STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	08/27/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365

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 0309 **Level of harm** - Minimal harm or potential for actual harm **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 physician interview, staff interview, and record review the facility failed to routinely observe and assess the gangrenous fingers of 1 of 2 sampled residents (Resident #1) who experienced amputations. Based upon observations, record review, and staff and pharmacy interviews, the facility also delayed the initiation of antibiotic therapy for two days after it was ordered for one of three residents, Resident #8. Findings included: 1. Resident #1 was admitted to the facility on [DATE], readmitted to the facility on [DATE], and expired in the facility on [DATE]. The resident's documented [DIAGNOSES REDACTED]. At 2:15 PM on [DATE] Nurse #2 stated in March and [DATE] Resident #1 had black, hard, dry patches on the fingers of her right hand. She reported both the facility and the [MEDICAL TREATMENT] center were aware of the necrosis, but there was some debate back and forth about obtaining consultation. According to the nurse, she decided to take action herself, and set up a consult for the resident with a vascular surgeon (on [DATE]). By that time the nurse explained the necrosis had spread from one finger to three fingers of her right hand. At 3:43 PM on [DATE], during a telephone interview, nursing assistant (NA) #1 stated she began to notice dark spots on Resident #1's fingers of the right hand in [DATE]. She reported these spots became larger and involved more fingers in April and [DATE]. A [DATE] neurology consult (referral from [MEDICAL TREATMENT] center) documented for the last three months Resident #1 was experiencing bilateral hand weakness and numbness. There were was no documentation of the physical appearance of the resident's hands in the [DATE] report. The neurologist confirmed via testing that the resident had ulnar [MEDICAL CONDITION]. In a [DATE] physician progress notes [REDACTED]. hand. At 10:38 AM on [DATE] the NP stated [DATE] was the first time she was aware of Resident #1 having skin integrity problems to her right hand. She reported these fingers were hard and dry, but presented without odor. According to the NP, Resident #1 had severe arterial disease, smoked cigarettes, and was on [MEDICAL TREATMENT]. She commented, depending on whether the damage to the fingers was the result of disease progression or embolism problems, the resident's fingers may have become necrotic anywhere from hours to months ago. In a [DATE] physician progress notes [REDACTED]. She (the resident) feels it is from having her blood sugars tested that her fingers have changed. She notes no prior fistula or shunt to right arm. Her hand is is cool at times. A [DATE] physician order [REDACTED]. A [DATE] ultrasound report documented Resident #1 had arterial occlusive disease of the right arm. Resident #1's [DATE] quarterly minimum data set (MDS) documented her cognition was moderately impaired. During the physical exam on a [DATE] follow-up neurology consult the neurologist documented, Necrotic changes were noted on digits 3 - 5 of right hand. A [DATE] vascular surgery consult (referral from nursing home) documented Resident #1 had necrosis of the entire right third digit (her third finger was necrosed all the way to the base of her hand) and partial fourth and fifth digits. Heart valve studies were completed, and the resident was referred to orthopedics for further evaluation for digit amputation. In a [DATE] physician progress notes [REDACTED]. In the meantime, monitor all areas of ischemia and eschar for infection or wet gangrene--currently dry. A [DATE] orthopedic consult documented, .her fingers are mummified and necrotic and this has been going on for a long time. At this time the orthopedist only had information from the resident to evaluate so he scheduled a follow-up appointment. A [DATE] orthopedic consult documented, She is demarcating (developing a more defined zone of [MEDICAL CONDITION] reaction separating gangrenous tissue from healthy tissue) a little bit more, and I told her that we are going to have to wait until she demarcates further to try to figure out exactly what we are going to do and whether we are going to amputate her fingers. A [DATE] follow-up orthopedic consult documented, Her fingers are demarcating. We are still waiting for the right ring finger to demarcate further. A [DATE] follow-up orthopedic consult documented, _____ (name of resident) is demarcating her fingers. She still complains of pain with this. She wants to keep her index finger, but it is as black as her other fingers.We will get notes from ____ (name of vascular surgeon) office, and we will talk to him and see what we can do at this point. I went ahead and scheduled her surgery. A [DATE] 2:00 PM nursing home interdisciplinary progress note documented Resident #1 returned from a fishing trip with family with pain and swelling of the right hand. The resident reported she thought this was caused by a fly bite to her hand during the trip. Record review revealed the [DATE] interdisciplinary progress note was the first time direct care staff at the nursing home documented on the appearance or assessment of Resident #1's right hand/fingers. A [DATE] physician progress notes [REDACTED].#1's primary physician, documented, She (the resident) is scheduled for right finger amputations next week. She has had progressive gangrene dry to her right hand, but now has developed increased swelling and drainage to her right hand at the first MCP (metacarpal).Staff has noted her picking at the dried dead black skin to her fingers. The physician plan documented, Monitor closely and consider expanding antibiotic if clinically worsens. (This was the last physician progress notes [REDACTED].#1 until after her amputation). A [DATE] physician order [REDACTED]. On [DATE] Resident has gangrene area on her right hand was identified as a problem on Resident #1's care plan. Interventions to this problem included Monitor for any increased s/sx (signs/symptoms) of infection and alert (primary physician) as needed. (The care plan identified a problem with Resident #1's skin integrity on the right hand previously on [DATE], but the revision on [DATE] wiped out the original electronic problem and interventions). Review of the June and [DATE] medication and treatment administration records revealed Resident #1 received the antibiotic and the ointment as ordered. A [DATE] follow-up orthopedic consult documented, She (the resident) is going to lose her hand, the thumb will probably be the only thing left, and she may even have to go back further with further amputations and she understands that, but she is ready to proceed with this plan because of severe pain. At 3:43 PM on [DATE], during a telephone interview, NA #1 stated up until [DATE] the fingers on Resident #1's right hand were black and dry. However, she reported after the fly bite in [DATE] the resident's fingers had a rotten smell right up until she left the facility for her amputation. The NA explained the fingers on the right hand were weepy after the fly bite. Record review revealed no documentation about the appearance or assessment of the resident's right hand/fingers by nursing home direct care staff after the fly bite on [DATE] and before the resident was discharged on [DATE] for amputation of the fingers on her right hand. A [DATE] hospital operative report documented, Gangrene of the index, middle, ring and small fingers up to the metacarpophalangela joints and somewhat beyond on the volar aspect. Some pus was found as there were some areas of wet gangrene.After amputation of these fingers fairly good tissue was seen. There was good bleeding at the open end of the amputations. [DATE] interdisciplinary progress notes documented Resident #1 expired in the facility. At 5:05 PM on [DATE] the director of nursing (DON) stated she expected nursing staff to observe and assess Resident #1's fingers on her right hand daily, starting in March when blackened areas were first noted through discharge for the amputation. She reported this information should have been documented daily in the interdisciplinary progress notes. At 11:42 AM on [DATE], during a telephone interview, Resident #1's primary physician stated he referred the resident to the vascular surgeon who would had a better idea about the optimal time to amputate necrotic fingers. He reported as long as the resident's fingers remained dry, the only danger of waiting on the amputation was the loss of viable tissue. However, he commented when the gangrene became wet it became more imperative to amputate because the chance of infection [MEDICAL CONDITION] was increased. According to the physician, he expected nursing home staff to assess and document on the necrotic fingers weekly, but when the wet gangrene developed he expected the staff to assess and document daily.

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 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 2. A review of the Admission assessment dated [DATE] revealed Resident #8 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An observation of medication administration for Resident #8 was made on [DATE] at 9:15 AM. Upon observation, the medication nurse, Nurse #1, discovered that the resident's [MEDICATION NAME] was not available in the medication cart. After Nurse #1 administered the other medications that Resident #8 was scheduled to receive, she went to the nurse's station to make a request for a [MEDICATION NAME] dose from the facility's local back-up pharmacy. Nurse #1 explained that a facility staff member would need to pick up the order from the pharmacy. A review of the [DATE] Medication Administration Record [REDACTED]. Start Date- [DATE]. ([MEDICATION NAME] Hydrate is an antibiotic for the treatment of [REDACTED]. The MAR indicated [REDACTED]. A review of the handwritten physician's orders [REDACTED]. The order was signed by the Nurse Practitioner on [DATE]. In an interview with Nurse #1 on [DATE] at 10:00 AM, she stated that the [MEDICATION NAME] was to be given twice per day for 7 days starting [DATE], and she did not know why the medication was not started until [DATE]. She stated that the MAR indicated [REDACTED]. An interview was conducted with Nurse #2 on [DATE] at 10:30 AM. During the interview, she stated that she was the nurse who read the physician's orders [REDACTED]. She explained that she reported to the nurse who was coming in for the following shift that the [MEDICATION NAME] had been ordered, and that she would probably need to get the first dose from the back up medication kit in the facility. Nurse #1 further stated that she did not know why the [MEDICATION NAME] was not administered to Resident #8 on [DATE] or [DATE]. In an interview with the facility's Nurse Practitioner on [DATE] at 11:00 AM, she stated that she wrote the order for [MEDICATION NAME] for Resident #8 on [DATE], and that she expected for the antibiotic to be started the same day, or at least the next day, depending on the time the order was written on [DATE]. She reiterated that if an infection was present for the resident, the antibiotic therapy initiation should not have been delayed until 2 days after it was ordered. In addition, she stated that the MAR indicated [REDACTED]. She also stated that [MEDICATION NAME] was not a medication that would be kept in the back up kit in the facility. An interview was conducted with the Director of Nursing (DON) on [DATE] at 5:30 PM. During the interview, the DON stated that she would expect for the [MEDICATION NAME] to be started on the same day as it was ordered, or at least the next day if the order was made late in the day. The DON also stated that [MEDICATION NAME] was never kept in the back up medication kit in the facility. In a telephone interview with the pharmacy representative on [DATE] at 1:00 PM, she stated that the new order for [MEDICATION NAME] was faxed to the pharmacy on [DATE], and that the pharmacy dispensed 10 doses on [DATE] in the evening. She explained there was no start or stop date included with the order, and no duration for the [MEDICATION NAME] to be administered, so the pharmacy could only dispense 10 doses until clarification of the order could be made. The representative also stated that if a medication could not be dispensed immediately after it was ordered, then the order would be provided by the local back-up pharmacy for the facility. In addition, she stated that it is the responsibility of the facility to provide start dates, stop dates, and duration of antibiotic therapy to the pharmacy when a new order was placed. She added that a request was made for 2 doses of [MEDICATION NAME] on [DATE] and for 2 doses on [DATE], and that these orders were filled by the facility's local back up pharmacy. Also, the representative stated the pharmacy had provided training for the facility regarding protocol for ordering new medications for residents and that refresher training could by provided by request at any time.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review the facility failed to make changes in the treatment of [REDACTED].#1) with pressure ulcers. Findings included: A [DATE] hospital discharge summary documented, .she (Resident #1) has a known history of decubitus ulcer with underlying osteo[DIAGNOSES REDACTED] of the sacral bone in the past. She was completely noncompliant with her antibiotics. Resident #1 was admitted to the facility on [DATE], readmitted to the facility on [DATE], and expired in the facility on [DATE]. The resident's documented [DIAGNOSES REDACTED]. A [DATE] admission nursing assessment documented Resident #1 had a stage II pressure ulcer on her sacrum, and there was pain associated with this wound. A [DATE] interdisciplinary progress note documented, Wound round completed, sacral stage II wound assessed. Area was present on admission, measures 3.5 x 1.3 x 0.3 cm (centimeters). Wound bed is greater than (symbol used) 50 [MEDICATION NAME] tissue with macerated wound edges, surrounding tissue healthy. Minimal amount of serosanguineous drainage with no odor. Pt. (patient) does not complain of (symbol used) pain. Will start daily dressing changes with [MEDICATION NAME] as per protocol. Has wound clinic appointment [DATE]. A [DATE] physician progress notes [REDACTED]. Resident #1's [DATE] admission minimum data set (MDS) documented her cognition was intact, and she had a stage II pressure ulcer. Record review revealed Resident #1 was hospitalized from [DATE] until [DATE]. A [DATE] physician progress notes [REDACTED]. The facility did not assess the resident's wound after [DATE] until [DATE]. On [DATE] the sacral pressure ulcer remained a stage II wound measuring 3.0 x 0.5 x less than 0.1 cm. Record review revealed Resident #1's first wound clinic appointment was [DATE]. Comparison between wound clinic recommendations and treatment administration records (TARs) revealed the facility followed wound clinic recommendations until [DATE] when Resident #1's physician assistant (PA) ordered the sacral wound treatment of [REDACTED]. Record review revealed members of Resident #1's primary physician team signed off on wound clinic recommendations made on [DATE], [DATE], [DATE], and [DATE], but the facility did not provide the recommended wound treatments. The facility continued to provide [MEDICATION NAME] Ag with border gauze daily through [DATE]. The wound clinic's treatment recommendations were for Iodosorb gel with xtrasorb foam dressing every three days on [DATE], zinc oxide/[MEDICATION NAME] Ag/xtrasorb/[MEDICATION NAME] or medipane every three days on [DATE], [MEDICATION NAME] or Promagran/zinc oxide/foam/tape or [MEDICATION NAME] every three days on [DATE], and skin prep and sensicare to the periwound/[MEDICATION NAME] or Promagran to the wound bed/xtrasorb foam dressing every three days on [DATE]. Review of the Skin Integrity Reports revealed Resident #1's sacral pressure ulcer was not assessed between [DATE] and [DATE]. Resident #1's [DATE] quarterly MDS documented her cognition was moderately impaired, and she had a stage II pressure ulcer. On [DATE] the facility began to follow the treatment recommendations made by the wound clinic on [DATE] and [DATE] for skin prep and sensicare to the periwound/[MEDICATION NAME] or Promagran to the wound bed/xtrasorb foam dressing every three days. On [DATE] Resident has actual skin breakdown related to incontinence, vascular disease, limited mobility, refuses incontinent care at times; resident has a pressure ulcer on her sacrum was identified as a problem on the resident's care plan. Interventions to this problem included Provide wound treatment as ordered, Weekly skin assessment by licensed nurse, and Weekly wound assessment to include measurements and description of wound status. Resident #1's Skin Integrity Report documented on [DATE] her sacral wound had declined to a stage III pressure ulcer measuring 1.8 x 1.5 x 0.3 cm with 75% [MEDICATION NAME] tissue and 25% slough in the wound bed. Review of the Skin Integrity Reports revealed Resident #1's sacral pressure ulcer was not assessed between [DATE] and [DATE]. [DATE] and [DATE] the wound clinic recommended continuing its [DATE] and [DATE] recommendations for the treatment of [REDACTED]. These recommendations were signed off on by Resident #1's primary physician team. Change dressing every other day or as needed for excessive drainage. Review of Resident #1's May and [DATE] TARs revealed the facility continue to change the dressing to the sacral pressure ulcer every three days. A [DATE] physician progress notes [REDACTED]. May d/c (discontinue) wound clinic and continue current care and monitoring with staff. Resident #1's Skin Integrity Report documented on [DATE] the resident had a stage II sacral pressure ulcer measuring 1.0 x 0.6 x 0.2 cm with greater than 75% granulation tissue in the wound bed. Record review revealed no further assessments of the resident's sacral pressure ulcer until she expired in the facility on [DATE]. At 4:12 PM on [DATE] the director of nursing (DON) stated per facility protocol pressure ulcers were to be measure and assessed weekly. She also reported when members of the primary physician team signed off on consult recommendations, the facility was supposed to follow them. The DON commented she could not explain why the facility did not follow wound clinic recommendations for treatment of [REDACTED]. The DON stated these recommendations should have been followed by the facility since all of them were signed off on by the resident's primary physician team. At 4:20 PM on [DATE] Unit Manager #1 stated wounds were to be measured and assessed weekly. She reported this was important to capture any decline in the wounds quickly and react by possibly changing treatments/frequencies and increasing nutrition interventions to promote healing. She explained she was the only unit manager in the facility for a long period of time, and she did the best she could, but was not always able to assess wounds/pressure ulcers weekly per facility protocol. According to this unit manager, when members of the primary physician team signed off on consult recommendations, the facility was supposed to follow them.