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	HAL049023	A. BUILDING: _____ B. WING _____	07/11/2016

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THE GARDENS OF STATESVILLE	2147 DAVIE AVENUE STATESVILLE, NC 28625

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on July 6, 2016 through July 8, 2016, and July 11, 2016, with a telephone exit on July 11, 2016.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews, and record reviews, the facility failed to assure referral and follow-up to obtain physician ordered lab testing for 1 of 2 residents (Resident #1) currently taking Coumadin. The findings are: Review of Resident #1's current FL2 dated 5/23/16 revealed: -Diagnoses included chest pain and atrial fibrillation. -A medication order for Coumadin 6mg daily in the evening. (Coumadin is a medication used to prevent blood clots in medical conditions such as atrial fibrillation, pulmonary embolism, and deep vein thrombosis.) -A physician's lab order to obtain a PT/INR weekly on Thursday for anticoagulation therapy. (PT/INR stands for prothrombin time/international normalized ratio and is a measure of the effectiveness of Coumadin to prevent blood clots.	D 273		

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D 273	Continued From page 1 Depending on the condition being treated, a desired INR range would be 2.0 to 3.0.) Review of Resident #1's record revealed: -A subsequent order on a signed physician's order sheet (POS) dated 6/9/16 to check the PT/INR weekly and continue Coumadin 6mg every evening. -There was a hospital discharge summary dated 6/17/16 with a primary diagnosis of unstable angina, and a PT/INR of 1.78. -A subsequent order dated 6/29/16 to change the frequency of the PT/INR monitoring to monthly. -There were no weekly PT/INR results in the resident's record. Observation of Resident #1 on 7/6/16 at 10:15am revealed bruising on the top of both hands. Interview with Resident #1 on 7/6/16 at 10:10am revealed: -She was admitted to the facility on 5/27/16. -She took the blood thinner Coumadin, and had not had any blood work performed since admitted to the facility. -Her Primary Care Physician (PCP) had not checked her PT/INR since she had been admitted to the facility. -She had never refused to have blood work drawn at the facility. Interview with the Resident Care Coordinator (RCC) at 8:35am on 7/7/16 revealed: -Resident #1 had an appointment with her PCP this morning for her PT/INR. -The facility did not have any lab work scheduled for Resident #1 prior to today. -The PCP wanted to check the PT/INR himself at his office. -The facility doesn't do the fingerstick PT/INR	D 273		

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checks.
-Home Health agencies won't do fingersticks or blood draws for PT/INRs.
-The facility sent residents out to have their PT/INRs checked.
-She believed Resident #1 had a PT/INR at the PCP's office back on 6/2/16.

A second interview with the RCC on 7/7/16 at 9:03am revealed:
-She had checked with the PCP's office and they had not checked Resident #1's PT/INR on the 6/2/16 office visit.
-A PT/INR was checked at the hospital on 6/17/16 when Resident #1 went to the emergency room at the local hospital.
-It was the responsibility of her and the facility's Registered Nurse (RN) to have residents' scheduled lab work completed.

Interview with Resident #1's family member on 7/7/16 at 10:25am revealed:
-She had spoken with the RCC about the resident's lab work for her blood thinner.
-Resident #1 had never refused to have lab work completed.
-The facility had scheduled a PT/INR for Resident #1 to be completed today at her PCP's office.

Interview with an RN from the PCP's office on 7/7/16 revealed:
-Resident #1 had a PT/INR checked today at their office and it was 2.0.
-The dose of Coumadin was not changed from 6mg daily.
-The PCP assumed Home Health would continue to check the resident's PT/INR weekly at the current facility just as they had at the skilled nursing facility Resident #1 came from.
-The PCP was not sure if the PT/INR of 1.78 on

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6/17/16 contributed to Resident #1's chest pain and her subsequent evaluation in the local emergency room.
-The PCP had written an order today (7/7/16) for Home Health to evaluate Resident #1 to obtain PT/INRs.

Interview with an RN from a local Home Health Agency on 7/8/16 at 10:00am revealed:
-She was in the facility to evaluate Resident #1 for the agency's ability to perform PT/INRs.
-If a resident was stable, the Home Health Agency could not keep performing PT/INRs unless the resident had another skilled nursing task.

Interview with the facility's RN on 7/8/16 at 11:09am revealed:
-When residents are first admitted, "we try to get them in to see their PCP as soon as possible."
-She believed the resident's relative had cancelled one of her doctor appointments.
-Resident #1 went to see her PCP on 6/2/16 and to the hospital on 6/17/16.
-The facility's RN was not sure why Resident #1's PT/INRs had not been scheduled.
-The scheduling of labs was her and the RCC's responsibility.

The facility did not provide a requested policy on obtaining lab work for residents.

On 7/7/16, the facility provided the following Plan of Protection:
-Resident #1 was transported to the MD's office for a stat reading of PT/INR on 7/7/16.
-MD aware of reading of 2.0.
-No medication dosing changes.
-Residents with lab orders will be monitored by

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D 273	Continued From page 4 the RCC and /or Executive Director with oversight, or RN to ensure results are obtained from MD office. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 25, 2016.	D 273		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure that 5 of 5 sampled residents who received meals in their rooms were served on non-disposable service ware. (Residents #1, #3, #6, #7, and #8) The findings are: Observation on 7/6/16 at 12:25pm of Resident 3's lunch tray revealed: -The food was served in a Styrofoam to-go box. -The resident was given a cloth napkin with silverware wrapped in it. Interview on 7/6/16 at 12:25pm with Resident #3	D 287		

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revealed:
-She did not know why she had silverware today because she normally just got plastic ware.
-She liked to eat in her room away from the other residents.
-It was hard for her to get to the dining room because of her illness (severe chronic obstructive pulmonary disease).
-She had just started getting a plastic knife and fork about one week ago, prior to that she had only had a spoon.
-She did not know why she was served her food in Styrofoam to-go boxes with plastic eating utensils.
-She would like to have her food on "real plates and be able to eat with real silverware".
-She had not told anyone that it bothered her to eat on Styrofoam to-go boxes and plastic ware.
-She did not have any trouble eating with the plastic ware.

Refer to interview on 7/6/16 at 4:40pm with the Resident Care Coordinator.

Interview on 7/6/16 at 12:45pm with the Dietary Manager revealed:
-He had been the dietary manager for 6 months.
-The residents who eat in their rooms are served their food in "Styrofoam to-go boxes with plastic ware".
-He did not know why the residents that ate in their room were served on Styrofoam.
-There were tray lids for the non-disposable plates that could be used for those residents.
-No one had ever addressed the issue of residents eating on Styrofoam with him.
-He had never asked anyone about the use of the Styrofoam plates.

Interview on 7/6/16 at 3:06pm with Resident #7

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D 287	Continued From page 6 revealed: -She only ate in her room about three times per week when she did not felt like going to the dining room. -When she ate in her room she was served her food in a Styrofoam box. -She had to eat with plastic spoons, forks and knifes. -She would have liked to have been able to eat in her room with "real silverware" and on "plates not paper", but it did not bother her. -She did not know why they served on "paper plates" for the residents who did not want to-go to the dining room. -The staff had encouraged her to-go to the dining room, but sometimes she did not feel like getting out of her room. -She had never asked anyone about eating on real plates and with real silverware in her room. Interview on 7/6/16 at 4:20pm with Resident #6 revealed: -She ate breakfast in her room every morning. -She was served her food in Styrofoam to-go boxes and given plastic ware to eat with. -It did not bother her to eat with plastic ware and out of Styrofoam boxes. -She generally did not eat breakfast brought to her because she sleeps late. Observation on 7/6/16 at 5:25pm revealed a nursing assistant took a Styrofoam to-go box with plastic utensils into Resident #1's room. Interview with Resident #1 on 7/6/16 at 5:30pm revealed: - She rarely ate in her room, today was only the second time since she was admitted in May 2016. -She was going to eat in her room this evening	D 287		

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because she wasn't feeling well.
-The only other time she ate in her room, the meal was served in a Styrofoam to-go box with plastic utensils.

Observation on 7/7/16 at 10:45am revealed Resident #8's lunch was served in a Styrofoam to-go box with a lid and her beverages were served in 8 ounce Styrofoam cups with plastic lids.

Interview on 7/7/16 at 10:45am with Resident #8 revealed:
-She did not mind eating on Styrofoam plates with plastic ware.
-She preferred to eat on Styrofoam plates with plastic ware because she did not have to remember to let someone know they needed to-go back to the kitchen.
-It did not bother her to "eat on paper."

Interview on 7/7/16 at 11:15am with the Administrator revealed:
-The practice of serving residents who ate in their rooms on Styrofoam to-go boxes started before she came to the facility.
-She had not been aware of why the residents who ate in their rooms were served on Styrofoam to-go boxes.
-There had not been any residents or families ever complain to her about the residents being served on Styrofoam.

Review on 7/7/16 of the facility's dietary policy under the meal service / room service section revealed:
-Residents who choose to eat in their rooms will be provided room service on take out dinnerware at no additional cost.
-Residents who choose to have every meal in

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D 287	Continued From page 8 their room will be encouraged to join the other residents in the dining room without impeding the resident's right to choose. Refer to interview on 7/6/16 at 4:40pm with the Resident Care Coordinator. _____ Interview on 7/6/16 at 4:40pm with the Resident Care Coordinator revealed: -She had worked at the facility for 18 years. -She did not know why the residents who ate in their rooms used paper plates and plastic ware. -The staff tried to encourage all residents to go to the dining room. -Resident #7 used to eat in her room a lot, but she had started going down to the dining room. -Resident #3 did not like to eat around other people, and she also gets out of breath going to the dining room. -No residents had ever said anything to her about not wanting to eat on Styrofoam plates and with plastic ware. -There were some residents who occasionally wanted to eat in their rooms and "we always accommodated them."	D 287		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 9 This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to assure a resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules an regulations in the area of health care referral and follow-up. Based on observation, interviews, and record reviews, the facility failed to assure referral and follow-up to obtain physician ordered lab testing for 1 of 2 residents (Resident #1) currently taking Coumadin. [Refer to Tag D 273 10A NCAC 13F .0902(b) Health Care, (Type B Violation.)]	D912		