STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	06/30/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORNERSTONE NURSING AND REHABILITATION CENTER	711 SUSAN TART ROAD BOX 948 DUNN, NC 28334

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and physician interviews, the facility failed to immediately notify the physician of a significant change in a resident's condition for 1 (Resident #1) of 3 sampled residents. The resident had episodes of nausea and vomiting, low blood pressure, and yellow skin discoloration. The resident was transferred to the hospital. The Immediate Jeopardy began on 5/31/14. The administrator was notified of the Immediate Jeopardy on 6/30/14 at 9:10 am. The Immediate Jeopardy was removed on 6/30/14 at 8:59 pm when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy (D). The facility was in the process of full implementation and monitoring of their corrective action. The findings included: Resident #1 was admitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. The nurses note dated 5/28/14 through 5/30/14 documented the resident was alert and oriented. Review of the nurses note dated 5/31/14 at 1:21pm by Nurse #1 documented the resident was alert and oriented. The same note documented resident has been sick this shift and has not eaten since breakfast, [MEDICATION NAME] administered for nausea and vomiting. The nurse's note further documented Resident has been nauseated and throwing up since before lunch. Call light cord within reach. On 6/13/14 at 12:09 pm NA #2 was interviewed. NA #2 worked on the 7am -3 pm shift on 5/30/14 and 5/31/14 and she was assigned to take care of the resident. NA #2 stated the resident told her she did not feel well on Saturday (5/31/14) morning, she stated she (the resident) was nauseated. NA #2 stated she set Resident #1 up with her breakfast tray. She stated after Resident #1 took a couple of bites, she started throwing up. She stated she took the resident's vital signs after the vomiting episode and her blood pressure was low in the 80's over 50's. She stated I think it was 89/50 to be exact. NA #2 stated she informed Nurse #1 of the resident's vital signs and recorded the vital signs on the sheet at the nurse's station. The NA stated Resident #1 did not eat lunch. The NA further stated the resident's family members came in around lunch time and asked why the resident was looking yellow. The NA stated she informed the family member that the resident was sick and not feeling well. The NA stated she informed the nurse of the resident's family members concerns and the resident's continued complaints of not feeling well. NA #2 further stated (Resident #1) did not even go to therapy today because she was so sick and too weak. Review of the written statement by RN supervisor documented in part On May 31st around lunchtime, I was called to (Resident #1's) room. When I entered the room, (Nurse #1) was cleaning up some vomitus off the resident's gown. The vomitus appeared to be some of the food resident was eating. During an interview on 6/13/14 at 12:58 pm, the OTA (Occupational Therapist Assistant) #1 stated the resident complained of not feeling well on 5/31/14. She further stated she worked with the resident from 12:15 pm to 12:30 pm approximately. She stated the resident complained of feeling tired and sick. She stated she scooted the resident up in bed to prepare her for her lunch meal. She stated the resident was sick and throwing up. She further indicated the resident was puffy and glossy from the [MEDICAL CONDITION]. She further stated she went and got Nurse #1. The OTA further stated after Nurse #1 assessed the resident and the nurse withheld treatment of [REDACTED]. She stated Nurse #1 informed her that she was calling the physician and possibly sending the resident out to the hospital. The OTA stated she went back about 30 minutes later to check on Resident #1 and could not understand why the resident had not been sent out to the hospital. The OT (Occupational Therapy) Daily Treatment Note dated 5/31/14 by OTA #1 read Pt (patient) dependent with bed mobility. Pt provided optimal positioning in bed for lunch as pt too fatigued and complaining of nausea. Pt presented with cool moist skin and moderate [MEDICAL CONDITION] noted. After a couple of bites of food and sips of beverage patient vomited, OTA called nurse (Nurse #1) to room. After nurse assessment, nursing withheld treatment of [REDACTED]. On 6/13/14 at 11:17 am, NA #1 was interviewed. NA #1 worked the 7-3 shift on 5/31/14 but she was not responsible for this resident during this shift. NA#1 was responsible for this resident on the 3 pm -11 pm shift on 5/31/14. NA #1 stated Resident #1 complained of not feeling well at the beginning of the shift. She further stated Resident #1 vomited during her breakfast meal. NA #1 stated Resident #1 was not acting her normal self. The NA further stated She was out of it, tired, sleepy and weak. NA #1 stated NA #2 had taken the resident's vital signs that morning after the vomiting episode and the blood pressure was low. The NA stated she remembered seeing the blood pressure reading on the machine after NA #2 took the vital signs for Resident #1. NA #1 further stated she worked a double shift and after 3 pm she was assigned to Resident #1. She stated when she went in to check on Resident #1 shortly after 3 pm, Resident #1's skin was yellow and her mouth was open. She stated she asked NA #3 to come and verify with her that the resident's color was yellow. She stated the resident was not talking straight to them. NA #2 further stated she went to the nurse's station and reported the findings to Nurse #1. She stated Nurse #1 told her she had given the resident some medication earlier. The NA stated she told Nurse#1 that the resident was still not feeling well. She stated after she left Nurse #1, she stopped by the Medication Aide on duty and informed her that the resident was not feeling well and was yellow in color. Review of a written statement by NA#1 documented in part On Saturday, 5/31/14 (Resident #1) was very sick, sick vomiting and having diarrhea. As the day went on, (Resident #1) was still feeling bad. I asked (Nurse #1) around 2:45pm, what would we do about (Resident #1) because she was still doing bad. She raised her voice at me and stated I can't send her out for vomiting and diarrhea. I then walked away. Around (time unclear) she was looking yellow. I told (NA #3) to look at her and she agreed with me. I then went to RN supervisor and asked her to look at (Resident #1) and she stated 'I'm sending her out, I've called EMS!' During an interview on 6/13/14 at 11:40 am, Medication Aide #1 (worked 3-11 shift on 5/31/14) stated she was not informed of the resident's condition by the off-going nurse. The medication aide further stated she did not go in and actually see the resident after she assumed her duties for the hall at 3pm. She stated she was informed later in the shift by NA #1 that was on duty of the resident being sick during the day and vomiting. Review of the nurse's note dated 5/31/14 at 5:31pm by RN supervisor documented Med Tech and CNA asked writer to come to room to assess resident (rsdt). Resident's family member was present and stated that resident was not responding normally, that she was pale in color and swollen. Writer noticed that resident was hard to arouse, cool and clammy with shallow respirations of 28. Oxygen saturation =78%. Foley with tea colored urine. Also, CNA informed writer that resident was not able to participate in PT (physical therapy) today. Writer, physician and resident's family member agree to send resident to the hospital for evaluation. Review of the Physician Please Sign and Return form revealed an order dated 5/31/14 at 4:55 pm for Resident to hospital for evaluation for change in mental status, nausea and vomiting, weakness, Temperature of 99 degrees axillary per RP (responsible party) request, O2 sat =76%. On 6/13/14 at 10:32 am in an interview, the RN supervisor stated she was initially called to the resident's room about lunch time. She stated the resident had vomited a little bit and the assigned hall nurse stated she was going to give the resident a dose of [MEDICATION NAME]. The RN supervisor stated she was later told by the assigned nurse somewhere between 1pm and 2pm that the resident was just resting. The RN supervisor stated she did not personally do an assessment of the resident at the time of the vomiting

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) episode. She further stated she looked at the emesis and it looked like the food she was eating. She stated the resident appeared [MEDICAL CONDITION] to her but she thought it was just obesity. The RN supervisor further stated she was not familiar with the resident because the resident was a new admission to the facility. She further indicated she was later called to the resident's room approximately 4:45 pm at the family member's request. She stated the resident's color had changed and her blood pressure was down. The RN supervisor stated she was aware of the resident's blood pressure being low earlier in the shift but she was advised by the assigned nurse that the resident's blood pressure normally run low. The RN supervisor stated she did not personally review the resident's recorded blood pressures to verify any history of low blood pressures. The RN supervisor further stated the resident's oxygen saturation was 76% on room air. The RN supervisor stated she went by the resident's room later during the day but she did not stop to check on the resident personally because she was told by the assigned hall nurse that the resident was resting. Review of written documentation from the local EMS (Emergency Medical Services) revealed the EMS unit arrival to the facility was 5:14 pm. Review of the patient record of the local Emergency Medical Services documented on 5/31/14 at 5:16 pm revealed it was noted that the patient didn't have a radial pulse. The resident's record documented on 5/31/14 at 5:17 pm Respirations 8 and shallow, pulse rate 38 and oxygen saturation of 78%. Further review of the patient record of the local Emergency Services documented oxygen was initiated at 5:18 pm at 15 liters per a non-rebreather (nrb) mask due to SPO2 (peripheral capillary oxygen saturation) and decreased respirations. Multiple attempts to contact Nurse #1 were unsuccessful. Attempts to contact Nurse #1 were made on 6/13/14 at 12:50 pm, 2:49 pm and 5:37 pm. The last attempt to contact Nurse #1 was made on 6/30/14 at 9:43 am. On 6/13/14 at 2:55 pm in an interview, the attending physician stated it was his expectation that the facility notify him immediately of a change in a resident's condition. After discussing the reports per the staff of the resident having nausea and vomiting, low blood pressure reading and yellow skin discoloration, the physician further stated The three symptoms together meant something was going wrong here. The administrator was notified of the Immediate Jeopardy on 6/30/14 at 9:10 am. The Immediate Jeopardy was removed on 6/30/14 at 8:59 pm. The credible allegation read as follows: Resident # 1 was assessed by hall nurse on 5/31/14 and observed to have skin warm and dry, breathing even and unlabored, no productive cough present, lung sounds normal, 02 sats at 95% and nausea and vomited food. [MEDICATION NAME] given for Nausea and Vomiting on 5/31/14 by hall nurse per PRN as needed order. Med tech and Certified Nursing Assistant summons nursing supervisor to come to residents room to assess resident on 5/31/14. Resident #1 was assessed on 5/31/14 by the nursing supervisor for response, color, [MEDICAL CONDITION], respirations, 02 sats, and urine color in Foley. The RP was present during the assessment of resident #1 by nursing supervisor. The attending physician was made aware by telephone of resident #1 condition on being hard to arouse, cool and clammy with shallow respirations of 28, 02 sats at 76%, tea colored urine in Foley and not able to participate in therapy on 5/31/14. A telephone order was received on 5/31/14 from the attending physician at 4:55pm for resident #1 to be sent to (the hospital) for evaluation. Hall nurse on 7-3pm shift assigned to resident #1 during the acute change resigned on 6/2/14. All other licensed nurses were in-serviced on 6/18/14 by Staff Facilitator (Staff Educator) regarding notification to physician by telephone when an acute change in condition to include cognitive status, behavior, immune system response, normal body system functioning, changes in cognitive status, changes in behavior, changes in oral intake to include fluids, changes in immune system, changes in normal body functioning, Panic laboratory values, resident's condition warrants based upon nurse's assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility's Medical Director. Notification of the physician of these types of changes in a resident's condition by fax is not acceptable. As of 6/30/14, all licensed nurses have been in-serviced on notification to physician by telephone when an acute change in condition to include cognitive status, behavior, immune system response, normal body system functioning, acute change in resident condition, changes in cognitive status, changes in behavior, changes in oral intake to include fluids, changes in immune system, changes in normal body functioning, Panic laboratory values, resident's condition warrants based upon nurse's assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility's Medical Director; and Notification of the physician of these types of changes in a resident's condition by fax is not acceptable. Acute Change is defined as anything outside the norm for a resident to include but not limited to change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls. 100% audit of all resident's daily progress notes in last 30 days was initiated by MDS nurse Coordinator, MDS nurse, QI (quality improvement) nurse, Treatment nurse and Staff Facilitator on 6/19/14. 6/20/14, 6/21/14, 6/22/14, 6/23/14, 6/24/14, 6/25/14, 6/26/14, 6/27/14, 6/28/14, 6/29/14, and completed by 6/30/14 to ensure residents who have had an acute change in condition to include but not limited to change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls were assessed to include vital signs and 02 sats, appropriate interventions placed, and Attending Physician and Responsible Party were notified of acute change. One resident was identified to not have Attending Physician notification. The resident was assessed and Attending Physician notified on 6/19/14. This assessment along with interventions, Attending Physician and Responsible Party notification will be documented in the progress notes by the hall nurse. 100% head to toe assessment was completed by ADON, (assistant director of nursing) Staff Facilitator, QI nurse, MDS Coordinator, MDS nurse and Treatment nurse on 6/30/14 on all residents for any acute change in condition to include but not limited to change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls. The Attending Physician and Responsible Party will be notified and appropriate interventions initiated with all identified changes in condition to include but limited to change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls. This assessment, Attending Physician, Responsible Party notifications and appropriate interventions documented in the progress notes by the hall nurse. 100% of licensed nurses have been in-serviced on notification to physician by telephone when an acute changes in condition occur, including changes in cognitive status, behavior, oral changes to include fluids, immune system response, normal body system functioning, Panic laboratory values, resident's condition warrants based upon nurse's assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility's Medical Director. Notification of the physician of these types of changes in a resident's condition by fax is not acceptable. All licensed nurses working have been in-serviced in notification of the physician completed on 6/30/14. The Staff nurse is responsible to assess, document, provide appropriate intervention and notify Attending Physician and Responsible Part of any acute changes in condition noted. The staff nurse will implement appropriate interventions based on the needs of the resident and notify Attending Physician and Responsible Party. All staff nurses will document all acute changes in condition on the 24 hour report/communication board daily. The staff nurses will communicate all acute changes utilizing the communication board during shift report. DON (director of nursing), ADON, and Weekend Supervisor will review the 24 hour/communication board utilizing a 24 hour report/communication tool daily to ensure all acute changes are identified and followed up with an assessment/intervention and Attending Physician and Responsible Party notification. The credible allegation completion date was set to be 6/30/14. On 6/30/14 at 9:01 pm, verification of the credible allegation was evidenced by interviews of licensed nursing staff related to notification of physician related to changes in a resident's condition. The licensed nursing staff verified examples of acute changes and the need for documentation in the medical record. The licensed nurses also verified the need to implement medical intervention as indicated for the change in condition and document the interventions.
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to intervene for a resident experiencing pain with associated injury for 1 of 3 resident's (resident #1) reviewed for pain. Findings include: Resident #1 was admitted on [DATE] with cumulative [DIAGNOSES REDACTED]. Her annual Minimum (MDS) data set [DATE] indicated she had severe cognitive

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) impairment and required extensive assistance with bed mobility, total assistance of one using a lift, non-ambulatory and total assistance for all other activities of daily living. Resident #1 was care planned for pain associated with [MEDICAL CONDITION], arthritis and decreased mobility. A nursing note dated 5/1/14 and timed 8:07 AM, read that resident #1 was fussy during the beginning of third shift. Nursing assistant (NA) #1 was concerned about resident #1's right upper leg. Nurse #1 assessed the leg and noted slight swelling but resident #1 able to move both legs without problem. There was no noted increased grimacing when moving her right leg. A nursing note dated 5/1/14 and timed 2:41 PM, read the third staff noted abnormal rotation and [MEDICAL CONDITION] to resident #1's right upper leg. The leg was outwardly rotated and absent of obvious signs of trauma such as bruising. There was noted increased pain. An x-ray was ordered. A review of an incident report dated 5/1/14 indicated resident #1 was noted with abnormal rotation of the right leg by the third shift staff. There was observed swelling to the right thigh and evidence of pain. Witness statements from NA #1 indicated resident #1 was yelling when she came in at 11:00 PM. She recalled resident #1 yelling most of the shift and other staff working witnessed her yelling. NA #1 notified the nurse that resident #1's right foot was turned outward the right thigh was swollen. The witness statement from nurse #1 stated that NA #1 reported resident #1 was fussy but would quiet down. She administered her breathing treatment and medicated her with Tylenol for pain at the beginning of the shift. It was around 3:30 AM, NA#1 reported concerns about resident #1's right leg. Nurse #1 assessed her and resident #1 was able to move both legs and did not yell. At the end of the shift she stated the right foot looked more rotated. In an interview on 5/14/14 at 12:10 PM, nurse #2 who worked first shift on 5/1/14 stated nurse #1 reported to her that resident #1 was fussy on third shift and that NA #1 thought something was wrong with her leg. Nurse # 1 and nurse #2 went to assess resident #1. Nurse #2 stated she knew immediately something was wrong with resident #1's right leg and she was moaning. Nurse #2 went and got the staff facilitator and physical therapist to assess resident #1's leg. Nurse #2 advised nurse #1 she needed to notify the physician and get an order for [REDACTED].#2 stated the x-ray technician stated resident #1 was experiencing pain during x-ray so he stopped and spoke with the assistant director of nursing (ADON) about resident #1 pain. Nurse #2 stated the x-ray was positive for a right femur fracture and she notified the RP and physician. The physician ordered an orthopedic consult and a medication for pain. Nurse #2 stated she was unable to get an appointment with an orthopedic doctor until the following Monday but due to resident #1's pain, the RP requested resident #1 to be sent to the hospital for an evaluation. She stated she administered the ordered pain medication to resident #1 at 12:00 PM prior to her being transported to the hospital. In an interview on 5/14/14 at 12:20 PM, nurse #3 recalled resident # 1 slept most of the day on second shift on 4/30/14. She recalled the NA #3 put resident #1 to bed at the early part of second shift and it was at the end of the shift she noted resident #1 yelling. Nurse #3 stated she did not go and assess resident #1 because she had reported off to nurse #1. In an interview on 5/14/14 at 12:40 PM, NA #2 stated she worked with resident #1 on first shift 4/30/14 and she had gotten resident #1 up in her chair using the lift before lunch and when she left for the day, resident #1 was still sitting up in her chair. NA #2 stated resident #1's care guide indicated she was a lift with one person assistance. She exhibited her usual behavior of babbling but expressed no yelling or evidence of pain. In a telephone interview on 5/14/14 at 12:45 PM, NA #1stated she heard resident #1 yelling when she came in on for her shift at 11:00 PM on 4/30/14. NA #1 stated she requested nurse #1 give resident #1 something for pain and she continued with making her first rounds of the shift. NA #1 stated it was about 10 minutes later that resident #1 again began yelling and she noted her peers discussed that something was wrong with resident #1 because it was not like her to yell. Na #1 stated she went into the room and pulled the cover back to check to see if resident #1 was wet and she noticed her thigh was swollen. NA #1 stated she went and told nurse #1 but nurse #1 did not go and assess resident #1 at that time. NA #1 stated at around 3:00 AM or 4:00 AM, she and nurse #1 went together to look at resident #1's right leg. Nurse #1 stated it looked normal but did appear slightly swollen to her right thigh. At the end of her shift, NA # 1 noted resident #1 was still yelling when she left at 7:00 AM. In an interview on 5/14/14 at 1:40 PM, the ADON stated resident #1 never yelled or screamed and her normal behavior was verbal gibberish. She recalled the staff facilitator telling her that resident #1's leg did not look right but she did not appear in pain. She recalled getting an order for [REDACTED].#1 pain and got an order for [REDACTED]. In a telephone interview on 5/14/14 at 1:45 PM, NA #3 stated when she came in at 3:00 PM on 5/1/14, resident #1 was sitting up in her chair. She stated she used the lift to put resident #1 into the bed and made rounds on her at approximately 8:00 PM and again at 10:30 PM. NA #3 recalled resident #1 being wet at 10:30 PM so she rolled resident #1 onto her left side using the lift pad and changed her brief. NA #3 stated resident #1 did not exhibit any overt signs of pain while care was provided. It was at around 10:50 PM, she heard resident #1 yelling. She stated she went into the room to check resident #1 but did not touch her or remove her covers to see her body. In an interview on 5/14/14 at 2:20 PM, the staff facilitator stated nurse #2 asked her to assess resident #1's right leg. She recalled asking the physical therapist (PT) to go with her to assess resident #1. The staff facilitator stated resident #1's right foot was turned outward and her right thigh was swollen but resident #1 was not yelling out in pain. In an interview on 5/14/14 at 2:30 PM, the PT stated on assessment of resident #1's right leg on 5/1/14, she observed resident #1 thrashing about in the bed. She was not screaming but she was crying and grimacing. The PT stated she felt a boney prominence to the right lateral side of the hip and thought resident #1 ' s right leg was either dislocated or fractured. The PT noted the leg being externally rotated as well. She suggested an x-ray of the entire leg and not just the hip to rule out a femur fracture. In a telephone interview on 5/14/14 at 2:45 PM, NA #4 stated she heard resident #1 yelling and hollering when she came in on third shift 5/1/14. She recalled discussing with her peers that something wrong with resident #1 because she does not normally behave in that manner. In a telephone interview on 5/14/14 at 2:50 PM, the nurse practitioner (NP) stated she recalled speaking to the ADON about not being able to get resident #1 into to see an orthopedic doctor and she gave an order for [REDACTED]. In a telephone interview on 5/14/14 at 3:00 PM, NA #5 stated resident #1 was known to throw her legs over the side of the bed and she would babble when she was cold or wet. NA #5 stated she was working on 200 hall on 5/1/14 and did not hear resident #1 yelling but she did recall hearing her peers discussing concerns about why resident #1 was yelling. In a telephone interview on 5/14/14 at 3:20 PM, nurse #1 stated she recalled NA #1 approaching her midway through third shift stating that resident #1 was fussy. She stated she gave her Tylenol and later in the shift NA #1 asked her to look at resident #1's right leg. Nurse #1 stated resident #1 was moving her legs but the right leg look more turned outward so she notified the NP around 6:45 AM. The NP ordered an x-ray of right leg. Nurse #1 stated she did not hear resident #1 yelling or screaming on her shift. In a review of the hospital emergency room record, resident #1 was diagnosed with [REDACTED]. In an interview on 5/14/14 at 4:00 PM, the administrator and the DON stated it was their expectation that the staff call the physician and not wait when a resident exhibits evidence of pain or injury.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to comprehensively assess a change in a resident 's condition for 1 (Resident #1) of 3 sampled residents; and failed to initiate medical treatment of [REDACTED].#1) of 3 residents with an oxygen saturation of 78% for greater than 15 minutes. The Immediate Jeopardy began on [DATE]. The administrator was notified of the Immediate Jeopardy on [DATE] at 9:10 am. The Immediate Jeopardy was removed on [DATE] at 8:59 pm when the facility provided an acceptable Credible Allegation of Compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action. The findings included: Resident #1 was admitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. The nurses note dated [DATE] through [DATE] documented the resident was alert and oriented. Review of a written statement by NA #2 documented On Saturday I told Nurse #1 that morning that Resident #1 was sick. She was vomiting that morning. I told her and she said that she gave her a pill. I got her blood pressure and it was too low and her pulse. Family member came in and said that she did not look right. I told Nurse #1 and she said that the resident was fine. I told her that morning that the woman should be sent out. On [DATE] at 12:09 pm NA #2 was interviewed. NA #2 worked on the 7am -3 pm shift on [DATE] and [DATE] and she was assigned to take care of the resident. NA #2 stated Resident #1 was feeling good the day before on Friday. She stated the resident stated she did not feel well on Saturday ([DATE]) morning, she stated she was nauseated. NA #2 stated she set Resident #1 up with her breakfast tray. She stated after Resident #1 took a couple of bites, she started throwing up. She stated she took the resident's vital signs after the vomiting episode and her blood pressure was low in the 80's over 50's. She stated I think it was ,[DATE] to be exact. NA #2 stated she informed Nurse #1 of the resident's vital signs and recorded the vital signs on the sheet at the nurse's station. The NA stated Resident #1 did not eat lunch. The NA further stated the resident's family members came in around lunch time and asked why the resident was looking yellow. The

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) NA stated she informed the family member that the resident was sick and not feeling well. The NA stated she informed the nurse of the resident's family members' concerns and the resident's continued complaints of not feeling well. She further stated Resident #1 did not even go to therapy today because she was so sick and too weak. Review of the OT (Occupational Therapy) Daily Treatment Note dated [DATE] by OTA (Occupational Therapy Assistant) #1 documented Pt (patient) dependent with bed mobility. Pt provided optimal positioning in bed for lunch as pt too fatigued and complaining of nausea. Pt presented with cool moist skin and moderate [MEDICAL CONDITION] noted. After a couple of bites of food and sips of beverage patient vomited, OTA called nurse to room. After nurse assessment, nursing withheld treatment of [REDACTED]. During an interview on [DATE] at 12:58 pm, the OTA (Occupational Therapist Assistant) #1 stated the resident complained of not feeling well on [DATE]. She further stated she worked with the resident from 12:15 pm to 12:30 pm approximately. She stated the resident complained of feeling tired and sick. She stated she scooted the resident up in bed to prepare her for her lunch meal. She stated the resident was sick and throwing up. She further indicated the resident was puffy and glossy from the [MEDICAL CONDITION]. She further stated she went and got Nurse #1. The OTA further stated after Nurse #1 assessed the resident and the nurse withheld treatment of [REDACTED]. She stated Nurse #1 informed her that she was calling the physician and possibly sending the resident out to the hospital. The OTA stated she went back about 30 minutes later to check on Resident #1 and could not understand why the resident had not been sent out to the hospital. Review of the nurses note dated [DATE] at 1:21 pm by Nurse #1 documented the resident was alert and oriented. The same note documented resident has been sick this shift and has not eaten since breakfast, [MEDICATION NAME] administered for nausea and vomiting. The nurse's note further documented resident resting in room. Able to make wants/needs known to staff. Skin warm and dry. Breathing even and unlabored. Meds tolerated well. Resident has been nausea and throwing up since before lunch. Call light cord within reach. Review of the Medication Administration Record [REDACTED]. Further review of the MAR indicated [REDACTED]. Multiple attempts to contact Nurse #1 were unsuccessful. Attempts to contact Nurse #1 were made on ,[DATE] at 12:50 pm, 2:49 pm and 5:37 pm. The last attempt to contact Nurse #1 was made on [DATE] at 9:43 am. Review of a written statement by NA #1 read in part On Saturday, [DATE] Resident #1 was very sick, sick vomiting and having diarrhea. Her Aid (NA#2) took her vitals and informed Nurse #1 that she wasn't doing well. As the day went on, Resident #1 was still feeling bad. I asked Nurse #1 around 2:45pm, what would we do about Resident #1 because she was still doing bad. She raised her voice at me and stated I can't send her out for vomiting and diarrhea. I then walked away. Around (time unclear) she was looking yellow. I told NA #3 to look at her and she agreed with me. I then went to RN supervisor and asked her to look at Resident #1 and she stated I'm sending her out, I've called EMS! Nurse #1 was asked to get oxygen for Resident #1. After about ,[DATE] minutes, I looked for Nurse #1. She was at the nurse's station doing her MARS (Medication Administration Records). I asked Nurse #1 where was the oxygen? Nurse #1 stated I don't have keys to the room and I'm not on the hall anymore. She never got the oxygen that the RN supervisor asked her to get. On [DATE] at 11:17 am NA #1 was interviewed. NA #1 worked the ,[DATE] shift on [DATE] but she was not responsible for this resident during this shift. NA#1 was responsible for this resident on the 3 pm -11 pm shift on [DATE]. NA #1 stated Resident #1 complained of not feeling well at the beginning of the shift. She further stated Resident #1 vomited during her breakfast meal. NA #1 stated Resident #1 was not acting her normal self. The NA further stated She was out of it, tired, sleepy and weak. NA #1 stated NA #2 had taken the resident's vital signs that morning after the vomiting episode and the blood pressure was low. The NA stated she remembered seeing the blood pressure reading on the machine after NA #2 took the vital signs for Resident #1. NA #1 further stated she worked a double shift and after 3 pm she was assigned to Resident #1. She stated when she went in to check on Resident #1 shortly after 3 pm, Resident #1's skin was yellow and her mouth was open. She stated she asked NA #3 to come and verify with her that the resident's color was yellow. She stated the resident was not talking straight to them. NA #2 further stated she went to the nurse's station and reported the findings to Nurse #1. She stated Nurse #1 told her she had given the resident some medication earlier. The NA stated she told Nurse #1 that the resident was still not feeling well. She stated after she left Nurse #1, she stopped by the Medication Aide on duty and informed her that the resident was not feeling well and was yellow in color. In an interview on [DATE] at 1:52 pm, NA # 3 stated she was asked by NA #1 on [DATE] to come look at the resident to see if she looked yellow to her. The NA stated Resident #1 was sick and her skin was yellow. NA #3 further stated She did not look good and she was just laying there. During an interview on [DATE] at 11:40 am, Medication Aide #1 (worked ,[DATE] shift on [DATE]) stated she was not informed of the resident's condition by the off-going nurse. The Medication Aide further stated she did not go in and actually see the resident after she assumed her duties for the hall at 3pm. She stated she was informed later in the shift by NA #1 that was on duty of the resident being sick during the day and vomiting. The Medication Aide stated the daughter came up to her in the hall around 4:30 pm and asked what was wrong with Resident #1. She stated she informed the family member that nothing was wrong with the resident that she was aware of. The medication aide stated she continued her medication pass. She further stated a few minutes later she asked the RN supervisor to go and check the resident. The Medication Aide stated she was informed by the RN supervisor later that the resident was being sent to the hospital. Review of the nurse's note dated [DATE] at 5:31 pm by RN supervisor read Med Tech and CNA asked writer to come to room to assess resident (rsdt). Resident's family member was present and stated that resident was not responding normally, that she was pale in color and swollen. Writer noticed that resident was hard to arouse, cool and clammy with shallow respirations of 28. Oxygen saturation =78%. Foley with tea colored urine. Also, CNA informed writer that resident was not able to participate in PT (physical therapy) today. Writer, physician and resident's family member agree to send resident to the hospital for evaluation. See VS's (vital signs). Resident's family member to meet resident at the hospital. Review of the written statement by RN supervisor read in part On [DATE]st around lunchtime, I was called to (Resident #1's) room. When I entered the room, Nurse #1 was cleaning up some vomitus off the resident's gown. The vomitus appeared to be some of the food resident was eating. Then around 4:45 pm, I was called to (Resident #1's) room again. This time I was greeted by the resident's family member who asked if I could help her with Resident #1. I asked her what she needed me to do and she stated Resident #1 was not doing good. I asked her what she thought was different about Resident #1. She told me that Resident #1 was swollen, that her color was not good and that she was not acting right. I told the resident's family member that I could send Resident #1 out to the hospital for evaluation and she agreed. After the resident's family member was out of the room, I quickly assessed the resident. EMS and the attending physician were called. Nurse #1 did offer to get the oxygen but did not immediately because EMS had already been called. However after a few minutes and the fact that EMS had not gotten there, I asked the CNA to have Nurse #1 get oxygen. CNA came back to the room and stated that Nurse #1 said she was off the floor and someone else needed to get the oxygen. EMS arrived shortly and resident was transferred to the hospital. On [DATE] at 10:32 am in an interview, the RN supervisor stated she was initially called to the resident's room about lunch time. She stated the resident had vomited a little bit and the assigned hall nurse stated she was going to give the resident a dose of [MEDICATION NAME]. The RN supervisor stated she was later told by the assigned nurse somewhere between 1pm and 2pm that the resident was just resting. The RN supervisor stated she did not personally do an assessment of the resident at the time of the vomiting episode. She further stated she looked at the emesis and it looked like the food she was eating. She stated the resident appeared [MEDICAL CONDITION] to her but she thought it was just obesity. The RN supervisor further stated she was not familiar with the resident because the resident was a new admission to the facility. She further indicated she was later called to the resident's room approximately 4:45 pm at the family member's request. She stated the family member was concerned about the resident and stated she was not acting right. She stated the resident's color had changed and her blood pressure was down. The RN supervisor stated she was aware of the resident ' s blood pressure being low earlier in the shift but she was advised by the assigned nurse that the resident's blood pressure was normally low. The RN supervisor stated she did not personally review the resident's recorded blood pressures to verify any history of low blood pressures. The RN supervisor further stated the resident's oxygen saturation was 76% on room air. The RN supervisor stated she did not provide any medical intervention for the resident's low oxygen saturation because EMS had been called and they usually get there within a few minutes. She further stated that EMS took longer to get to the facility on [DATE] but she did not provide any oxygen to the resident. The RN supervisor stated she was later told after she sent the resident to the hospital that the resident was not able to participate in therapy that morning because she was too weak. The RN supervisor stated she went by the resident's room later during the day but she did not stop to check on the resident personally because she was told by the assigned hall nurse that the resident was resting. Review of the Physician Please Sign and Return form revealed an order dated [DATE] at 4:55 pm for Resident to hospital for evaluation for change in mental status, nausea and vomiting, weakness, Temperature of 99 degrees axillary per RP (responsible party) request, O2 sat =76%. Review of the Emergency Medical Services Report dated [DATE] documented the patient was found lying in bed not real responsive and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	06/30/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORNERSTONE NURSING AND REHABILITATION CENTER	711 SUSAN TART ROAD BOX 948 DUNN, NC 28334

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) very pale almost light blue in color from the neck up. Review of written documentation from the local EMS (Emergency Medical Services) documented the 911 call was placed at 5:00 pm and the time of the EMS unit arrival to the facility was 5:14 pm. Review of the patient record of the local emergency services dated on [DATE] at 5:16pm read, it was noted that the patient didn't have a radial pulse. The patient record documented on [DATE] at 5:17 pm Respirations 8 and shallow, pulse rate 38 and oxygen saturation of 78%. Further review of the patient record of the local emergency services documented oxygen was initiated at 5:18 pm at 15 liters per a non-rebreather (nrb) mask due to SPO2 (peripheral capillary oxygen saturation) and decreased respirations. The same report documented on [DATE] at 5:28 pm read the patient's SPO2 started to improve and her color also started to improve. Review of the local hospital emergency room report documented when EMS arrived, the patient was basically a [MEDICATION NAME] (sic) and blood pressure was in the 60 systolic. On [DATE] at 2:55 pm in an interview, the attending physician stated the sooner a resident is evaluated, the more likely the outcome would be different for the resident. After discussing the reports per the staff of the resident having nausea and vomiting, low blood pressure reading and yellow skin discoloration, the physician further stated, The three symptoms together meant something was going wrong here. In an interview on [DATE] at 11:38 am, the Director of Nursing (DON) stated an investigation was initiated on [DATE] regarding the care delivery for Resident #1. The DON further revealed the facility was not aware of the oxygen not being readily accessible to the nurses until [DATE] at which time the lock on the oxygen room was changed to a keypad where a key would not be required. During an interview on [DATE] at 11:48 am, the Director of Emergency Services stated Resident #1 was cyanotic (blue in color) from a lack of oxygen on EMS arrival to the facility. He further stated the resident did not have a palpable pulse at the wrist due to the low blood pressure. He stated EMS was not able to obtain a blood pressure initially but the first obtainable blood pressure was ,[DATE]. The resident died on [DATE]. The facility provided the following Credible Allegation on [DATE] at 8:59 pm. Credible Allegation of Compliance: F-Tag 309 For the Provision of Care to Maintain the highest level of function for residents. Completion date [DATE] ? Resident # 1 was assessed by hall nurse on [DATE] and observed to have skin warm and dry, breathing even and unlabored, no productive cough present, lung sounds normal, 02 sats at 95% and nausea and vomited food. [MEDICATION NAME] given for Nausea and Vomiting on [DATE] by hall nurse per PRN as needed order. Med tech and Certified Nursing Assistant summons nursing supervisor to come to residents room to assess resident on [DATE]. Resident #1 was assessed on [DATE] by the nursing supervisor for response, color, [MEDICAL CONDITION], respirations, 02 sats, and urine color in foley. The RP was present during the assessment of resident #1 by nursing supervisor. The attending physician was made aware by telephone of resident #1 condition on being hard to arouse, cool and clammy with shallow respirations of 28, 02 sats at 76%, tea colored urine in foley and not able to participate in therapy on [DATE]. A telephone order was received on [DATE] from the attending physician at 4:55pm for resident #1 to be sent to Betsy Johnson Hospital for evaluation. Hall nurse assigned to resident #1 during the acute change resigned on [DATE]. All other licensed nurses were in-serviced on [DATE] by Staff Facilitator (Staff Educator) regarding notification to physician by telephone when an acute change in condition to include cognitive status, behavior, immune system response, normal body system functioning, changes in cognitive status, changes in behavior, changes in oral intake to include fluids, changes in immune system, changes in normal body functioning, Panic laboratory values, resident ' s condition warrants based upon nurse ' s assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility ' s Medical Director. Notification of the physician of these types of changes in a resident ' s condition by fax is not acceptable. As of [DATE], all licensed nurses have been in-serviced on notification to physician by telephone when an acute change in condition to include cognitive status, behavior, immune system response, normal body system functioning, acute change in resident condition, changes in cognitive status, changes in behavior, changes in oral intake to include fluids, changes in immune system, changes in normal body functioning, Panic laboratory values, resident ' s condition warrants based upon nurse ' s assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility ' s Medical Director; and Notification of the physician of these types of changes in a resident ' s condition by fax is not acceptable. ? Acute Change is defined as anything outside the norm for a resident to include but not limited to change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls. ? 100% audit of all residents daily progress notes in last 30 days was initiated by MDS nurse Coordinator, MDS nurse, QI nurse, Treatment nurse and Staff Facilitator [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and completed by [DATE] to ensure residents who have had an acute change in condition to include but not limited to change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls were assessed to include vital signs and 02 sats, appropriate interventions placed, and Attending Physician and Responsible Party were notified of acute change. One resident was identified to not have Attending Physician notification. The resident was assessed and Attending Physician notified on [DATE]. This assessment along with interventions, Attending Physician and Responsible Party notification will be documented in the progress notes by the hall nurse. 100% head to toe assessment was completed by ADON, Staff Facilitator, QI nurse, MDS Coordinator, MDS nurse and Treatment nurse on [DATE] on all residents for any acute change in condition to include but not limited to change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls. The Attending Physician and Responsible Party will be notified and appropriate interventions initiated with all identified changes in condition to include but limited to change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change is sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls. This assessment, the Attending Physician, Responsible Party notifications and appropriate interventions will be documented in the progress notes by the hall nurse. ? 100% in-service was initiated with all C.N.A ' s, Housekeeping, Dietary and Therapy staff on [DATE] on all shifts by Staff Facilitator regarding observation and reporting changes in resident ' s condition promptly to the hall nurse or supervisor. 100% in-service was initiated on [DATE] on the completion of The Early Warning Tool Stop and Watch tool and to be completed by C.N.A ' s, licensed nurses, housekeeping, dietary, Therapy staff on any acute change in condition noted to include Seems different than usual, talks or communicates less than usual, overall needs more help than usual, participated in activities less than usual, ate less than usual (not because of dislike of food), Drank less than usual, weight change, agitated or nervous more than usual, tired, weak, confused, or drowsy, change in skin color or condition, and help with walking, transferring, toileting more than usual and given to hall nurse. No staff will be allowed to work until they have received in-service. The hall nurse will follow up when the Early Warning Tool by assessing the resident, reporting to Attending Physician and Responsible Party, appropriate interventions initiated and documentation is in progress notes. The Early Warning Tool will be placed in the DON mailbox for review to ensure that the resident was assessed, reporting to Attending Physician and Responsible Party was completed, appropriate interventions initiated and documentation is in progress notes. Other examples of changes in resident condition in-service included in the in-service were; change in mental alertness and orientation, increased weakness or fatigue, change in abilities to feed, bathe, or groom self, change in sitting balance, transfer, or walk, change in appetite, change in ability to chew/swallow food, difficulty with breathing, complaints of dizziness, change in bowel elimination habits, complaints of nausea and vomiting, and falls; If you notice an acute change in a resident you must report it to the hall nurse immediately; If you feel that the resident ' s acute change in condition has not been addressed; report the change in the resident to the supervisor or another hall nurse if supervisor is not available; If you feel that the acute change has still not been addressed, then the DON or ADON must be notified. All but four staff members have been in-serviced regarding observation and reporting changes in condition promptly to the hall nurse. These four employees will not be allowed to work until in-serviced. All newly hired C.N.A ' s, Housekeeping, Dietary and Therapy Staff will be in-serviced in orientation regarding acute changes in condition. 100% of all licensed nurses have been in-serviced on notification to physician by telephone to include second shift, third shift and weekends; when an acute changes in condition occur, including changes in cognitive status, behavior, oral changes to include fluids, immune system response, normal body system functioning, Panic laboratory values, resident '

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) s condition warrants based upon nurse ' s assessment; If you are unable to reach Attending Physician, you may call On-call for physician; If you are unable to reach attending or on-call physician, you may call the facility ' s Medical Director. Notification of the physician of these types of changes in a resident ' s condition by fax is not acceptable. All licensed nurses working have been in-serviced in notification of the physician completed on [DATE]. All newly hired licensed nurses will be in-serviced in orientation on notification of physician on resident acute changes in condition. ? The Staff nurse is responsible to assess, document, provide appropriate intervention and notify Attending Physician and Responsible Part of any acute changes in condition noted. The staff nurse will implement appropriate interventions based on the needs of the resident and notify Attending Physician and Responsible Party. All staff nurses will document all acute changes in condition on the 24 hour report/communication board daily. The staff nurses will communicate all acute changes utilizing the communication board during shift report. DON, ADON, and Weekend Supervisor will review the 24 hour/communication board utilizing a 24 hour report/communication tool daily to ensure all acute changes are identified and followed up with an assessment/intervention and Attending Physician and Responsible Party notification. On [DATE] at 8:59 pm, verification of the credible allegation was evidenced by interviews of licensed nursing staff related to acute changes, assessment and documentation in the medical record. Nurses verified the need to assess a resident exhibiting a change in condition, document the findings and notify the physician and responsible party. Verification of the credible allegation was also evidenced by interviews of all staff on reporting change to the hall nurse continuing up to the DON or ADON if necessary. The staff verified the implementation of the STOP WATCH documentation to be completed when a change in condition is identified in a resident.