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GOLDEN LIVINGCENTER - CHARLOTTE	2616 E 5TH ST CHARLOTTE, NC 28204

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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, staff interviews and record reviews, the facility failed to provide wheelchair foot support for a resident (Resident #117) dependent on staff for mobility and order a wheelchair and ankle brace for contracture prevention for a resident (Resident #22) per therapy recommendation for 2 of 3 residents reviewed for wheelchair positioning. The findings included: 1. Resident #117 was admitted to the facility on 03/19/13. Diagnoses included cognitive communication deficit, idiopathic scoliosis, congenital anomaly of diaphragm, and Down's syndrome. Review of a quarterly minimum data set dated 03/20/14 assessed Resident #117 with a height of 59 inches, and totally dependent on staff for locomotion on the unit. Review of a care plan updated 05/9/14 revealed Resident #117 had physical functioning deficit and mobility impairment related to a cognitive	F 246	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements Resident #22 has the appropriate wheelchair and ankle brace in place. Resident was re-evaluated by therapy for positioning. Resident #117 has been reevaluated and footrest has been provided and is in place. An audit has been completed to identify any other residents in need of foot rest and proper positioning in chair. Residents identified have been reviewed by therapy or designee to assess for positioning and proper foot rests.	6/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla Hamphill — TITLE: Executive Director — (X6) DATE: 6/19/14

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 Received Blue Mountain WRO JUN 20 2014 by: SKH

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F 246	Continued From page 1 communication deficit with the wheelchair as the primary mode of locomotion. Staff interventions included to provide wheelchair locomotion assistance and assess the need for foot rests. Resident #117 was observed seated in her wheelchair on 05/19/2014 at 3:41 PM. Both feet were observed hanging without support approximately 6 inches above the footrests. A pillow was observed positioned partially on the right footrest and hanging off, but did not provide support under her feet. A second observation of the same occurred on 5/21/14 at 10:22 AM. Resident #117 was observed in her wheelchair in her room with her feet hanging in the same position as previously described. A pillow was positioned behind her legs, from her knees to her ankles, but did not provide support for her feet. During this observation, Resident #117's right leg was observed to tremble. An interview with nurse aide #3 (NA #3) occurred on 05/21/14 at 10:25 AM. NA #3 stated that Resident #117 had used the same wheelchair for at least the past 3 months and the Resident's feet have always hung without the use of footrests. NA #3 further stated that a pillow was placed behind the Resident's legs for support, but NA #3 had never repositioned the footrests to support her feet. NA #3 also stated that she had noticed the Resident's right foot would tremble at times, but thought this was because the Resident did not like to be up to her wheelchair. NA #3 stated that she had not reported this to the nurse. Resident #117 was observed again on 05/21/14	F 246	Staff has been inserviced by therapy or designee on proper positioning in wheelchair and to ensure all equipment is in place. Adaptive equipment will be placed on CNA care cards to ensure compliance. Random audits will be done on identified residents and new residents will be assessed at admission per DNS or designee. Results will be addressed and reviewed for 3 months in QAA and then as determined by the QAA Committee.	

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F 246	Continued From page 2 at 10:38 AM and 11:51 AM in her wheelchair in the main dining room with her feet hanging without the support of the footrests. A pillow was positioned behind her knees and provided support from her knees to her ankles. Resident #117's right leg was observed to tremble. On 05/21/14 at 11:56 AM, nurse #1 was interviewed and stated that Resident #117 required encouragement to get up to her wheelchair daily. Nurse #1 further stated that due to Resident #117 short stature the Resident's feet did not reach the footrests, so a pillow was positioned behind her legs to help with support. The nurse stated she was not aware that at times the Resident's right foot trembled. On 05/21/14 at 11:59 AM an interview with the unit manager on the east unit revealed that nursing staff noticed about two months ago that when Resident #117 sat in her wheelchair, she would not relax her legs, but rather hold her legs up. She stated as a result, nursing staff placed a pillow behind the Resident's legs for support and due to the Resident's short stature her legs/feet were not long enough to reach the footrests. The unit manager further stated that the use of a pillow was a nursing intervention used for about the last 2 months when staffed noticed that Resident #117 would yell out when placed in her wheelchair and become rigid trying to hold her feet up. When the pillow was placed, the unit manager stated Resident #117 stopped yelling out and relaxed her legs, so nursing staff were advised to continue the use of a pillow for support rather than a referral to therapy. The unit manager stated she had not been made aware that at times the Resident's right leg trembled.	F 246		

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F 246	Continued From page 3 A follow-up interview on 05/21/14 at 12:10 PM with the unit manager of the east unit revealed that she just spoke to therapy staff who advised her how to reposition the footrests to support the Resident's feet. The unit manager was observed to position both footrests for Resident #117 up about 6 inches to support the Resident's feet. An interview on 05/21/14 at 12:20 PM with the director of nursing (DON) revealed she expected nursing staff to round daily and anyone who observed a resident in a wheelchair with feet hanging and not supported by foot rests could refer the resident to therapy or request therapy staff to assist with repositioning the resident's footrests for support. The DON further revealed that Resident #117 was typically up to her wheelchair about 2 hours daily and because of the Resident's inability to make her needs known the DON stated she expected staff to anticipate the Resident's needs. 2. Resident #22 was admitted to the facility on 11/13/07. Diagnoses included dementia, cerebrovascular accident (stroke), generalized pain and osteoarthritis. Review of therapy notes revealed that on 01/31/14, the family of Resident #22 expressed a concern that the Resident's left ankle and foot were turning too far to the right and requested a splint for correction. Resident #22 was referred for therapy evaluation and treatment. Review of a quarterly minimum data set dated 02/06/14 assessed Resident #22 with impaired cognition, requiring extensive assistance with locomotion on the unit, and the use of a wheelchair as the primary mode of transportation.	F 246		

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F 246	Continued From page 4 Review of therapy notes dated 02/11/14 revealed Resident #22 was being treated in physical therapy. Resident #22 received therapy for wheelchair positioning due to the effects of a stroke, abnormal posture and left ankle contracture prevention with recommendation for a splint as the Resident's left foot would not maintain upright position once repositioned by nursing staff. Physical therapy notes dated 02/24/14 documented that the wheelchair for Resident #22 was too small, but a different wheelchair was not available. Physical therapy notes dated 03/10/14 documented that Resident #22 was experiencing left lower extremity and ankle/foot swelling. The goal was to achieve adequate positioning in bed and wheelchair to reduce the risk of skin breakdown/contracture. Resident #22 would require a new wheelchair and left ankle night time splint. Physical therapy notes dated 03/24/14 recorded that Resident #22 was placed in the most appropriate wheelchair found in the facility, but that the wheelchair used was still inappropriate. A splint for night time wear and an appropriate wheelchair was requested for Resident #22 with plans to discontinue therapy services and resume when equipment was received. Therapy to Nursing Communication/Functional Maintenance Program dated 03/31/14 documented nursing approaches to include maintain Resident straight in wheelchair with left foot flat on the floor or footrest and not rolled out.	F 246		

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F 246	Continued From page 5 Physical therapy notes dated 04/04/14 indicated that Resident #22 was fitted for an appropriate wheelchair and left night time ankle splint. Both items were requested for order. Resident #22's pain and swelling were improved and he was discharged from physical therapy with plans to resume services when the wheelchair and splint arrived. A care plan, updated 05/09/14 identified Resident #22 as unable to reposition self independently. Care Plan interventions included staff to provide assistance with proper positioning. Resident #22 was observed on 05/20/2014 at 11:00 AM in his wheelchair. His left foot was positioned on its side rolled out towards the right. There was no splint in place. Resident #22 was observed with both knees hyper-flexed, both feet on the footrests with the seat of the wheelchair providing support to the mid thigh area. There was approximately 6 inches from the end the wheelchair seat to his knees without support from the wheelchair seat. Resident #22 was observed again with the same wheelchair positioning as previously described on 05/21/14 at 10:41 AM, 05/21/14 at 3:50 PM and 05/22/14 at 09:19 AM seated in his wheelchair with his left ankle resting on floor and not on the foot rests. An interview on 05/23/14 at 1:30 PM with a physical therapy assistant (PTA) revealed she measured Resident #22 for the appropriate wheelchair and left ankle night time splint in March 2014. The PTA stated she provided the	F 246		

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F 246	Continued From page 6 measurements to the therapy coordinator to place the order, but Resident #22 was still in the same inappropriate wheelchair. The PTA stated she did not know the status of the equipment and did not know if the wheelchair or splint had been ordered. An interview on 05/23/14 at 1:32 PM with the rehab director revealed that when a resident was evaluated for therapy services and determined that new equipment was needed the resident was measured for the equipment by a therapy assistant. The rehab director further stated that the therapy assistant should forward the measurements to the therapy coordinator who would complete the requisition form and forward it to the director of nursing or administrator for approval. Once the requisition was approved, the rehab director stated then the requisition went to central supply for ordering. The rehab director further stated she was unable to locate the requisition form that was completed for the wheelchair and night time ankle splint for Resident #22 and could not speak to whether or not the equipment had been ordered because the therapy coordinator was on vacation. The rehab director also stated that she would expect the therapy coordinator to follow up on the status of equipment within a couple weeks of completing the equipment requisition. The rehab director further stated that either she or the therapy coordinator attended morning staff meetings to ensure concerns from therapy were addressed, which included pending equipment orders, but she was not aware that Resident #22 was evaluated for the need of a new wheelchair and ankle splint. An interview on 05/23/14 at 3:20 PM with nurse aide #4 (NA #4) revealed he worked with	F 246		

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F 246	Continued From page 7 Resident #22 routinely. NA #4 stated that the Resident had used the same wheelchair, but NA #4 had not noticed the wheelchair seat was not large enough for the Resident. NA #4 further stated that Resident #22 required frequent repositioning of his left ankle. The NA also stated that it was difficult to keep the Resident's ankle positioned upright and the NA thought this was being addressed by therapy. An interview on 05/23/14 at 3:25 PM with the unit manager of west unit revealed she had not noticed that the seat of the wheelchair for Resident #22 was too short for him and she was not aware that a new wheelchair was pending per therapy recommendation. The unit manager stated "This wheelchair does not appear to fit him." An interview with the administrator and director of nursing on 05/23/14 at 2:30 PM revealed a requisition order form had not been received for Resident #22 for a new wheelchair or an ankle splint and therefore the equipment requisition had not been forwarded to central supply and the equipment had not been ordered.	F 246		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312	Resident #80 has had oral care done and continues daily and as needed. Audits have been done of like residents to assess oral care needs.	6/20/14

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F 312	Continued From page 8 Based on observations, record review and resident and staff interviews the facility failed to brush a resident's teeth who had a feeding tube for 1 of 5 residents observed for activities of daily living. (Resident #80). The findings included: Resident #80 was admitted to the facility on 07/05/13 with diagnoses which included brain injury, anxiety, psychosis and difficulty swallowing. A review of a care plan initiated on 07/11/13 titled tube feeding dependence due to dysphagia listed interventions in part to provide oral care daily or as needed. A review of a care plan initiated on 07/19/13 titled physical functioning deficit due to brain injury listed interventions in part to provide personal hygiene assistance. A review of the most recent quarterly Minimum Data Set (MDS) dated 03/25/14 indicated Resident #80 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #80 was totally dependent on staff for assistance with activities of daily living (ADL) which included personal hygiene and there was no indication the resident refused care. During an observation on 05/21/14 at 8:35 AM Resident #80 was lying in bed and his mouth was observed with a heavy accumulation of white debris along the gum line of his upper teeth and also between his upper teeth.	F 312	Inservices have been done to educate appropriate staff on oral care. Management has assigned room rounds to department heads for daily rounds to include oral care needs assessment. Information is brought to daily stand up meeting and corrective action done as needed. Instructive inservice was done to educate department heads on effective room rounds. Random oral care and ADL rounds to be done per DNS or designee. Results will be addressed and reviewed for 3 months in QAA and then as determined by the QAA Committee.	

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F 312	Continued From page 9 During an observation on 05/21/14 at 2:58 PM Resident #80 was lying on his bed and smiled and his upper teeth had a heavy accumulation of white debris along the gum line and in between his upper teeth. The resident was interviewed and stated he had a toothbrush but it had not been used because he could not brush his own teeth and staff had not brushed his teeth. During an observation on 05/22/14 at 10:23 AM Resident #80 was sitting in a wheelchair in the hallway. He smiled and his upper teeth had a heavy accumulation of white debris along the gum line and in between his upper teeth. Resident #80 also had saliva present with white stringy debris sticking to his upper and lower lips. During an interview on 05/23/14 at 11:16 AM with Nurse Aide (NA) #5 she stated she routinely provided ADL care for Resident #80. She explained he could not do any ADL care for himself and was usually cooperative with care. She stated she used a swab with mouthwash on it earlier that morning to wipe out his mouth but did not use a toothbrush to brush his teeth. She stated she routinely used the swabs instead of a toothbrush because she knew that Resident #80 was not supposed to drink any water and she was afraid if she brushed his teeth he might swallow too much water and get choked. She confirmed Resident #80 had a toothbrush in his bedside cabinet and toothpaste but she had not used it. During an observation on 05/23/14 at 11:37 AM Resident #80 was lying in bed and his upper teeth had a heavy accumulation of white debris along the gum line and in between his upper teeth. He also had stringy saliva present with white debris	F 312		

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F 312	Continued From page 10 sticking to his upper and lower lips. During an interview on 05/23/14 at 11:41 AM Nurse #3 explained it was common for Resident #80 to collect the whitish debris along his gum lines and in between his teeth. She further explained Resident #80 had a lot of saliva and mouth swabs were effective to remove the saliva but they did not get his teeth clean. During an interview on 05/23/14 at 12:00 PM the west wing Unit Manager explained Resident #80 could not have anything by mouth and was fed with a feeding tube. She also explained he was cooperative with ADL care and nurse aides were encouraged to provide mouth care during morning and evening care. The Unit Manager observed Resident #80's mouth and confirmed he had an accumulation of white debris along his gum lines and in between his teeth. She stated it was her expectation for nurse aides to attempt to use the toothbrush first to clean Resident #80's teeth and if they had difficulty or if the resident refused they should notify the nurse and it should be documented. The Unit Manager stated it was her observation that Resident #80's teeth could have had a better cleaning with a toothbrush and confirmed there had been no documentation that he had refused to have his teeth brushed. During an interview on 05/23/14 at 12:30 PM the Director of Nursing (DON) stated it was her expectation for staff to provide oral care for residents with tube feedings and that included brushing their teeth on a daily basis. She explained Resident #80 had difficulty with swallowing but staff still needed to brush his teeth each day.	F 312		

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F 322	Continued From page 11	F 322		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to start infusing and to continue infusing Jevity 1.5, an enteral feeding product, per physician's order for 2 of 2 observations resulting in a resident's loss of approximately 225 calories and 114 milliliters of water for 1 of 3 sampled residents fed via a gastrostomy feeding tube. (Resident #117) The findings included: Resident #117 was admitted to the facility on	F 322	Resident #117 enteral feeding has been addressed and is compliant according to MD orders. Nurse assigned was educated and inserviced as to the importance of timely and appropriate administration of enteral feedings. Audits have been completed of all enteral feeding residents to ensure compliance with administration times, amount and rate of enteral product. Inservices have been completed for licensed staff regarding following MD orders in relation to compliance with enteral feeding recommendations. Monitoring tool has been implemented to ensure compliance with enteral feeding. DNS/designee is responsible for implementation and compliance. Results will be addressed and reviewed for 3 months in QAA and then as determined by the QAA Committee.	6/20/14

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F 322	Continued From page 12 03/19/13. Diagnoses included dysphagia, aspiration pneumonia, idiopathic scoliosis, and congenital anomaly of diaphragm. A physician's order dated 03/17/14 recorded Resident #117 received an NPO diet (nothing by mouth). Review of a quarterly minimum data set dated 03/20/14 assessed Resident #117 with swallowing difficulty and as receiving greater than 51% of calories and fluids via a feeding tube. Review of a care plan updated 05/9/14 revealed Resident #117 had difficulty swallowing due to dysphagia and received all food and fluids via a tube feeding (TF). Staff interventions included to provide the TF as ordered. A physician's order dated 05/10/14 recorded Resident #117 received Jevity 1.5 at 50 milliliters (ml) per hour via gastrostomy tube for 20 hours per day, off at 10:30 AM and on at 2:30 PM. Resident #117 was observed on 05/20/14 at 3:39 PM in bed with the head of bed up approximately 30 degrees. A 1000 ml bottle of Jevity 1.5 was suspended on an IV pole with approximately 700 ml of product remaining. The pump was turned off and the TF product was not infusing. The bottle recorded that Jevity 1.5 was provided to Resident #117 on 05/19/14 at 06:15 AM at a rate of 50 ml per hour. Resident #117 was observed continuously on 05/20/14 from 3:39 PM until 5:50 PM in bed without the TF product infusing. Nurse #2 was interviewed on 05/20/14 at 5:32	F 322		

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PM. During the interview nurse #2 stated she was aware that the TF product was not infusing for Resident #117. Nurse #2 stated that earlier that day before 3:00 PM she tried to start the TF for Resident #117, but the Resident was in her wheelchair and not in bed. Nurse #2 stated that she asked the nurse aide to put Resident #117 to bed and then got busy with a new admission and did not get back to restart the TF for the Resident. Nurse #2 stated she preferred to start the TF for Resident #117 when the Resident was in bed, but did not provide a specific reason as to why. Nurse #2 was observed on 5/20/14 at 5:50 PM to start Jevity 1.5 at 50 ml per hour for Resident #117 while in bed.

An interview on 5/20/14 at 5:53 PM with the unit manager for the east unit revealed she was not aware that the start time of the TF product for Resident #117 was delayed that day. The unit manager stated she was not aware of any reason why Resident #117 could not have the TF product infusing while the Resident was in her wheelchair rather than in bed. The unit manager further stated that if a nurse got busy with other residents and was unable to start a TF product as ordered, the nurse should ask another nurse or the unit manager to assist.

An interview with the director of nursing (DON) occurred on 5/20/14 at 5:57 PM. The DON stated that she expected nurses to delegate responsibilities if time did not permit the nurse to implement a physician's order. The DON further stated she was not aware of a reason why Resident #117 could not receive a TF product while seated in her wheelchair and that actually because of the Resident's history of aspiration, that would be the preferred position. The DON

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stated she would notify the physician that Resident #117 did not receive her TF product as ordered on 5/20/14 in case the physician wanted to adjust the order to make up the calories lost.

A physician's order for Resident #117 dated 5/20/14 recorded that staff may start the TF at 5:30 PM one time only for 1 day. The order did not record to extend the TF time.

On 5/21/14 at 10:22 AM Resident #117 was observed in her wheelchair with the TF pump turned off and not infusing. Interview with nurse aide #3 at the time of this observation revealed she assisted Resident #117 with morning care around 10:00 AM that day after the nurse turned off the TF product.

A follow-up interview on 5/21/14 at 12:25 PM with the unit manager of the east unit revealed she spoke to the physician on 5/20/14 and received an order to start the TF for Resident #117 at 5:30 PM on 5/20/14 and to continue infusing the TF product until 1:30 PM on 5/21/14 to make up for the calories lost due to the delayed start time of the TF product. The unit manager stated she forgot to record on the physician's order to continue infusing the TF product until 1:30 PM on 5/21/14 so the nurse did not know to continue infusing the TF product.

An interview on 5/21/14 at 12:26 PM with nurse #1 revealed she turned off the TF product for Resident #117 on 5/21/14 about 10:10 or 10:15 AM because she was not aware that the Resident was to receive the TF product until 1:30 PM.

A follow up interview on 5/21/14 at 12:28 PM with the DON revealed she expected Resident #117 to

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F 322	Continued From page 15 receive the TF product as ordered on 5/21/14 to make up for the calories lost. An interview on 5/21/14 at 12:58 PM with the consultant registered dietitian (RD) revealed Resident #117 was recently reviewed and identified with significant weight gain. The RD further stated that as a result she spoke to the physician and an order was written to decrease the Resident's TF rate to 50 ml per hour with continued monitoring. The RD also stated that even though Resident #117 recently had significant weight gain, her nutritional needs should still be met. The RD stated that since the physician gave the order to extend the TF time, she expected the TF product to be provided per the order to make up for the possible loss of nutrition. The RD stated she calculated that Resident #117 potentially missed 225 calories and 114 ml of water on 5/20/14 and her current weight checked on 5/21/14 was the same as her previous weight, so the error did not result in weight loss.	F 322		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, and physician interview the facility failed to prevent a significant medication error by administering the incorrect medication dose as ordered for 1 out of 25 residents reviewed for medication administration (Resident #134).	F 333	Resident #134 has been assessed and found to have no negative effects. Nurse was immediately inserviced and counseled on proper administration of medications. The MD was notified and no new orders given.	6/20/14

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F 333	Continued From page 16 The findings included: Resident #134 was admitted to the facility on 12/04/13 with diagnoses which included in part anoxic (lack of oxygen) brain damage and respiratory failure. The most recent quarterly Minimum Data Set (MDS) dated 03/03/14 indicated Resident #134 was cognitively intact. The MDS assessment further indicated Resident #134 required extensive assistance with bed mobility, dressing, eating, and toileting but required total assistance for transfers and bathing. Review of the physician's orders dated 03/18/14 revealed Propranolol (Inderal) medication was to be decreased to 40 mg by mouth 2 times a day. Further review of the physician's orders dated 03/31/14 revealed a decrease in the Propranolol (Inderal) medication to 20mg by mouth 2 times a day starting on 04/01/14. During medication administration observation on 05/21/14 at 9:02 AM Nurse #2 administered a medication Propranolol (Inderal) 40 milligrams (mg) one tablet by mouth to Resident #134. During review of the physician's orders (reconciliation) dated 04/01/14 indicated Propranolol (Inderal) tablet 20 mg by mouth two times a day related to unspecified cerebral artery occlusion with infarct. An interview was conducted with Nurse #2 on 05/21/14 at 9:44 AM and she stated she had been giving Resident #134 the Propranolol (Inderal) 40 mg since he was admitted to the facility on 12/04/13. She further stated she was unaware of a medication dosage change dated 04/01/14 for Resident #134. Nurse #2 pulled the	F 333	Medication observations will be done per DNS and designees to monitor medication pass proficiency. Audits have been done to compare medication in cart to MD orders for compliance and accuracy. Inservices have been held for licensed staff for proper administration of medications to include verification of medication in cart to the EMAR. Inservices will be done to call pharmacy to ensure orders received to ensure receipt. Random audits will be done per DNS/designee to compare medication in the care to the EMAR. Results will be addressed and reviewed for 3 months in QAA and then as determined by the QAA Committee.	

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Propranolol (Inderal) medication package from her medication cart. She reviewed the pharmacy label affixed to the medication package for Resident #134 and indicated the medication pharmacy label read as follows: Propranolol (Inderal) 40mg by mouth 3 times a day. She then looked in the computer on top of her medication cart, reviewed the physician's order, and verified Resident #134 was to be given Propranolol (Inderal) 20 mg by mouth 2 times a day. She indicated the 40mg dose of Propranolol (Inderal) she administered on 05/21/14 at 9:02 AM to Resident #134 was the wrong dosage strength and the medication label had the wrong frequency listed.

A telephone interview was conducted with the physician on 05/23/14 at 2:08 PM. She stated she was made aware on 05/21/14 that Resident #134 was given the wrong frequency of the Propranolol (Inderal) medication since 03/18/14 and the wrong dosage strength was given since 04/01/14. She further stated she expected the facility nursing staff to follow the orders as prescribed for all residents.

A telephone interview was conducted with the pharmacist on 05/23/14 at 2:14 PM. He stated the only faxed copy and telephone call was received on 05/21/14 from the facilities East Wing Unit Manager regarding Resident #134's Propranolol (Inderal) medication dosage strength and frequency changes. He verified the pharmacy received a faxed physician's order from the facility on 05/21/14 to reduce the dosage strength and frequency of the Propranolol (Inderal) medication to 20 mg by mouth 2 times per day for Resident #134. The pharmacist confirmed they had not received any physician's orders from the facility

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F 333	Continued From page 18 on 03/18/14 or on 03/31/14. An interview was conducted with the East Wing Unit Manager on 05/23/14 at 2:28 PM. She stated she expected the nurses to always compare the medication packets and/or medication bottles with the physician's orders and the residents Medication Administration Record (MAR) before administering a medication. An interview was conducted with the Director of Nursing on 05/23/14 at 2:37 PM. She stated she expected the nurses to always check and verify all medication pharmacy labels with the physician's orders, and the residents MARs.	F 333		