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ENFIELD OAKS NURSING AND REHABILITATION CENTER	**208 CARY ST ENFIELD, NC 27823**

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation WI3211.	F 000		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interviews the facility failed to clarify orders for tracheostomy care and failed to follow manufacturer specifications for use of a disposable inner cannula for one of one resident reviewed for tracheostomy care (resident # 41). Findings included: Resident # 41 was readmitted to the facility on 2/19/13 with diagnoses which included pneumonia, bronchitis, respiratory failure and anxiety. The resident was cognitively intact based on the quarterly Minimum Data Set (MDS) dated 2/7/14. Medical record review revealed a physician order	F 328	F328 1. Resident # 41□s tracheostomy care orders were clarified on April 12, 2014 to include a Shiley size 7 XLT with tracheostomy care and disposable inner cannula to be changed twice daily and as needed according to manufacturer□s specifications and physician order. 2. A 100% audit of tracheostomy care orders was completed and any incomplete orders were clarified on April 12, 2014, by the Director of Nursing (DON) and/or the Minimum Data Set (MDS) nurse. Results of the audit revealed Resident #41 is currently the only resident residing in the facility with a tracheostomy requiring tracheostomy care orders. All current	5/8/14

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

Electronically Signed | 04/30/2014

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F 328	Continued From page 1 dated 3/20/14 written as a telephone order from the doctor by the Director of Nursing (DON) which stated, "Inner cannula (tube placed through the tracheostomy to provide an airway) to be changed daily on 7-3. Trach (tracheostomy, opening through the neck into the wind pipe) to be cleaned with NS (normal saline) and hydrogen peroxide on 3:00 PM-11:00 PM shift, 11:00 PM-7:00 AM shift and as needed." Additional record review revealed a consultation report from the Ear, Nose and Throat (ENT) doctor dated 4/4/14. The report revealed recommendations which read in part that the inner cannula used by this resident was corrugated, not cleanable and a new inner cannula was needed two times per day. These recommendations were then written on a doctor ' s order sheet. The next order in the resident's record read, "New inner cannula 1 time per day and PRN (as needed)." This order was signed by the resident's facility doctor. There was no corresponding progress note to explain this order. The last written order in resident #41's medical record was dated 4/6/14 and read "Change cannula PRN." This order was a telephone order from the physician assistant. During an interview with resident # 41 on 4/7/14 she stated that the facility only provided a new inner cannula during the morning tracheostomy care. Resident # 41 reported that during any other tracheostomy care the nursing staff removed the inner cannula, cleaned it in peroxide then reinserted the same inner cannula. In addition, resident #41 stated that for the first 2 years while at the facility, when she received tracheostomy care the inner cannula was replaced with a new one but that last month the	F 328	licensed staff will be educated on writing a complete tracheostomy care order to include an inner cannula size and how frequently the physician would like for the inner cannula to be changed by the DON and/or the Staff Facilitator on April 18, 2014. Information regarding manufacturer□s specifications for disposable inner cannulas is sent as part of each package ordered. The instructions were retrieved by the DON. The information in the package indicated the disposable inner cannulas were to be disposed after one use. This information was included in the April 18, 2014 in-service presented by the DON. All newly hired licensed staff will be educated on writing a complete tracheostomy care order, to include size of the inner cannula, the frequency the care should be given (per physician□s orders) and disposal of the inner cannula after one use by the Staff Facilitator. 3. Any new orders for tracheostomy care, to include when care should be provided and the use of disposable cannulas will be reviewed and signed off on the order by two licensed nurses at the time the order is received. The first nurse will sign as receiving the order. The nurse will then transcribe the order. The signature of the second nurse verifies accuracy in transcription of the order to the Medication and/or the Treatment Administration Record. The pink copy of the order will be reviewed during morning clinical meeting by the DON and/or the MDS nurse Monday through Friday. After review of the physician□s order on	

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F 328	Continued From page 2 order for tracheostomy care was changed. The resident reported that she was referred to the ENT specialist and had received written orders to have the inner cannula changed with a new inner cannula two times each day. On 4/9/14 at 2:30 PM nurse #2 demonstrated an unopened inner cannula which was the kind used for resident # 41. The outside of the package read, "Inner Cannula XLT disposable." Nurse #2 stated she only worked on the 7:00 AM -3:00 PM shift so she replaced the inner cannula with a new one every day. A review of the manufacturer specifications provided with the Inner Cannula XLT tubes revealed a warning that the inner cannula was disposable, designed for single use and should not be cleaned or reused. An interview on 4/10/14 at 9:55 AM with the DON revealed the resident's facility doctor was present when the resident returned from the ENT doctor on 4/4/14. The DON stated the resident's facility doctor changed the order from the ENT doctor so that the resident received a new inner cannula once per day and as needed. The DON confirmed this order was present in the medical record with the resident's facility doctor's signature dated 4/4/14. The DON also stated that on 4/7/14 after a conversation with the resident he sent a fax to the resident's facility doctor which requested to change the inner cannula two times per day. At the bottom of a copy of the fax was written "Leave order as it is." The DON confirmed that was what the resident's facility doctor wrote and signed. The DON reviewed the facility's doctor's orders during this interview. He stated the order	F 328	tracheostomy care the DON and/or the MDS nurse will check the MAR and/or the TAR for accuracy of transcription and completion of care per the physician□s orders. Review of the pink slips for accuracy in transcription and review of the MAR and/or TAR for completion of tracheostomy care will occur daily x 4 weeks, then twice weekly for 2 weeks, then monthly x 2 months. The resident census will be used to designate any resident with tracheostomy care orders that were reviewed and completion of tracheostomy care per the physician□s orders. Tracheostomy care will be observed and findings documented twice weekly by the DON/and or MDS nurse x 4 weeks, random weekly observations x 4 weeks and then continued ongoing random observations. 4. Results of the tracheostomy care order audits and observation audits will be reviewed monthly at the QA meeting to identify trends and continued need for monitoring. The information will be presented to the QA committee by the DON and/or MDS nurse	

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F 328	Continued From page 3 "Change cannula PRN" was not a complete order and needed to be clarified. On 4/10/14 at 12: 58 PM nurse #1 stated that the other 2 shifts were to remove the inner cannula, wash it with peroxide by putting the peroxide and normal saline from the kit into a small syringe. She also stated that the plastic inner cannula used for this resident had grooves which could not be cleaned. The nurse stated that the resident continued to have a lot of upper respiratory secretions which were thicker and had color variations. Multiple attempts to reach the resident's facility physician during the survey were unsuccessful.	F 328		
F 329 SS=D	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	F 329		5/8/14

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F 329	Continued From page 4 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a diagnosis and subsequent laboratory monitoring for the use of Simvastatin 20 milligrams (mg) by mouth (PO) daily for 1 of 5 residents (Resident 54) reviewed for unnecessary medications. Findings included: Resident 54 had documented diagnoses of anxiety disorder, Alzheimer's disease, dementia, psychosis, depression, history of aggression with mood lability, and history of seizures. Resident's current medications included: Remeron 15 mg PO at bedtime (q hs) to promote appetite Depakene 500 mg PO twice daily (bid) for mood disorder Zoloft 50 mg PO qhs Namenda 10 mg PO bid Norvasc 10 mg PO daily MVI PO daily Vitamin C 500 mg PO daily Simvastatin 20 mg PO nightly (q PM) Aricept 10 mg PO qhs Zyrtec 10 mg PO qhs Tylenol 325 mg PO every 4 hours as needed (q 4 hrs prn) pain/fever	F 329	BF329 1. Resident # 54□s physician was notified and a supporting diagnosis of hyperlipidemia was obtained for the Simvastatin was received on April 15, 2014. Blood was obtained and a lipid panel completed for Resident # 54 on April 9, 2014. The Hepatic panel had previously been completed on 2/25/14. 2. A 100% audit of all residents receiving Simvastatin was completed on April 30, 2014, by the DON and/or the MDS nurse to assess the need for a supporting diagnosis or monitoring laboratory blood work. A total of seven residents from the audit were noted to be on Simvastatin. All other residents from the audit were found to have a supporting diagnosis and supporting monitoring laboratory results for the Simvastatin. The Pharmacy Policy for obtaining monitoring laboratory work indicated a lipid panel and liver function test are to be collected within the first 30 days and every 6 months thereafter. All current licensed staff were in-serviced on the policy regarding obtaining a supporting diagnosis for Simvastatin and were in-serviced on the Pharmacy Policy for obtaining monitoring blood work for Simvastatin by the DON and/or the Staff	

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F 329	Continued From page 5 All medications except Simvastatin 20 mg PO q PM had associated diagnoses and laboratory monitoring as recorded in both the medical record and the computer records. The recommendation for cholesterol management and monitoring from the 2013 American College of Cardiology/American Heart Association Guidelines on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults are as follows: "A high level of randomized controlled trial evidence supports the use of an initial fasting lipid panel (total cholesterol, triglycerides, high-density lipoprotein cholesterol, and calculated low-density lipoprotein cholesterol), followed by a second lipid panel 4 to 12 weeks after initiation of statin therapy, to determine a patient's adherence. Thereafter, assessments should be performed every 3 to 12 months as clinically indicated." An interview with the staff who arranged for laboratory draws on 4/9/14 at 3:00 PM said that a lipid panel had been ordered for the resident in February 2014 but the results are not in the medical record. She stated that she will contact the laboratory agency to have them fax the laboratory values. An interview with the DON at 5:00 PM confirmed that he agrees that the resident's medical record lacked a definitive diagnosis for the use of Simvastatin. He also stated that the lipid panel for the resident could not be procured from the laboratory agency although it was ordered on 2/20/14. The DON said that his expectation is that the laboratory coordinator should follow up on laboratory values that may not have been reported. He confirmed that the staff personnel	F 329	Facilitator by May 2, 2014. All newly hired licensed staff will be in-serviced on the policy regarding obtaining a supporting diagnosis for Simvastatin and will be in-serviced on the Pharmacy Policy for obtaining monitoring blood work for Simvastatin by the DON and/or the Staff Facilitator during orientation. 3. All new resident medications, including any orders for Simvastatin will be assessed for a supporting diagnosis by the admitting nurse and/or the DON. Clarification for the supporting diagnosis will be obtained from the physician as needed by the admitting nurse and/or the DON. Baseline and follow up laboratory work for monitoring will be collected as outlined in the Pharmacy. The DON and/or the MDS nurse will review pink slips for new orders for Simvastatin during the Monday through Friday clinical meetings. A monitoring tool was initiated on to document supporting diagnoses for all new medications including Zocor and any monitoring blood work as outlined in the Pharmacy Policy. Monitoring will continue weekly x 4, q 2 weeks x 4 and then monthly x 1. The Consultant Pharmacist will monitor for a supporting diagnosis and needed monitoring blood work for medications during the monthly drug regimen review. This will be on-going. Any resident without a supporting diagnosis or the needed blood work will be identified by the pharmacist on the monthly recommendation sheets reviewed by the resident□s physician. 4. Results of the audit for residents receiving Simvastatin, to include	

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F 329	Continued From page 6 do not have anywhere to document if or when the laboratory agency was contacted about a missing laboratory value and is not sure if the contact with the laboratory agency was ever made regarding the missing lipid panel. The DON then proceeded to obtain an emergent (stat) blood draw, to send for stat lipid panel values to the laboratory agency, and then contacted the physician to obtain a diagnosis for the use of Simvastatin. On 4/10/14 at 9:36 AM, it was confirmed that the diagnosis and lipid panel results had been placed in the resident's medical record.	F 329	supporting diagnosis and monitoring lab work, will be reviewed at the monthly QA meeting to identify trends and continued need for monitoring.	
F 514 SS=B	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; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to document as needed (PRN) controlled medications as being	F 514	F514 1. Residents will continue to receive PRN (as needed) medications as ordered	5/8/14

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F 514	Continued From page 7 administered on the medication administration record (MAR) for 7 of 7 residents reviewed (Residents 10, 20, 24, 28, 42, 63, and 69). Findings include: From 4/9/14 to 4/10/14, a random selection of residents' Controlled Substances Receipt/Count Sheets (CSR) and MARs were reviewed to see if PRN controlled substances were documented as per facility policy and expectations of administrative staff. The facility's Controlled Substances policy, as reviewed on 4/10/14, indicates that nursing staff must document "An entry for each dose administered to include date and time of administration, quantity of medication administered and signature of the nurse administering." 1. Resident 10 had Lortab 7.5/500 milligrams (mg) signed out 20 times from 5/3/2013 - 5/27/13, as documented on the CSR. The May 2013 MAR indicated that the Lortab was administered to the resident only 3 times, on the dates of 5/3/13 (twice) and 5/6/13. The signatures on both the CSR and MAR belonged to the Director of Nursing (DON) who was appointed as a staff nurse at that time. During an interview with the DON on 4/9/14 at 09:19 AM, he acknowledged that all of the signatures on the CSR of the stated resident for May 2013 belonged to him. He said that he took care of her when she came in after a leg amputation and acknowledged that a nurse is supposed to sign the MAR. The DON stated that "documentation is one of our weaknesses."	F 514	by the physician. 2. One hundred percent of licensed staff will be in-serviced by the DON and/or the Staff Facilitator by April 30, 2014 on completing proper documentation for PRN (as needed) controlled medications to include: documenting a declining count on the narcotic sheets, signing the front of the MAR to denote the medication was given, listing the indication for use on the back of the MAR and document the effectiveness of the medication in the appropriate section on the back of the MAR. All newly hired licensed nurses will be in-serviced by the DON and/or the Staff Facilitator on completing proper documentation for PRN (as needed) controlled medications to include: documenting a declining count on the narcotic sheets, signing the front of the MAR to denote the medication was given, listing the indication for use on the back of the MAR and document effectiveness of the medication in the appropriate section on the back of the MAR. 3. During shift change, the on-coming and the off-going nurse will review each resident that received a PRN controlled substance to make sure the narcotic count sheet and the resident□s MAR match. The nurses will check for nurse□s initials indicating a PRN was given, will check for the reason the PRN given and the effectiveness, if appropriate, at the time of shift change. The audit will be reviewed daily x 2 weeks, then Monday, Wednesday and Friday x 2 weeks, then q Wednesday x 2 weeks, then monthly x 2 months by the DON and/or the MDS	

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F 514	Continued From page 8 2. Resident 20 had Lortab 5/500 mg signed out 15 times during the date range of 4/1/14 - 4/9/14, as documented on the CSR. The April 2014 MAR indicated that the Lortab was administered to the resident 4 times, on the dates of 4/2/14, 4/4/14, 4/5/14, and 4/9/14. The signatures belonged to several members of the nursing staff. 3. Resident 24 had Norco 10/325 mg signed out 19 times during the date range of 4/1/14 - 4/9/14, as documented on the CSR. The April 2014 MAR indicated that the Norco was administered to the resident 9 times, on the dates of 4/1/14, 4/2/14, 4/5/13 (twice), 4/6/13 (twice), 4/7/13 (twice) and 4/8/13. The signatures belonged to several members of the nursing staff. 4. Resident 28 had Lorazepam 1 mg signed out 10 times during the date range of 4/1/14 - 4/9/14, as documented on the CSR. The April 2014 MAR indicated that the Lorazepam was administered to the resident 0 times. The signatures on the CSR belonged to several members of the nursing staff. 5. Resident 42 had Lorazepam 1 mg signed out 3 times during the date range of 4/1/14 - 4/9/14, as documented on the CSR. The April 2014 MAR indicated that the Lorazepam was administered to the resident 1 time, on 4/1/14. The signatures belonged to a member of the nursing staff. 6. Resident 63 had Lorazepam 0.5 mg signed out 5 times during the date range of 4/4/14 - 4/9/14, as documented on the CSR. The April 2014 MAR indicated that the Lorazepam was administered to the resident 2 times, on the dates of 4/4/14 and 4/8/14. The signatures belonged to a member of the nursing staff.	F 514	nurse. A monitoring tool was implemented on 4/28 in order to audit shift change reconciliation of the MAR and Narcotic Count sheets. 4. The Consultant Pharmacist will review a selection of 10% of residents receiving PRN narcotics during the monthly medication review for documentation the PRN was given, reason for giving the medication documented and effectiveness of medication. The number of PRN□s for the 10% resident pool will be validated against the narcotic count sheet. This will occur 1 x month x 3 months. Results of the Pharmacist audit will be recorded on the Pharmacy Consult Sheets. 5. Results of the audit for residents receiving PRN narcotics, to include validating the number of PRN□s received against the narcotic count sheet, signature of dispensing nurse, documentation of indication for use and effectiveness will be reviewed in the monthly QA meeting to identify trends and need for continued monitoring. The DON and/or the MDS nurse will present the results of the audits to the QA committee.	

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F 514	Continued From page 9	F 514		

7. Resident 69 had Alprazolam 0.5 mg signed out 8 times during the date range of 4/1/14 - 4/9/14, as documented on the CSR. The April 2014 MAR indicated that the Alprazolam was administered to the resident 4 times, on the dates of 4/1/14, 4/4/14, 4/6/14, and 4/7/14. The signatures belonged to several members of the nursing staff.

During the same interview with the DON, as mentioned above on 4/19/14 on 9:19 AM, he stated that his expectations of the nursing staff are that they assess the resident, pick the appropriate controlled agent for the specific behaviors, document on both the CSR as having been taking out of the narcotic box and on the MAR as having been administered to the resident, and then follow up to see if the symptoms have improved and/or resolved. He stated that he has begun in-servicing the nursing staff about documentation and plans to begin randomly reconciling CSRs with the MARs and narcotic count checks.

The administrator, during an interview at 1:48 PM on 4/10/14, stated that the nursing staff is expected to "legibly document on controlled substances sheet that a med(medication) was taken out of narcotic box, then document on front and back of MAR that the med(ication) was given. Not documenting means that the med (medication) was not given to patient (resident)." She continued stating that she thinks that nursing staff may assume that documenting only on the CSR is sufficient practice. She stated that she understands that education will be necessary to see a change in documentation habits from the nursing staff and that she understands the

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F 514	Continued From page 10 severity of the issue as she "used to be a pharmacy technician."	F 514		