STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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 0563 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff, and family interview the facility failed to honor a resident's right to allow a resident's immediate family member to have end of life visitation in accordance with Center for Medicare and Medicaid Services (CMS) memo COVID-19 QSO-,[DATE]-NH and the facility's COVID-19 plan for 1 of 1 resident reviewed for visitation (Resident #1). The findings included: Review of the facility's Visitation Protocol read in part, given the recent guidance from CMS and the American Health Care Association, we strongly discourage visitation at this time except for third party healthcare professional caring for residents. Under the following circumstances visitation must be limited or restricted: If you live in a county or adjacent county where community-based spread of Coronavirus or COVID-19 is occurring or has occur we ask that you not visit the Center. The only exceptions are those situations that involve end of life, situation where the visit is necessary to complete the admission process and paperwork or situations where staff believe that the visit is necessary for clinical or psychosocial needs. The protocol contained no date. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Responsible Party (RP) #1 was listed at Resident #1's emergency contact and health care power of attorney. Review of the comprehensive Minimum Data Set ((MDS) dated [DATE] revealed that Resident #1 was severely impaired for daily decision making and required extensive assistance with activities of daily living. Review of a nurses note dated [DATE] at 6:28 PM read in part, at 10:29 AM Resident #1 was found unresponsive by staff on the hall. No pulse palpated. Resident #1 transferred to the floor and cardiopulmonary resuscitation (CPR) initiated. RP #1 was contacted and 911 called. All rescue efforts turned over to emergency personnel. Emergency personnel correlated with the emergency room physician. Resident #1 was in asystole, no pulse palpated or auscultated. No respirations auscultated. Emergency personnel pronounced time of death. Postmortem care performed by staff. Upon entrance to the facility on [DATE] at 10:00 AM on observation of the front door to the facility was made. There was a sign on the door indicating no visitation was allowed due to the COVID-19 pandemic and the door was locked. Upon entering the facility the Visitation Protocol was provided again with no date to the protocol. An interview was conducted with RP #1 on [DATE] at 3:59 PM. RP #1 stated that on [DATE] at approximately 10:00 AM she received a call from the facility staff notifying her that Resident #1 was found unresponsive and CPR was in progress. She stated that she hung up the phone picked up another family member and began the 1-hour drive to the facility. She stated that about 20 minutes into the drive she called the facility for an update and got the Director of Nursing (DON) on the phone and inquired on the status of Resident #1. The DON stated that CPR was still in progress, but she would have to get the chart to see the events of the day. Approximately 10 minutes later the DON called RP #1 back and provided the events of the day but stated unfortunately Resident #1 had passed away. RP #1 stated she informed the DON of the funeral home to contact and stated that they were in route to the facility and when they arrived could they come in and see Resident #1. RP #1 stated the DON replied no Resident #1 has already passed and you will have to wait for the funeral home to bring Resident #1 out. RP #1 stated that she and the other family member arrived at the facility and the staff brought Resident #1's belongings to the front door and sat them outside and they waited approximately 45 minutes to an hour for the funeral home to arrive and bring Resident #1 outside so they could say their final goodbyes. An interview was conducted with the DON on [DATE] at 11:20 AM. The DON stated following the events and death of Resident #1 on [DATE] they have done some research and there was no clear guidance on the end of life visitation. She stated that at the same time they had received notice that they had 3 positive cases of COVID-19 and their mind set was to protect the resident. The DON stated it did not cross her mind to offer RP #1 an end of life visit because they were in protection mode and just wanted to keep everyone safe. An interview was conducted with the Administrator on [DATE] at 1:32 PM. The Administrator stated that on [DATE] the facility was in heightened protection mode because the facility had 3 recent cases of COVID-19. She added they focused on end of life care and it never crossed her mind to offer RP #1 an end of life visit with Resident #1 because they were just trying to keep everyone safe.
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family, and staff interviews the facility failed to immediately notify a resident's Responsible Party of a change in the resident's treatment that included the commencement of intravenous fluids for 1 of 3 residents reviewed for notification of a significant change (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the comprehensive Minimum Data Set ((MDS) dated [DATE] revealed that Resident #1 was severely impaired for daily decision making and required extensive assistance with activities of daily living. No intravenous fluids (IV) were used during the observation period. Review of a physician order [REDACTED]. The order was placed in the electronic health record by the Unit Manager (UM) at 3:00 PM on 08/11/20. Review of the Medication Administration Record [REDACTED]. Review of a nurses noted dated 08/11/20 at 5:27 PM read, 24-gauge (iv catheter) right antecube (right arm) infusing at 50 ml per hour. The note was signed by Nurse #2. Review of a nurses note dated 08/12/20 at 10:03 AM read in part, Responsible Party (RP) #1 contact and updated on resident status. Informed of past labs and results. Labs and medication reviewed with RP #1. The noted was electronically signed by the UM. An interview was conducted with RP #1 on 09/02/20 at 3:59 PM. RP #1 stated that on 08/12/20 she had received a call from the Director of Nursing (DON) who stated she had just spent some time with Resident #1 and she felt like Resident #1 had perked up and requested a soft drink but was unable to drink it through the straw. RP #1 stated that she told the DON she wanted to video chat with Resident #1 and the DON stated she would arrange the video chat. RP #1 stated that at approximately 8:00 PM on 08/12/20 the UM assisted with that video chat. RP #1 indicated that Resident #1 was drowsy and would not converse with her. The UM offered to RP #1 that Resident #1 had been awake earlier and maybe she had waited too late in the evening to do the video chat. The UM panned out on the video chat to show RP #1 that Resident #1 had IV fluids infusing. RP #1 stated had no idea Resident #1 had been started on IV fluids and asked the UM when they were started. The UM stated to RP #1 that they had been started the day prior on 08/11/20. An interview was conducted with Nurse #2 on 09/02/20 at 2:47 PM. Nurse #2 confirmed that she had initially started the IV fluids on 08/11/20 because there had been a physician order [REDACTED]. Nurse #2 stated that generally the UM would notify the family of new orders when she signed them off and entered them into the electronic record. She stated she had not notified the family of the specific IV fluids but did speak to the family extensively during Resident #1's stay in the facility. Nurse #2 stated she was not sure who or when the family was notified of the IV fluids but stated either the UM would have done it or the DON who also spoke often to the family about Resident #1's condition. An

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) interview was conducted with the UM on 09/03/20 at 4:37 PM. The UM stated that she rounded with the medical providers on their visits to the facility and when they wrote orders in the chart, she would sign them off and enter them into the electronic health record. The UM stated that prior to the COVID-19 pandemic she always called the families to make them aware of any new orders that occurred. She added it is very tough with COVID to make that happen. The UM stated she recalled video chatting with RP #1 on 08/12/20 and updating them on Resident #1. She does not specifically recall notifying them on 08/11/20 when the order was received but stated she did notify them on 08/12/20. An interview was conducted with the DON on 09/04/20 at 11:20 AM. The DON stated that they try to notify the families of any changes and numerous staff members step up and make those calls. She stated she would expect any changes to be communicated to the family the day the change was made. An interview was conducted with the Administrator on 09/04/20 at 1:32 PM. The Administrator stated that she expected the families to be notified of any changes within a few hours. She added that she was aware that the conversations about the IV fluids had occurred, but she could not speak to the timing of that notification.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, text message documentation, staff, and family interview the facility failed to protect private health information by sending confidential protected health information home in a resident's suit case who was discharged from the facility for 1 of 1 resident investigated for privacy/confidentiality (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Responsible Party (RP) #1 was listed at Resident #1's emergency contact and health care power of attorney. Review of the comprehensive Minimum Data Set ((MDS) dated [DATE] revealed that Resident #1 was severely impaired for daily decision making and required extensive assistance with activities of daily living. Resident #1 expired in the facility on [DATE]. An interview was conducted with RP #1 on [DATE] at 3:59 PM. RP #1 stated that on [DATE] Resident #1 had passed away in the facility and she had picked up Resident #1's belongings the same day. RP #1 stated when she arrived home and went through Resident #1's suite case, she discovered a document in her suite case that was titled Care Provider Daily Schedule and dated [DATE]. RP #1 stated that the document contained Resident #1's name along with other resident name and information. RP #1 stated she did not know how the document got placed in Resident #1's suite case but she was sure it was not supposed to be there. Text message review of the Care Provider Daily Schedule found in Resident #1's suite case was made on [DATE] at 4:30 PM. The document contained the name of Resident #1 and 5 other residents. The document included the residents room number, payor information, and any precautions the residents had. The document indicated it was the Speech Therapist (ST) daily schedule. An interview was conducted with the ST on [DATE] at 2:03 PM. The ST stated she treated Resident #1 during her stay in the facility. She stated she worked at the facility on a as needed basis and when she arrived for work, she would pick up her schedule that had been printed for her and start seeing the residents listed on her daily schedule. The ST stated that she did not recall leaving her daily schedule in Resident #1's room but she stated from time to time she would realize she had lost or misplaced her schedule and would have to print another one. The ST stated that the daily schedule should not have been left in Resident #1's room and definitely not sent home with her belongings as it did contain names and other information of other residents. An interview was conducted with Housekeeper #1 on [DATE] at 12:20 PM. Housekeeper #1 confirmed that she packed up Resident #1's belongings on [DATE] because her family was at the facility to collect her things. Housekeeper #1 stated she did not recall any paper documents that contained resident names, room number, payor source, or precautions on it and if she would have seen them, she would have turned them into the nursing staff at the facility. An interview was conducted with the Director of Nursing (DON) on [DATE] at 11:20 AM. The DON stated that on [DATE] when Resident #1 expired her family came to the facility to pick up her belongings and so Housekeeper #1 went to Resident #1's room to pack up her belongings. The DON stated that Housekeeper #1 placed Resident #1's papers in a side pocket of her suite case without realizing what the papers where. The DON stated the ST should not have left the daily schedule that contained the names, room numbers, payor source, and precautions of residents in Resident #1's room and it certainly should not have been sent home in Resident #1's suite case. An interview was conducted with the Administrator on [DATE] at 1:32 PM. The Administrator stated that the confidential health information that was included on the ST daily schedule should not have been left in Resident #1's room and absolutely not sent home with her belongings.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Nurse Practitioner, and Medical Director interviews the facility failed to ensure a resident's drug regimen was free from unnecessary drugs when a resident was administered an antibiotic for 4 days after the facility received a laboratory report that specified the resident was resistant to the antibiotic for 1 of 3 residents reviewed for unnecessary drugs (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the comprehensive Minimum Data Set ((MDS) dated [DATE] revealed that Resident #1 was severely impaired for daily decision making and required extensive assistance with activities of daily living. No antibiotic use was noted during the reference period. Review of a physician order [REDACTED]. The order was entered into the electronic health record by Nurse #1. Review of the Medication Administration Record [REDACTED]. Review of a laboratory report dated 08/08/20 indicated this was the final report of Resident #1 urinalysis and sensitivity report. The report indicated that Resident #1's urine sample was dark orange and turbid and contained a trace of blood and a trace of protein. The report also indicated that Resident #1's urine contained greater than 100,000 colony forming units (cfu) per milliliter (ml) of lactose fermenting gram negative rods (organism) and was resistant (immune) to Cipro. Review of the Nurse Practitioner (NP) progress note dated 08/10/20 read in part, urinalysis was reviewed which demonstrated greater than 100,000 Ecoli (organism). The plan was to [MEDICATION NAME] mg by mouth twice a day for 7 days for urinary tract infection. The note was electronically signed by the NP. Review of a physician order [REDACTED]. [MEDICATION NAME] (antibiotic) 1 gram (gm) intramuscularly (IM) for 7 days for urinary tract infection. An interview was conducted with Nurse #1 on 09/02/20 at 3:18 PM. Nurse #1 stated that she did not recall Resident #1 and had no recollection of the order she entered for Resident #1 on 08/07/20. Nurse #1 stated that she may have pulled the lab results off the fax machine and called the on-call provider who gave the verbal orders, but she could not recall and could say with certainty that was what occurred. An interview was conducted with the NP on 09/03/20 at 9:55 AM. The NP stated that she visited with Resident #1 often during her stay at the facility and upon review of her progress notes indicated that she [MEDICATION NAME] 08/10/20 and then changed it to [MEDICATION NAME] on 08/12/20 after the family reported to the staff that Resident #1 had a history of [REDACTED]. The NP was unaware that [MEDICATION NAME] been started on 08/07/20 and stated that it was possible that someone called the report to the on-call provider who initiated the Cipro. She added that when she reviewed the lab report on 08/10/20 she had not seen the culture report. The NP stated that if she had seen the culture report indicating that Resident #1 was resistant to Cipro, she would have chosen a different antibiotic to treat her infection. The NP further indicated that [MEDICATION NAME] not helping with Resident #1's infection and it certainly did not help her overall health condition. She added that Resident #1 had so many other contributing factors that may have led to her overall decline including dementia and dysphagia with pocketing of food, her kidney function was getting worse and she had a urinary tract infection on top of all that. An interview was conducted with the Medical Director (MD) on 09/03/20 at 3:02 PM. The MD stated that he had visited with Resident #1 during her stay at the facility. The MD was not certain who or why [MEDICATION NAME] been initiated. He reviewed the lab reported and stated that he would not have started empiric antibiotic based off the Resident #1's urinalysis report. The MD stated that her urine was very concentrated which was due to her overall hydration status. He stated he would have given her fluids and repeated the urinalysis. The MD stated that if he would have seen the culture report he would have certainly changed the antibiotic to something that would have been effective because [MEDICATION NAME] not benefiting Resident #1 at all. The MD stated that someone missed the culture report and he would have to try and find out how that happened and correct the issue. An interview was conducted with the Unit Manager (UM) on 09/03/20 at 4:37 PM. The UM stated that lab reports were received via fax machine in the business office. She stated that she went periodically throughout the day and checked for any new lab reports that may have come through. The UM stated that she reviewed the lab reports and discerned which lab reports needed to be called to the provider and which ones could wait until the provider returned to the facility. If the lab report could wait until the provider returned to the facility, she would place the report in a folder at the nurse's station and the provider would review it on their next scheduled day at the facility. The UM stated that she recalled getting [MEDICATION NAME] because Resident #1 was having a hard time swallowing her medications. She added that she did not recall seeing the sensitivity report where Resident #1 was resistant to Cipro, if she had seen it, she would have called the provider to get it discontinued and get something else initiated.

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F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) The UM stated she was not sure who pulled the lab sheet off the printer or who called the provider but stated someone should have caught the fact that Resident #1 was resistant to the antibiotic (Cipro) she had been prescribed. An interview was conducted with the Director of Nursing (DON) on 09/04/20 at 11:20 AM. The DON stated that the NP signed off the final sensitivity on 08/10/20 and she was not certain if she read it wrong or did not see it. She further stated that at some point the resident's family reported that Resident #1 had a history of [REDACTED]. The DON added she would have expected the sensitivity to have been noted sooner and the antibiotic changed sooner. An interview was conducted with the Administrator on 09/04/20 at 1:32 PM. The Administrator indicated she had been notified of the unnecessary antibiotic and stated it should not have happened. The lab report should have been reviewed and called to the provider so the antibiotic could have been changed to something that would have helped Resident #1's urinary tract infection.