STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345153	A. BUILDING _____ B. WING _____	12/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(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 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based upon record review and staff interview the facility failed to update care plans for 2 of 6 sampled residents (Resident # 47, and Resident #107). The finding included; 1. Resident # 47 was admitted to the facility on 8/13/14 with a diagnosis that included diabetic neuropathy, opioid dependence, chronic pain, and atrial fibrillation. Review of the Minimum Data Set (MDS) dated 11/5/14 revealed Resident #47 was moderately cognitively impaired.	F 280	A. Resident #107-Care plan was revised by Minimum Data Set nurse to remove "encourage fluid intake" on 12-18-2014. Resident #43 care plan was updated 01-12-2015 by social worker. B. All residents have the potential to be affected. Care plans were audited by Minimum Data Set nurses to ensure that interventions are appropriate for the residents and care plans have been updated timely. Care plans audit completed by 01-15-2015.	1/15/15

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

Electronically Signed | 01/15/2015

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F 280	Continued From page 1 Review of Resident #47 ' s care plan dated 8/21/14 revealed a " problem " of, I experience hallucinations by seeing " boys " in my room. The goal indicated, " I will inform staff when I am having hallucinations, I will accept diversion, and I will have no signs of anxiety. The approaches for Nurses included reassure, encourage verbalization, identify stressor, reduce stressors, administer anti-anxiety meds as ordered by physician, and calm gentle approach. The approaches identified for Nurse Aide (NA) revealed offer reassurance, involve resident in cares, use calm tone of voice, provide gentle encouragement, allow ventilation of feelings, remove resident form situation, provide a quiet area for resident, offer diversion, allow time to talk. The approaches identified for Social Services included one on one visits, allow to vent, teach relaxation techniques, make referrals, and reorient PRN (as needed). Approaches for activity indicated assess interest, assess strengths, determine limitations, inform of activities, assist to activities, and promote relaxation. Review of Resident #47 ' s psychiatric evaluation dated 9/11/14 indicated that in an interview with Resident #47 she stated the kids are bothering her sometimes, but not much. Resident #47 indicated today the boys aren ' t really bothering her, but sometimes get loud. Staff report they can usually reassure her that she is safe. Resident did have 1 day when she thought the boys had a gun and were going to hurt her, but that passed. Overall though, staff report hallucinations are improved in that they are not bothering her like they used to. The current medications listed on the psychiatric evaluation listed Seroquel 25mg, 50mg QHS and PRN, and	F 280	C. The Interdisciplinary Care Team was in-serviced on timeliness of care plans/updates and appropriateness of interventions by the Staff Development Coordinator on 01-13-2015. The Minimum Data Set nurse will monitor the Minimum Data Set for completion and audit all care plan updates that are due weekly to ensure timeliness of updates and appropriate interventions per Resident Assessment Instrument requirements. D. The Staff Development Coordinator or Director of Nursing will audit ten care plans weekly for four weeks, then biweekly for two months, then monthly for three months. Results will be reported and evaluated for effectiveness monthly in the Senior Leadership Team / Quality Assurance & Performance Improvement meeting with revisions made as indicated.	

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Remeron 15mg QHS. The recommendations on the evaluation indicated patient has some hallucinations, but overall staff are able to meet her needs. Would consider increasing dose of Seroquel if visual hallucinations continue or worsen, but for now, hold changes. Continue meds; and follow up with the patient in one to four months time or PRN.

Review of Resident #47 ' s physician note dated 11/12/14 indicated Resident #47 was being seen for 90 day post admission visit. The physician note revealed " Problem " presents today for 90 day post admit visit after ten day hospitalization at NE Senior behavioral unit under care. Resident #47 frequently reports seeing and interacting with a number of " boys " in her room because her distress at times. Hallucinations improved after her Seroquel was increased during her last hospitalization. They began to worsen last week. the assessment and plan indicated, continue Seroquel twice daily, continue to monitor for severity of hallucinations. May need readmission or further med titration as appropriate, coordinate with psychiatry for possible readmission if hallucinations continue to worsen.

Review of Resident #47 ' s nursing note dated 11/5/14 indicated resident having delusions about boys in her room; believes they are under her wheelchair. Nursing note identified as a late entry for 11/6/14 at 11:41am revealed interdisciplinary team discussed residents continued hallucinations and delusions about the " boys " in her room. Resident has started to see them daily and is becoming more fearful of them. NP increased residents Seroquel and prescribed Ativan on 11/5/14. staff will continue to monitor and ensure resident of her safety. nursing note

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dated 11/6/14 at 10:11am - Resident is seeing the little boys again, and this is disturbing her and causing her to be anxious. PRN meds given per orders. Nursing note dated 11/12/14 indicated Resident #47 stated the boys cutter her ribs and shaking the bed. Resident redirected. Nursing noted dated 11/13/14 revealed Resident #47 was in bed when she called for assistance, saying that she wants to sit in the chair because there ' s someone under the bed and trying to grab her feet. Note dated 11/15/14 physical behavior directed towards other: kicking/hitting pushing/grabbing at this nurse in the hallway; resident also refused to take all of her medications. The note also indicated verbal behaviors directed to others: resident was combative with staff and could have easily injured herself for someone else in the process. Nurses note dated 11/19/14 indicated Resident #47 refused am duoneb treatment would not allow nurse to get her in position for the treatment due to the boys are under the bed. Resident put her feet down and would not accept treatment. Resident also stated " I don ' t need it. " Nursing noted dated 11/28/14 indicated at 8:30pm resident #47 refused to allow nursing assistant (NA) to put her pajamas on and stated that there was a man in her room, in/under bed. Resident hit NA on the arm. Also stated there was somebody under her wheelchair.

Interview with Social worker for long term care on 12/18/14 at 10:11am revealed care plans were to be updated on a quarterly basis and new approaches should have been developed due to increase in the residents exhibited behaviors. The MDS coordinator indicated she had not updated Resident #47 ' s care plan.

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F 280	Continued From page 4 Interview with the Administrator on 12/18/14 at revealed it was his expectation that care plans be updated quarterly. 2. Resident #107 was re-admitted to the facility on 5/30/2014, with diagnoses to include hypertension, neurogenic bladder, obstructive uropathy, urinary tract infection, diabetes, aphasia, cerebrovascular accident, congestive heart failure and swallowing problems. A review of Resident #107 ' s Minimum Data Set (MDS) dated 11/14/2014 revealed the resident had a feeding tube and a therapeutic diet. The tube feeding and average fluid intake by tube feeding was 501 cubic centimeters per day or more. A review of Residents #107 ' s Care Area Assessment, Nutritional Status, dated 5/13/2014, revealed that he had a swallowing problem, functional limitation in range of motion, hemiplegia and hemiparesis, the inability to perform activities of daily living without significant physical assistance, and he requires tube feeding. A review of Residents #107 ' s Care Area Assessment for a problem ofDehydration and Fluid Maintenance dated 5/13/2014, revealed that he triggered due to tube feeding, depression or anxiety and Alzheimer's or other dementia that interferes with eating due to short attention span, resisting assistance, slow eating and drinking, etc., difficulty making self understood and difficulty understanding others. Feeding tube was	F 280		

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F 280	Continued From page 5 in use. A decision was made to develop a care plan and revise the current plan. Resident #107 ' s Care Plan was reviewed and revealed an intervention documented 11/14/2014 for Foley catheter. The approaches included to encourage fluid intake which was to be provided by the Nurse Aide. There had been no revision of the care plan to remove encouraging fluid intake since the resident received nothing by mouth. On 12/18/2014 at 9:58 AM, an interview was conducted with the MDS nurse. The MDS nurse stated that "In TREK (interdisciplinary committee that reviews high risk residents), we discussed limiting how much (fluids) he was getting". The MDS nurse stated, regarding nurse aides, "They can't do that. We do that for everybody else with urinary problems. We made a mistake. The doctor, nurses and dietician said the resident could not get any more fluid due to his aspiration problem." The MDS nurse stated that encourage fluid intake had been on Resident #107's care plan for both nurse aides and for nurses, and she said that they were removing encourage fluid intake from his care plan.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		1/15/15

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F 314	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide treatment and interventions on admission for an unstageable pressure ulcer for one (Resident #203) of two sampled residents with pressure ulcers. The findings included: Resident #203 was initially admitted to the facility on 12/8/14 with diagnoses including fracture of the right femur, deep vein thrombosis, cardiomyopathy, Chronic Obstructive Pulmonary Disease and diabetes type 2. Review of the admission assessment completed by the floor nurses, dated 12/8/14, revealed a skin assessment was not available for review. Record review of a nurse ' s note dated 12/10/14 at 3:59 PM indicated Resident # 203 had a skin assessment completed. The note read in part "... redness noted on buttocks, peri area. Skin intact to right heel, left heel has reddish purplish area noted ... " Review of the nurse practioner ' s progress note dated 12/10/14 indicated he was requested to do an evaluation of a " new wound/lesion to left lateral heel. " Wound measures "approximately 4 x 5 centimeters (cm) intact darkened red/black blister with some fluid palpable to left lateral heel. Has surrounding ring of erythema; no warmth ... " The treatment plan included " We ' ll begin applying skin prep and order heel lift boots, air	F 314	A. Resident #203-Treatment was initiated 12-10-2014. Admitting nurse in-serviced that treatment must be initiated upon identification of the area of concern using facility protocol on 12-18-2014 by the Director of Nursing. B. All residents have the potential to be affected; therefore, Nursing Supervisors conducted mandatory in-services on 01-12-2015 thru 01-15-2015 for all nursing staff regarding identification of areas or any changes in skin condition and the initiation of appropriate treatment per facility protocol. Weekly skin checks were audited 01-09-2015, by the Nursing Supervisors against the treatment record to ensure that identified areas received orders for treatment. C. To ensure that pressure areas are identified and treatment is initiated timely, the admission/readmission checklist is initialed when completed by the admitting nurse. The checklist will be reviewed by oncoming nurse/charge nurse to ensure treatment has been initiated when an area is identified. Nursing staff in-serviced regarding this system by the Director of Nursing or Nursing Supervisor and completed by 01-15-2015. Residents with identified pressure areas are reviewed during weekly Inter Disciplinary Team meeting (TREK) to ensure that identified areas have	

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F 314	Continued From page 7 mattress and initiate turning schedule given prolonged immobility due to non weight bearing. " Review of the physician ' s orders dated 12/10/14 included treatment to the left heel with skin prep three times a day. Heel lift boot to be worn at all times when in bed and turn every two hours. The order for the heel lift boot was discontinued on 12/10/14. A new order for a " heel manager " was to be used to float the heels. The device was a wedge type cushion to be placed under the lower legs with the heels floated off the mattress. Record review of a nurse ' s note dated 12/12/14 at 2:28 PM by the Director of Nursing indicated the onset/discovery date of the heel wound was on 12/8/14 " noted on admission. " The assessment included " Suspected deep tissue. Tissue type: purple, red. No drainage. Surrounding tissue: warm. area reddish purple in color. " The measurements of the heel wound were length of 3.2 cm and width 4.1 cm. The wound stage was unstageable. Current treatment included use of skin prep to the heels and float heels. Prevention included " teaching the resident how to reposition self; the benefits of doing this and the risks of not doing this, use of pressure reduction/relieving devices. " Record review of the December 2014 treatment recorded revealed the skin prep to the heels was initiated on 12/10/14. The prevention of floating the heels with use of heel manager under both lower legs was initiated on 12/10/14. An interview was conducted with nurse #1 on 12/18/14 at 11:45 AM. Nurse #1 explained she had completed a skin assessment on the date of admission but did not document the assessment.	F 314	appropriate treatment orders per the wound care protocol. Physician□'s orders for residents with pressure areas will be reviewed weekly by the Director of Nursing or Nursing Supervisor to ensure that identified areas have appropriate treatment orders per facility protocol for wound care. D. The Director of Nursing or Nursing Supervisor will audit admission/readmission skin assessments for initiation of treatment weekly for four weeks, then biweekly for two months and then monthly for an additional three months. This report will be reviewed and evaluated for effectiveness monthly in Senior Leadership Team and Quality Assurance & Performance Improvement meetings with revisions made as indicated.	

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The nurse ' s note of 12/10/14 should have been identified as a " late entry. " Further interview revealed she had observed the heel wound on the day of admission. The left heel was described as " red/purple area. " Treatment that was initiated on the day of admission was to " float heels. " The Director of Nursing was not notified of the wound on the day of admission. Resident #203 entered the facility on the evening of 12/8/14. Communication with the next shift included a verbal report the wound was observed and the treatment to float the heels. Nurse #1 explained the facility ' s treatment protocol included provision of a skin prep to the wound on the heel. This nurse was not sure why the treatment was not initiated on admission.

An interview was conducted on 12/18/2014 at 11:59 AM with the Director of Nursing. Interview revealed she would expect some type of treatment to be provided on admission using the facility wound protocol. She further explained she did not know why a treatment had not been provided. The nurses had standing orders for wound care and the skin prep should have been initiated on admission. During the interview the Director of Nursing explained the resident should have her heels floated off the mattress.

Observations on 12/17/2014 at 10:24 AM revealed Resident #203 was positioned on back, with the head of the bed up about 45 degrees. A wedge (positioning device) was under both lower legs. Both heels were resting on the mattress.

On 12/17/2014 at 1:11 PM Resident # 203 was observed in bed, lying on her back, with the wedge under both lower legs. Both heels were not floated off the bed, and were resting on the

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F 314	Continued From page 9 mattress. Observations on 12/17/2014 at 47PM of wound care provided by the medication tech included cleaning the wound with normal saline and prepping the heel with a skin prep. The wedge was under the both lower legs. The left heel had black eschar covering the wound bed. On 12/17/2014 at 2:14 PM an interview was conducted with aide # 1 and revealed she provided care for Resident #203. She explained part of the care she provided included turning the resident from side to side and keeping her legs propped so the heels stay off the bed. Observations on 12/18/14 at 8:40 AM and 11:20 AM revealed Resident #203 ' s heels were resting on the mattress. The wedge was under the lower legs, but the heels were not floated. Interview with the nurse practioner #1 on 12/18/14 at 10:45 AM revealed the heel manager (positioning device) would do as well as the heel lift boot he had ordered. As far as he knew, the wound was observed on 12/10/14. He was asked to see the wound on that day.	F 314		
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		1/15/15

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F 323	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to ensure residents environments were free of accident hazards whose ½ side rails were not secured to the bed for 3 of 25 residents reviewed for accidents. (Resident #62, #94 and #130) Findings included: 1. Resident #62 was admitted to the facility on 7/9/13 with the diagnosis of anemia, hypertension, diabetes mellitus and arthritis. The annual Minimum Data Set (MDS) assessment dated 11/12/14 indicated that Resident #62 was cognitively intact and required extensive assistance with activity of daily living (ADL ' s) including transfers and bed mobility. During an observation on 12/16/14 at 10:20 AM revealed Resident #62 lying on her back in bed with both ½ side rails up, the left side rail (residents left) was leaning inward toward the resident and very loose. During a second observation on 12/18/14 at 8:40 AM revealed Resident #62 with both 1/2 side rails up and the left side rail was still very loose and leaning inward toward the resident and the right ½ side rail was loose and easily pushed inward towards the bed. An interview with nurse aide (NA) #5 on 12/18/14 at 8:45 AM indicated that when there is a problem with the side rails a work order is completed for maintenance to fix the side rail. The work orders are kept at the nurse ' s station and left in a basket for maintenance to pick up. During an interview with maintenance staff #1 on 12/18/14 at 9:00 AM revealed that weekly checks are completed on side rails to ensure that the proper side rail is in place and that it is secured	F 323	A. Side rails on residents #62, #94, and #130 were tightened by maintenance department on 12-18-2014. These residents were reassessed and it was determined side rails were no longer necessary; therefore, maintenance removed side rails on 01-08-2015. B. All residents with side rails have the potential to be affected; therefore, maintenance conducted an audit of all beds with side rails to ensure safety requirements were met. C. All staff in serviced on identification of and the process for reporting loose or ill-fitting side rails to maintenance via a work order. Maintenance director will review work orders to ensure side rails are repaired to maintain resident safety. Maintenance will add side rail checks to their quarterly preventative maintenance check list. D. Maintenance director/assistant will conduct weekly audit of side rails on all units for four weeks, then biweekly for two months, then monthly for three months. Audit results will be reviewed by administrator and concerns addressed immediately. Findings will be reviewed and evaluated monthly in Senior Leadership Team / Quality Assurance & Performance Improvement meeting with revisions made as indicated.	

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and fits properly. The list is provided by the MDS staff each week. If a problem arises with the side rails then the staff will do a work order to communicate to maintenance staff that repairs are needed.
An interview with MDS nurse #1 on 12/18/14 at 9:30 AM indicated that the list for side rail checks is generated by the MDS quarterly assessments that are due for the week and the list is given to maintenance to check side rails to make sure they are appropriate and a safety check is completed. Each resident ' s side rail is checked on a quarterly basis.
On 12/18/14 at 11:44 AM an interview with the staff development coordinator (SDC) revealed that the safety committee meets monthly and safety checks are completed quarterly. Review of the safety checks for the identified departments revealed that the check list does not include side rails.
During a second interview with maintenance staff #1 on 12/18/14 at 2:30 PM indicated that work orders for repairs are kept at each nurse ' s station and left in a basket for maintenance to pick up. The work orders are picked up each morning and periodically throughout the day by maintenance staff. The work order is signed that the task is completed.
An interview with the director of nurses (DON) on 12/18/14 at 2:40 PM revealed that her expectations were that the staff were to report and do a work order for any loose and unsecured side rails.
2. Resident #94 was admitted to the facility on 3/27/10 with the diagnosis of Alzheimer disease, parkinson ' s disease and malnutrition.
The quarterly MDS assessment dated 12/29/14 indicated that Resident #94 was severely cognitively impaired and required extensive

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TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12 assistance with ADL ' s including transfers and bed mobility. During an observation on 12/18/14 at 8:45 AM Resident #94 was observed sitting in geri chair being assisted with breakfast. The right and left ½ side were not secured to the bed. The right side rail was loose and could be tilted to the left and to the right at an angle and the left side rail could be tilted inward almost flat to the bed and was not secured to the bed. An interview with nurse aide (NA) #5 on 12/18/14 at 8:45 AM indicated that when there is a problem with the side rails a work order is completed for maintenance to fix the side rail. The work orders are kept at the nurse ' s station and left in a basket for maintenance to pick up. During an interview with maintenance staff #1 on 12/18/14 at 9:00 AM revealed that weekly checks are completed on side rails to ensure that the proper side rail is in place and that it is secured and fits properly. The list is provided by the MDS staff each week. If a problem arises with the side rails then the staff will do a work order to communicate to maintenance staff that repairs are needed. An interview with MDS nurse #1 on 12/18/14 at 9:30 AM indicated that the list for side rail checks is generated by the MDS quarterly assessments that are due for the week and the list is given to maintenance to check side rails to make sure they are appropriate and a safety check is completed. Each resident ' s side rail is checked on a quarterly basis. On 12/18/14 at 11:44 AM an interview with the staff development coordinator (SDC) revealed that the safety committee meets monthly and safety checks are completed quarterly. Review of the safety checks for the identified departments revealed that the check list does not include side	F 323		

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F 323	Continued From page 13 rails. During a second interview with maintenance staff #1 on 12/18/14 at 2:30 PM indicated that work orders for repairs are kept at each nurse ' s station and left in a basket for maintenance to pick up. The work orders are picked up each morning and periodically throughout the day by maintenance staff. The work order is signed that the task is completed. An interview with the director of nurses (DON) on 12/18/14 at 2:40 PM revealed that her expectations were that the staff were to report and do a work order for any loose and unsecured side rails. 3. Resident #130 was admitted to the facility on 9/14/13 with the diagnosis of anemia, congestive heart failure, hypotension and alzheimer disease. The quarterly MDS assessment dated 10/8/14 indicated that Resident #130 was severely cognitively impaired and required extensive assistance with ADL ' s including transfers and bed mobility. During an observation on 12/16/14 at 2:57 PM revealed Resident #130 lying on her back in bed with the left side rail down and left side of bed pushed against the wall and the right 1/2 side rail loose with a 2 inch gap between the mattress and the side rail. During a second observation on 12/18/14 at 8:35 AM revealed Resident #130 up in a geri chair and the right side rail remained loose with a 2 inch gap between the mattress and the rail. An interview with nurse aide (NA) #5 on 12/18/14 at 8:45 AM indicated that when there is a problem with the side rails a work order is completed for maintenance to fix the side rail. The work orders are kept at the nurse ' s station and left in a basket for maintenance to pick up. During a third observation with maintenance staff	F 323		

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F 323	Continued From page 14 on 12/18/14 at 9:00 AM revealed that Resident #130 ' s right 1/2 side rail was loose with a 2 inch gap between the mattress and the side rail. Maintenance staff #1 tightened the side rail during the observation and indicated there was not a work order in place for the repair. During an interview with maintenance staff #1 on 12/18/14 at 9:00 AM revealed that weekly checks are completed on side rails to ensure that the proper side rail is in place and that it is secured and fits properly. The list is provided by the MDS staff each week. If a problem arises with the side rails then the staff will do a work order to communicate to maintenance staff that repairs are needed. An interview with MDS nurse #1 on 12/18/14 at 9:30 AM indicated that the list for side rail checks is generated by the MDS quarterly assessments that are due for the week and the list is given to maintenance to check side rails to make sure they are appropriate and a safety check is completed. Each resident ' s side rail is checked on a quarterly basis. On 12/18/14 at 11:44 AM an interview with the staff development coordinator (SDC) revealed that the safety committee meets monthly and safety checks are completed quarterly. Review of the safety checks for the identified departments revealed that the check list does not include side rails. During a second interview with maintenance staff #1 on 12/18/14 at 2:30 PM indicated that work orders for repairs are kept at each nurse ' s station and left in a basket for maintenance to pick up. The work orders are picked up each morning and periodically throughout the day by maintenance staff. The work order is signed that the task is completed. An interview with the director of nurses (DON) on	F 323		

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F 323	Continued From page 15 12/18/14 at 2:40 PM revealed that her expectations were that the staff were to report and do a work order for any loose and unsecured side rails.	F 323		
F 332 SS=D	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, staff interviews and record reviews the facility failed to ensure the medication error rate was less than 5% as evidenced by 2 medication errors being made during 26 opportunities for error, which resulted in an error rate of 7.69 percent. (Residents # 198 and 138) Findings included: 1. Resident # 198 was admitted to the facility on 10/31/14 with diagnosis of depressive disorder. Record review revealed an order dated 12/2/14 to administer Celexa 40 milligrams (mg) (an antidepressant) one tablet every day at breakfast. An order dated 12/11/14 was received to administer Celexa 20 mg 1 every day at breakfast and discontinue the 40 mg dose of Celexa. Observations on 12/18/14 at 7:54 AM of medication aide #1 (MA) revealed Celexa 40 mg was obtained from the card of pills. MA #1 gave Resident #198 her medications. Resident #198 asked which pill was her Celexa and requested	F 332	A. Resident #198-Medication card with incorrect dosage was pulled from the medication cart and returned to the pharmacy. Medication card with correct dosage was placed in medication cart. Medicating nurse was in-serviced regarding facility protocol for discontinued medication on 12-18-2014 by the Director of Nursing. Resident #138- Medication aide was in-serviced 12-18-2014 by the Director of Nursing regarding manufacturer'□s recommendation that medication be shaken prior to administration. Medication administration record updated to include shake prior to use. B. All residents have the potential to be affected; therefore, the nursing staff was in-serviced 01-12-2015 thru 01-15-2015 by the Director of Nursing and Nursing Supervisors regarding the medication administration policy and procedure to ensure that medications are given per	1/15/15

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F 332	Continued From page 16 the MA#1 to check the pills. Resident #198 stated she was aware the dosage had been decreased. Resident #198 held the 40mg tab until MA #1 returned. Interview on 12/18/14 at 7:58 am with MA #1 revealed the wrong dose of Celexa had been given to Resident #198. The card of pills was checked with the order in the electronic record by the MA. The order for Celexa 20mg was noted in the chart. The pill card had Celexa 40 mg on the label.. The MA obtained another Celexa tablet and split it in half. The correct dose was then given to Resident #198. The Celexa 40mg was obtained from Resident #198 and discarded by MA #1. Interview on 12/18/2014 at 10:20 AM with nurse #2 revealed the process for a change in medication dose included the medication card would be pulled from the cart. The pharmacy would be faxed the new order when a medication dose was changed. When the new medication card was received, the nurse would place it in the medication cart. Interview on 12/18/2014 at 10:26 AM with nurse #4 revealed she was the floor nurse supervising MA#1. The wrong dose of Celexa was brought to her attention this morning. Nurse # explained a new system of faxing the pharmacy order changes for medications had been in place for about a month. Nurse #4 did not know if the medication was ordered or if the correct dose was available in the medication cart. Interview with nurse #2 and the Director of Nursing on 12/18/14 at 10:45 AM revealed the Celexa 20mg was ordered and received from the	F 332	manufacturers recommendations and that discontinued medications are pulled from the cart when discontinued. Medication carts and medication administration records have been audited by Nursing Supervisors to ensure that medication□s match the physician□s orders, completed 01-15-2015. C. The nurse processing the physician□s orders will add special instructions,for example: shake before use, to the medication administration record. Upon receipt of medications from the pharmacy, the receiving nurse will compare the label against the Medication Administration Record and will ensure that special instructions are reflected on the Medication Administration Record. The pharmacy consultant will audit resident medication regimen and monitor/observe medication pass quarterly and as needed and report to the Director of Nursing. Medicating staff were in-serviced regarding proper medication administration per policy and procedure and how to process discontinued medications. In-services were conducted by the Director of Nursing and Nursing Supervisors and completed by 01-15-2015. D. The Staff Development Coordinator will conduct a weekly audit of medication orders specifically targeting special instructions and medications that have been discontinued and monitor medication cart to ensure that	

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F 332	Continued From page 17 pharmacy. The medication card for the Celexa 20mg was in the bottom of the cart. The discontinued medication had not been removed from the cart, and replaced with the 20 mg dose of Celexa. 2. Resident # 138 was admitted to the facility on 8/21/14 with diagnoses including seasonal allergic rhinitis. Record review revealed an order dated 8/23/14 for Flonase 50 micrograms (mcg)/ACT suspension via nasal was ordered with 2 sprays to be administered daily in the morning. Observations on 12/18/14 at 8:13 AM of medication aide #2 (MA) revealed Resident #138 received Flonase 2 sprays in the nose. The medication was not shaken prior to administration. The manufacturer ' s recommendations require the medication to be shaken prior to administration. The medication was not lableed with instructions to shake prior to administration. Interview on 12/18/2014 at 10:40 AM with MA#2 revealed she did not have to shake the Flonase prior to administration. On 12/18/2014 at 10:46 AM an interview was conducted with a facility pharmacist. The pharmacist explained prior to administration, the MA would have to shake it (Flonase). Further explanation provided included the medication was a suspension which required shaking it to mix it. There was a potential for an incorrect dose to be received if the MA did not shake the Flonase. The pharmacist added, the container should have a sticker on it to remind staff to shake prior to	F 332	discontinued medications are pulled from cart. Audit will be done weekly for four weeks, then biweekly for two months, then monthly for three months. This will be reviewed and evaluated for effectiveness monthly in the Senior Leadership Team / Quality Assurance & Performance Improvement meeting with revisions made as indicated.	

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F 332	Continued From page 18 administration. Interview with MA#2 on 12/18/14 at 10:30 AM revealed she had checked the package insert and read the Flonase should be shook prior to administration.	F 332		