Amended

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. BUILDING ____ B. WING ____	C 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

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F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff and nurse practitioner interviews, and record review, the facility failed to attempt alternatives to drug therapy for behavioral symptoms for three (3) of three (3) sampled residents who received psychoactive medications (Resident #134, #205 and #232). The findings are: 1. Resident #134 was admitted to the facility with diagnoses which included Alzheimer's Disease. The most recent quarterly Minimum Data Set dated 5/24/12 revealed short and long term memory impairment with severely impaired decision making skills. Resident #134's assessment documented physical behavioral problems directed towards others and daily rejection of care. Review of Resident #134's care plan updated on 7/19/12 revealed problematic behavior with verbal/physical aggression or combativeness related to cognitive impairment listed as a focus. Interventions included approach slowly and from the front; re-approach if he becomes combative; behavior management consult if needed; do not	F 250	University Place Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. University Place Nursing and Rehabilitation Centers response to this Statements of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, University Place Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on the statement of deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	9/21/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James A Keffer (signature) | TITLE: Administrator | (X6) DATE: 9-21-12

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 250	Continued From page 1 argue or condemn resident; help resident identify activities that tend to decrease angry behavior, identify stressful times of the day, medication as prescribed, remove from area when behavior is disruptive, reassure resident of personal safety and stay with resident during periods of anger if appropriate or resident wishes. Review of the resident care guide used for nursing assistant direction documented Resident #134 was "combative at times." There were no listed interventions for behavioral management. Review of Resident #134's June 2012 Medication Administration Record (MAR) revealed documentation of twice daily administration of Seroquel (an antipsychotic) 100 mg. Ativan 0.5 mg was documented as administered for agitation four times (on 6/12/12, 6/19/12, 6/20/12 and 6/29/12). Review of Resident #134's July 2012 MAR revealed the twice daily Seroquel 100 mg was increased to 150 mg twice daily on 7/13/12. The Ativan as needed for increased agitation was documented as administered five times (on 7/6/12, 7/7/12, 7/9/12, 7/13/12 and 7/19/12). There was documentation of one Ativan injection intramuscularly on 7/18/12 for severe agitation. Review of Resident #134's August 2012 MAR revealed documentation of Seroquel 150 mg twice daily except for refusal on 8/23/12, 8/24/12, 8/27/12, and 8/29/12. The Ativan as needed for increased agitation was documented as administered twelve times (on 8/6/12, 8/8/12, 8/10/12, 8/11/12, 8/14/12, 8/15/12, twice on 8/17/12, 8/20/12, 8/21/12, 8/24/12 and on	F 250	**F250** **Criteria One:** Resident #134, #205 and #232 were assessed by the social workers on 09/11/2012 to assure the residents' behavior and implement behavioral interventions prior to the administration of psychoactive medication. **Criteria Two:** A 100% audit of residents that exhibit behavioral symptoms was completed by the social workers on 9-17-12 and behavioral interventions were implemented as appropriate to meet resident's needs prior to the administration of psychoactive medications. An InterventionTechniques Communication Book was implemented on 09/18/2012 to assure communication between staff about residents who exhibit behavioral symptoms.	

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F 250	Continued From page 2 8/28/12). Review of nursing progress notes revealed the following behavioral incidents: · 6/19/12 at 2:00 AM: Resident kicked and tried to bite a nursing assistant. · 6/20/12 at 2:00 AM: Resident fought a nursing assistant. · 6/29/12 at 5:45 AM: Resident became combative and hit and kicked nursing assistant. · 7/10/12 at 12:00 AM: Resident refused to go to bed and became combative. Ativan was administered. · 7/12/12 at 2:25 AM: Resident combative with nursing staff. · 7/14/12 at 11:45 PM: Resident combative and redirection unsuccessful. · 7/18/12 at 2:46 PM: Resident combative, hitting and trying to bite staff. · 7/19/12 at 1:19 PM Resident attempting to grab and hit staff. · 7/19/12 at 11:16 PM: Resident attempted to hit staff. · 8/2/12 at 1:53 PM: Resident attempted to bite staff and agitated during care. · 8/14/12 at 3:52 PM: Resident was combative with care. · 8/21/12 at 3:30 PM: Resident attempted to bite staff and combative. · 8/28/12 at 2:30 AM: Resident combative with care. Observation of Resident #134 on 8/29/12 at 9:17 AM, 9:52 AM, 10:18 AM and 10:28 AM revealed he sat in a wheelchair with a lap buddy. There were no behavior concerns.	F 250	The Nursing staff were re-educated by the Staff Development Coordinator-RN on the development of the behavioral assessment and intervention techniques on 09/11/2012 and again on 09/13/2012. The social workers were re-educated by the Administrator on the development of behavioral interventions prior to the administration of psychoactive medication on 09/11/2012. The Social Worker will review the behavior documentation for proper behavioral intervention techniques and interview families of these residents one time weekly for four weeks then monthly for six months utilizing the behavioral assessment QI Audit tool. **Criteria Four:** The Administrator and Director of Nursing will review the Behavioral Documentation Quality Indicator (QI) Audit tool to assure interventions are effective weekly for four weeks then monthly for six months.	

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F 250	Continued From page 3 Interview with Nursing Assistant (NA) #5 on 8/29/12 at 11:50 AM revealed Resident #134 became combative with personal care. NA #5 reported there were no specific directions on approach to Resident #134 and was unaware of an approach which would be successful. Interview with NA #3 on 8/29/12 at 3:37 PM revealed Resident #134 became combative and she did not approach him unless someone was with her. NA #3 explained Nurse #1 shared different ways to approach Resident #134 but she was not aware of any meetings or definite approach in behavior management. Interview with NA #4 on 8/29/12 at 3:48 PM revealed Resident #134 frequently refused care or was combative. NA #4 reported she did not know different approaches for the Resident and tried to figure out what would be successful. NA #4 explained Resident #134 would attempt to hit her. Interview with Nurse #2 on 8/29/12 at 4:10 PM revealed she met with the nursing assistants at the beginning of each shift for report. Nurse #2 explained she informed the nursing assistants of Resident #134's behaviors. Nurse #2 reported she was not aware of direct care nursing staff meetings specific to Resident #134's behavior management. Interview with Nurse #1 on 8/30/12 at 10:19 AM revealed she spoke with family members and visitors to gather information which could be helpful with Resident #134's behavior. Nurse #1 explained nursing staff received information related to behavior management on an informal	F 250	The Administrator will review the QI audit tools documentation with the Quality Assurance and Assessment Committee monthly for further follow-up, recommendations, and continued compliance in this area.	

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F 250	Continued From page 4 basis. Interview with Social Worker (SW) #1 on 8/3012 at 11:14 AM revealed Resident #134 was combative and agitated with care. SW #1 explained the facility's mental health provider worked with the facility's staff to develop a behavior management plan. SW #1 reported Resident #134's behaviors would be developed by the mental health provider, nursing staff and the MDS Coordinator. Interview with the mental health Nurse Practitioner (NP) on 8/30/12 at 1:29 PM revealed she relied on facility staff to develop and attempt alternative approaches for behavior. The NP explained she managed the psychoactive medications in consultation with the resident's primary physician. The NP indicated she saw residents only after staff attempted different approaches. Staff would then request her involvement for medication. Interview with the MDS Coordinator on 8/30/12 at 1:48 PM revealed different approaches specific to each resident should be listed on the resident care guide. Interview with the Assistant Director of Nursing (ADON) on 8/30/12 at 2:23 PM revealed the resident care guide should contain specific interventions of behavior management. The ADON reported anyone on staff can update the care guide but most information was shared on an informal basis. Interview with the Director of Nursing (DON) on 8/30/12 at 4:22 PM revealed communication of	F 250		

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F 250	Continued From page 5 different approaches for behavior management would be communicated by the resident care guide, care plan and on an informal basis. 2. Resident #232 was admitted to the facility with diagnoses which included Alzheimer's Disease. Resident #232's admission Minimum Data Set (MDS) dated 6/6/12 and most recent quarterly Minimum Data Set (MDS) dated 8/7/12 assessed cognitive impairment with physical and verbal behavioral symptoms. The quarterly MDS documented Resident #232 rejected care less than daily. Review of Resident #232's care plan dated 6/11/12 revealed a focus area of ineffective coping and anxiety related to delusions. Interventions included administration of medication, keep a routine and predictable schedule, remove from public area when behavior is disruptive, divert attention with activities and offer reassurance. Review of the resident care guide revealed there were no directions for behavior management. Review of Resident #232's June 2012 Medication Administration Record (MAR) revealed documentation of twice daily administration of Ativan 0.5 mg until 6/13/12 when the dosage increased to 1 mg. twice daily. Depakote Sprinkles 250 mg at 8:00 AM and at 2:00 PM was increased in frequency to three times daily. Review of Resident #232's July 2012 and August 2012 MARs revealed documentation of Ativan 1 mg twice daily and Depokote Sprinkles 250 mg. three times daily.	F 250		

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Review of Resident #232's nursing progress notes revealed the following:

- 6/1/12: Resident combative with care.
- 6/2/12: Resident combative and yelling at staff. Refused to allow staff to care for her roommate.
- 6/4/12: Resident verbally abusive to staff and other residents.
- 6/7/12: Resident agitated and redirected successfully.
- 6/8/12: Resident attempted to hit staff and yelled at other residents.
- 6/18/12: Resident scratched a staff member during care.
- 6/19/12: Resident became combative during shower and scratched staff member.
- 6/28/12: Resident refused to get up off of floor and bumped right side of forehead.
- 7/18/12: Resident screaming at staff and agitated.
- 7/20/12: Resident resistant to care and refused to remove wet clothing.
- 7/23/12: Resident agitated and verbally abusive.
- 8/3/12: Resident verbally abusive to staff.
- 8/7/12: Resident combative with care.
- 8/16/12: Resident refusing care and yelling.
- 8/17/12: Resident yelled and attempted to hit staff.
- 8/29/12: Resident attempted to pull another resident with her and fell.

Observation on 8/28/12 at 3:35 PM on 8/28/12 revealed Resident #232 ambulated in her room, yelled at Nursing Assistant (NA) #3 and closed the door.

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F 250	Continued From page 7 Interview with NA #3 on 8/28/12 at 3:36 PM revealed Resident #232 was independent and would wander on the dementia unit. NA #3 explained Resident #232 would become very angry if approached for care. Observation on 8/29/12 at 9:26 AM, 12:06 PM to 12:15 PM and from 3:02 PM to 3:46 PM revealed Resident # 232 ambulated independently on the dementia unit. Interview with NA #1 on 8/30/12 at 9:30 AM revealed Resident #232 frequently became agitated with care. NA #1 explained she learned from Resident #232's family member that another resident on the dementia unit resembled another member of Resident #232's family. NA #1 reported she would point out this other resident to Resident #232 because she would smile and become more cooperative with care. NA #1 revealed she received no specific direction in behavior management for Resident #232 but would try different approaches on her own. NA #1 added Resident #232 liked to sleep late in the morning. Interview with Nurse #1 on 8/30/12 at 10:03 AM revealed she met with Resident #232's family members to gather information regarding approaches. Nurse #1 explained the sharing of information occurred on an informal basis between the nursing staff, social worker and MDS Coordinator. Interview with Social Worker (SW) #1 on 8/3012 at 11:14 AM revealed Resident #134 was combative and agitated with care. SW #1	F 250		

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F 250	Continued From page 8 explained the facility's mental health provider worked with the facility's staff to develop a behavior management plan. SW #1 reported Resident #232's behavior plan would be developed by the mental health provider, nursing staff and the MDS Coordinator. Interview with the mental health Nurse Practitioner (NP) on 8/30/12 at 1:29 PM revealed she relied on facility staff to develop and attempt alternative approaches for behavior. The NP explained she managed the psychoactive medications in consultation with the resident's primary physician. The NP indicated she saw residents only after staff attempted different approaches. Staff would then request her involvement for medication. Interview with the MDS Coordinator on 8/30/12 at 1:48 PM revealed different approaches specific to each resident should be listed on the resident care guide. He explained he used information gathered from staff to develop the care plan and resident care guide. Interview with the Assistant Director of Nursing (ADON) on 8/30/12 at 2:23 PM revealed the resident care guide should contain specific interventions of behavior management. The ADON reported anyone on staff can update the care guide but most information was shared on an informal basis. Interview with the Director of Nursing (DON) on 8/30/12 at 4:22 PM revealed communication of different approaches for behavior management would be communicated by the resident care guide, care plan and on an informal basis.	F 250		

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3. Resident #205 was admitted to the facility with diagnoses which included Alzheimer's Disease. Resident #205's quarterly Minimum Data Set (MDS) dated 6/24/12 assessed severe cognition impairment with physical behavioral symptoms and rejection of care less than daily.

Review of Resident #205's care plan dated 4/2/12 listed ineffective coping and wandering as a focus related to cognitive impairment and restlessness. Interventions included administration of medication, approach in a non-threatening manner, at risk wandering protocol with transfer to the secured unit should elopement behaviors occur and not easily redirected.

Review of a nursing progress note dated 5/11/12 revealed Resident #205 transferred to the secured dementia unit.

Review of Resident #205's resident care guide revealed there were no directions for behavior management.

Review of Resident #205's June 2012 Medication Administration Record (MAR) revealed documentation of Ativan 0.25 mg administration for aggressive behavior twice daily as needed eight times (6/5,6/7, 6/19, 6/24, 6/25, 6/28, 6/29 and 6/30). Resident #205 also received Depakote 250 mg daily for behaviors.

Review of Resident #205's July 2012 MAR revealed documentation of Ativan 0.25 mg administration fifteen times (7/8, twice on 7/10, 7/13, 7/16, 7/17, 7/18, twice on 7/19, 7/20, 7/24, 7/25, 7/26, 7/27 and 7/30). The Depakote was

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increased on 7/16/12 to 125 mg every morning, 250 mg at 4:00 Pm and 250 mg at bedtime. Resident #205 began to receive nightly administration of Paxil for depression on 7/16/12.

Review of Resident #205's August 2012 MAR revealed documentation Resident #205 received Ativan 0.25mg for aggressive behavior four times (8/2, 8/4, 8/5 and 8/7). The Ativan order changed on 8/7/12 to routine administration of 0.5 mg at 8:00 AM and 2:00 PM. The Ativan as needed dose was increased to 0.5mg every 8 hours as needed.

Review of a physician's order dated 8/7/12 revealed direction to obtain a psychiatric evaluation due to increased aggressive behaviors.

Review of nursing progress notes revealed the following behavioral incidents:
- 6/7/12: Resident kicked and banged on doors; hit windows and yelled at staff.
- 6/27/12: Resident kicked doors and hit staff members.
- 7/10/12: Resident kicked doors; agitated and redirection was successful.
- 7/16/12: Resident pulled exit doors, touched staff buttocks and shirt.
- 7/17/12: Resident began to fondle another resident.
- 7/18/12: Resident agitated with continual attempt to exit door.
- 7/25/12: Resident attempted to hit staff.
- 7/27/12: Resident attempted to touch staff and other residents.
- 7/28/12: Resident kicked patio door.
- 8/2/12: Resident "pulls and hits door daily."

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F 250	Continued From page 11 · 8/7/12: Resident kicked door and attempted to run over staff with wheelcahri and hit cart. · 8/13/12: Resident propelled self in to door repeatedly. · 8/14/12: Resident kicked and "banged" at the door. Observation on 8/28/12 at 3:20 PM revealed Resident #205 self propelled in a wheelchair on the dementia unit. At 3:37 PM, Resident #205 attempted to exit the patio door and knocked on the glass pane several times and left the area. Observation on 8/29/12 at 10:20 AM, revealed Resident #205 self propelled to the patio door and attempted to open the door three times. Resident #205 remained at the door and looked out of the window. Interview with Nurse #1 on 8/29/12 at 11:00 AM revealed Resident #205 frequently attempted to exit the patio door. Nurse #1 explained staff would frequently remove him from the door because he would start kicking and hitting the window pane. Nurse #1 reported staff would try to take him outside when possible because he appeared to enjoy the outdoors. Interview with Social Worker #1 on 8/30/12 at 11:19 AM revealed she referred Resident #205 for a psychiatric evaluation on 8/16/12 due to disruptive and socially inappropriate behavior. SW #1 explained she talked with staff and informed them Resident #205 did not like groups and required one to one care without distraction. SW #1 explained the facility's mental health provider worked with the facility ' s staff to develop a behavior management plan.	F 250		

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F 250	Continued From page 12 Interview with the mental health Nurse Practitioner (NP) on 8/30/12 at 1:29 PM revealed she relied on facility staff to develop and attempt alternative approaches for behavior. The NP explained she managed the psychoactive medications in consultation with the resident's primary physician. The NP indicated she saw residents only after staff attempted different approaches. Staff would then request her involvement for medication. Interview with the MDS Coordinator on 8/30/12 at 1:48 PM revealed different approaches specific to each resident should be listed on the resident care guide. Interview with the Assistant Director of Nursing (ADON) on 8/30/12 at 2:23 PM revealed the resident care guide should contain specific interventions of behavior management. The ADON reported anyone on staff can update the care guide but most information was shared on an informal basis. Interview with the Director of Nursing (DON) on 8/30/12 at 4:22 PM revealed communication of different approaches for behavior management would be communicated by the resident care guide, care plan and on an informal basis.	F 250	**F253** **Criteria One:** The chairs were replaced in the dementia unit on 09/04/2012 by the Administrator. **Criteria Two:** A 100% audit of the chairs throughout the facility was completed on 09/18/2012. The chairs that were determined to not be in good condition were removed/replaced on 09/18/2012 by the Administrator. **Criteria Three:** The Maintenance Director was re-educated by the Administrator on proper repair and replacement of chairs in the dementia unit on 09/11/2012.	9/21/2012
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	The Maintenance Director will audit the facility chairs monthly for six (6) months then annually thereafter utilizing a preventative QI maintenance schedule. To assure chairs are maintained in good repair or are replaced as necessary.	

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F 253	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide dining room chairs in good condition without rips or tears in the dementia unit dining room. The findings are: Observation during the lunch meal on 8/27/12 at 12:15 PM revealed 11 chairs in the dementia unit dining room with large rips and tears on the seats. Residents were seated on the chairs during the meal. Observation during the breakfast meal on 8/29/12 revealed residents sat on the same dining room chairs. Observation of eleven dining room chairs on 8/29/12 at 9:22 AM revealed two chair seats with torn sections which covered a third of the chair seat with yellow stuffing exposed. Three chair seats had ripped areas approximately 3 inches by 1 ½ inches with white backing exposed. The remaining six chairs had rips which varied from approximately one inch by two inch areas to approximately three inch and 1 ½ inch areas with white backing exposed. Interview with the dementia unit's activity assistant on 8/29/12 at 10:09 AM revealed the dining room chairs were ripped and torn since last fall. Interview with Nurse #1 on 829/12 at 10:46 AM revealed the chair rips began last fall and worsened due to residents tugging at the rips.	F 253	**Criteria Four:** The Administrator will review the completed QI maintenance schedule of the chair audits and preventative maintenance log with the Maintenance Director for further areas of concern and corrective action as indicated. The Administrator will review any areas of concerns with the Quality Assurance and Assessment Committee monthly for further recommendations and follow-up as indicated.	

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F 253	Continued From page 14 Nurse #1 estimated the ripped chair seats were torn and ripped for approximately 9 months. Interview with the Administrator on 8/29/12 at 11:19 AM revealed he placed a call last week to an interior designer in order to obtain a bid for replacement chairs. The Administrator explained replacement chairs would be requested once the estimate of cost arrived from the designer.	F 253		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews, the facility failed to assess the daily heart (pulse) rate before administration of Digoxin for one (1) of ten (10) sampled residents reviewed and who had orders to check pulse prior to medication administration (Resident #132). The findings are: Resident #132 was readmitted to the facility on 06/22/12 with diagnoses including pulmonary valve disorder, chronic ischemic cardiomyopathy and atrial fibrillation. A medical record review revealed physician orders dated 6/22/2012 to administer Digoxin 250mcg (microgram) daily and check pulse prior to administration of Digoxin. The physician ' s order was renewed every month including for August 2012. This order directed the nurse to	F 281	**F281** **Criteria One:** Resident #132 was assessed by the physician on 08/28/2012 and no adverse effects were identified from not checking the pulse prior to administration of medication. **Criteria Two:** A 100% audit of the residents on Digoxin was completed by the Assistant Director of Nursing - Registered Nurse on 08/30/2012 to assure pulse was taken prior to the administration of Digoxin medication. **Criteria Three:** The licensed Nurses were re-educated on the administration protocol of Digoxin on 09/11/2012 by the Staff Development Coordinator-RN.	9/21/2012

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F 281	Continued From page 15 check the resident ' s pulse rate at the time of medication administration. A review of Resident #132 ' s Medication Administration Records (MAR) for the months of July and August 2012 revealed the correct transcription of this order and scheduling the medication at 9:00 AM. A further review of these MARs revealed that for the 50 total days Resident #132 accepted to receive his ordered Digoxin during this two month period, daily pulse check was documented only for seven (7) days, the last pulse check being 72 beats per minute and documented on 08/10/12. On 08/29/12 at 3:25 PM Nurse #3 was interviewed. Nurse #3 stated she was the morning medication nurse on numerous dates in the months of July and August 2012. She stated that on 08/29/12 she administered to Resident #132 his daily dose of Digoxin. Nurse #3 stated she did not obtain his pulse rate before administration on 08/29/12 or on any other day in August 2012 because he sometimes refused to have it taken. Nurse #3 stated she did not document these refusals in the medical record nor on the MAR. Nurse #3 stated the awareness of the nursing practice and as per the physician orders to obtain pulse rate before Digoxin administration and to hold the medication if the pulse was less than 60 beats per minute. On 08/30/12 at 1:29 PM the DON was interviewed. The DON stated her expectation that nurses first obtain a resident ' s pulse rate before administering Digoxin and hold the medication if the pulse was less than 60 per minute and document the pulse rate in the MAR.	F 281	The ADON will review the Medication Administration Record (MAR) on the residents who receive Digoxin medication to assure pulse was taken utilizing a Digoxin QI Audit tool for four (4) weeks then monthly for six (6) months. **Criteria Four:** The Director of Nursing will review the completed Digoxin QI Audit tools to ensure the pulse was taken per protocol three times per week for 4 weeks then monthly for six months. Any areas of concern will be reviewed with the Administrator for follow up as indicated. The Administrator will review monthly with the Quality Assurance and Assessment Committee the areas of concern for further follow up as indicated.	
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES	F 319		

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F 319	Continued From page 16 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a psychiatric evaluation for one (1) of three (3) sampled residents with behavioral symptoms (Resident #232). The findings are: Resident #232 was admitted to the facility with diagnoses which included Alzheimer's Disease. A mental health history dated 5/8/12 revealed staff reported Resident #232 was agitated with some sleeping difficulty. The mental health history documented a plan for a psychiatric evaluation. Review of Resident #23's admission Minimum Data Set (MDS) dated 6/6/12 revealed assessment of cognitive impairment with physical and verbal behavioral symptoms. Review of a nurse practitioner's order dated 6/8/12 revealed Resident #232 should receive a psychiatric evaluation. Review of Resident #232's clinical record revealed there was no documentation of a	F 319	**F319** **Criteria One:** Resident #232 was seen by the Psychiatric Provider on 09/05/2012. **Criteria Two:** A 100% audit of resident physician orders was completed by the Registered Nurse Managers on 09/10/2012 to assure the residents that were referred for a psychiatric evaluation. **Criteria Three:** The licensed nurses and social workers were re-educated by the Staff Development Coordinator-RN on the transcription and follow through of physician orders on 09/11/2012. Physician orders will be reviewed by the Nursing Administration to include Director of Nursing and/or Assistant Director of Nursing, and/or RN Unit Managers during the clinical meeting to	9/21/2012

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F 319	Continued From page 17 psychiatric evaluation. Review of Resident #232's nursing progress notes revealed the following: · 6/1/12: Resident combative with care. · 6/2/12: Resident combative and yelling at staff. Refused to allow staff to care for her roommate. · 6/4/12: Resident verbally abusive to staff and other residents. · 6/7/12: Resident agitated and redirected successfully. · 6/8/12: Resident attempted to hit staff and yelled at other residents. · 6/18/12: Resident scratched a staff member during care. · 6/19/12: Resident became combative during shower and scratched staff member. · 6/28/12: Resident refused to get up off of floor and bumped right side of forehead. · 7/18/12: Resident screaming at staff and agitated. · 7/20/12: Resident resistant to care and refused to remove wet clothing. · 7/23/12: Resident agitated and verbally abusive. · 8/3/12: Resident verbally abusive to staff. · 8/7/12: Resident combative with care. · 8/16/12: Resident refusing care and yelling. · 8/17/12: Resident yelled and attempted to hit staff. · 8/29/12: Resident attempted to pull another resident with her and fell. Interview with Social Worker (SW) #1 on 8/30/12 at 11:05 AM revealed she coordinated mental health referrals for residents. SW #1 reported she was not aware of the psychiatric evaluation	F 319	assure proper transcription and follow-up has been completed three times per week for four weeks then one time per week for six months. The Director of Nursing will audit a 10% random sample of the physician orders weekly for four weeks and monthly for six (6) month utilizing the QI Medication Transcription Accuracy and Follow up tool to assure compliance is achieved and maintained. **Criteria Four:** The Director of Nursing will review the QI Medication Transcription Accuracy Audit Tool with the Administrator weekly for four weeks then monthly for six months. The Administrator will review with the Quality Assurance and Assessment Committee monthly for further recommendation and follow up as indicate any identified areas of concern.	

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F 319	Continued From page 18 order for Resident #232. SW #1 explained the nursing staff would forward all mental health referrals to her. SW #1 explained she scheduled and coordinated the psychiatric evaluations and treatments. Interview with Nurse #2 on 8/30/12 at 3:01 PM revealed she transcribed the order on 6/8/12. Nurse #2 explained she either handed the order directly to SW #1 or placed it into SW #1's internal mailbox. Interview with the Director of Nursing on 8/30/12 at 4:22 PM revealed she expected the nursing staff to forward the referral for a psychiatric evaluation to the facility's social worker either directly or by placing the order into the SW's mailbox..	F 319		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to supervise a resident on the dementia unit during snack time and prevent distribution of a peanut butter sandwich to a resident with swallowing problems (Resident #134) and failed to supervise ambulation for one	F 323	F323 **Criteria One:** A. Resident #134 re-assessed by the Speech Therapist 09/03/2012 and Attending Physician 09/03/2012 and physician ordered a mechanical soft diet. B. Resident #232 had their fall risk assessment revised, and plan of care updated with appropriate intervention on 09/18/2012 by the Assistant Director of Nursing-Registered Nurse.	9/21/12

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F 323 Continued From page 19
(1) of three (3) sampled residents at risks for falls (Resident #232).

The findings are:

1. Resident #134 was admitted to the facility with diagnoses which included Alzheimer's Disease and Dysphagia. A physician's order dated 3/8/12 directed Resident #134 was to receive a pureed diet, thin liquids, with a soft sandwich for snack. A physician's order dated 3/21/12 clarified the diet to include No Concentrated Sweets.

Review of Resident #134's care plan dated 3/21/12 revealed a risk for weight changes with difficulty chewing/swallowing food related to cognitive impairment. Interventions included observation for signs/symptoms of gagging or choking during meals and provision of diet as ordered.

Review of Resident #134's quarterly Minimum Data Set dated 5/24/12 revealed short and long term memory problems with severely impaired decision making skills. Resident #134 required the extensive assistance of one person with a mechanically altered diet.

Review of a physician's order dated 8/22/12 revealed speech therapy initiation of evaluation and treatment.

Review of the speech therapist evaluation dated 8/22/12 revealed referral due to exacerbation of dysphagia to determine a least restrictive diet for Resident #134. The speech therapist documented Resident #134 preferred sandwiches and the goal of safe consumption

F 323

Criteria Two:

A. A 100% audit of the resident diets was completed 09/04/2012 by the Certified Dietary Manager and Registered Dietician. The correct diets were entered into the electronic medical record and care guide were update on 09/04/2012.
B. 100% audits of residents that are at risk for falls was completed by the Registered Nurse Unit Managers to assure interventions were implemented on 09/19/2012

Criteria Three:

The licensed nurses and certified nursing assistants were re-educated on providing supervision to prevent accidents and incidents including fall risk interventions and resident diets on 09/11/2012 by the Staff Development Coordinator-Registered Nurse.

The Director of Nursing or Registered Nurse Designee will audit the residents that are at risk for falls or swallowing problems utilizing the QI Supervision audit tool to assure the preventative measures are appropriate and updated weekly for four week then monthly for six months.

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F 323	Continued From page 20 with prompting and modeling. Observation on 8/29/12 at 10:15 AM revealed the dementia unit activity assistant offered vanilla pudding to Resident #134 which he refused. Activity assistant exited the dementia unit after the snack delivery. Nursing Assistant (NA) #5 was in a resident's room and NA #1 was at the end of the dining area assisting a resident with ambulation. Nurse #1 was at the nursing station on the telephone. Observation on 8/29/12 at 10:37 AM revealed another resident gave Resident #134 a peanut butter and jelly sandwich. Resident #134 began to eat the sandwich. The surveyor interrupted the bite and summoned NA #1. NA #1 immediately took the sandwich from Resident #134 and announced Resident #134 should not have the sandwich. Interview with NA #1 on 8/29/12 at 10:39 AM revealed Resident #134 should not eat or receive a sandwich but it was difficult to supervise the residents when another resident needed physical assistance. Interview with Nurse #1 on 8/29/12 at 10:41 AM revealed staff attempted to supervise the residents during snack times but it was difficult to always have one of the two nursing assistants or herself present due to unanticipated events such as resident needs, physician or family calls, and resident behaviors. Nurse #1 explained the thirty residents in the dementia unit required supervision with eating. Interview with the speech therapist on 8/29/12 at	F 323	Any identified area of concern will be corrected upon identification. **Criteria Four:** The Director of Nursing will review the QI Supervision audit tool with the Administrator weekly for four weeks then monthly for six months for further recommendation as necessary. The Administrator will review QI Supervision Audit weekly for four weeks then monthly for six months. The Administrator will review with the Quality Assurance and Assessment Committee monthly for further recommendation ad and follow up as indicate any identified areas of concern.	

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12:24 PM revealed Resident #134 required a pureed diet due to swallowing problems. She explained Resident #134 required close supervision of a trial of soft food and hoped Resident #134 could advance to safe consumption of a soft diet. The speech therapist reported Resident #134 should not receive a peanut butter sandwich.

Interview with the Assistant Director of Nursing (ADON) on 8/30/12 at 2:27 PM revealed there were no specific directions for staff supervision during the snack times since many of the residents were independent in ambulation and eating.

Interview with the dietary manager on 8/30/12 at 3:45 PM revealed puddings were delivered as snacks for Resident #134.

Interview with the Director of Nursing on 8/30/12 at 4:29 PM revealed she expected nursing staff to supervise distribution and consumption of snacks on the dementia unit.

2. Resident #232 was admitted to the facility with diagnoses which included Alzheimer's Disease, Unspecified Backache, Abnormality of Gait and Osteoporosis. The admission Minimum Data Set (MDS) dated 6/6/12 assessed cognitive impairment with physical and verbal behavioral symptoms. The MDS documented Resident #232's walking required supervision and the physical assistance of one person with walking. Resident #232's balance moving from seated to standing was not steady and only able to stabilize with staff assistance. Resident #232's walking was not steady but able to stabilize without staff

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F 323	Continued From page 22 assistance. Review of Resident #232's care plan dated 6/11/12 and revised on 7/31/12 revealed a risk for falls characterized by a history of falls, and multiple risk factors related to impaired cognition, poor safety awareness and use of psychotropic medications. The care plan indicated Resident #232 would get down on the floor and crawl. Interventions included assistance during transfer and mobility with staff to redirect resident out of the room in to the common area. Other interventions included encouragement of rest periods, activity participation, use of handrails or assistive devices, and clutter free environment. Review of the resident care guide for Resident #232 revealed the requirement for nursing assistants to supervise ambulation and ensure non skid footwear. Review of Resident #232's nursing progress notes revealed the following: · 6/28/12 at 9:58 AM: Resident on her hands and knees on the floor and refused to get up. Resident bumped the right side of the forehead on the floor resulting in a red, raised area above the right eyebrow. · 7/30/12 at 2:09 PM: Resident fell when bending down to pick up paper off of the floor in another resident's room. There was no injury. Staff observed pants on floor with wet paper towels. · 8/17/12 at 3:30 PM: Resident on floor of another resident's room. There was no injury. Observation of Resident #232 on 8/28/12 at 3: 30	F 323		

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F 323	Continued From page 23 PM revealed she ambulated independently in her room. Resident #232 walked into the bathroom and closed the door. Interview with Nursing Assistant (NA) #3 8/28/12 at 3:35 PM revealed Resident #232 ambulated independently and was continent of urine and bowel on the day and evening shifts. NA #3 reported there were no directions related to fall prevention for Resident #232. Observation on 8/29/12 at 9:26 AM revealed Resident #232, with non skid socks, stood up independently from a seated position with stand by assistance from Nurse #1. Resident #232 ambulated slowly to the activity area of the dementia unit using a wide stance gait. Resident #232 seated herself independently. At 9:37 AM, Resident #232 fell asleep. At 10:31 AM, Resident #232 awoke for a snack of graham crackers. Resident #232 dropped one of the crackers and bent down to retrieve it. Observation on 8/29/12 at 12:04 PM revealed Resident #232 walked independently to her room and used the bathroom. Resident #232 came into the dining room area carrying a handful of wet paper towels. Resident #232 attempted and failed to insert the paper towels into the trash can lid. She lifted the lid of a trash can and disposed of the paper towels. Interview with NA # 5 on 8/29/12 at 12:11 PM revealed Resident #232 was independent in walking and transfers. NA #5 reported Resident #232 used the bathroom independently and required supervision for agitated behavior not falls.	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 Observation on 8/29/12 at 12:13 PM revealed Resident #232 walked unsteadily through the dining room and toward a chair in the activity area. Resident #232 felt the chair seat with her hands behind her and sat down. Observation on 8/29/12 from 3:02 PM to 3:50 PM revealed the following: · 3:02 PM: Resident #232 walked independently across the activity area with an unsteady gait holding a paper cup. Her gait changed from a wide stance to small measured steps. · 3:05 PM, Resident #232 moved a dining room chair to a dining room table. The activity assistant asked her not to move the chairs. Resident #232 complied and walked away from the dining area. · 3:06 PM, Resident #232 entered another resident's room. She patted the bottom sheet and began to make the bed. Resident #232 lifted the mattress on each side and tucked the top sheet under the mattress. · 3:10 PM, Resident #232 picked a pillow off of the floor and placed it on the bed. · 3:12 PM, Resident #232 unmade and remade the bed. · 3:19 PM, a nursing assistant entered the resident room with another resident and asked Resident #232 to leave the room. Resident #232 left the room. · 3:22 PM, Resident #232 entered another resident's room with an unsteady gait. Resident #232 approaches the bed next to the window and bends over to straighten the bed covers. She lifts the mattress and tucks the sheets. Resident #232 attempted to move the bed from the wall.	F 323		

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	345142	A. BUILDING ______ B. WING ______	C 08/30/2012

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F 323	Continued From page 25 She stoop on her toes on a floor mat and reached over to straighten a bed cover. · 3:27 PM, Resident #232 moved to the other bed in the room. Resident #232 unmade and made the bed. She stood on a floor mat and lifted the mattress. Nurse #2 entered the room and redirected her out of the room and closed the door. 3:30 PM, Resident #232 opened the door and walked into the same room. · 3:40 PM, Resident #232 walked independently into the activity area and sat down. Interview with NA #4 on 8/29/12 at 3:42 PM revealed Resident #232 required supervision due to agitated and combative behaviors. NA # 4 reported Resident #232 walked independently on the dementia unit. Review of nursing progress notes dated 8/29/12 at 7:15 PM revealed Resident #232 attempted to pull another resident, tripped over the foot of a bed and fell. There was no injury. Interview with NA #1 on 8/30/12 at 9:30 AM revealed Resident #232 required no special supervision or intervention related to falls. NA #1 reported all of the residents on the dementia required supervision due to confusion. Interview with the Assistant Director of Nursing (ADON) on 8/30/12 at 2:21 PM revealed Resident #232 required supervision with ambulation. The ADON was unable to explain the type or amount of supervision required. Interview with the Quality Assurance (QA) Nurse on 8/30/12 at 2:42 PM revealed she investigated	F 323		

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F 323	Continued From page 26 Resident #232's falls. The QA Nurse explained Resident #232's safety in walking varied due to her behaviors. Interview with the Director of Nursing (DON) on 8/30/12 at 4:17 PM revealed supervision of ambulatory confused residents would require close supervision. The DON reported she expected nursing staff to notice if a resident became tired or had an unsteady gait.	F 323		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews	F 425	F425 **Criteria One:** a. Resident # 175's physician gave a clarification order to administer pulmacort upon arrival from back up pharmacy on 08/28/2012. **b.** The Bronana nebulizer solution was discarded on 08/28/2012 by the RN-Unit manag**er.** **Criteria Two:** A 100% audit of all resident MD orders and MARs was completed by the Registered Nurse-Unit Managers on 08/31/2012 to assure the residents medication was available for administration. All facility medication rooms were audited by the RN Unit Managers on 08/28/2012 to assure no unlabeled medication was present.	9/21/2012

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F 425	Continued From page 27 and staff interviews the facility failed to procure medication (Pulmicort nebulizer suspension) timely for one (1) of ten (10) sampled resident observed for medication administration and failed to label accurately with proper identifications for a medication (Brovana nebulizer solution) stored in one (1) of three (3) medication room refrigerators. (Resident #175) The findings include: 1) A review of the facility policy on 'Ordering Medication from the Pharmacy' on page 42 included procedures to obtain medications from back-up pharmacy within the time frames for medication administration. Resident #175 was observed for Medication administration on 8/29/12 at 8:45 AM. A review of medical record revealed Resident #175 residing in the facility with diagnoses including Acute and Chronic Respiratory failure, Chronic Obstructive Pulmonary Disease and Obstructive Sleep Apnea Syndrome. A review of the current physician orders included an order dated 7/27/2012 to administer 2 ml (milliliter) equal to 0.5mg (milligram) Pulmicort Nebulizer Suspension two times daily scheduled at 8:30 AM and 8:30 PM. Nurse #5 was observed administering medications to Resident #175 on 8/29/2012 at 8:45 AM. Nurse #5 searched for Pulmicort nebulizer package in the medication cart and failed to find Pulmicort and completed the administration of other ordered medications except Pulmicort. Nurse #5 searched in the	F 425	**Criteria Three:** The licensed nurses were re-educated by the Staff Development Coordinator-RN on 08/29/2012 on proper procedure to obtain and store medication from the pharmacy. Physician orders will be reviewed by the Nursing Administration to include Director of Nursing and/or Assistant Director of Nursing, and/or RN Unit Managers during the clinical meeting to assure proper transcription and follow-up has been completed three times per week for four weeks then one time per week for six months. The Director of Nursing will audit a 10% random sample of the physician orders utilizing the QI Transcription audit tool' weekly for four weeks then monthly for six (6) months to assure 100% compliance is achieved and maintained. The medication rooms will be monitored by a registered nurse daily for four weeks then weekly for six (6) months to ensure no unlabeled medications are present utilizing the	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 425	Continued From page 28 medication room storage area also and stated that she would have to skip giving this medication as it had not been sent by the provider pharmacy. The nurse was unable to provide any documentation when the Pulmicort had been reordered for Resident #175. An interview with Nurse #5 on 8/29/12 at 8:50 AM revealed that she would get the medication from the backup pharmacy only if it was a narcotic medication, and stated that the resident would have to miss this dose as it was not a narcotic medication. The interview revealed that she was not aware of the back-up pharmacy protocol and procedures at the time of this interview. An interview with the Director of Nursing (DON) on 8/29/12 at 10:12 AM revealed that all nurses were aware of the back-up pharmacy procedures to obtain medication if not made available by the provider pharmacy. The DON ' s expectation included that ' no medications were missed for the residents ' . The DON stated that when a dose is missed at the time of the scheduled medication time the physician had to be notified and obtain orders for alternative time of administration and obtain the medication from the back-up pharmacy. The DON also stated that an on call pharmacist was available to make arrangements to obtain medications from the back-up pharmacy. 2. The facility had three medication storage rooms which had place to store medications in the refrigerators. All medication storage areas were reviewed for medication storage. Observation on 8/29/2012 at 12:59 PM in the	F 425	medication room QI Audit tool. **Criteria Four:** The Administrator will review QI Transcription Audit weekly and QI Medication Room audit tool for four weeks then monthly for six months. The Administrator will review with the Quality Assurance and Assessment Committee monthly for further recommendation ad and follow up as indicate any identified areas of concern.	

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F 425	Continued From page 29 Garden city medication room refrigerators two small packets containing ten (10) 2 ml (milliliter) Brovana nebulizer packs were found with no proper identification label from the pharmacy and had no information to whom it was prescribed and how it had to be used. The Garden city unit supervisor was interviewed on 8/29/2012 at 12:59 PM. The interview revealed that he was aware that all medications from the pharmacy had to have a dispensing label and was not aware who was using Brovana nebulizer. The unit supervisor stated that he would return the medication to the pharmacy immediately. An interview with the Director of Nursing on 8/30/2012 at 1:29 PM confirmed that all medications should have the complete identification label from the pharmacy. The interview also revealed that medication room and refrigerators were expected to be checked by the unit supervisors every week for accuracy.	F 425	F514 **Criteria One:** The nurse practitioner ordered the Gradual Dose Reduction for Ativan on 09/01/2012 for Resident #196 **Criteria Two:** A 100% audit of psychiatric recommendations was completed on 09/10/2012 by the ADON to assure the residents that were referred for a psychiatric evaluation was completed and recommendations followed by attending physician.	9/21/2012
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514	Physician orders will be reviewed by the Nursing Administration to include Director of Nursing and/or Assistant Director of Nursing, and/or RN Unit Managers during the clinical meeting to assure proper transcription and follow-up has been completed three times per week for four weeks then one time per week for six months.	

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F 514	Continued From page 30 and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews the facility failed to accurately transcribe timely a psychotropic medication consultation order of medication (Ativan tablet strength) reflecting the reduction of the dosage for one (1) of ten (10) sampled residents reviewed for unnecessary mediations. (Resident #196) Findings include: Resident #196 was originally admitted to the facility on 7/21/2011. The admitting diagnoses included Psychosis, Anxiety status and Cirrhosis of liver. A review medication included a physician order dated 2/12/2012 for Ativan 0.5mg (milligram) three times daily for anxiety. During a routine review of psychotropic medication reviews on 7/11/2012 by the Psychological medication consultation advised to reduce the Ativan 0.5mg tid (three times daily) to Ativan 0.25mg tid per clinical needs. Further review of the Medication Administration Records for the month of July 2012 and August 2012 and a review of the written physician orders the dose change was not effected and the resident received Ativan 0.5mg three times daily in the month of July and August 2012. An interview with the Nurse #4 on 8/29/12 at 3:02 PM revealed that once the ' Psych consult ' is complete the charge nurse or the nurse manager	F 514	The Director of Nursing will audit a 10% random sample of the physician orders utilizing the QI Transcription audit tool weekly for four weeks then monthly for six (6) months to assure 100% compliance is achieved. **Criteria Four:** The Administrator will review the completed QI Transcription Audit Tool weekly for four weeks then monthly for six months. The Administrator will review with the Quality Assurance and Assessment Committee monthly for further recommendation and follow up as indicated any identified areas of concern.	

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F 514	Continued From page 31 of the unit would transcribe and completed that order for approval by the physician. The interview revealed that when Resident #196 was transferred from 500-hall to 800-hall recently and the transcription and completion of the order was not completed resulting in continuation of the previously ordered strength of Ativan 0.5mg three times daily for over a month. An interview with the Director of Nursing (DON) on 8/30/12 at 1:29 PM confirmed that it was the responsibility of the floor nurse or the nurse manager to complete the transcription and document to write the order to obtain the approval from the physician/medical director. The DON was not aware of this transcription error and the change was immediately effected from September 2012.	F 514		