31 changes in conditions noted with 31 physician notifications identified.</p> <p>On 12/13/2018 the Director of Nursing and/or Nurse Managers began reviewing the 24-hour report sheet daily to identify change of conditions and validate that physician notification is documented in the nursing notes. The Director of Health Services, Unit Managers and Nurse Managers utilizes the "Notification Review" form, to review the 24-hour report sheets weekly for 4 weeks then monthly thereafter.</p> <p>The Director of Nursing and/or Nurse Managers as of 1/7/2019 are reviewing the nursing documentation for residents with change in condition until resident has 72 hours of return to</p>	F 684			

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F 684	<p>Continued From page 58</p> <p>baseline documentation. This review has been added to the "Notification Review" form on 1/8/2018 The Director of Nursing and/or Nurse Managers will complete this review daily for 5 days then weekly for 4 weeks then monthly thereafter.</p> <p>On 1/7/2019 the Director of Nursing began tracking and trending the results of the 24-hour report sheet, physician notification regarding resident change in condition, documented in the nursing notes on the "Notification review" DHS form. The analysis of the tracking and trending will be presented at the monthly Quality Assurance meeting until 3 consecutive months of compliance is sustained then quarterly thereafter.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure the deficient practice does not recur</p> <p>Effective 1/7/2019 the Medical Doctors' phone number has been posted at both nurse's stations to provide Nurses direct contact with the Physician for resident care needs. Prior to 1/7/2019 the nurses' contacted the Director of Nursing and/or Unit Managers prior to contacting the physician. The audit completed on 12/14/2018 did not reveal a systemic issue with contacting the physician.</p> <p>On 1/8/2018 the facility Nurse Managers began interviewing 3 nurses per day to audit their understanding of the training and change in condition and when to contact the physician. This will continue weekly for 12 weeks and results will be brought to the QA Committee monthly.</p> <p>On 1/8/18 the Clinical Competency Coordinator</p>	F 684			

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F 684	<p>Continued From page 59</p> <p>began interviewing 5 ancillary staff members (Certified Nursing Assistants, housekeeping, maintenance, therapy, social services, activities, and administration) per day to audit their understanding of stop and watch cards and how to use them. The Clinical Competency Coordinator will be responsible for bringing the results to the QA committee monthly.</p> <p>The Clinical Competency Coordinator is responsible that all new staff (Certified nursing assistance, housekeeping, maintenance, therapy department, social services, activities, and administration) are educated regarding stop and watch (the stop and watch cards identifying a resident change in condition with notification to the Licensed Nurse). The Clinical Competency Coordinator will report the number of staff educated to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly to ensure 100% of employees hired have completed the education.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained:</p> <p>On 12/14/2018 the Administrator of the facility met with the Department Managers regarding pending survey results and began to develop an on-going plan of correction.</p> <p>The Medical Director was notified regarding the survey and facility plan on 12/14/2018 and was updated on 1/7/2019 regarding the plan changes.</p> <p>On 12/13/2018 the Director of Nursing and/or Nurse Managers began reviewing the 24-hour</p>	F 684			

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F 684	<p>Continued From page 60</p> <p>report sheet daily to identify change of conditions and validate that physician notification is documented in the nursing notes. The Director of Health Services, Unit Managers and Nurse Managers utilizes the "Notification Review" form, to review the 24-hour report sheets weekly for 4 weeks then monthly thereafter. The Director of Nursing will report the analysis of the track and trending of the "Notification Review" to the Quality Assurance / Performance Improvement Committee monthly until 3 months of sustained compliance is maintained then quarterly thereafter.</p> <p>The Director of Nursing and/or Nurse Managers as of 1/7/2019 are reviewing the nursing documentation for residents with change in condition until resident has 72 hours of return to baseline documentation. This review has been added to the "Notification Review" form on 1/8/2018 The Director of Nursing and/or Nurse Managers will complete this review daily for 5 days then weekly for 4 weeks then monthly thereafter. The Director of Nursing will report the analysis of the track and trending of the "Notification Review" to the Quality Assurance / Performance Improvement Committee monthly until 3 months of sustained compliance is maintained then quarterly thereafter.</p> <p>The Clinical Competency Coordinators/Director of Nursing will ensure all staff is educated related to utilization of the interact change in condition (stop and watch, SBAR communication form, MD communication form for non-emergent) will be taken to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly to ensure all employees who have worked have completed</p>	F 684			

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F 684	<p>Continued From page 61 and understand the education.</p> <p>The Clinical Competency Coordinator/ Director of Nursing will present the number of new staff educated related to Stop and Watch will be taken to the Quality Assurance / Performance Improvement committee by the Clinical Competency Coordinator monthly until three months of continued compliance is sustained then quarterly thereafter, to ensure all newly hired employees have completed and understand the education.</p> <p>The Administrator is responsible to ensure the plan of correction is completed.</p> <p>Completion date 1/8/2019."</p> <p>Immediate Jeopardy was removed on 1/8/19 at 1:00PM when observations and staff interviews revealed the credible allegation of</p> <p>Immediate Jeopardy removal had been implemented and staff education had been completed.</p>	F 684			