

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345568	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/26/2021
NAME OF PROVIDER OR SUPPLIER DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG			STREET ADDRESS, CITY, STATE, ZIP CODE 83 CAVALIER DRIVE, STE 200 WILMINGTON, NC 28405	
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E 000	Initial Comments An unannounced Recertification Survey and Complaint Investigation was conducted onsite 03/22/21 through 03/24/21 and remotely through 03/26/21. The facility was found to be in compliance with 42 CFR §483.73, Emergency Preparedness. Event ID# Z88V11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification Survey and Complaint Investigation was conducted onsite from 03/22/21 through 03/24/21 and remotely through 03/26/21. One of 16 complaint allegations was substantiated with deficiency for another resident and 2 of 16 complaint allegations were substantiated without deficiency. Event ID # Z88V11.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Consultant Pharmacist interviews staff failed to remove a resident's (Resident #218) Nitroglycerin Transdermal Patch at bedtime as ordered by the physician for 1 of 5 residents observed during a medication pass observation. Findings included: Resident #218 was admitted to the facility on 02/24/21 with diagnoses to include; Atrial	F 658	F658 Davis Health and Wellness Center at Cambridge Village acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Davis	4/1/21

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

TITLE

(X6) DATE

Electronically Signed

04/13/2021

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 658	<p>Continued From page 1</p> <p>Fibrillation, Hypertension, Diabetes, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Congestive Heart Failure, Immunodeficiency, and Rheumatoid Arthritis.</p> <p>The Minimum Data Set admission assessment dated 03/02/21 documented Resident #218 had no cognitive impairments and required supervision with activities of daily living.</p> <p>A review of the care plan dated 03/23/21 revealed Resident #218 received Hospice services and was at risk for dehydration and altered comfort due to pain. Interventions included in part; to monitor for efficacy of medications, and monitor signs and symptoms of adverse effects.</p> <p>Record review revealed a physician's order for Nitroglycerin Transdermal Patch 0.4 mg (milligrams) dated 02/24/21 for Atherosclerotic Heart Disease, apply one patch every 24 hours and leave patch off for 6 hours every night.</p> <p>Record review revealed an order to remove Resident #218's Nitroglycerin Transdermal Patch 0.4 mg at hour of sleep.</p> <p>During a medication pass observation with Nurse #6 on 03/24/21 at 08:45 AM it was discovered that the Nitroglycerin Transdermal Patch which should have been removed at hour of sleep on 03/23/21 was still intact on Resident #218's right side chest area. Nurse #6 removed the old patch and held the new Nitroglycerin Patch pending notification of the physician.</p> <p>During an interview with Nurse #6 on 03/24/21 at 08:45 AM she stated the old Nitroglycerin patch should have been removed on 03/23/21 at hour</p>	F 658	<p>Health and Wellness Center at Cambridge Village's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Davis Health and Wellness Center at Cambridge Village reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings.</p> <ol style="list-style-type: none"> 1. Resident #218 was assessed by the nurse, the physician was contacted and the patch was replaced per MD order during the onsite survey. 2. Other residents with medications received via patch were reviewed with no other concerns identified. 3. Staff was retrained regarding proper removal of transdermal patches on 4/1/2021. 4. The DON or designee will review the administration of transdermal patches weekly for 1 month. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months. 		

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F 658	<p>Continued From page 2</p> <p>of sleep according to the order in the electronic medical record. She stated she held the new Nitroglycerin patch and would notify the physician.</p> <p>During an observation of Resident #218 on 03/24/21 at 08:45 AM she was observed sitting up on the side of her bed. She was complaining of a headache, and irritability, but allowed the nurse to administer her medications.</p> <p>A review of the electronic Medication Administration Record revealed the Nitroglycerin Transdermal Patch 0.4 mgs was signed off as having been removed at hour of sleep by Nurse #3.</p> <p>Attempts were made to contact Nurse #3 from 03/24/21 through 03/26/21 with no response.</p> <p>During a follow up interview with Nurse #6 on 03/24/21 at 1:30 PM she stated the physician was notified that the old Nitroglycerin Patch had not been removed on 03/23/21 at hour of sleep and stated the physician instructed her to apply the new Nitroglycerin Transdermal Patch to Resident #218 at that time. Nurse #6 stated she applied the new patch and Resident #218 reported she was feeling better.</p> <p>An interview was conducted with the Consultant Pharmacist on 03/26/21 at 9:12 AM. She stated residents that have an order for a Nitroglycerin Patch must have a nitrate free interval to decrease the risk of developing a tolerance to the medication. She indicated it was important for the patch to be removed during intervals according to the physician's order.</p> <p>An interview was conducted with the Director of</p>	F 658			

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F 658	Continued From page 3 Nursing on 03/24/21 at 4:30 PM. She stated her expectation was that the nursing staff followed the physicians order on the Medication Administration Record and the Nitroglycerin Patch should have been removed at bedtime per the physician's order.	F 658			
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to	F 732		4/1/21	

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F 732	<p>Continued From page 4 exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately document the resident census number on 1 of 22 daily staffing reports reviewed and failed to accurately document the actual number of personnel assigned to the shift on 22 of 22 daily staffing reports reviewed.</p> <p>Findings included:</p> <p>An observation upon arrival to the facility on 03/22/21 revealed the daily nursing staffing form (census form) was posted at the entry way. The census form was noted to have a line to indicate Today ' s Date and Today ' s Resident Census (# of residents in the facility.) The census form had the date documented but there was no number recorded to indicate the census. The nursing staffing form was broken down by 3 columns: Shift, Staff and Number. The shift column included day shift, evening shift, and night shift. The staff column indicated Registered Nurse (RN), Licensed Practical Nurses (LPN)/Licensed Vocational nurses (LVN) and Certified Nurse Aides (CNA) for each shift. The Number column recorded only the number of hours the staff worked and not the number of personnel assigned for the shift.</p> <p>An observation of the daily nursing staffing forms</p>	F 732	<p>F732</p> <ol style="list-style-type: none"> 1. The posted nurse staffing form was revised to include the actual number of personnel assigned during the onsite survey. 2. The revised form was implemented during the onsite survey. 3. Staff was retrained regarding the proper information required on the daily nursing staffing form on 3/30/2021. The nurse staffing posting will be posted by staff with the confirmed accurate census and the revised form that includes the actual number of personnel. 4. The DON or designee will review the posting for accuracy weekly for 4 weeks. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months. 		

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F 732	Continued From page 5 from 03/01/21 through 03/21/21 revealed the staffing form recorded only the number of hours the staff worked and not the number of personnel assigned for the shift for each staff: RN/LPN/and CNAs. An interview was conducted with the Clinical Nurse Director (CD) on 03/24/21. The CD stated when she assigned the task to complete the daily nurse staffing form to the night shift nurses who were responsible, she attached a copy of the regulation to the Daily Nurse Staffing Form and expected them to follow the directions on how to complete the form correctly.	F 732			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		4/1/21	

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F 761	<p>Continued From page 6</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews the facility failed to label opened dates on 3 of 3 insulin pens with shortened expiration dates that were opened and kept inside the locked medication storage cabinets in the resident rooms (Resident #218 and Resident #3) for 2 of 5 medication storage cabinets observed during a medication pass observation.</p> <p>Findings included:</p> <p>A review of the manufacturers instructions read in part; to discard Humalog Kwikpen 28 days after opening, and to discard Levemir FlexTouch 42 days after opening.</p> <p>1a. During an observation with Nurse #1 on 03/23/21 at 11:30 AM an opened Humalog Insulin KwikPen and an opened Levemir FlexTouch pre-filled insulin pen were observed with no opened date labeled on the pens that were kept in the locked storage cabinet in a resident's room (Resident #218).</p> <p>b. During a second observation with Nurse #1 on 03/23/21 at 12:30 PM an opened Humalog Insulin KwikPen was observed with no opened date recorded on the pen inside the locked storage cabinet in a resident's room (Resident #3).</p> <p>In an interview with Nurse #1 on 03/23/21 at 12:30 PM he stated medications including opened insulin pens were stored in the resident</p>	F 761	<p>F761</p> <ol style="list-style-type: none"> The identified insulin pens were disposed of upon identification during the onsite survey. Other residents with physician orders for insulin pens were reviewed with no additional concerns. Staff was retrained regarding proper dating of insulin pens upon opening on 4/1/2021. The DON or designee will audit insulin pen dating weekly for 4 weeks. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months. 		

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F 761	Continued From page 7 rooms in the locked medication cabinets. He acknowledged that the Humalog Insulin KwikPens and the Levemir FlexTouch were opened and did not have opened dates labeled on the pens. He stated the insulin pens should have been labeled with a date when it was opened. An interview was conducted with the Director of Nursing on 03/24/21 at 4:30 PM. She stated the nursing staff were responsible for assuring the insulin pens were labeled with an opened date once it was opened, and indicated the nursing staff should always check that the pens were labeled and dated every shift and before administering.	F 761			
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		4/1/21	

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F 842	Continued From page 8 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842			

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F 842	<p>Continued From page 9</p> <p>and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to provide consistent information regarding a resident's code status for one of one resident (Resident #218) reviewed for code status.</p> <p>Findings included:</p> <p>Resident #218 was admitted to the facility on 02/24/21 with a cumulative diagnosis including Hospice Care, acute pyelonephritis, diabetes (DM), Acute Respiratory failure (ARF), moderate depression, Parkinson's, gastric esophageal reflux disease (GERD), atrial fibrillation (A-fib), chronic obstructive pulmonary disease (COPD), rheumatoid arthritis (RA), and anxiety.</p> <p>A review of the Minimum Data Set (MDS) dated 03/02/21 indicated that resident had no cognitive impairments. The resident was independent or needed supervision only for toileting, personal hygiene, and bed mobility for activities for daily living (ADL).</p> <p>A review completed of Resident #218's Electronic Medical Record (EMR) Face Sheet (a sheet providing information about the resident) revealed the resident's Advance Directives were documented as Resuscitate (DNR) (meaning that life saving measures should not be attempted),</p>	F 842	<p>F842</p> <ol style="list-style-type: none"> 1. The EMR data entry error noting FULL CODE was corrected during the onsite survey. 2. The EMR order for code status for other residents was reviewed to ensure consistency in the record. No other concerns were identified. 3. Staff was retrained regarding consistency in code status on 3/30/2021. 4. The DON or designee will verify code status to EMR order entry weekly for 4 weeks. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months. 		

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F 842	<p>Continued From page 10 and Hospice.</p> <p>A review completed of Resident #218's medical record (Hard Chart) revealed the resident had a goldenrod stop sign Do Not Resuscitate (DNR) (meaning that life saving measures should not be attempted) sheet with an effective date of 02/11/20. Further review of the resident's Electronic Medical Record (EMR) general physician orders in her medical record revealed a physician's order dated 02/24/21 revealed Code Status: Full Code, may initiate emergency protocol to include Cardio-Pulmonary Resuscitation (CPR), insert peripheral Intravenous (IV) Normal Saline infusion at 125 ml/hr., oxygen nasal cannula (NC)/mask, suction as needed, call 911 if appropriate, and notify MD as soon as possible (ASAP).for a Full Code. Further review of resident's Physician Progress notes dated 03/11/21, 03/04/21, and 03/02/21 revealed Code Status: Full Scope of Treatment (meaning that life saving measures should be attempted).</p> <p>An interview was conducted on 03/23/21 at 2:40 PM with Nurse #5. Nurse #5 stated she entered Resident #218's admission orders on 02/24/21 and while entering the resident's orders she hit the wrong button when entering Resident #218's code status, which should have been as coded as DNR, instead of Full CODE. Nurse #1 said it was her entry error.</p> <p>An interview was conducted on 03/23/21 at 2:45 PM with MD #1. MD #1 stated Full Scope of treatment meant Full Code on her 03/02/21 Physician Progress Note. MD #1 stated Resident #218's Full Code Order should not have been on the resident's EMR. MD #1 stated the reason her</p>	F 842			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 842	<p>Continued From page 11</p> <p>03/02/21 progress note had Full Scope of Treatment listed at the top of the note, was because she got the resident's code status from the resident's electronic physician order sheet, which showed that the resident was a Full-Code, so she used that documented order, and carried it over to her progress note "Full Scope of Treatment", which was listed at the top of her progress note dated 03/02/2. She said her Nurse Practitioner (NP) must have looked at her progress note for a code status, or referenced the EMR order sheet like she had, and listed the same code status on her 03/04/21 and 03/11/21 Nurse Practitioner (NP) progress notes. MD#1 said when she needed to know a resident's code status, she would routinely refer to the code status located on the residents' EMR order sheet.</p> <p>An interview was conducted on 03/23/21 at 3:04 PM with Nurse #5. Nurse #5 stated Resident #218 was entered as a Full Code on the EMR physician orders, was an error on her part. She said the resident should have been a DNR. She said she clicked on the wrong button by mistake, making the resident a Full Code on the physician orders in the resident's EMR, and not a DNR.</p> <p>An interview was conducted on 03/23/21 at 3:08 PM with the facility Administrator stated Resident #218's code status had been put in the resident's hard chart, the actual DNR. She said Nurse #5 involved in the resident's code status up admission on 02/24/21, entered the wrong code status on Resident #218's EMR physician orders, needed to be educated on entering a resident's code status into the EMR, and needed to cross check the orders with the hard chart code status forms. She further stated it was her expectation for a resident's code status match in the hard</p>	F 842			

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

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F 842	Continued From page 12 chart records to the EMR. An interview was conducted on 03/24/21 at 11:13 AM with the Director of Nursing (DON). She stated Resident #218 was indeed a DNR resident, and "yes" it was her expectation that the Physician EMR orders should match the hard chart DNR and didn't. She said the resident was a Hospice, DNR resident.	F 842		