STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

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F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews the facility failed to resolve a grievance for 1 of 1 residents wearing TED hose. (Resident #2). The findings include: Resident #2 was originally admitted to the facility on 11/21/11 and was readmitted on 5/2/12 with diagnoses including Debility, Dementia with behavior disturbance and Alzheimer's Disease. Review of a Physician's note dated 5/9/12 read in part, "2. RLE (Right Lower Extremity) edema - TED stockings" Review of doctor's orders dated 5/31/12 read in part, "TED compression hose 15-20 thigh high. The physician signed the order on 6/8/12." Review of Resident #2's Treatment Record revealed the times Ted Hose were on and off: Ted hose on 7:00AM-3:00PM and off 3:00P-11:00PM. Review of Resident #2's Treatment Record from June, 2012 through October, 2012 revealed the TED hose was not initialed by a Nurse as being on: In June TED compression hose was not initialed by a Nurse on Treatment Record six days out of thirty days, 6/1/12, 6/2/12, 6/7/12, 6/15/12, 6/25/12 and 6/29/12. In July, 2012, the compression hose was initialed by a Nurse 29 days out of thirty days. In August, 2012, the	F 166	F166 On resident #2, the grievance was responded to within 48 hours of receipt. The surveyor found the TED hose to be off and in the wash due to being soiled on the day of the survey. The hose were reapplied when received from the laundry. Another set of hose were obtained as a backup for times that her other ones were soiled. Also, a care plan for the TED hose was developed. An audit was completed on all residents with TED hose by the DON, ADON, Treatment Nurse, SDC, MDS and the RN Supervisor. Ten residents had orders for TED hose and each one had their care plan reviewed and updated as necessary. Other residents that may be affected by this have had another pair of hose ordered and received so there would be no break in their	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 11/5/12

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 166	Continued From page 1 compression hose was initialed by a Nurse, twenty-six days out of thirty days . The days not initialed in August included: 8/26/12, 8/27/12, 8/28/12 and 8/29/12. In September, 2012, the TED hose was initialed by a Nurse twenty seven days out of thirty days. In October, 2012, the TED compression hose was not initialed in the Treatment Record by a Nurse on 10/8/12 and 10/9/12. On 10/9/12 at 11:30AM Resident #2 was observed sitting in her wheelchair in her room. She was not wearing ted hose. A family member sitting in Resident#2's room was concerned Resident #2 was not wearing ted hose because of her medical condition. During an interview on 10/9/12 at 3:10PM, NA#6 revealed she usually put on Resident #2's TED hose every day. She revealed the reason Resident #2 was not wearing TED hose was because they were in the laundry and she had not gone to the laundry to get them because it had slipped her mind. During an interview on 10/9/12 at 3:20PM, Staff Nurse #5, stated the reason Resident #2 did not have on TED hose was because the TED hose had not come back from the laundry. She revealed Resident #2 had two pair of TED hose but apparently both were in the laundry. She stated Resident #2 needed a new pair of TED hose. She revealed Resident #2 did not have a problem wearing TED hose. Staff Nurse #5 stated when she passed medication during the morning, she checked to see if Resident #2 had on TED hose. She stated the reason the Treatment Record for Resident #2's TED hose was not checked off on the morning of 10/9/12 was that she had not gotten around to documenting everything.	F 166	application as ordered. Other residents that utilize TED hose have also had their care plans updated to reflect their use. Residents that are given orders for TED hose will be reviewed at the morning meetings, and care plans will be developed immediately by the MDS nurse. All residents will have a backup pair available to exchange if the need arises. Nurses have been in serviced on documentation of the application of the TED hose on October15, 2012 by the DON, ADON, SDC and the 3-11 RN supervisor. The application of TED hose will be monitored by the charge nurses, DON, ADON, SDC, RN Supervisor, and the corporate nurse consultant. The results of the monitoring will be brought before the Quality Assurance Committee monthly for 3 months and then every 6 months thereafter for a period of 1 year.	10/31/12

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F 166	Continued From page 2 During an interview on 10/10/12 at 2:25PM, the facility Treatment Nurse had a pair of thigh length TED hose in her hands. She revealed she bought the pair of TED hose yesterday, but there were several in the central supply room in the facility and more could be ordered if needed. During an interview on 10/9/12 at 4:10PM, the Director of Nursing (DON) stated Resident #2 wore TED hose because she had fluid or circulatory issues. She stated, in May, the doctor examined Resident #2 and noticed she had right lower extremity edema and he ordered the TED hose. She revealed the medical doctor told them when to put TED hose on and when to take them off. She stated Resident #2 should have them off in the evening. The DON stated Resident #2's family wanted the thigh high TED hose and those kind of TED hose cost about $100.00. The DON stated the family had a complaint one morning in July when Resident #2 did not have on TED hose. One pair of TED hose was soiled and they (staff) had to get another pair. The DON revealed sometimes one pair of TED hose might have been in the laundry and there was a delay in getting the other pair, but it was not a lengthy time. The DON revealed if one pair of TED hose was soiled they tried to have another pair available. The DON stated her expectation for ensuring Resident #2 wore TED hose was when she was up the TED hose should be on her clean and dry. If one pair was soiled, get another pair to put them on within time constraints.	F 166		
F 253 SS=D	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		

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F 253	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to maintain a clean and sanitary wheelchair for 1 of 11 sampled residents. (Resident # 1) Finings include: Resident #1 was admitted to the facility on 8/24/2004 with diagnoses of dementia, hypertension, congestive heart failure, and dysphasia. Review of the resident ' s latest annual assessment for the Minimum Data Set (MDS) was dated 7/23/12. The MDS documented staff had to anticipate resident ' s needs due to cognitive impairment with severe impairment of daily decision making skills. Resident #1 was dependent on staff for all areas of daily care. The resident was incontinent of bowel and bladder and received all nutrition through a gastronomy tube. The MDS revealed the resident often resisted care. The resident was observed during the initial tour on 10/9/12 at 10:10 AM. Resident #1 was sitting in her wheel chair with Jevity 1.5 infusing through the gastronomy tube. Each time the resident was observed on 10/9/12 she was sitting in her wheelchair with the feeding pump beside her chair. A review of the resident ' s medical record revealed she had a history of pulling at her gastronomy tube and it had last been replaced in	F 253	F253 Resident #1 had her wheelchair cleaned on the day of the survey by the housekeeping supervisor. The housekeeping supervisor had developed a schedule to clean wheelchairs on Thursday nights on an ongoing basis for all wheelchairs in the facility. This plan was to and did begin on the following day, October 11 on the evening shift. At that time, wheelchairs were thoroughly washed and returned to the residents that they belonged to. An in-service was held with housekeeping and nursing staff on October 11, 2012 concerning the new schedule. The supervisor's schedule provides a systemic change for the entire facilities wheel chair washing. Also, any staff or resident may request that a problem chair be washed by letting the housekeeping supervisor or the assistant housekeeping supervisor know.	

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F 253	Continued From page 4 August of 2012. Resident #1 was observed on 10/10/12 at 2:00 PM receiving incontinent care. The empty wheelchair was located beside the bed facing the door. The wheelchair was observed to have multiple drips of a dried brown substance which extended from one side of the inner back panel of the chair to the other side. The drips began at the top of the back support panel of the chair and extended the entire length down to the seat cushion. The right side inner panel of the wheelchair was covered with a dried brown substance that had started to flake off . The seat cushion had a quarter sized area of a dried brown substance on the back right corner and three pea sized areas on the same dried substance near the middle of the seat. A 3 inch area of a dried brown substance was noted on the front of the wheelchair cushion. The resident had been sitting in the wheelchair during all previous observations. Nursing Assistant (NA) #4 stated on 10/9/12 at 11:15 AM residents in wheelchairs are checked every two hours. She indicated the residents are assisted to stand with a sit to stand lift or the NA helps them stand so they can be checked to see if they need incontinent care. NA #5 stated on 10/10/12 at 2:10 PM the resident had pulled her gastronomy tube out several times. She pointed out an abdominal band the resident wore to protect the site. The NA the resident had her gastronomy tube last replaced in August and she was not aware of any further incidents with the tube.	F 253	Wheelchairs will be monitored by the CNAs, charge nurses, housekeeping supervisor and assistant housekeeping supervisor and administrative staff for cleanliness and adherence to the cleaning schedule. Results of the monitoring will be brought to the quality assurance committee for 3 months and then every 6 months thereafter for 1 year.	10/31/12

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F 253	Continued From page 5 The Director of Nursing (DON) observed the wheelchair on 10/10/12 at 2:20 PM. She stated it should have been cleaned. She stated someone should have seen the chair and either cleaned it or reported the chair to housekeeping. The DON revealed housekeeping was responsible for cleaning wheelchairs. She called NA #5 into the room to clean the chair. NA# 5 returned to the room with cleaner and a towel. She scrubbed the chair but the substance would not come off. The Housekeeping Supervisor came into the resident ' s room at 2:45 PM. He stated he was new to the job and had only been at the facility for 3 weeks. The Supervisor revealed he had initiated a cleaning schedule for all facility equipment and wheelchairs. He stated the medical equipment and wheelchairs would get a thorough cleaning once a month on a specified day in addition to as needed cleaning. Resident #1 ' s wheelchair was scheduled to be cleaned the next day. The Supervisor stated he did not have a system currently in place for staff to report equipment that needed cleaning. He indicated staff verbally reported any cleaning needs to him. On 10/10/12 at 3:30 PM the Housekeeping Supervisor reported he had personally cleaned Resident #1 ' s wheelchair. The Supervisor stated he sprayed the wheelchair with UI (a disinfect and clearer used by the facility) and let it soak for about 15 seconds. The wheelchair was then scrubbed with steel wool. The dried substance was removed by the steel wool. The Supervisor reported the wheelchair was sprayed and wiped clean with a dry cloth. The wheelchair was observed in Resident #1 ' s	F 253		

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F 253	Continued From page 6 room on 10/10/12 at 4:00 PM. The chair was clean.	F 253	F 279	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to develop a care plan for behaviors for 2 of 5 sampled residents with behaviors (Resident #3 and Resident #2) and failed to care plan anti-embolism stockings for 1 of 1 sampled residents with anti-embolism stockings (Resident #2). The findings include:	F 279	Resident #3 had a care plan developed for behaviors by the social worker of the facility. Resident #2 had a care plan developed by the MDS staff for TED hose. Both were completed on October 11, 2012. An audit was completed on all residents that have behavior issues as well as those having TED hose to determine if they had care plans in place for behaviors or TED hose. Ten residents had their care plans updated for the TED hose and 27 had their behavior care plan updated. Any resident that did not have the appropriate care plans available had a care plan completed. The facility MSW completed behavior care plans as appropriate and the MDS nurses completed care plans concerning TED hose. These were completed by October 19, 2012.	

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F 279	Continued From page 7 1. Resident #3 was admitted to the facility on 01/25/11 and had diagnoses that included Dementia with Behavioral Symptoms. The Care Area Assessment (CAA) for behaviors dated 04/18/12 showed that the resident resisted care at times and that the resident was at risk for injury related to poor safety awareness. The CAA read: "Care plan will be developed to assure resident's safety." The Quarterly Minimum Data Set (MDS) Assessment dated 7/13/12 showed that the resident had short and long term memory problems and was severely cognitively impaired. The MDS showed that the resident had no behaviors during the 7 day assessment period. The resident's Care Plan dated 02/01/11 and last updated on 10/08/12 did not address the resident ' s behaviors. An interview was conducted with a nursing assistant (NA #1) frequently assigned to the resident on 10/10/12 at 9:30 AM. NA #1 stated that the resident did not resist care every day but when in a certain mood the resident would hit and curse at staff and tell them to leave him alone. On 10/10/12 at 1:20 PM NA #2 and NA #3 were observed to enter the resident ' s room to provide incontinent care. The 2 NAs explained to the resident what they needed to do but the resident pushed his hand toward NA #2 and shook his head no. NA #2 stated that they would have to come back later and try again.	F 279	As a systemic change the administrative staff has been in serviced (on October 11, 2012 by the SDC and DON) to pick out of the morning meetings the residents that have new orders for TED hose and those that have exhibit behaviors overnight so that a care plan can be generated for them. Each morning the 24 hour reports indicate new information concerning each resident change. The DON, ADON, RN supervisor, SDC, MDS nurses and the social worker will monitor care plans on residents with behaviors and those with TED hose. The monitoring will be presented to the Quality Assurance committee monthly for 6 months then every 6 months thereafter for a period of 1 year. 10/31/12	

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F 279	Continued From page 8 MDS Nurse #1 stated in an interview on 10/10/12 at 2:36 PM that the social worker did the care plans for behaviors. The MDS Nurse was observed to review the resident's care plan and stated that there was not a care plan for behaviors. The MDS Nurse stated that the social worker might have the care plan in her computer but that it should be with the resident's care plan. The Director of Nursing stated in an interview on 10/10/12 at 2:45 PM that the social worker did the care plans for behaviors and that they were usually the first ones completed. The DON stated that she did not understand why the resident did not have a care plan for behaviors. The Social Worker stated in an interview on 10/10/12 at 3:50 PM that she knew that she did a care plan for behaviors for the resident but did not know what happened to it. The Social Worker stated that she could not find a care plan for behaviors following the admission or quarterly MDS assessment. 2. Resident #2 was originally admitted to the facility on 11/21/11 and was readmitted on 5/2/12 with diagnoses including Debility, Dementia with behavior disturbance and Alzheimer's Disease. Resident #2's Care Area Trigger Worksheet (CAT) for behaviors dated 7/18/12, included, Illnesses or Conditions, " Long standing mental health problem associated with the behavioral disturbances, such as schizophrenia, bipolar disorder, depression, anxiety, post-traumatic stress disorder." "Seriousness of Behavior Symptoms" included, "Resident displays	F 279		

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F 279	Continued From page 9	F 279		

behavior symptoms that impacts self or others. Resident is immediate threat to self, (Immediate Intervention Required). Resident is immediate threat to others. (Immediate intervention required)." Possible causes and contributing factors and risk factors related to the care area: " Resident yells out continuously throughout the day. When asked what she needs she stated , " I'm bored," "I'm lonely," or not given reason. "Resident is new admit and has diagnosis of advanced dementia. This puts resident at risk for social isolation and needs not being addressed. Under Care Plan Considerations read, "Care Plan will be developed to attempt to reduce behaviors."

The Significant Change Minimum Data Set (MDS) Assessment dated 07/18/12, revealed Resident #2 Had a BIMs score of 13 which indicated she was cognitively intact.

Resident #2's Care Plan was last reviewed on 8/13/12. The Care Plan addressed the resident's behaviors of yelling throughout the day, however the Care Plan did not address the resident's behaviors of hitting, kicking , biting staff, hitting resident and threatening behaviors.
During an interview on 10/9/12 at 3:10PM, Nursing Assistant #6 stated Resident #2 was very aggressive, would fight and used vulgar language. She revealed when Resident #2 exhibited aggressive behaviors she would talk to her to try to get her calm. Nursing Assistant #6 stated she did not know what caused Resident #2 to get upset.
The Director of Nursing stated in an interview on 10/10/12 at 2:45 PM that the social worker did the care plans for behaviors.

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F 279	Continued From page 10 During an interview on 10/10/12 at 3:53PM, MDS Nurse #1 stated the social worker was responsible for doing care plans for behaviors. During an interview on 10/10/12 at 11:23AM, the facility Social Worker stated she could not find a care plan for behaviors which addressed hitting, kicking and other behaviors. She revealed facility staff had received training on resident's behaviors that escalate. She stated she had gotten the Assistant Director of Nursing and the Staff Development Coordinator involved in the process. 3. Resident #2 was originally admitted to the facility on 11/21/11 and was readmitted on 5/2/12 with diagnoses including Debility, Dementia with behavior disturbance and Alzheimer's Disease. The Quarterly Minimum Data Set Assessment dated 07/18/12 showed that resident #2 required extensive assistance with dressing. Review of doctor ' s orders dated 5/31/12 read in part, "TED compression hose 15-20 thigh high. The physician signed the order on 6/8/12." Review of Resident #2's treatment record revealed the times ted hose were on and off: Ted hose on from 7:00AM-3:00PM and off 3:00PM through 11:00PM. During an interview on 1010/12 at 3:53PM the MDS Coordinator stated sometimes she would update the Care Plan if they had an order for TED hose. Review of Resident #2's Care Plan dated 7/19/12 revealed TED hose was not addressed in the Care Plan. The last time Resident #2's Care Plan was reviewed was 8/13/12. During an interview on 10/9/12 at 4:10PM, the Director of Nursing (DON) stated that Resident	F 279		

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F 279	Continued From page 11 #2 wore TED hose because she had fluid or circulatory issues. She stated in May, the doctor examined Resident #2 and noticed she had right lower extremity edema and he ordered the TED hose. She revealed the medical doctor told them when to put TED hose on and when to take them off. She stated Resident #2 should have them off in the evening. The DON revealed her expectation for ensuring Resident #2 wore TED hose was she was up, the TED hose should be on her clean and dry. If one pair was soiled, get another pair to put them on within time constraints. She stated Resident #2's TED hose should have been included on her Care Plan.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews, the facility failed to ensure a resident wore TED hose as ordered by the Physician for 1 of 1 residents wearing TED hose. (Resident #2) The findings include: Resident #2 was originally admitted to the facility on 11/21/11 and was readmitted on 5/2/12 with diagnoses including Debility, Dementia with behavior disturbance and Alzheimer's Disease. Review of a Physician's note dated 5/9/12 read in	F 309		

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F 309	Continued From page 12 part, "2. RLE (Right Lower Extremity) edema - TED stockings" Review of doctor's orders dated 5/31/12 read in part, "TED compression hose 15-20 thigh high. The physician signed the order on 6/8/12." Review of Resident #2's Treatment Record revealed the times Ted Hose were on and off: Ted hose on 7:00AM-3:00PM and off 3:00P-11:00PM. Review of Resident #2's Treatment Record from June, 2012 through October, 2012 revealed the TED hose was not initialed by a Nurse as being on: In June TED compression hose was not initialed by a Nurse on Treatment Record six days out of thirty days, 6/1/12, 6/2/12, 6/7/12, 6/15/12, 6/25/12 and 6/29/12. In July, 2012, the compression hose was initialed by a Nurse 29 days out of thirty days. In August, 2012, the compression hose was initialed by a Nurse, twenty-six days out of thirty days . The days not initialed in August included: 8/26/12, 8/27/12, 8/28/12 and 8/29/12. In September, 2012, the TED hose was initialed by a Nurse twenty seven days out of thirty days. In October, 2012, the TED compression hose was not initialed in the Treatment Record by a Nurse on 10/8/12 and 10/9/12. On 10/9/12 at 11:30AM Resident #2 was observed sitting in her wheelchair in her room. She was not wearing ted hose. A family member sitting in Resident#2's room was concerned Resident #2 was not wearing ted hose because of her medical condition. During an interview on 10/9/12 at 3:10PM, NA#6 revealed she usually put on Resident #2's TED hose every day. She revealed the reason Resident #2 was not wearing TED hose was because they were in the laundry and she had not	F 309	F309 On resident #2, the grievance was responded to within 24 hours of receipt by the DON. The surveyor found the TED hose to be off and in the wash due to being soiled on the day of the survey. The hose were reapplied when received from the laundry by the CNA. Another set of hose were obtained as a backup for times that her other ones were soiled. Also, a care plan for the TED hose was developed. An audit was completed on all residents with TED hose. Other residents that may be affected by this have had another pair of hose ordered and received so there would be no break in their application as ordered. Five residents were identified as needing another pair of TED hose. Other residents that utilize TED hose have also had their care plans updated to reflect their use.	

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F 309	Continued From page 13 gone to the laundry to get them because it had slipped her mind. During an interview on 10/9/12 at 3:20PM, Staff Nurse #5, stated the reason Resident #2 did not have on TED hose was because the TED hose had not come back from the laundry. She revealed Resident #2 had two pair of TED hose but apparently both were in the laundry. She stated Resident #2 needed a new pair of TED hose. She revealed Resident #2 did not have a problem wearing TED hose. Staff Nurse #5 stated when she passed medication during the morning, she checked to see if Resident #2 had on TED hose. She stated the reason the Treatment Record for Resident #2's TED hose was not checked off on the morning of 10/9/12 was that she had not gotten around to documenting everything. During an interview on 10/10/12 at 2:25PM, the facility Treatment Nurse had a pair of thigh length TED hose in her hands. She revealed she bought the pair of TED hose yesterday, but there were several in the central supply room in the facility and more could be ordered if needed. During an interview on 10/9/12 at 4:10PM, the Director of Nursing (DON) stated Resident #2 wore TED hose because she had fluid or circulatory issues. She stated, in May, the doctor examined Resident #2 and noticed she had right lower extremity edema and he ordered the TED hose. She revealed the medical doctor told them when to put TED hose on and when to take them off. She stated Resident #2 should have them off in the evening. The DON stated Resident #2's family wanted the thigh high TED hose and those kind of TED hose cost about $100.00. The DON stated the family had a complaint one morning in July when Resident #2 did not have on TED	F 309	Residents that are given orders for TED hose will be reviewed at the morning meetings and care plans will be developed immediate the MDS nurse. All residents will have a backup pair available to exchange if the need arises. Nurses have been in serviced on documentation of the application of the TED hose on October 15, 2012 by the DON, ADON, SDC and the 3-11 RN supervisor. The application of TED hose will be monitored by the charge nurses, DON, ADON, SDC, RN Supervisor, and the corporate nurse consultant. The results of the monitoring will be brought before the Quality Assurance Committee monthly for 3 months and then every 6 months thereafter for a period of 1 year.	10/31/12

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F 309	Continued From page 14 hose. One pair of TED hose was soiled and they (staff) had to get another pair. The DON revealed sometimes one pair of TED hose might have been in the laundry and there was a delay in getting the other pair, but it was not a lengthy time. The DON revealed if one pair of TED hose was soiled they tried to have another pair available. The DON stated her expectation for ensuring Resident #2 wore TED hose was when she was up the TED hose should be on her clean and dry. If one pair was soiled, get another pair to put them on within time constraints.	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews with staff, the facility failed to ensure residents received the correct dosage of Exelon by not removing prior medicated patches before applying a new patch for 2 of 2 residents. (Resident #1, Resident #8) Findings include: 1). Resident #8 was admitted to the facility on 7/15/2010 with diagnoses of Alzheimer's disease, severe dementia with psychotic agitated features, anxiety disorders, and depression. A review of the resident's Physician Orders revealed the resident had an order for the dementia medication Exelon. The resident's medical order read: " Exelon 9.5mg/24hr patch. Apply one patch topically daily " . Exelon is a medicated patch for mild to moderate dementia symptoms which is applied directly on the patient. The medication is absorbed through the skin. The drug insert stated failure to remove an old patch before the application of a new patch could result in overdose side effects to the patient. The most common side effects listed were nausea, vomiting, and diarrhea. More severe side effects included confusion, hallucinations, cerebral vascular accidents (stokes), irregular heart rates, and gastrointestinal bleeding. During medication pass on 10/9/12 at 10:45 AM Resident #8 was observed while the nurse	F 329	F329 Resident #1 and resident #8 had their Exelon patch removed immediately upon discovery. Both residents did not exhibit any adverse side effects of the expired patch. The DON and ADON began an immediate investigation of the incident on these two residents in an attempt to locate the cause of the residents not having the old patch removed prior to application of the new patch. Staff was immediately in serviced on proper patch administration. The DON, ADON, SDC and the RN Supervisor immediately audited all residents on patch therapy. Nineteen residents were noted to have patch orders. Body checks were conducted on those residents	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 16 administered her morning medications. Nurse # 3 lowered the resident's top to place an Exelon patch on her back. The resident was observed to have 2 Exelon patches on. One patch located on her upper left arm near the juncture of the shoulder was dated 10/7/12. The second patch dated 10/8/12 was located on the right upper flank area of the back. Nurse #3 removed the two patches and stated the resident should only have one patch on. The nurse revealed all staff knew you were to take off a transdermal patch before you placed a new one on the resident.. The facility policy was to date and initial the patch before placement. Observation of the resident did not reveal any signs or symptoms of adverse effects of the double dosage. During an interview with the Director of Nursing (DON) on 10/10/12 at 2:35 PM she stated it was her expectation staff nurses would check each resident carefully and remove any old transdermal patches prior to placing a new one on the resident. 2). Resident #1 was admitted to the facility on 8/24/2004 with diagnoses of dementia, hypertension, congestive heart failure and dysphasia. A review of the resident's Physician Orders revealed the resident had an order for the dementia medication Exelon. The resident ' s medical order read: " Exelon 9.5mg/24hr patch. Apply one patch topically daily " . Exelon is a medicated patch for mild to moderate dementia	F 329	that utilize the patch by the DON, ADON, Treatment nurse, SDC, and RN supervisor. No further incidents were found with expired patches on the residents. In-services began immediately (October 11, and another on October 25 with nurses and med aides) concerning proper application of patches on residents by the SDC, Don, and ADON. The ADON developed a patch placement protocol form to show where and when patches should be placed on the body. This was in serviced on the same dates. The DON, ADON, SDC, RN supervisor and the corporate nurse consultant will monitor residents with patches on a weekly basis for 3 months and then quarterly thereafter for a period on 1 year. This monitoring will be presented to the Quality Assurance Committee each month for 6 months and quarterly thereafter for 1 year.	10/31/12

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F 329	Continued From page 17	F 329		

symptoms which is applied directly on the patient. The medication is absorbed through the skin. The drug insert stated failure to remove an old patch before the application of a new patch could result in overdose side effects to the patient. The most common side effects listed were nausea, vomiting, and diarrhea. More severe side effects included confusion, hallucinations, cerebral vascular accidents (stokes), irregular heart rates, and gastrointestinal bleeding.

During an observation of Resident #1 on 10/9/12 at 11:50 AM Nursing Assistant (NA) #4 lifted the resident's shirt. Two Exelon patches dated 10/7/12 and 10/8/12 were observed on the resident. One patch was located on the right upper shoulder blade. The second patch had been placed on her left upper arm near the juncture of the shoulder. Observation revealed the Exelon patch scheduled for 10/9/12 at 9:00 AM had not been applied.

Observation of the resident did not reveal any signs or symptoms of adverse effects of the double dosage.

NA #4 stated the two patches should not have been on the resident. She revealed nursing takes off one patch before another patch is placed on the resident. NA#4 reported staff nurses date the patches to ensure the resident receives a new patch each day. The NA stated if the resident had on more than one patch the resident was getting too much medication. The NA immediately left the room and told the nurse about the two patches.

During an interview with the Director of Nursing

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F 329	Continued From page 18 (DON) on 10/10/12 at 2:35 PM she stated it was her expectation staff nurses would check each resident carefully and remove any old transdermal patches prior to placing a new one on the resident.	F 329	F332 Resident #8, #9, #10 and #11 have been getting their medications as ordered. Medications that should not be crushed are no longer crushed, medications that are to be administered within a certain time frame are being given on time, medications that are required to be coated and patches are being given as per proper protocol. The DON, ADON, SDC, and RN supervisor audited resident medication passes and corrected any potential issues that came up. Since the survey, the DON, ADON, RN Supervisor, SDC and Consultant Pharmacist have been following each nurse on med passes to observe for any errors in medication administration.	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and physician interviews the facility failed to ensure a medication error rate of less than 5% as evidenced by 5 errors out of 61 opportunities resulting in an error rate of 8.19% for 4 of 14 resident ' s observed during medication pass (Resident #10, #11, #8 and #9). The findings include: 1. Resident #10 was admitted to the facility on 07/30/10 and had diagnoses that included Alzheimer ' s Dementia. A review of the resident ' s October 2012 monthly physician ' s orders revealed an order that read: " Aricept 10mg (milligrams) tablet. Take 1 tablet by mouth once daily. " Aricept is a medication used to slow the progression of Dementia. The resident ' s Medication Administration Record for October 2012 revealed an entry that read: "	F 332		

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F 332	Continued From page 19 Aricept 10mg tablet. Take 1 tablet by mouth once daily (DO NOT CRUSH). On 10/09/12 at 10:36 AM, Nurse #1 was observed to administer medications to Resident #10. The nurse was observed to place 1 Aricept 10mg tablet, 1 multivitamin tablet and 1 Namenda 10mg tablet in a medicine cup. The nurse then emptied the cup of pills into a small plastic bag and put the bag in a pill crusher and crushed the medications. The nurse then combined the medications with applesauce and administered the mixture to the resident. In an interview with Nurse #1 on 10/09/12 at 3:05 PM the Nurse stated that she crushed the resident ' s medications because this was the only way to get the resident ' s medications in her. The Nurse stated that she needed to call the doctor. On 10/09/12 at 4:00 PM an interview was conducted with a pharmacist at the facility ' s consulting pharmacy. The Pharmacist stated that research was done and data could not be found that Aricept could be crushed and get the desired effect. The Pharmacist stated that if they know that a resident ' s medication needs to be crushed they send a disintegrating Aricept tablet instead of the regular tablet. The Pharmacist stated that they had no information that Resident #10 ' s medications needed to be crushed. The Director of Nursing stated in an interview on 10/10/12 at 2:45 PM that if a resident ' s medications needed to be crushed she would expect the nurse to call the pharmacy to see if there was a liquid or alternative medication that	F 332	In-services were held on October 11, 15, 18, 25 and 29th. The in-services contained information on crushing meds, proper medication administration, medication administration documentation, timeliness of administration, patch administration, and utilizing the medication that was ordered for the resident. Med pass competency was held with all nurses, and medication aides. Notification of social worker of any resident that exhibits behaviors was also in serviced. Medication error rates will be monitored by the DON, ADON, SDC, consultant pharmacist and the RN Medication error rates will be monitored by the DON, ADON, SDC, consultant pharmacist and the RN supervisor by following a nurse during medication passes and calculating and errors. Any errors will be dealt with on the spot and return demonstrations will be asked for.	

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F 332	Continued From page 20 could be used for the resident. 2. Resident #10 was admitted to the facility on 07/30/10 and had diagnoses that included Gustatory Rhinorrhea. A review of the resident ' s physician ' s orders for October 2012 showed an order that read: " Atrovent nasal spray. Use 2 sprays into each nostril before breakfast. Atrovent nasal spray works by decreasing the fluid production in the glands that line the nasal passages, helping to relieve a runny nose. The resident ' s Medication Administration Record revealed an entry that read: " Atrovent Nasal Spray. Use 2 sprays into each nostril before breakfast. The MAR showed that the medication was to be given at 8:00 AM. Nurse #1 was observed to administer medications to Resident #10 on 10/09/12 at 10:36 AM. The Nurse was observed to administer Atrovent Nasal Spray 2 sprays in each nostril. Nurse #1 stated in an interview on 10/09/12 at 3:05 PM that she worked on a long hall and that she had to get resident ' s their insulin and was unable to get the resident the Atrovent nasal spray before breakfast. The Nurse stated that the resident did not usually get the medication before breakfast. An interview was conducted with the resident ' s physician on 10/10/12 at 8:50 AM. The Physician stated that the resident had Gustatory Rhinorrhea which was a condition in which the resident ' s	F 332	Results of the monitoring will be presented to the Quality Assurance committee each month for 6 months and then quarterly thereafter for a period of 1 year. 10/31/12	

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nose ran profusely when eating. The Physician stated that the Atrovent nasal spray worked like a charm to control the runny nose so the resident could eat and this was the reason it was important to give the medication prior to the meal.

The Director of Nursing stated in an interview on 10/10/12 at 2:45 PM that she expected the nurse ' s to follow the doctor ' s orders when giving medications.

3. Resident #11 was admitted to the facility on 11/17/09 and had diagnoses including Cerebrovascular Accident, Ischemic Heart Disease, Pre-pyloric Ulcer, Gastritis and Gastro-Esophageal Reflux Disease.

A review of the monthly Physician ' s Orders for October 2012 revealed an order that read: " Ecotrin 325mg (milligrams). Take 1 tablet by mouth once daily. "

Ecotrin is aspirin with a special coating that helps to prevent stomach upset.

The resident ' s Medication Administration Record showed an entry that read: " Ecotrin 325mg. Take 1 tablet by mouth once daily. "

On 10/10/12 at 8:03 AM, Nurse #2 was observed to administer medications to Resident #11. The Nurse administered 1 Aspirin 325mg tablet. The bottle of Aspirin did not indicate that the medication had a coating for stomach protection.

An interview was conducted with Nurse #2 on 10/10/12 at 8:20 AM. The Nurse stated that he gave the resident aspirin from their regular stock

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F 332	Continued From page 22 med and that this was what they used. The nurse was observed to look on the medication cart and was unable to find a bottle of Ecotrin or Enteric Coated Aspirin 325mg tablets. The Director of Nursing (DON) stated in an interview on 10/10/12 at 2:45 PM that if there was not enteric coated aspirin on the medication cart she expected the nurse to call the pharmacy and get it. The DON stated that she had already put enteric coated aspirin on the med cart and had educated the nurse. 4. Resident #8 was admitted to the facility on 7/15/2010 with diagnoses of Alzheimer ' s disease, severe dementia with psychotic agitated features, anxiety disorders, and depression. A review of the resident ' s Medication Administration Record revealed the resident had an order for the dementia medication Exelon. The resident ' s medical order read: " Exelon 9.5mg/24hr patch. Apply one patch topically daily " . Exelon is a medicated patch for mild to moderate dementia symptoms which is applied directly on the patient. The medication is absorbed through the skin. The drug insert stated failure to remove an old patch before the application of a new patch could result in overdose side effects to the patient. The most common side effects listed were nausea, vomiting, and diarrhea. More severe side effects included confusion, hallucinations, cerebral vascular accidents (stokes), irregular heart rates, and gastrointestinal bleeding. During medication pass on 10/9/12 at 10:45 AM Resident #8 was observed while the nurse	F 332		

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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 332	Continued From page 23	F 332		

administered her morning medications. Nurse # 3 lowered the resident ' s top to place an Exelon patch on her back. The resident was observed to have 2 Exelon patches on. One patch located on her upper left arm near the juncture of the shoulder was dated 10/7/12. The second patch dated 10/8/12 was located on the right upper flank area of the back. Nurse #3 removed the two patches and stated the resident should only have one patch on. The nurse revealed all staff knew you were to take off a transdermal patch prior to placing a new one. The facility policy was to date and initial the patch before you placed it on the resident.

During an interview with the Director of Nursing (DON) on 10/10/12 at 2:35 PM she stated it was her expectation staff nurses would check each resident carefully and remove any old transdermal patches prior to placing a new one on the resident.

5. Resident #9 was admitted to the facility on 4/1/2009 with diagnoses that included hypertension, sinus bradycardia (slow heart beat), Alzheimer ' s disease, dementia with psychotic acute psychosis, and diabetes.

A review of the resident ' s Physician Order sheet revealed an order for: " Clonidine 0.3mg patch. Apply 1 patch every 7 days on Wednesday. Remove old patch 1st". The Federal Drug Administration (FDA) classifies Clonidine as a medication used to treat high blood pressure. It works to relax the blood vessels so blood can flow more easily through the body which lowers blood pressure. A Clonidine patch provides a continuous delivery of the medication for 7 days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 10/10/2012

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F 332	Continued From page 24 at a continuous rate. During medication pass on 10/9/12 at 10:45 AM Resident #9 was observed while the nurse administered her morning medications. Nurse #3 lowered the resident ' s blouse to indicate where the Clonidine patch was placed on the resident. The resident did not have a Clonidine patch on. A review of the resident ' s Medication Administration Record (MAR) revealed the Clonidine patch had been applied on 10/3/12 . The next patch was scheduled to be applied on 10/10/12. Nurse #4 stated the resident should have the Clonidine patch on. She stated the patch must have washed off during the resident ' s bath or shower. The nurse revealed the resident needed the medication to help keep her blood pressure down. A second observation of Resident #9 on 10/10/12 at 9:50 AM revealed the resident did have on a Clonidine patch dated 10/10/12. Nurse #4 stated she placed the patch on the resident during her medication pass. The nurse revealed the resident did not have on a Clonidine patch when she applied the scheduled patch that morning. During an interview with the Director of Nursing on 10/10/12 at 2:35 PM she stated it was her expectation all staff would assess each resident with a transdermal patch daily to ensure the patch was on as scheduled and would replace the patch if it were missing.	F 332		