STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVE NW LENOIR, NC 28645

(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 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and resident and staff interviews the facility failed to provide a properly sized wheel chair and a pressure relieving cushion for 1 of 3 residents observed for positioning. (Resident #78). The findings included: Resident #78 was admitted to the facility 10/01/07. Resident #78's diagnoses included dementia. Review of Resident #78's Annual Minimum Data Set (MDS) dated 05/30/12 revealed walking had not occurred during the assessment period. The MDS assessed Resident #78 as needing a wheelchair for mobility. Further review of the MDS revealed Resident #78 was 70 inches tall and weighed 262 pounds. Review of physical therapy notes dated 10/02/12 read in part, "During sit to stand patient required prompting to initiate and was able to stand x 30 seconds. However patient refused to reach back for wheelchair prior to sitting." Review of Resident #78's most recent Quarterly	F 246	**This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.** **F 246** With regard to this alleged deficient practice, the facility has taken the following actions: 1. Resident #78 suffered no harm. Resident #78 was accommodated with an appropriate 24 inch wheelchair. 2. All residents have the potential to be affected by the alleged deficient practice. All nursing staff will be inserviced regarding the process of referring any resident to therapy by 3/7/13. All current residents will have evaluations completed by therapy regarding appropriate size of wheelchairs to accommodate the residents' size by 3/7/13.	3/7/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Letta M. Madison | TITLE: Administrator | (X6) DATE: 3-1-13

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.

DHSR Plan Mgmt Unit WRO Received MAR 04 2013 by: MMH

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F 246	Continued From page 1 MDS dated 11/13/12 revealed he had long and short term memory loss and was moderately impaired for daily decision making. Further review of the MDS, Resident #78 needed extensive assistance with transfers and needed a wheelchair for mobility. Resident #78 was assessed as being 70 inches tall and weighing 258 pounds. Review of Resident #78's care plan updated 11/13/12 revealed the risk for impaired skin integrity with a goal to comply with therapeutic position changes as indicated. Interventions for this goal included a pressure relieving chair cushion. During an observation on 02/05/13 at 9:54 AM Resident #78's wheelchair appeared too small. His thighs were touching the arm rests on the wheel chair. Resident #78 did not have a cushion in the wheelchair. During an interview on 02/05/13 at 9:54 AM with Resident #78 he stated his chair was uncomfortable and his bottom hurt. On 02/06/13 at 8:00 AM an observation was made of Resident #78 in his room sitting up in his wheelchair. The resident's thighs were touching the arm rests on the wheelchair and the seat bottom came to the midway point of the resident's thighs. There was no cushion in Resident #78's wheelchair. During an interview on 02/06/13 at 8:00 AM with Resident #78 he continued to complain about his wheelchair being uncomfortable. He stated he had not told anyone else about the wheelchair	F 246	3. The Director of Clinical Services or designee will complete a Quality Improvement Monitoring Tool by 3/7/13 noting the appropriate sizes of each residents' wheelchair then will review wheel chairs to validate appropriate size 3 x weekly for 4 weeks, then 2 x weekly for 4 week, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months using a sample size of 5. 4. The Nursing Home Administrator/Director of Clinical Services will report the results of Quality Improvement Monitoring to the Quality Improvement/Risk Management Committee members monthly x 12 months to identify trends and needs for further education and/or monitoring.	

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F 246	Continued From page 2 being uncomfortable. An interview was conducted on 02/06/13 at 8:05 AM with Nurse #1. Nurse #1 stated the residents were given wheelchairs by physical therapy when they have had a decline and required a wheelchair after they were admitted. An interview was conducted on 02/06/13 at 8:15 AM with Nursing Assistant (NA) #1. NA #1 reported that Resident #78 had never complained to him that his wheelchair was uncomfortable. An interview was conducted on 02/06/13 at 9:31 AM with a Physical Therapy Assistant (PTA). She stated criteria for basic fitting of a wheelchair is to be able to get a hand between the arm rest and the person's leg. She further explained the seat should hit the resident's thigh about 2 inches behind the resident's bend in the knee. An interview was conducted on 02/06/13 at 10:52 AM with Resident #78. He stated, "This chair is killing me." An interview was conducted on 02/06/13 at 10:55 PM with the Rehab Director (RD). The RD stated that all wheelchairs are to have cushions in them. The RD further stated it was nursing's responsibility to fill out a referral to assess for a larger chair. She stated the wheelchair Resident #78 was sitting in was the chair he has been in for at least 6 months. The RD stated when physical therapy worked with Resident #78 he did not complain about the chair being too small. The RD also explained it was all of our faults if the resident did not have a cushion in his chair. She stated she was unaware if Resident #78 ever had	F 246		

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F 246	Continued From page 3 a cushion in his chair. During a later interview on 02/06/13 at 3:02 PM with the Rehab Director (RD) she stated she feels confident the resident had a wheelchair that fit him when they worked with him in September of 2012. The RD stated anyone could have gotten him a larger wheel chair or cushion as they are stored out in the storage building. She stated physical therapy needs physician orders to do the assessment and to treat, i.e. change the wheelchair. So it could be a few days before the wheelchair would be changed. An interview was conducted on 02/06/13 at 3:29 PM with the Director of Nursing (DON). The DON stated Resident #78 had been in the same chair since she had came to work at the facility in November. She stated it was nursing's responsibility to make a referral to therapy to evaluate. The DON stated the cushion should have been in the chair. She further stated it is everyone's job to notice that the resident's chair was too small. The DON stated someone could have gotten a larger chair for Resident #78 and then made a referral to physical therapy to make sure it was the appropriate size for him. The DON confirmed the chair was too small and provided him a larger chair.	F 246		
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.	F 323	**F 323** With regard to this alleged deficient practice, the facility has taken the following actions: 1. Residents # 46 and #167 suffered no harm. Liquid bleach solution was immediately removed from resident #46's and resident #167's room.	3/7/13

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F 323	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to store hazardous chemical supplies out of reach for 2 residents on 1 of 6 resident halls. (Resident #46 and #167). The findings included: Review of Material Safety Data Sheet product label information for liquid bleach dated 02/25/05 read in part: "Causes eye and skin burns. Harmful if swallowed. Causes respiratory tract irritation." Resident #46 was admitted 01/12/13. Diagnosis included dementia. MDS data dated 01/27/13 assessed the resident with severely impaired cognition. Resident #167 was admitted 01/30/13. Diagnoses included dementia. MDS data dated 01/29/13 assessed the resident with moderately impaired cognition. On 02/04/13 at 10:16 AM until 10:36 AM a continuous observation was made. Resident #46 was seated in the room in his wheelchair. Resident #167 who shared the same room, was seated near the doorway in the room. Both residents were observed able to self propel in their wheelchairs. A spray bottle approximately one third full labeled "bleach water" was on Resident #167's bedside table easily accessible	F 323	2. All residents have the potential to be affected by the alleged deficient practice. All current housekeeping staff was inserviced regarding storage of hazardous chemicals on 2/5-2/8/13. In addition, facility staff was inserviced on 2/27/13 at the monthly staff meetings regarding proper storage and safety of hazardous chemicals. 3. Morning rounds are completed daily by Department Managers. During these rounds managers will observe each resident room to assure no hazardous chemicals are left unattended in resident areas. Upon any findings of any improper storage, managers will correct immediately. Quality Improvement Monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks and then 1 x monthly for 9 months using a sample size of 5. 4. The Nursing Home Administrator or Housekeeping Supervisor will report findings of Quality Improvement Monitoring to the Quality Improvement/Risk Management Committee members to identify trends and need for further education and/or monitoring monthly X 12 months.	

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F 323	Continued From page 5 to both residents in the room. On 02/04/13 at 10:36 AM an interview was conducted with NA #2 in the residents' room. NA #2 stated the housekeeper was asked to clean Resident #167's mattress and the spray bottle must have been forgotten and left on the resident's bedside table. NA #2 stated the bleach solution should not be left in the room and immediately removed the spray bottle from the residents' room. On 02/04/13 at 10:44 AM an interview was conducted with Housekeeper #1. The Housekeeper confirmed the spray bottle contained a solution of bleach and water. The housekeeper stated Resident #167 had an episode of diarrhea and she cleaned and sanitized the mattress with the bleach solution. The housekeeper reported she was trained to store housekeeping chemical supplies in her locked cart for resident safety. She stated that she had forgotten and left the solution in the residents' room. The housekeeper stated she should not have left the bleach solution on the bedside table where the residents might have access to hazardous chemicals. On 02/06/13 at 8:45 AM an interview was conducted with the Housekeeping Supervisor who stated housekeeping staff were trained to secure chemical supplies in their carts. The Housekeeping Supervisor stated he expected staff to store chemical supplies properly to minimize resident access to hazardous solutions.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review the facility failed to administer a medication dosage as ordered and to provide a diagnosis for an antipsychotic medication and to initiate a gradual dose reduction for 2 of 10 residents reviewed for unnecessary medications. (Resident #39 and #116). The findings included:	F 329	**F329** With regard to this alleged deficient practice, the facility has taken the following actions: 1. Resident #39 and #116 suffered no harm. Resident #39 and resident #116 will be evaluated by pharmacy for a gradual dose reduction by 3/7/13. 2. Current facility residents who are being administered anti-psychotic medications will be reviewed by the Interdisciplinary team. Those meeting the criteria, will have a Gradual Dose Reduction or an attempted Gradual Dose Reduction in accordance with the pharmacist's recommendations by 3-7-13. Otherwise these residents being administered anti-psychotic medications will have physician documentation that outlines the risk versus the benefits for the continued use of the antipsychotic or other rationale for the declination.	3/7/13

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F 329	Continued From page 7 1. Resident #39 was admitted on 11/02/11. Diagnoses included anxiety and bipolar disorder. Resident #39 was followed by psychiatry services for management of his mood disorder. Resident #39 was care planned for psychotropic medications with the goal of no adverse side effects. Approaches included to evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs to ensure the least possible therapeutic dose or possible discontinuation. Psychiatry service progress notes dated 10/19/12 revealed a recommendation for gradual dose reduction of zyprexa 15mg (milligrams) qhs (every night at bedtime) to zyprexa 10mg qhs. Physician order dated 10/19/12 decreased zyprexa dosage to 10mg qhs. Review of Medication Administration Record (MAR) for October 2012 and November 2012 revealed the decreased dosage for zyprexa was given as ordered. Review of December 2012 monthly Physician Order Sheets (POS) and December 2012 MAR revealed zyprexa 10mg was discontinued with dosage increased to zyprexa 15mg qhs. No physician order for change in dosage was identified. Psychiatry service progress notes dated 12/31/12 recommended to continue zyprexa 10mg qhs. Psychiatry service progress notes dated 01/21/13 revealed gradual dose reduction for zyprexa was not indicated on the MARs. Psychiatry service notes again recommended a gradual dose reduction of zyprexa to 10mg qhs. Physician	F 329	3. Physician has been re-educated that within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic, the facility must attempt a gradual dose reduction (GDR) in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. Otherwise, these residents must have physician's documentation that outlines the risk versus the benefit for the continued use of the antipsychotic or other rationale for the declination. Director of Clinical Services or designee will conduct Quality Improvement Monitoring to ensure this standard is in accordance with the pharmacy recommendations to ensure the GDR has been done according to regulations or an appropriate rationale for declination has been provided. Quality Improvement Monitoring will be conducted 1 x monthly x 12 months using a sample size of 10. 4. The Director of Clinical Services/Nurse Manager will report results of Quality Improvement Monitoring to the Quality Improvement/Risk Management Committee monthly X 12 months to identify trends and the need for any further education and/or monitoring.	

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F 329	Continued From page 8 order dated 01/23/13 decreased zyprexa dosage to 10mg qhs. Review of January 2013 MAR revealed the decreased dosage for zyprexa was given as ordered. An interview was conducted with Nurse #3 on 02/07/13 at 11:30 AM. Nurse #3 stated two nurses verified monthly POS and MARs to ensure accuracy. Nurse #3 stated she verified the December 2012 and January 2013 POS and MARs against any new physician orders. Record review at the time of the interview revealed no physician order to increase zyprexa dose to 15mg qhs. Nurse #3 stated this incorrect dosage was missed with the verification of monthly POS. An interview was conducted with Nurse #4 on 02/07/13 at 2:35 PM. Nurse #4 stated she verified the December 2012 and January 2013 POS against any new physician orders. Nurse #4 stated she transcribed the increased dosage to the POS and MARs but was unsure of where she had obtained the order. Nurse #4 stated this incorrect dosage was missed with the verification of monthly POS. An interview was conducted with the Director of Nursing (DON) on 02/07/13 at 2:40 PM. The DON stated she expected nursing staff to correctly verify the monthly POS and MARs to ensure accurate medication administration for residents. 2. Resident #116 was admitted to the facility with the diagnosis of dementia. Review of Resident #116's most recent Quarterly Minimum Data Set (MDS) dated 12/29/12 revealed he had long and short term memory problems and was impaired for daily decision making. Further review of the	F 329		

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F 329	Continued From page 9 MDS revealed under the assessment section entitled Mood, Resident #116 had felt down and depressed. Under the assessment section entitled Behavior, Resident #116 was assessed as having no psychosis but the behavior of wandering was checked as having occurred daily. Review of Resident #116's care plan updated 07/18/12 with a target date of 03/31/13 revealed he had the potential for adverse side effects from psychotropic medication use. The care plan goal was no side effects from psychotropic medications. Interventions included evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs to ensure the least possible therapeutic dose or possible discontinuation. Further review of Resident #116's medical record revealed no indication of diagnoses for behaviors or psychiatric illness. Review of physician orders for the month of January 2012 revealed an order for Zyprexa (an anti-psychotic medication) 5 milligrams (mg) to be given every day. Review of pharmacy progress notes dated 05/24/12 revealed a recommendation to decrease Zyprexa 5 mg to 2.5 mg every day. Review of a consultation report dated 05/24/12, written to the physician requesting the GDR of Zyprexa revealed the physician's written response to decline the request as it "would increase distressed behavior."	F 329		

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F 329	Continued From page 10 Further review of pharmacy progress notes revealed the pharmacist again on 09/01/12 requested a gradual dose reduction (GDR) of Zyprexa. Review of a consultation report dated 09/01/13, written to the physician requesting the GDR of Zyprexa revealed the physician's written response to decline the request as it would "likely to make him unmanageable." Review of behavior assessment sheets for the months of October and November of 2012 revealed Resident #116 was assessed for hitting himself. This behavior was monitored each shift, every day for both months as not occurring. Further review of behavior assessment sheets for the month of December 2012 revealed Resident #116 was assessed for agitation and hitting self. The behaviors were monitored each shift, every day for the month of December 2012 as not occurring. Review of Resident #116's Abnormal Involuntary Movements Scale (AIMS) dated 01/24/13 assessed his involuntary movements as minimal. All previous assessments which had been done at least quarterly revealed Resident #116 had no involuntary movements. On 02/07/13 at 9:36 AM an interview was conducted with Nurse #1 who worked frequently with Resident #116. Nurse #1 stated Resident #116 had not been agitated nor had any behaviors for a very long time. She stated nursing charted on Resident #116's agitation because the	F 329		

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F 329	Continued From page 11 resident was taking Zyprexa. She stated no agitation had occurred this month (February 2012). An interview was conducted on 02/07/13 at 9:44 AM with Nursing Assistant (NA) #1. NA #1 stated he had not seen any agitation from Resident #116 nor had he ever given him any trouble. On 02/07/13 at 5:00 PM an interview was conducted with the Director of Nursing (DON). The DON stated if a GDR had not ever been attempted the GDR should have been attempted by the physician.	F 329		
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 interviews the facility failed to ensure medication errors less than 5% as evidenced by 5 non-significant medication errors out of 50 opportunities, resulting in a medication error rate of 10%, for 2 of 14 residents observed during medication pass. (Resident #92 and #116). The findings included: Review of the Facility's policy entitled General Dose Preparation and Medication Administration read in part, "Confirm that the Medication Administration Record reflects the most recent	F 332	**F332** With regard to this alleged deficient practice, the facility has taken the following actions: 1. Resident #116 suffered no harm. Physician was notified on 2/7/13 of medication administration error regarding colace. Order from physician was given, received and implemented. Responsible Party notified of medication time change ordered by physician. The facility has identified Resident #92 rather than Resident #116 cited to be the resident who was administered the medications noted of glucophage, amaryl, klonopin and Aricept. Resident #92 suffered no harm. Physician was notified 2/7/13 and orders given, received and implemented..	3/7/13

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F 332	Continued From page 12 medication order." 1. Review of physician orders dated 01/31/13 revealed an order for Colace 100 milligrams (mg) to be given twice per day at 9:00 AM and at 8:00 PM for Resident #116. Review of Medication Administration Record (MAR) for the months of January and February of 2013 revealed the time for the Colace had been changed to 5:00 PM. This time, 5:00 PM was hand written over the printed MAR which read 8:00 PM. On 02/05/13 at 3:54 PM an observation was made during a medication administration pass for Resident #116. Nurse # 2 was observed to administer Colace 100 mg to Resident #116. On 02/07/13 at 8:13 AM an interview was conducted with the Director of Nursing (DON). The DON stated the medications should be given at the time that the medication is ordered. She stated the medication could be given an hour before or an hour after the time the medication is ordered. She stated she was unaware the times on the MAR were changed and they should not have been changed without a physician's order. 2. Review of physician orders dated 01/31/13 revealed the following medication orders for Resident #116: Amaryl 2 mg to be given twice daily at 9:00 AM and 8:00 PM Glucophage to be given twice daily at 9:00 AM and 8:00 PM Klonopin 0.5 mg take ½ tab (0.25 mg) at bedtime -8:00 PM Aricept 10 mg at bedtime -8:00 PM	F 332	2. All residents have the potential to be affected by this alleged deficient practice. The Director of Clinical Services/ Nurse Manager reviewed all current licensed nursing staff to ensure that they were able to appropriately and properly administer residents' medications according to facility's policy and procedure for medication administration. Any current resident's medication identified as not having been administered properly by the facility was reported to the Physician for any further intervention, as well as notification made to the responsible party, as applicable. Facility nurses identified as not having given medications appropriately were immediately reeducated. The Director of Clinical Services or Nurse Manager will re-educate all current Licensed Nursing Staff by 3/7/13 on the facility's Policy and Procedure for Medication Administration with return medication administration demonstration to ensure medications are being administered properly.	

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F 332	Continued From page 13 Review of MARs for the months of January and February 2013 revealed the times for the Amaryl, Glucophage, Klonopin and Aricept had been changed to 5:00 PM. The time, 5:00 PM had been hand written over the printed time of 8:00PM. On observation was made on 02/05/13 at 4:23 PM of Nurse # 2 administering medications to Resident #116. Nurse #2 gave the following medications to Resident #116: Amaryl 2 mg, Glucophage 100 mg, Klonopin 0.25 mg and Aricept 10 mg. An interview was conducted on 02/06/13 a 4:40 PM with Nurse #2. Nurse #2 stated the medication times were changed on the MAR. He stated the times were changed on the MAR in mid January 2013. He stated he gave the medications by the times written on the MAR and he did not know who changed the MAR or why. On 02/07/13 at 8:13 AM an interview was conducted with the Director of Nursing (DON). The DON stated the medications should be given at the time that the medication is ordered. She stated the medication could be given an hour before or an hour after the time the medication is ordered. She stated medications that were to be given at bedtime should be given as close to 8:00 PM. She stated she was unaware the times on the MAR were changed and they should not have been changed without a physician's order.	F 332	3. The Director of Clinical Services/Nurse Manager will conduct Quality Improvement Monitoring to ensure medications are administered properly. Quality Improvement Monitoring will be conducted 5 X weekly for 4 weeks, then 3 X weekly for 4 weeks, then 1 X monthly for 10 months using a sample size of 5 nurses (2 nurses will be monitored on 7a-3p shift and 3p – 11p shift and 1 nurse on 11p-7a shift). 4. The Director of Clinical Services/Nurse Manager will report results of Quality Improvement Monitoring to the Quality Improvement/Risk Management Committee monthly x 12 months to identify trends and need for further education and/or monitoring.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333		

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F 333	Continued From page 14 any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews the facility failed to administer a prescribed intravenous antibiotic for 6 days for a leg wound in 1 of 2 residents who received intravenous antibiotics. (Resident #42). The findings included: Resident #42 was re-admitted to the facility on 12/17/12 with diagnoses which included diabetes, cellulitis (a type of skin infection caused by bacteria) on her left (L) lower leg with a chronic ulcer (open wound) on her (L) lower leg. The most recent 30 Day Minimum Data Set (MDS) dated 01/15/13 indicated Resident #42 had short term and long term memory problems and was severely impaired with cognition for daily decision making. The MDS further indicated Resident #42 required extensive assistance with transfers and with walking in her room. A review of a hospital discharge summary dated 12/17/12 indicated Resident #42 had cellulitis of her (L) lower leg along with a chronic venous stasis ulcer (a wound that occurred due to improper functioning of the veins in the legs), which was worsening. Resident #42 was started on intravenous antibiotics and treatments to her wound and her wound was "healing quite nicely." The hospital discharge summary further indicated Resident #42 was to receive an antibiotic (Cefepime) 2 grams intravenously every 24 hours	F 333	**F333** With regard to this alleged deficient practice, the facility has taken the following actions: 1. Resident #42 suffered no harm. Physician notified on 1/15/13; orders were given, received and implemented. 2. All residents have the potential to be affected by the alleged deficient practice. The Director of Clinical Services/Nurse Manager reviewed all current residents to ensure that no residents had a significant medication error in the 7 days prior to the date of compliance on 3/7/13. No current residents were identified as having any significant medication errors. Staff were re-educated on the facility policy and procedure for processing orders with specific regard to consultation reports. Consultation reports are currently given to the nurse of the specific resident who had a consultation completed and copies of the consultation are provided to the Director of Clinical Services. Copies of consult reports along with physicians' orders from the previous day are reviewed in Departmental Morning Meetings to ensure given physicians' orders are received and implemented as written.	3/7/13

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F 333	Continued From page 15 for 3 weeks after discharge from the hospital. A review of physician's orders dated 12/17/12 indicated Cefepime 2 grams intravenously every 24 hours for 3 weeks for cellulitis. A review of nurse's notes dated 12/17/12 at 4:00 PM indicated Resident #42 was readmitted to the facility with a Heparin Lock (a small intravenous tube) in her (L) wrist and was to begin an intravenous antibiotic due to the venous stasis ulcer in her (L) lower leg and pharmacy was to send the antibiotic tonight. A review of the Medication Administration Record (MAR) for the month of December indicated the intravenous antibiotic (Cefepime) was documented as given daily from 12/18/12 through 12/31/12. A review of a "Report of Consultation" dated 01/02/13 indicated Resident #42 was seen in consultation for follow up by a wound care physician for her (L) lower leg ulcer and the physician recommended to continue the intravenous antibiotic daily for 2 more weeks with daily wound treatments. A review of the MAR for the month of January indicated the intravenous antibiotic (Cefepime) was documented as given daily from 01/01/13 until 01/07/13. A review of a nurse's note dated 01/08/13 at 6:00 PM revealed Resident #42 finished the intravenous antibiotic on 01/07/13. A review of a physician's order dated 01/14/13	F 333	3. The Director of Clinical Services/Nurse Manager will conduct Quality Improvement Monitoring to ensure given physician's orders are received and implemented as written. Quality Improvement Monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, then 1 x monthly for 9 months using a sample size of 5. 4. The Director of Clinical Services/Nurse Manager will report results of Quality Improvement Monitoring to the Quality Improvement/Risk Management Committee monthly X 12 months to identify trends and need for further education and/or monitoring.	

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F 333	Continued From page 16 indicated to start Cefepime 2 grams every 24 hours for 7 days. A review of a "Report of Consultation" dated 01/15/13 indicated Resident #42 was seen in follow up by a wound care physician for her (L) lower leg ulcer. The notes revealed the (L) lower leg ulcer was red, painful and tender with swelling, was not healing and the physician recommended to continue the intravenous antibiotics and wound care with follow up at the wound care center. A review of a monthly MAR indicated intravenous Cefepime was documented as given daily from 01/15/13 until it was discontinued on 01/21/13. During an observation of wound care on 02/06/13 at 2:17 PM the wound care nurse removed dressings from Resident #42's (L) lower leg which revealed an open wound with bloody drainage and the skin on the resident's (L) lower leg was red and swollen. The wound care nurse cleaned the wound and applied clean wound dressings. During an interview on 02/06/13 at 4:40 PM the wound care nurse explained that Resident #42 should have received the first 3 weeks of daily intravenous antibiotics from 12/17/12 through 01/07/13. He further explained when Resident #42 went to see the wound care physician on 01/02/13 he ordered for the resident to continue the antibiotic for 2 more weeks until 01/15/13. He stated the antibiotic was discontinued on 01/07/13 when the first 3 week course of intravenous antibiotic therapy ended and the nurse did not process the orders to continue the intravenous antibiotic for 2 more weeks. The wound care	F 333		

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F 333	Continued From page 17 nurse verified Resident #42 missed 6 days of intravenous antibiotics after she saw the wound care physician on 01/02/13. He explained he routinely did audits of resident's who received antibiotics each week and discovered the antibiotic had not been given and called the wound care physician on 01/14/13 to clarify if he wanted Resident #42 to have more antibiotics since doses had been missed. He stated the physician ordered for Resident #42 to receive 7 more days of intravenous antibiotic (Cefepime) since she had missed the doses of medication. The wound care nurse stated when a resident went out of the facility to see a physician the transporter gave the doctor's orders or consult notes to the nurse when the resident was brought back to the facility and it was the nurse's responsibility to process the orders or to get clarification from the resident's physician if there were questions. During an interview on 02/07/13 at 3:33 PM Nurse #2 explained she worked on 01/02/13 when Resident #42 was brought back to the facility from her appointment at the wound care center. She stated she was unaware of the process of writing up the physician orders from "The Report of Consultation." She explained she asked a co-worker what she should do with the report and she was told to put it in a book for the resident's physician to review when he next came to the facility. She stated she thought the resident's physician came to the facility every week and she was under the impression that once he approved the orders they would be processed and the intravenous antibiotics would be started at that time.	F 333		

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F 333	Continued From page 18 During an interview on 02/07/13 at 4:06 PM the Director of Nursing (DON) explained it was her expectation that nurses should administer medications as ordered by their physician. She stated it was also her expectation for nurses to treat the documentation on "The Report of Consultation" as physician's orders. She explained if nurses had any questions about the documentation or needed clarification they should call the resident's physician. The DON further stated it was her expectation that medication orders should not be overlooked or missed.	F 333		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview with the consultant pharmacist, the facility failed to identify an irregularity in the medication regimen where the psychiatrist had ordered zyprexa dose reduction that was not reduced as ordered for 1 of 10 residents reviewed for unnecessary medications. (Resident #39). The findings included:	F 428	**F428** With regard to this alleged deficient practice, the facility has taken the following actions: 1. Resident # 39 suffered no harm. A drug regimen review will be conducted by the Consultant Pharmacist for Resident #39 by the Pharmacist 3/7/13 to ensure drug regimen is appropriate. 2. All residents have the potential to be affected by the alleged deficient practice. The Consultant Pharmacist will be re-educated by 3/7/13 by the Director of Nursing that all residents must have their drug regimen reviewed at least once per month. The facility Director of Clinical Services reviewed current facility residents'medical records to validate that they have a documented drug regimen review in the past month by the Consultant Pharmacist.	3/7/13

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F 428	Continued From page 19 Resident #39 was admitted on 11/02/11. Diagnoses included anxiety and bipolar disorder. Resident #39 was followed by psychiatry services for management of his mood disorder. Resident #39 was care planned for psychotropic medications with the goal of no adverse side effects. Approaches included to monitor pharmacist drug regimen review for identification of potential drug interactions. Psychiatry service progress notes dated 10/19/12 recommended a gradual dose reduction of zyprexa 15mg (milligrams) qhs (every night at bedtime) to zyprexa 10mg qhs. Physician order dated 10/19/12 decreased zyprexa dosage to 10mg qhs. Review of Medication Administration Record (MAR) for October and November 2012 revealed the decreased dosage for zyprexa was given as ordered. Psychiatry service progress notes dated 12/31/12 recommended to continue zyprexa 10mg qhs. Review of December 2012 monthly Physician Order Sheets (POS) and December 2012 MAR revealed zyprexa 10mg was discontinued in error with dosage changed to zyprexa 15mg qhs. Psychiatry service progress notes dated 01/21/13 revealed gradual dose reduction for zyprexa was not listed on the MARs. Psychiatry service notes again recommended a gradual dose reduction of zyprexa 15mg qhs to zyprexa 10mg qhs. Physician order dated 1/23/13 decreased zyprexa dosage to 10mg qhs. Review of January 2013 MAR revealed the decreased dosage for zyprexa was given as ordered.	F 428	3. The Director of Clinical Services/Nurse Manager will conduct Quality Improvement Monitoring to ensure residents have a documented drug regimen review monthly by the Consultant Pharmacist in the medical record. Quality Improvement Monitoring will be conducted monthly x 12 months using a sample size of the current month's census. . 4. The Director of Clinical Services/Nurse Manager will report results of Quality Improvement Monitoring to the Quality Improvement Risk Management Committee monthly x 12 months to identify trends and need for further education and/or monitoring.	

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F 428	Continued From page 20 Monthly pharmacy review for December 2012 and January 2013 identified no discrepancy for the incorrect zyprexa dosage administered 12/01/12-01/21/13. An interview was conducted with the Director of Nursing (DON) on 02/07/13 at 4:50 PM. The DON stated she expected the Pharmacist to review residents' medication regimens to identify any medication discrepancies. An interview with the Pharmacist was conducted on 02/07/13 at 6:00 PM with a follow up interview conducted 02/08/13 at 10:35 AM. The Pharmacist stated he conducted the monthly review of Resident #39's medication regimen for December 2012 and January 2013. The Pharmacist stated he overlooked the medication error and did not identify the discrepancy with the gradual dose reduction ordered for Resident #39's psychotropic medication.	F 428		