

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

DEC 13 2013

PRINTED: 12/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345431	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/21/2013
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NAME OF PROVIDER OR SUPPLIER OUR COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 921 JUNIOR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874
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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have fall interventions in place for a resident who was at risk for falls, which resulted in a hematoma to the forehead and a skin tear to the right wrist for 1 of 2 residents reviewed for falls (Resident #1). The findings included:</p> <p>Resident #1 was admitted into the facility on 3/1/13. Diagnosis included Dementia and history of falls. The admission minimum data set completed on 3/14/13 indicated Resident #1 cognitive status was severely impaired. Extensive assistance of one person physical assist was required with bed mobility. Total dependence was indicated with transfer and toileting. Balance was listed as did not occur. The lower extremity (hip, knee, ankle, foot) was indicated as impaired on both sides. Mobility device included a wheelchair. A fall with no injury was indicated as occurred in the last month, prior to admission/entry or reentry. The care plan with a goal date of 6/12/13 in part read "at risk for falls related to a history of falls. Interventions: place fall mat on the floor at beside when in bed and bed alarm."</p> <p>A review of the nurse's note dated 5/23/13 at 4:40</p>	F 323	<p>The requirement will be met as evidenced by documentation in the electronic medical record (EMR) of risk assessment, Morse Fall Scale (MFS). The MFS will be done within 24 hrs of admission; a care plan will be initiated as per policy, if resident is identified as being at risk for falls. (MDSC, Licensed Nurses) Attachment#1 DON, or designee, will review the record of all new admissions for compliance of policy. A report will be submitted to Quality Assurance monthly of the findings with a threshold expectation of 100%. The MFS will be done on admission, Quarterly, and updated as necessary whenever a resident falls. The care plan will be reviewed after each fall to determine if interventions remain applicable, if needed the care plan will be updated by the MDSC to reflect current approaches and interventions. All resident incidents will be reported to the Risk Meeting weekly for trends, causes and analysis. (DON or Designee)</p> <p>Actions to be taken:</p> <ol style="list-style-type: none"> 1. Environmental rounds to remove or correct potential hazards such as excess clutter in rooms and hallways, dim lighting etc. Monitor for the use of assistive devices for compliance with care plan through random daily rounds x 3 months. Findings will be reviewed with the DON and will be reported at 	12/10/13 12/18/13 12/10/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE 12/11/13
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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 329	<p>Continued From page 2</p> <p>duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to use a non-pharmacological approach to address anxious behavior prior to administering Ativan for 1 of 1 resident reviewed for unnecessary medication (Resident #1). The findings included:</p> <p>Resident #1 was admitted into the facility on 3/1/13. Diagnosis included Dementia and depression. The admission minimum data set completed on 3/14/13 indicated Resident #1 cognitive status was severely impaired. Verbal behavior symptoms directed toward others and behavior symptoms not directed toward others</p>	F 329	<p>Interventions have been attempted and found to be ineffective as evidenced by documentation in the nursing notes and on the Antipsychotic Flow sheet. (Nursing Staff and MD)</p> <p>The DON has reviewed the Policy/Procedure for Antipsychotic Medication and Examples of Non-Pharmacological Interventions, currently in place, with the nursing staff and with the physician. Policy outlines when it is appropriate to initiate a psychoactive medication as well as the benefits versus the negative outcomes: (attachment #3,4)</p> <p>Documentation of any unusual behavior or "agitation" will be required prior to initiation and will include type of behavior and which non-pharmacological interventions were used and the outcome. If the interventions fail, or the behavior is not easily redirected, or the behavior causes undue distress to the resident, the nurse will initiate the physician order as written. Documentation is required in either the nurse's note or on the electronic medication administration record (EMAR) (All licensed nurses)</p> <p>As per policy, enlistment of assistance from Activities and/or Social Services Departments as needed, in addition to the C.N.A.s, for non-pharmacological interventions.(Nursing staff, Activities Director, Social Worker under direction of DON or designee)</p> <p>The DON, with assistance from consultant</p>	<p>12/10/13</p> <p>12/11/13</p> <p>12/10/13</p> <p>12/11/13</p>

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F 329	<p>Continued From page 3</p> <p>was listed as occurred within the last 1 to 3 days. No rejection of care was listed. Antipsychotic and antianxiety medications were listed as received during the last seven days or since admission/entry or reentry. The care plan with a goal date of 6/12/13 in part read "requires the use of psychotherapeutic medication due to dementia and anxiety."</p> <p>A review of a letter of concern brought to the facility's attention dated 2/26/13 written by the responsible party addressed a concern in part that read "the use of Ativan for the purpose of keeping Resident #1 calm due to any agitation that she might develop from the situation or actions of her roommate."</p> <p>A review of the nurse's note dated 5/23/13 at 6:52 pm in part read "heard resident from the nurse's station yelling out. Nurse #1 entered room to observe resident having thrown covers off her and has her feet and legs off the bed. Assisted back onto the bed, calmly spoke to and encouraged to remain in bed. Noted residents upper extremities are shaking, resident leans forward off the bed and screams loudly at this nurse, then states "you don't want to help me do nothing, you idiot. Ativan 0.5 milligrams (mg) given at this time by Nurse #1."</p> <p>A review of the electronic medication administration record revealed on 5/26/13 at 6:52 pm Ativan 0.5 mg was administered by mouth for "yelling out, attempts to get out of bed" by Nurse #1.</p> <p>In an interview on 11/20/13 at 2:41 pm, Nurse #1 when questioned why she did not assist Resident #1 with getting out of the bed, and or reevaluate</p>	F 329	<p>Pharmacist will monitor for compliance of facility policy through monthly chart audits and Consultant Pharmacist Resident Review recommendations for resident who receive psychoactive medications. DON or designee will report monthly to Quality Assurance on psychoactive Medication usage and outcomes.</p>	12/18/13

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F 329	Continued From page 4 her behavior after she spoke calmly to her, prior to administering the Ativan stated "I administered the Ativan because she was agitated." In an interview on 11/21/13 at 3:00 pm, the director of nursing stated that her experience with Resident #1 when she became agitated, that sitting one on one with the resident was an effective approach at times. She concluded that she did not consider administering the Ativan initially as the best approach.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	The facility will maintain an Infection Control Program to provide systematic management of infection control issues for residents and employees. The program will comply with Federal, State, and Local regulations. To minimize the risk or spread of an infection or communicable disease the facility will continue to implement the following procedures as per facility policy: 1. Infection Control Designee (ADON) will notify the DON, Medical Director and the Administrator of any potential outbreak situations. 2. The Administrator, or designee, will notify the local health department within 24 hours of a known or suspected outbreak. The facility will follow the recommendations of the health department. 3. The DON, or designee, will remain in contact with the health department in order to facilitate	

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F 441	<p>Continued From page 6</p> <p>facility on 3/26/13, regarding several residents with similar symptoms: nausea, vomiting and diarrhea. The investigation revealed eleven ill residents who sought medical care for related symptoms that included nausea, vomiting, and diarrhea. As part of the investigation completed by the local health department, investigation methods included case findings and environmental inspection. Laboratory methods in part read "specify organism: suspect/norovirus. Public health interventions/control measures in part read "isolated/cohorted residents, shared state guidance."</p> <p>A review of the "specific control measures" provided to the facility on 3/26/13 by the local health department related to public health recommendations for the norovirus in part read "post notice for visitors: consider restricting visitors to a single entry point, and monitor compliance with contact isolation precautions."</p> <p>A review of a statement dated 3/27/13 written by the director of nursing in part read "information on norovirus posted at nursing stations (long term care and emergency room) for all staff."</p> <p>During an observation on 11/19/13 at 9:55 am, after entering through the front of the facility where visitors entered, administrative offices were observed upon entry. Residents' rooms were observed prior to getting to the nurse's station. The nurse's station was observed greater than 20 feet once on the care unit.</p> <p>In an interview on 11/20/13 at 3:21 pm, the director of nursing when questioned was there signage posted within the facility that could easily be identified or seen by visitors during the</p>	F 441			

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F 441	Continued From page 7 norovirus outbreak in March 2013, stated she posted a sign at the nursing station that read "see nurse before visiting residents." When further questioned, if families or visitors did not proceed to the nurses station, and chose to enter residents rooms once on the care unit, was there other signage that alerted one, the DON indicated "I only posted the sign that read "see nurse before visiting residents" located at the nursing station. In an interview on 11/21/13 at 12:33 pm, the administrator stated the facility's plan going forth was to do a better job with informing visitors during any communicable outbreak within the facility, such as the norovirus outbreak. He concluded that he was aware that there was a norovirus outbreak, within the facility during the month of March 2013.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	This requirement will be met as evidenced by proper, accurate, and timely documentation in the resident's electronic medical record (EMR), on the MDS, and in the activity log. (Activity Director) The activity director will complete the Individual Resident Daily Activities log on a daily basis indicating types of activities in which resident participated, how often attended activities, whether 1:1 or group. (Attachment #10) In addition to the Admission Activity Assessment and the daily log, the activity director will document quarterly on residents who were discussed at resident care conference. Notes will be reflective of resident's participation in activities.	12/11/13	

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F 514	Continued From page 8 by: Based on record review and staff interviews, the facility failed to maintain records of the type of activities that a resident participated in for 1 of 2 residents reviewed for activities (Resident #1). The findings included: Resident #1 was admitted into the facility on 3/1/13. Diagnosis included Dementia and depression. The admission minimum data set (MDS) completed on 3/14/13 indicated Resident #1 cognitive status was severely impaired. Listening to music, participating in religious services or practices and doing things with groups of people were indicated as somewhat important. A review of the initial activity assessment dated 3/4/13 in part read "will continue to encourage to participate in activities; interests in part included pet visits, current events, spiritual-religious, games, parties." Resident #1 was indicated as preferred passive, one on one and small/large group activities. In an interview on 11/19/13 at 3:15 pm, the activity director (AD) when questioned regarding verification of the types of activities that Resident #1 participated in from March 2013 to August 2013 indicated that she was unable to provide such documentation in the clinical record. The AD added by memory that she recalled Resident #1 participated in and enjoyed in part assisted bingo, bible study, birthday parties and pet visits. She concluded that she believed she shredded the activity participation log for Resident #1. In an interview on 11/19/13 at 3:35 pm, the director of nursing stated that she expected the	F 514	Care plans will be updated with any change in resident status and/or change in activity participation. The Individual Resident Daily Activities log sheet will be removed from activity notebook at the end of each month and given to the Medical Records Director to be scanned into the resident's EMR thereby becoming a permanent part of the resident's medical record. The DON, or designee, will monitor activity documentation through monthly random chart audit with results reported to Quality Assurance Committee each month x 3 months and then quarterly.	12/11/13 12/11/13 12/18/13

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F 514	Continued From page 9 clinical record to reflect the types of activities that residents' participated in.	F 514		