| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345161 | A. Building<br>B. Wing | 07/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Abernethy Laurels | 102 Leonard Avenue<br>Newton, NC 28658 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045<br><br>Based on record review, staff interview, and Nurse Practitioner (NP) interviews the facility failed to ensure a resident's (Resident #32) code status election was accurate throughout the medical record for 1 of 2 residents (Resident #32) reviewed for advanced directives.<br><br>The findings included:<br><br>Resident #32 was admitted to the facility on [DATE] with a diagnosis of heart disease.<br><br>A review of a physician's order dated [DATE] revealed Resident #32 was a full code.<br><br>A review of a Medical Orders for Scope of Treatment (MOST) form dated [DATE] indicated Resident #32 wanted cardiopulmonary resuscitation (CPR, chest compressions), limited scope of treatment which included to use medical treatment, intravenous (IV) fluids and cardiac monitoring as indicated, do not use intubation (breathing tube) or mechanical ventilation (ventilator); also provide comfort measures, transfer to the hospital if indicated, and avoid intensive care. The MOST form was signed by Nurse Practitioner (NP) #1 and completed by the Social Worker (SW).<br><br>A review of the advanced directives book at the nurse's revealed Resident #32 had a Medical Orders for Scope of Treatment (MOST) form dated [DATE] which indicated Resident #32 wanted cardiopulmonary resuscitation (CPR, chest compressions), limited scope of treatment which included to use medical treatment, intravenous (IV) fluids and cardiac monitoring as indicated, do not use intubation (breathing tube) or mechanical ventilation (ventilator); also provide comfort measures, transfer to the hospital if indicated, and avoid intensive care.<br><br>A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #32 was cognitively intact.<br><br>A review of a physician's progress note dated [DATE] written by the Medical Director (MD) revealed Resident #32 wanted a full scope of treatment.<br><br>An interview was conducted on [DATE] at 1:37 pm with Nurse #1. Nurse #1 stated when a resident was admitted a nurse manager would complete the MOST form and/or DNR form and place the form in the advanced directives book at the nurse's station. Nurse #1 verified not all residents have a MOST form and in the event of an emergency, she would refer to the order in Electronic Health Record (EHR). Nurse #1 verified Resident #32 was a full code in the EHR.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on [DATE] at 8:55 am with the SW. The SW stated when a resident was admitted to the facility, she was responsible for discussing code status with the resident and/or representative and completed the MOST form. The SW stated that she would ask the resident or resident representative if they wanted to have CPR and would elect either CPR or Do Not Resuscitate (DNR). The SW stated she then would read the scope of treatment options and elect the one the resident desired. The SW stated the facility did not require residents to have a MOST form. The SW stated after she completed the MOST form, she had a provider review and sign the form and she then would take the MOST form to medical records where it was scanned into the chart. The SW stated after Medical Records scanned the form into the chart, she delivered the form to the appropriate nursing unit, would have the resident's nurse review the form for accuracy and completion, and would put the completed form in the advanced directives book at the nurse's station. The SW stated she completed Resident #32's MOST form on [DATE]. The SW stated Resident #32 had elected to have CPR and she was unsure of what limitations, if any, that Resident #32 wanted. The SW verified Resident #32 had an order for full code in the Electronic Health Record (EHR) and agreed that the code status should match and reflect limitations. The SW stated the admitting nurse was responsible for entering the code status order into the computer.<br><br>An interview was conducted on [DATE] at 8:32 am with the Admission Nurse. The Admission Nurse stated she would ask residents about their code status and preferences on admission. The Admission Nurse reported after she verified the MOST form, she would enter the code status order in the chart. The Admission Nurse stated that if a MOST form indicated CPR with limited scope of treatment, she would enter the code status as full code and reported the facility does not enter limitations because the facility does not intubate or place residents on mechanical ventilation. The Admission Nurse stated the MOST form, active code status order, and code status on the progress note should have been consistent.<br><br>NP #2 was unavailable for interview.<br><br>The MD was unavailable for interview.<br><br>An interview was conducted on [DATE] at 11:15 am with Resident #32. Resident #32 stated he was able to remember someone, unsure of name, going over code status information on admission. Resident #32 expressed he wished to have CPR but he was not sure if he wanted any additional interventions because he was not sure what limitations were allowed.<br><br>An interview was conducted on [DATE] at 11:53 am with NP #2. NP #2 stated on admission, the SW reviewed and completed a MOST form with the resident. NP #2 stated when she conducted her visit with the resident upon admission, code status was reviewed with the resident and resident representative. NP #2 stated she was familiar with Resident #32 but was unaware that Resident #32 had a MOST form that indicated CPR with limited scope of treatment. NP #2 stated the facility would still enter in a full code order, but verbalized the progress note should not have said full scope of treatment if the resident wanted limited interventions. NP #2 stated she was not sure what limitations Resident #32 wanted.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on [DATE] at 4:36 pm with the Director of Nursing (DON). The DON stated she thought nursing was responsible for completing the MOST forms and was unaware the SW had been completing them. The DON stated not all residents had a MOST form, but it was recommended. The DON stated code status was discussed on admission with nursing staff and the medical provider. The DON stated if a resident had elected CPR and limited scope of treatment on the MOST form, nursing staff would enter a full code order into the EHR. The DON stated limited scope of treatment included everything that would be performed in the facility because we do not intubate or ventilate. The DON stated she was not aware of what limitations Resident #32 would want and stated that limitations should be written in under the instructions portion of the MOST form. The DON was unsure why the MD progress note dated [DATE] revealed Resident #32 wished to receive a full scope of treatment. The DON stated the MOST form, code status order, and medical provider's progress note should indicate the resident's wishes.<br><br>An interview was conducted on [DATE] at 5:20 pm with the Administrator. The Administrator reported the SW was responsible for going over code status wishes with the resident and/or resident representative upon admission and completed the MOST form at that time. The Administrator was not aware that Resident #32 had a MOST form that indicated CPR with limited scope of treatment, an order for full code in the EHR, and a physician progress note dated [DATE] that revealed Resident #32 wished to have a full scope of treatment. The Administrator verbalized Resident #32's code status should be consistent throughout the medical record. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045<br><br>Based on observations, record reviews and interviews the facility failed to post cautionary safety signs that indicated the use of oxygen for 5 of 6 residents reviewed for respiratory care (Resident #79, #93, #136, #137 and #161).<br><br>The findings included:<br><br>1) Resident #136 was admitted to the facility on [DATE] with a diagnosis of shortness of breath.<br><br>A review of a significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #136 was cognitively intact with no behaviors and no rejections of care. Resident #136 was coded for oxygen therapy.<br><br>Review of a physician's order dated 7/8/2024 revealed an order for Resident #136 was to have oxygen administered at 2 liters per minute via nasal canula continuously.<br><br>An observation was conducted on 7/8/2024 at 12:02 pm. Resident #136 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #136's room or on the doorframe.<br><br>An observation was conducted on 7/8/2024 at 2:09 pm. There was no oxygen signage on the unit doors or outside of Resident #136's unit.<br><br>An observation was conducted on 7/9/2024 at 9:42 am. Resident #136 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #136's room or on the doorframe.<br><br>An observation was conducted on 7/10/2024 at 8:47 am. Resident #136 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #136's room or on the doorframe.<br><br>An interview was conducted on 7/10/2024 at 3:57 pm with Nurse #3. Nurse #3 stated when a resident was on oxygen there would be an order for oxygen in the computer, there would be an oxygen concentrator in their room, and an emergency tank of oxygen on their wheelchair. Nurse #3 stated nurses had not put oxygen in use signs outside of resident's doors because it was a privacy issue.<br><br>An interview was conducted on 7/10/2024 at 4:24 pm with the Staff Development Coordinator (SDC). The SDC stated when a resident was on oxygen the nurse should verify the order on the Medication Administration Record (MAR). The SDC reported oxygen signage was not required in the facility except outside of the oxygen storage room.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview was conducted on 7/11/2024 at 4:03 pm with the Director of Nursing (DON). The DON stated when a resident is on oxygen the nursing staff changes the tubing weekly on night shift and there is an oxygen company that comes to the facility and cleans the filters. The DON reported the nurse on the hall is responsible for verifying the oxygen is being delivered at the correct rate based on the physician's order. The DON stated the facility had not used signage outside of resident rooms because the facility was smoke free and reported there was oxygen signage only outside of the oxygen storage rooms. The DON stated she was not aware there had to be signage outside of resident rooms.<br><br>2) Resident #161 was admitted to the facility on [DATE] with a diagnosis of chronic respiratory failure with hypoxia.<br><br>Review of a physician's order dated 6/28/2024 revealed an order for Resident #161 was to have oxygen administered at 2 liters per minute via nasal canula continuously.<br><br>A review of an admission Minimum Data Set (MDS) dated [DATE] revealed Resident #161 was severely cognitively impaired and was coded for oxygen therapy.<br><br>An observation was conducted on 7/8/2024 at 11:49 am. Resident #161 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #136's room or on the doorframe.<br><br>An observation was conducted on 7/8/2024 at 2:09 pm. There was no oxygen signage on the unit doors or outside of Resident #161's unit.<br><br>An observation was conducted on 7/9/2024 at 9:24 am. Resident #161 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #161's room or on the doorframe.<br><br>An observation was conducted on 7/10/2024 at 8:44 am. Resident #161 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #161's room or on the doorframe.<br><br>An observation was conducted on 7/11/2024 at 10:27 am. Resident #161 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #161's room or on the doorframe.<br><br>An interview was conducted on 7/10/2024 at 3:57 pm with Nurse #3. Nurse #3 stated when a resident was on oxygen there would be an order for oxygen in the computer, there would be an oxygen concentrator in their room, and an emergency tank of oxygen on their wheelchair. Nurse #3 stated nurses had not put oxygen in use signs outside of resident's doors because it was a privacy issue.<br><br>An interview was conducted on 7/10/2024 at 4:24 pm with the Staff Development Coordinator (SDC). The SDC stated when a resident was on oxygen the nurse should verify the order on the Medication Administration Record (MAR). The SDC reported oxygen signage was not required in the facility except outside of the oxygen storage room.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview was conducted on 7/11/2024 at 4:03 pm with the Director of Nursing (DON). The DON stated when a resident is on oxygen the nursing staff changes the tubing weekly on night shift and there is an oxygen company that comes to the facility and cleans the filters. The DON reported the nurse on the hall is responsible for verifying the oxygen is being delivered at the correct rate based on the physician's order. The DON stated the facility had not used signage outside of resident rooms because the facility was smoke free and reported there was oxygen signage only outside of the oxygen storage rooms. The DON stated she was not aware there had to be signage outside of resident rooms.<br><br>35789<br><br>3. Resident #93 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure.<br><br>Review of a physician order dated 04/20/24 read oxygen at 3 liters per minute continuously via nasal canula.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #93 was moderately cognitively impaired and required the use of oxygen.<br><br>An observation of Resident #93 was made on 07/09/24 at 9:27 AM. Resident #93 was resting in bed with oxygen being administered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.<br><br>An observation of Resident #93 was made on 07/10/24 at 4:11 PM. Resident #93 was resting in bed with oxygen being administered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.<br><br>An observation of Resident #93 was made on 07/11/24 at 11:28 AM. Resident #93 was resting in bed with oxygen being administered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.<br><br>An interview was conducted with Nurse #5 on 07/11/24 at 1:46 PM who confirmed she was caring for Resident #93. Nurse #5 stated that she had been working at the facility since November 2023 and knew that oxygen tubing was assigned to be changed weekly on third shift. She stated that she thought it was third shift but just knew that it was not assigned to be completed on her shift. Nurse #5 stated that she checked Resident #93's oxygen concentrator throughout her shift to ensure that the correct dose of oxygen was being delivered. Nurse #5 stated that the facility utilized the red no smoking signs on doors and was then asked to go and observe Resident #93's room. Nurse #5 confirmed that there was no cautionary sign on the door or on the door frame or in the environment where Resident #93 resided, and oxygen was being delivered.<br><br>The Director of Nursing (DON) was interviewed on 07/11/24 at 4:03 PM. The DON stated that oxygen tubing, oxygen cannulas and nebulizer sets were changed out weekly by the nurse on third shift. The nurse was responsible for checking the dose routinely throughout the shift. The DON stated that the facility utilized cautionary no smoking signs on the oxygen storage rooms only and added that something was posted on the front door of the facility about the facility being tobacco free. The DON stated that she believed that the cautionary signs only needed to be where oxygen was stored but added they could add the cautionary signs where oxygen was administered as well.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. Resident #137 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease and congestive heart failure.<br><br>Review of a physician order dated 06/13/24 read; oxygen via nasal cannula at 3 liters per minute continuously.<br><br>Review of a significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #137 was cognitively intact, had shortness of breath with exertion and when lying flat and required the use of oxygen.<br><br>An observation of Resident #137 was made on 07/08/24 at 3:18 PM. Resident #137 was resting in bed with oxygen being delivered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.<br><br>An observation of Resident #137 was made on 07/09/24 at 9:20 AM. Resident #137 was resting in bed with oxygen being delivered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.<br><br>An observation of Resident #137 was made on 07/10/24 at 9:15 AM. Resident #137 was resting in bed with oxygen being delivered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.<br><br>An observation of Resident #137 was made on 07/11/24 at 1:47 PM. Resident #137 was resting in bed with oxygen being delivered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.<br><br>An interview was conducted with Nurse #5 on 07/11/24 at 1:46 PM who confirmed she was caring for Resident #93. Nurse #5 stated that she had been working at the facility since November 2023 and knew that oxygen tubing was assigned to be changed weekly on third shift. She stated that she thought it was third shift but just knew that it was not assigned to be completed on her shift. Nurse #5 stated that she checked Resident #137's oxygen concentrator throughout her shift to ensure that the correct dose of oxygen was being delivered. Nurse #5 stated that the facility utilized the red no smoking signs on doors and was then asked to go and observe Resident #93's room. Nurse #5 confirmed that there was no cautionary sign on the door or on the door frame or in the environment where Resident #137 resided, and oxygen was being delivered.<br><br>The Director of Nursing (DON) was interviewed on 07/11/24 at 4:03 PM. The DON stated that oxygen tubing, oxygen cannulas and nebulizer sets were changed out weekly by the nurse on third shift. The nurse was responsible for checking the dose routinely throughout the shift. The DON stated that the facility utilized cautionary no smoking signs on the oxygen storage rooms only and added that something was posted on the front door of the facility about the facility being tobacco free. The DON stated that she believed that the cautionary signs only needed to be where oxygen was stored but added they could add the cautionary signs where oxygen was administered as well.<br><br>37280<br><br>5. Resident #79 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease and respiratory failure.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79's cognition was moderately impaired, and she wore supplemental oxygen.<br><br>A review of Resident #79's medical record revealed an order dated 07/08/24 for supplemental oxygen via nasal cannula at 2 liters per minute.<br><br>An observation was made on 07/08/24 at 11:55 AM of Resident #79's room. In the room sat an oxygen concentrator with the nasal cannula lying on the Resident's bed. The concentrator was infusing oxygen at 2 liters per minute. Resident #79 was not in the room. There was no oxygen cautionary sign posted on the Resident's door or near her room to indicate oxygen was in use.<br><br>An observation on 07/08/24 at 12:37 PM was made of Resident #79 sitting in the dining room wearing oxygen via nasal cannula delivered from the E-tank which was mounted on the back of the Resident's wheelchair.<br><br>On 07/08/24 at 1:30 PM an observation and interview made with Resident #79 revealed the Resident was sitting in the doorway of her room but would not respond to simple questioning. Resident #79 wore oxygen via nasal cannula delivered at 2 liters via E-tank which was mounted on the back of her wheelchair.<br><br>An interview was conducted with Nurse Aide (NA) #1 on 07/09/24 at 3:00 PM. The NA explained that the facility did not post cautionary signs for oxygen near the residents' door, but they did post the no smoking signs on the door where oxygen was stored.<br><br>On 07/10/24 at 10:05 AM Resident #79 was sitting up in bed wearing oxygen via nasal cannula at 2 liters from an oxygen concentrator. There was no oxygen cautionary sign posted on or near the Resident's door.<br><br>An interview was conducted with Nurse #2 on 07/10/24 at 10:24 AM. The Nurse explained that the facility did not post oxygen cautionary signs on the residents' rooms, and they only posted the signs on the rooms where oxygen was stored.<br><br>On 07/11/24 at 4:05 PM during an interview with the Director of Nursing (DON) she explained that the facility was a smoke free facility and did not allow smoking in the building or the grounds. The DON stated the cautionary signs were posted where oxygen was stored in the building, but the signs were not posted on the residents' doors where oxygen was in use. She indicated she thought having the smoke free facility sign posted on the front entrance was sufficient for the regulation. |