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	345282	A. BUILDING _____ B. WING _____	12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES NURSING CENTER	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to provide resolution to Resident Council concerns related to call bells and noise in the early morning hours. Findings included: An interview was conducted on 04/07/14 at 4:28 PM with the Resident Council President. (Resident # 77). According to her MDS dated 01/14/14 she was assessed as cognitively intact. She reported concerns had been discussed in many resident council meetings regarding issues relating to call light response time and noise in the early morning hours. She further reported the facility had not discussed with Resident Council the resolution for call light response time and noise in the early morning hours. Review of the Resident Council minutes for September 24, 2013 through October 28, 2014 revealed there was no documentation of follow up with grievances that had been discussed in the council meetings during this time. A review of the facility form entitled " Facility Request Form Statistical Report " for January 01,	F 244	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The facility will assure the residents concerns will continue to be documented in the minutes and the facilities resolutions will be discussed in the next Resident Council Meeting. Resident #77 will be notified of the facilities plan of correction and resolutions will be discussed at the next Resident Council Meeting on 12/29/14. Administrator educated the Activity Director regarding regulations conducting Resident Council meetings and providing resolutions to Resident Council grievances. Education provided on the new form which was developed to	1/1/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/24/2014

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F 244	Continued From page 1 2014 through November 28, 2014 revealed no documentation on resolution of concerns had been completed related to the concerns expressed by resident council during those months. An interview was conducted on 12/04/14 at 9:50 AM with the Activity Director. He stated minutes had been read at the following resident council meeting from the meeting before under old business and each resident in attendance received a copy. The Activity Director stated he had written up the minutes of the meetings and had sent them by email to the Interdisciplinary Team. The particular team member/department head would address the concerns. The Activity Director stated resident council reported call lights and noise in the early morning hours were continued problems that he had written up monthly and had emailed to each Department Manager. He further stated Department Managers would come to the Resident Council meeting and talk with the individual about their concern but the Activity Director stated there was no resolution discussed in Resident Council meetings. An interview was conducted on 12/4/14 at 12:45 pm with the Administrator who shared call bells being answered in a timely manner had been a problem and the facility was looking into a new call system. An interview was conducted on 12/05/14 at 10:46 AM with the DON stated she had never documented anything about Resident Council concerns. She further stated she had met with Resident Council and explained what her expectations about what staff should be doing but	F 244	maintain proper documentation. The Activity Director provided education to the activity staff regarding regulations for conducting Resident Council meetings and providing resolutions to Resident Council grievances and the use of the new form. All new activity staff will be educated on this process upon hire. 12/29/14 Resolutions will be reviewed by the Administrator/designee monthly to assure compliance. 12/29/14 Findings from any identified concerns will be reported during the monthly QAPI meetings for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 244	Continued From page 2 had not followed up with Resident Council on grievances residents had expressed in the council meetings. An interview was conducted on 12/05/14 at 12:20 pm with the Social Worker who stated she had attended the last two Resident Council meetings for a short period to make sure residents new who she was as she was still fairly new. She stated she would read over the email of the Resident Council meeting and delete it. An interview was conducted on 12/05/14 at 12:40 pm with the Maintenance Director who revealed concerns he was notified about would not be discussed at the next resident council meeting, just new ones as the came up. An interview was conducted on 12/05/14 at 6:52 PM with the Administrator. Resident council concerns were discussed with the Administrator but she did not offer any explanation as to why resolutions to concerns were not discussed with the Resident Council.	F 244		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;	F 272		1/1/15

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F 272	Continued From page 3 Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to comprehensively assess 3 of 7 sampled residents to be identified how their condition affected each resident's function and quality of life (Residents #20, #2, and #35). The findings included: 1) Resident #20 was admitted to the facility on	F 272	The facility will assure the Comprehensive Assessments are conducted periodically with a comprehensive, accurate, standardized, reproducible assessment of each resident. Resident #20 Care Area Assessment was reviewed and analyzed by the MDS	

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F 272	Continued From page 4 09/29/14 with the diagnoses of diabetes, high blood pressure, kidney failure, and blindness. The Admission Minimum Data Set (MDS) dated 10/06/14 coded Resident #20 as cognitively intact, capable of making his needs known, requiring total dependence on staff with toileting and bathing, and requiring extensive assistance with bed mobility, transfers, dressing, and personal hygiene. Resident #20 was coded as unsteady with balance and needing assistance of staff and occasionally incontinent of bowel, as having a urinary catheter, and receiving pain medication and anticoagulants in the previous 7 days. Review of the Care Area Assessment (CAA) dated 10/13/14 revealed under the areas of visual function, activities of daily living (ADLs), urinary incontinence/indwelling catheter, falls, nutritional status, and pain medications did not analyze the MDS information to determine Resident #20's strengths, weaknesses, and how his condition affected those areas as follows: a) Visual Function CAA: under risk factors was that the local hospital stated the resident was legally blind and he was at risk for other falls related to new environment; under causes/contributing factors was recent fall with left distal femur fracture per medical record. There was no analysis of how his visual function (blindness) affected his day to day routine. b) ADL CAA: under risk factors was requires assistance with ADL care; under causes/contributing factors was recent fall. There was no information or analysis of findings related to Resident #20's ADLs or how the ADLs affected Resident #20's day to day routine. c) Urinary Incontinence and Indwelling Catheter	F 272	Coordinators on Visual Function, ADL's, Urinary Incontinence/Indwelling Catheter, Falls, Nutritional Status, and Pain to determine affects on quality of life. Resident #2 Care Area Assessment was reviewed and analyzed by the MDS Coordinators on ADL's, Urinary Incontinence/Indwelling Catheter, Falls Nutritional Status, and Psychotropic Drug Use to determine affects on quality of life. Resident #35 Care Area Assessment was reviewed and analyzed by the MDS Coordinators on Cognition, Urinary Incontinence, ADL's, Nutritional Status, to determine affects on quality of life. MDS Coordinator were provided education by a member of corporate quality division regarding Federal and State regulation on completing an analysis to incorporate how the residents care areas affects their day to day routine. MDS Coordinators will review Care Area Assessment for all newly completed comprehensive assessment for December and forward to assure compliance. Director of Nursing will conduct weekly 10% audits of the Care Area Assessments to assure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator or Director of Nursing on a weekly basis and with QAPI	

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F 272	Continued From page 5 CAA: under risk factors was the risk for urinary tract infections related to Foley catheter use; under causes/contributing factors to consider was recent fall. There was no analysis to determine how Resident #20's incontinence affected his day to day life or if his incontinence could improve or the use of an indwelling catheter could be discontinued. d) Falls CAA: under risk factors indicated a recent hospital stay moved to another facility; under causes/contributing factors was history of fall with injury. There was no analysis of how the fall accidents affected his day to day routine and/or fall prevention. e) Nutritional Status CAA: under risk factors there was no information listed; under causes/contributing factors there was no information listed; under the analysis of findings indicated the resident was a diabetic, at risk for weight loss, and other diagnoses. There was no analysis of the information to determine the reason Resident #20's intake varied or determination for the risk of weight loss. f) Pain CAA: under risk factors indicated the resident had pain recently; under causes/contributing factors revealed a surgical intervention was required. There was no analysis to determine how Resident #20's pain could be controlled and the affects the pain had on his quality of life. Interview with the MDS Coordinator #2 on 12/05/14 at 4:38 PM revealed she completed most of the MDSs and CAAs in the building. She indicated when completing a CAA, the MDS Coordinator reviewed all the information gathered, talked with the resident and staff, and read the documentation in the medical record. She stated she had been trained that the CAA	F 272	monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 272	Continued From page 6	F 272		

information had to match what the care plan interventions included. She then stated the CAAs were written the same way with no analysis of the information just the repeat of the problem, diagnoses, MDS information, and that nursing would proceed with the care plan.

2) Resident #2 was admitted to the facility on 04/24/14 with the diagnoses of kidney failure, bacterial infection, congestive heart failure, diabetes, and coronary artery disease.

The Admission Minimum Data Set (MDS) dated 05/01/14 coded Resident #2 as cognitively intact, capable of making her needs known, requiring total dependence on staff with personal hygiene, transfers, and bathing, and requiring extensive assistance with bed mobility, dressing, and toileting. Resident #2 was coded as unsteady with balance and needing assistance of staff, as having an indwelling Foley catheter, and receiving diuretics, antipsychotics, antianxiety, and antidepressants in the previous 7 days.

Review of the Care Area Assessment (CAA) dated 05/09/14 revealed under the areas of ADLs, urinary incontinence/indwelling catheter, falls, nutritional status, and psychotropic medications did not analyze the MDS information to determine Resident #2's strengths, weaknesses, and how her condition affected those areas as follows:
a) ADL CAA: under risk factors there was no information provided; under causes/contributing factors there was no information provided. The information under analysis revealed the resident required assistance with ADLs but there was no information or analysis of findings related to

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Resident #2's ADLs or how the ADLs affected Resident #2's day to day routine.
b) Urinary Incontinence and Indwelling Catheter CAA: under risk factors there was no information provided; under causes/contributing factors there was no information provided. There was no analysis to determine how Resident #2's incontinence affected her day to day life or if her incontinence could improve or the use of an indwelling catheter could be discontinued.
c) Falls CAA: under risk factors there was no information provided; under causes/contributing factors there was no information provided. There was no analysis of how the risk for fall accidents affected her day to day routine and/or fall prevention.
d) Nutritional Status CAA: under risk factors there was no information provided; under causes/contributing factors there was no information provided. There was no analysis of the information to determine the reason Resident #2's intake varied or determination for the risk of weight loss.
e) Psychotropic Drug Use CAA: under risk factors there was no information provided; under causes/contributing factors there was no information provided. There was no analysis to identify the reason for the psychotropic medications and the affects the medication had on Resident #2's quality of life.

Interview with the MDS Coordinator #2 on 12/05/14 at 4:38 PM revealed she completed most of the MDSs and CAAs in the building. She indicated when completing a CAA, the MDS Coordinator reviewed all the information gathered, talked with the resident and staff, and read the documentation in the medical record. She stated she had been trained that the CAA

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information had to match what the care plan interventions included. She then stated the CAAs were written the same way with no analysis of the information just the repeat of the problem, diagnoses, MDS information, and that nursing would proceed with the care plan.

3) Resident #35 was admitted to the facility on 11/16/12 with the diagnoses of Alzheimer's disease, coronary artery disease, high blood pressure, osteoarthritis, atrial fibrillation, and anxiety.

The Annual Minimum Data Set (MDS) dated 07/09/14 coded Resident #35 having severe cognitive impairment, incapable of making her needs known, requiring total dependence on staff with bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. Resident #35 was coded as unsteady with balance and needing assistance of staff, always incontinent of bowel and bladder, and receiving anticoagulants and antibiotics in the previous 7 days.

Review of the Care Area Assessment (CAA) dated 07/17/14 revealed under the areas of cognition, urinary incontinence, ADLs, and nutritional status did not analyze the MDS information to determine Resident #35's strengths, weaknesses, and how her condition affected those areas as follows:
a) Cognition CAA: under risk factors there was no information provided; under causes/contributing factors indicated the resident had behavior problems. There was no analysis of how Resident #35's cognitive impairment affected her day to day routine of decision making or her quality of

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F 272	Continued From page 9 life. b) Urinary Incontinence CAA: under risk factors there was no information provided; under causes/contributing factors there was no information provided. There was no analysis to determine how her incontinence affected her day to day life or if her incontinence could improve. c) ADL CAA: there was no information or analysis of findings related to Resident #35's ADLs or how the ADLs affected Resident #35's day to day routine. d) Nutritional Status CAA: under risk factors there was no information provided; under causes/contributing factors there was no information provided. There was no analysis of the information to determine the reason Resident #35's intake varied, determination for the risk of weight loss, or the effects of Resident #35's quality of life. Interview with the MDS Coordinator #2 on 12/05/14 at 4:38 PM revealed she completed most of the MDSs and CAAs in the building. She indicated when completing a CAA, the MDS Coordinator reviewed all the information gathered, talked with the resident and staff, and read the documentation in the medical record. She stated she had been trained that the CAA information had to match what the care plan interventions included. She then stated the CAAs were written the same way with no analysis of the information just the repeat of the problem, diagnoses, MDS information, and that nursing would proceed with the care plan.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		1/1/15

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F 279	Continued From page 10 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to develop care plans to include measurable goals and individualized interventions for 4 of 17 sampled residents (Residents #20, #2, #35, and #167). The findings included: 1) Resident #20 was admitted to the facility on 09/29/14 with the diagnoses of diabetes, high blood pressure, kidney failure, and blindness. Resident #20's Admission Minimum Data Set (MDS) dated 10/06/14 revealed he was cognitively intact, requiring total dependence on staff with toileting and bathing, and extensive	F 279	The facility will assure the development of the Comprehensive Care Plan includes measurable objectives and timetables to meet the resident's medical, nursing and mental and psychosocial needs that are determined in the comprehensive assessment. Resident #20 Care Plans regarding ADLs were reviewed and analyzed by the MDS Coordinator and revised to reflect individualized interventions to meet the residents needs and goals that impact their quality of life.	

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F 279	Continued From page 11 assistance with bed mobility, transfers, dressing, and personal hygiene. The Care Area Assessment (CAA) dated 10/13/14 indicated nursing would proceed with care plans related to resident ' s need for assistance with activities of daily living (ADL) care. On 10/15/14 a comprehensive care plan was developed for the problem recent fall, occasional incontinence of bowel, Foley cath care, risk for pressure areas, legally blind with a goal for the resident to have ADL needs met daily, bowel incontinence will decrease to less than one episode every two days, skin will remain clean dry and intact, staff will explain to resident where items are located on his meal plate. Approaches included: · Introduce self when entering room · Set-up bath explaining where items are located using clock face as reference · Nursing uses mechanical lift for transfers as ordered · Foley catheter care as ordered · Toilet frequently · Explain to resident where items are located on meal tray · Assess skin with ADL care No individualized care plan had been developed to address the resident's ADL care needs. Interview with the MDS Coordinator #2 on 12/05/14 at 4:38 PM revealed she was responsible for developing care plans based on the information she obtained from record review, other documentation, and interviews with direct care staff. She stated the care plans were	F 279	Resident #2 Care Plans regarding an indwelling catheter was reviewed and analyzed by the MDS Coordinator and revised to reflect individualized interventions to meet the residents needs and goals that impact their quality of life. Resident #35 Care Plans regarding ADLs were reviewed and analyzed by the MDS Coordinator and revised to reflect individualized interventions to meet the residents needs and goals that impact their quality of life. #167 Care Plans regarding weight loss was reviewed and analyzed by the MDS Coordinator and revised to reflect individualized interventions to meet the residents needs and goals that impact their quality of life. MDS Coordinators were provided education by a member of corporate quality division regarding Federal and State regulation relating to developing individualized care plans that addresses residents care needs. MDS Coordinators will review Care Plans for all newly completed Comprehensive Assessments for December and forward to assure compliance. Director of Nursing will conduct weekly 10% audits of the Care Plans to assure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator or Director of Nursing on a	

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F 279	Continued From page 12 developed based on areas of concern, grouped under one problem, one goal, and that one approach was listed for the various areas. 2) Resident #2 was admitted to the facility on 04/24/14 with the diagnoses of kidney failure, bacterial infection, congestive heart failure, diabetes, and coronary artery disease. Resident #2's Admission Minimum Data Set (MDS) dated 05/01/14 revealed she was cognitively intact, requiring total dependence on staff with personal hygiene, transfers, and bathing, and requiring extensive assistance with bed mobility, dressing, and toileting. The CAA dated 05/09/14 indicated to proceed to care plan. Catheter care per facility protocol, increases risk for urinary tract infection (UTI). On 11/19/14 a comprehensive care plan was developed for the problem history of pressure ulcers; left heal and buttocks; healed, has a Foley catheter with a goal that the resident will be free of further skin breakdown and free of signs/symptoms of urinary tract infection related to Foley catheter. Approaches included: · Provide Foley catheter care every shift and as needed, change Foley monthly · Turn & reposition frequently · Prop feet off bed with pillows · Complete skin audits per facility policy · Keep physician & family informed related to any changes in condition No individualized care plan had been developed to address the resident's existing indwelling Foley	F 279	weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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catheter care needs.

Interview with the MDS Coordinator #2 on 12/05/14 at 4:38 PM revealed she was responsible for developing care plans based on the information she obtained from record review, other documentation, and interviews with direct care staff. She stated the care plans were developed based on areas of concern, grouped under one problem, one goal, and that one approach was listed for the various areas.

3) Resident #35 was admitted to the facility on 11/16/12 with the diagnoses of Alzheimer's disease, coronary artery disease, high blood pressure, osteoarthritis, atrial fibrillation, and anxiety. Resident #35's Annual Minimum Data Set (MDS) dated 07/09/14 revealed she had severe cognitive impairment, requiring total dependence on staff with bed mobility, transfers, dressing, toileting, personal hygiene, and bathing.

The CAA dated 07/17/14 had no information or analysis related to
Resident #35's ADL care that was required to ensure her quality of life.

On 10/15/14 a comprehensive care plan was developed for the problem of requires assistance with care due to diagnosis of dementia and a history of cerebral vascular accident (CVA) with right sided paralysis and a goal that the resident's needs would be met all of the time, and would fed herself daily.
Approaches included:
- Assist with all care
- Encourage to use side rails

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F 279	Continued From page 14 · Encourage her to use left hand and wash face and upper body · Keep call bell within reach at all times · Observe for unsafe acts · Assist and/or perform oral care · Use shower stretcher for comfort and safety · Wash feet with soap and water daily with bath/shower No individualized care plan had been developed to address the resident's ADL care needs. Interview with the MDS Coordinator #2 on 12/05/14 at 4:38 PM revealed she was responsible for developing care plans based on the information she obtained from record review, other documentation, and interviews with direct care staff. She stated the care plans were developed based on areas of concern, grouped under one problem, one goal, and that one approach was listed for the various areas. 4. Resident #167 was admitted to the facility 07/02/14 with diagnoses which included cerebrovascular accident (CVA), dysphagia, diabetes, hypertension, right neck mass and aspiration pneumonia. Since admission, Resident #167 was totally dependent on tube feeding for all caloric intake. The initial care plan for Resident #167 dated 07/21/14 included the problem area, "Resident receives all nutrition via tube feeding.	F 279		

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Resident is an insulin dependent diabetic. Resident has a diagnosis of CVA, inability to swallow and probable aspiration pneumonia." The goal for this problem area was, "Resident will tolerate tube feeding without nausea, vomiting, diarrhea and aspiration." Approaches to this problem area included, "Registered Dietitian (RD) to provide monthly nutritional assessment, assessing caloric, protein and fluid needs. RD to evaluate appropriateness and adequacy of tube feeding formula relative to resident's disease/condition."

Weights recorded in the medical record of Resident #167 included the following:
07/02/14 245 pounds
08/04/14 235 pounds
09/01/14 229 pounds
10/01/14 226 pounds
11/03/14 217 pounds

Physician progress notes, Quality Care Management Progress Notes and dietary progress notes in the medical record of Resident #167 were reviewed and addressed changes to the tube feeding formulary to address wounds and hyperglycemia issues. However these progress notes did not address the weight loss of Resident #167 to ascertain if it was desirable, planned or what the weight goals were for the resident.

An updated care plan was completed 10/13/14 with the problem area, "Resident receives all nutrition via tube feeding. Resident is an insulin dependent diabetic. Resident has a diagnosis of CVA, inability to swallow and probable aspiration pneumonia. Resident has a history of acute urinary tract infection. Albumin slightly low. Has

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F 279	Continued From page 16 a sacrum wound." The goal for this problem area was, "Resident will tolerate tube feeding without nausea, vomiting, diarrhea and aspiration. Albumin will improved to 3.5 or better by next review. Current weight 222.5". Approaches to this problem area included, "RD to provide monthly nutritional assessment, assessing caloric, protein and fluid needs. RD to evaluate appropriateness and adequacy of tube feeding formula relative to resident's disease/condition." The care plan did not address the actual weight loss of Resident #167 to ascertain it it was desirable, planned or what the goal was for the resident. On 12/05/14 at 10:20 AM the Minimum Data Set (MDS) nurse that coordinated the 07/21/14 and 10/13/14 care plans for Resident #167 stated she could not speak to the weight loss of Resident #167 because she relied on the RD to manage residents tube feedings and nutrition. The MDS nurse stated initially she would expect a resident fed by tube feeding to lose weight but, after that, the weight should be maintained. The MDS nurse stated she wasn't sure what the goal for weight maintenance was for Resident #167 and that the team would probably need to meet to determine the resident's goal for weight management.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		1/1/15

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F 309	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to initiate physician orders for a bowel protocol for 3 of 5 residents who went an extended time without a bowel movement. (Resident # 47, Resident #143 and Resident # 15). The findings included: 1. Resident #47 was admitted to the facility on 08/18/14 and readmitted to the facility on 08/25/14 with diagnosis that included diabetes mellitus, peripheral neuropathy and constipation. The care plan for Resident #47 dated 09/12/14 did not address Resident #47's issues with bowel movements. Review of physician orders in the medical record of Resident #47 noted medications which included Senna Plus (a laxative), 2 tablets at bedtime every day as needed (PRN) for constipation. The Bowel Protocol (as part of standing orders) in the medical record of Resident #47 included: May administer Milk of Magnesia 30 ml followed by 8 ounces of fluids if no bowel movement in three days. If no bowel movement by the following day give Dulcolax 10 milligram suppository and repeat X 1 if no bowel movement in one hour. If still no bowel movement after 1 hour after second suppository, give Fleet's enema. May repeat Fleet's enema every 12	F 309	The facility will assure each resident will be provided the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Resident #47 daily bowel log has been reviewed for compliance with facilities bowel protocol, no issues identified. Resident will continue to be monitored daily. Resident #143 daily bowel log has been reviewed for compliance with facilities bowel protocol, no issues identified. Resident will continue to be monitored daily. Resident #15 daily bowel log has been reviewed for compliance with facilities bowel protocol, no issues identified. Resident will continue to be monitored daily. The Director of Nursing reviewed all residents for compliance of the facilities bowel and bladder program. The Director of Nursing provided education to all licensed nurses & medication aide's on facilities bowel and bladder protocol.	

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F 309	Continued From page 18 hours until results or three enemas are given. On 12/04/14 at 3:14 PM the Assistant Director of Nursing (ADON) stated bowels are recorded by nursing assistants in the electronic medical record for all residents. The ADON stated nurses should pull a report from this documentation every shift to determine which of their assigned residents had not had a bowel movement in three days. The ADON stated if a resident did not have a bowel movement in three days the expectation was for the nurse to implement PRN orders (if the individual resident had these ordered) or the standing orders for the Bowel Protocol. The ADON stated these reports were not maintained by the facility once reviewed by the nurse. The bowel records for Resident #47 were reviewed from August 2014-December 2014. The electronic bowel records noted the following time frames without a documented bowel movement: 08/18/14-first shift - 08/25/14 second shift (7 days) 08/25/14- second shift - 09/06/14 second shift (12 days) 09/11/14 second shift - 09/21/14 second shift (10 days) 11/02/14 second shift - 11/08/14 second shift (6 days) 11/27/14- third shift - 12/03/14 first shift (6 days) On 12/05/14 at 11:45 AM Nurse #10 stated she received a list from the charge nurse of residents she was responsible for that did not have a bowel movement in three days. Nurse #10 stated she would implement PRN orders for the individual resident (if ordered) or the Bowel Protocol. Nurse #10 stated if PRN medications or the Bowel	F 309	RN Supervisors will audit daily the "no BM log" to assure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator or Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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Protocol was implemented it would be documented on the individual resident's MAR. Nurse #10 stated nursing staff are dependent on nursing assistants to document resident bowel movements in the electronic medical record. Nurse #10 could offer no explanation for the five time frames Resident #47 went without a bowel movement in August, September, November and December 2014.

On 12/05/14 at 6:03PM the Director of Nursing (DON) stated every morning the nurse on day shift should pull the report which indicated which residents did not have a bowel movement in three days. The DON stated residents that have not had a bowel movement in three days would have PRN medications for bowels (if ordered) implemented or the facility Bowel Protocol. The DON stated once implemented, the results would be reported to the nurse on the oncoming shift so additional measures could be implemented if needed. The DON reviewed the bowel records, nursing notes and MARs for Resident #47 and verified the five extended times without a bowel movement documented in August, September, November and December 2014. The DON stated the no bowel movement reports were not kept but that Resident #47 should have showed up on these reports during these time frames. The DON stated either the supervisors or nursing management staff monitored these reports to ensure there were no issues and could not explain what might have happened. Occupational therapy notes were reviewed at the time of the interview and there was no documentation regarding bowel during the extended time frames Resident #47 went without a bowel movement.

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2. Resident #143 was admitted to the facility 07/16/13 with diagnoses which included spinal cord disease and functional quadriplegia.

The care plan for Resident #143 included a problem area dated 11/19/14 which included, Incontinent of bowels. Requires extensive assist to total assist with activities of daily living. Exhibits confusion. Non ambulatory.

A care plan initiated by hospice services for Resident #143 included a problem area dated 09/19/14 of, "Patient maintains bowel function within limits of disease process/progression. Patient/caregiver adheres to bowel regimen and patient/caregiver verbalizes understanding of optimal bowel management related to disease process. Approaches to address the problem area included:
-assess bowel elimination patterns and gastrointestinal status/contributing factors
-assess for impaction, remove impaction if present
-instruct patient/caregiver on methods to reduce constipation
-instruct patient/caregiver on medication administration to relieve constipation

Review of physician orders in the medical record of Resident #143 noted medications which included Senna Plus (a laxative), 2 tablets at bedtime and Lactulose 30 milliliters (ml) every day as needed (PRN) for constipation.

The Bowel Protocol (as part of standing orders) in the medical record of Resident #143 included: May administer Milk of Magnesia 30 ml followed

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by 8 ounces of fluids if no bowel movement in three days. If no bowel movement by the following day give Dulcolax 10 milligram suppository and repeat X 1 if no bowel movement in one hour. If still no bowel movement after 1 hour after second suppository, give Fleet's enema. May repeat Fleet's enema every 12 hours until results or three enemas are given.

On 12/04/14 at 3:14 PM the Assistant Director of Nursing (ADON) stated bowels are recorded by nursing assistants in the electronic medical record for all residents. The ADON stated nurses should pull a report from this documentation every shift to determine which of their assigned residents had not had a bowel movement in three days. The ADON stated if a resident did not have a bowel movement in three days the expectation was for the nurse to implement PRN orders (if the individual resident had these ordered) or the standing orders for the Bowel Protocol. The ADON stated these reports were not maintained by the facility once reviewed by the nurse.

The bowel records for Resident #143 were reviewed from June 2014-December 2014. The electronic bowel records noted the following time frames without a documented bowel movement:
09/17/14 second shift-09/27/14 second shift (10 days)
11/16/14 first shift-11/21/14 second shift (5 days)

Review of nursing notes, hospice notes and the September and November Medication Administration Records (MAR) for Resident #143 did not indicate any bowel movements or implementation of PRN orders or the Bowel Protocol during these time frames.

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F 309	Continued From page 22 On 12/05/14 at 11:45 AM Nurse #10 (a nurse that worked routinely on the unit Resident #143 resided at the two time frames in question) stated she received a list from the charge nurse of residents she was responsible for that did not have a bowel movement in three days. Nurse #10 stated she would implement PRN orders for the individual resident (if ordered) or the Bowel Protocol. Nurse #10 stated if PRN medications or the Bowel Protocol was implemented it would be documented on the individual resident's MAR. Nurse #10 stated nursing staff are dependent on nursing assistants to document resident bowel movements in the electronic medical record. Nurse #10 stated she was familiar with Resident #143 and that he typically was regular with bowel movements. Nurse #10 could offer no explanation for the two time frames Resident #143 went without a bowel movement in September and November 2014. On 12/05/14 at 4:30PM the Director of Nursing (DON) stated every morning the nurse on day shift should pull the report which indicated which residents did not have a bowel movement in three days. The DON stated residents that have not had a bowel movement in three days would have PRN medications for bowels (if ordered) implemented or the facility Bowel Protocol. The DON stated once implemented, the results would be reported to the nurse on the oncoming shift so additional measures could be implemented if needed. The DON reviewed the bowel records, nursing notes and MARs for Resident #143 and verified the two extended times without a bowel movement documented in September and November 2014. The DON stated the no bowel movement reports were not kept but that Resident #143 should have showed up on these	F 309		

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reports during these time frames. The DON stated she would have expected the PRN Lactulose to be given to Resident #143 when he did not have a documented bowel movement in a three day period. The DON stated either the supervisors or nursing management staff monitored these reports to ensure there were no issues and could not explain what might have happened. The DON stated hospice staff was usually good to also monitor resident bowel movements and inform her of any concerns. Hospice notes were reviewed at the time of the interview and did not include specifics about bowels during the two extended time frames Resident #143 went without a documented bowel movement.

3. Resident #15 was admitted to the facility with diagnoses including diabetes mellitus, constipation, and dementia. The most recent Minimum Data Set (MDS) dated 11/05/14 indicated Resident #15 was severely cognitively impaired and totally dependent on staff for care. The MDS specified Resident #15 was always incontinent of bowel and bladder and impaired on both sides of upper and lower extremities.

A review of Resident #15's care plan dated 11/19/14 revealed the resident was at risk for potential side effects from psychotropic drug use with diagnoses of constipation and disease process. A care plan approach included administer medication per order and observe for effectiveness and possible side effects from psychotropic drugs.

Resident #15's bowel elimination records were reviewed and revealed the following:
On 06/11/14 through 06/16/14, 06/28/14 through 07/03/14, 07/19/14 through 07/24/14 and

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F 309	Continued From page 24 07/28/14 through 08/06/14 no bowel movements were recorded for Resident #15. Review of nurses notes for Resident #15 for the periods of 06/11/14 through 07/28/14 revealed no documentation of assessment for constipation or implementation of the facility's bowel protocol for constipation. Review of the Medication Administration Record (MAR) from 06/11/14 through 08/06/14 revealed no additional orders and/or interventions to address the episodes of constipation. An interview was conducted on 12/05/14 at 6:02 PM with the Director of Nursing (DON) about bowel protocol and bowel movements. The DON reviewed Resident #15's MARS from 06/11/14 through 08/06/14 and confirmed that Resident #15 had gone greater than 3 days without any bowel protocol being initiated. The DON stated the expectation was for the nurse on the hall to print the bowel movement log, documented in the computer program by the nurse aides, and initiate a bowel protocol for any resident noted not have a bowel movement within 3 days.	F 309		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		1/1/15

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F 431	Continued From page 25 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure one Tuberculin, Purified Protein Derivative (PPD) vial was dated when opened in 1 of 2 medication storage rooms and failed to properly label the dosage strength of a medication; Tranxene for 1 of 6 residents observed during medication administration (Resident #112). The findings included: 1) Observations of the medication storage	F 431	The facility will assure drugs and biologicals used in the facility will be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instruction, and the expiration date when applicable. Immediate correction accomplished by discarding improperly labeled medication. 12/3/14	

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	345282	A. BUILDING _____ B. WING _____	12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 26 refrigerator on 12/03/14 at 10:32 AM revealed one opened 1 mL (milliliter) vial of Tuberculin, PPD (used for skin test in the diagnosis of Tuberculosis) with an expiration date of 04/2016 with no date indicating when the vial had been opened. Review of the package information for Tuberculin, PPD revealed the manufacturer guidelines stated in part: "Once entered, the vial should be discarded after 28 days." Registered Nurse (RN) #2 was interviewed when the undated vial of Tuberculin, PPD vial was discovered on 12/03/14 at 10:32 AM and stated the Tuberculin, PPD vials should be dated when opened. During an interview on 12/05/14 at 5:18 PM the Director of Nursing (DON) stated nurses were expected to date Tuberculin, PPD vials when opened and discard the vials 28 days after the opened date. 2) Resident #112 was admitted to the facility on 05/18/11 with diagnoses of dementia and high blood pressure. The most recent quarterly Minimum Data Set (MDS) dated 09/09/14 coded Resident #112 with severe cognitive impairment and requiring total dependence on staff for her activities of daily living (ADLs). On 12/03/14 at 8:30 AM during medication administration Nurse #1 was observed to remove a tablet from a bubble medication packet card to be administered to Resident #112. Further observation revealed the label on the medication packet card was identified with Resident #112's	F 431	The tranxene 3.75 mg is unavailable and on a nationally manufacturer back order and until available the order will be clarified daily and relabeled in accordance with physicians orders. Other active RX labels/orders have been reviewed for clarity and accuracy by pharmacy consultant. Medication storage areas have been inspected by the pharmacy consultant to assure properly labeled medications. RN Supervisor educated licensed nursing staff on properly labeling medication with the correct dosage and/or strength when needed and to date TB PPD when opened. 12/5/14 The pharmacy consultant will inspect medication storage areas twice monthly during medication pass observations. Any issues found will be addressed at that time. Clinical Coordinator will monitor daily medication rooms and Tranxene medication packet card in each medication cart to insure proper labeling of medication. Any issues found will be addressed at that time. A new audit form was developed to insure compliance. Results of the monitoring will be shared with the Administrator or Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 431	Continued From page 27	F 431		

name, the name of the medication; Tranxene (benzodiazepine; used to manage anxiety), medication dosage strength; 7.5 mg (milligrams), how the medication was to be administered; one tablet orally every morning & ½ tablet at bedtime x 2 months then ½ tablet twice daily x 2 months then ½ tablet every morning x 2 months then DC (discontinue), and the medication route was by mouth (PO), on the medication packet card to the top right portion was stamped "1/2 tablet per bubble."

On 12/03/14 at 9:03 AM, during medication reconciliation; a review of Resident #112's medical record revealed physician orders dated 07/30/14 for "Tranxene 7.5 mg one tablet PO every AM (9:00 AM), Tranxene 3.75 mg one tablet PO at HS (bedtime) x 2 weeks then Tranxene 3.75 mg one tab BID (twice daily) x 2 weeks, then Tranxene 3.75 mg one tablet PO every AM x 2 weeks then DC."

Further review of the physician orders dated 09/30/14 revealed "Tranxene 7.5 mg take one tablet orally every morning & ½ tablet at bedtime x 2 months then ½ tablet twice daily x 2 months then ½ tablet every morning x 2 months then DC," a handwritten note beside this order read "Completed 09/30/14."

Continued review of the physician orders dated 10/01/14 revealed "Tranxene 3.75 mg PO BID x 2 months; starting 10/01/14 through 12/01/14, then Tranxene 3.75 mg every AM x 2 months then DC" with the dates starting 12/02/14 through 02/02/15.

On 12/03/14 at 9:17 AM a review of the Medication Administration Record (MAR) dated for the month of December 2014 revealed the

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medication "Tranxene 3.75 mg PO BID x 2 months 10/01/14 through 12/01/14, then Tranxene 3.75 mg every AM x 2 months then DC 12/02/14 through 02/02/15."

On 12/03/14 at 9:20 AM an interview was conducted with Nurse #1. She verified the medication packet card was the medication Tranxene and that the dosage strength on the label was 7.5 mg and that was not the correct dosage strength that was administered to Resident #112 during the observation of medication administration on 12/03/14 at 8:30 AM. She indicated the Tranxene was to be titrated for Resident #112 and she had administered 3.75 mg during the medication observation. She indicated the dosage strength on the medication label was incorrect and should be labeled for the correct dosage for the accurate verification of the five rights prior to administering any medication to a resident. She revealed the five rights as follows:
1) Right Resident
2) Right Medication
3) Right Dosage/Strength
4) Right Route
5) Right Time

On 12/03/14 at 9:25 AM an interview was conducted with the Pharmacy Liaison. He verified the Tranxene label indicated 7.5 mg dosage strength. He stated the dosage strength on the label was incorrect and the ½ tablets in each bubble on the medication packet card actually had a dosage strength of 3.75 mg. He further stated the medication was to be titrated for Resident #112 and according to the physician orders Resident #112 was to be given 7.5 mg every morning and ½ tablet (3.75 mg) at bedtime.

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F 431	Continued From page 29 He indicated he was unaware of a better way to label the medication. He indicated the stamp on the top right corner of the packet card that indicated ½ tablet per bubble means that there was ½ tablets in the bubble but did not indicate whether the ½ tablet was that of a dosage strength of 7.5 mg or 3.75 mg. He stated the pharmacy label was not very clear as to the dosage strength that should be administered to Resident #112. On 12/03/14 at 11:04 AM an interview was conducted with the Pharmacist. She stated the Tranxene medication was to be titrated for Resident #112 and the pharmacy does not change the label from the original order with a titration medication. She verified the label indicated Tranxene 7.5 mg and the stamp on the top right hand corner of the card indicated ½ tablet per bubble. She was unable to verify according to the directions on the package at what process of titration the resident was currently at or that the dosage strength on the packet was anything other than 7.5 mg. She further stated the nurses should go by the MAR and not so much by the label on the medication packet cards. On 12/05/14 at 5:18 PM an interview was conducted with the Director of Nursing (DON). She stated she expected the correct dosage strength to be labeled on all medications.	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		1/1/15

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F 465	Continued From page 30 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to clean one of two ice scoop holders used to distribute ice. The findings included: During the initial tour of the facility on 12/01/14 at 10:20 AM observations were made of the ice scoop holder in a room housing the ice machine on the 300 hall. The ice scoop holder was clear plastic with a clear plastic removable insert. The clear plastic insert had holes (for drainage) in the area that came in contact with the base of the ice scoop holder. The scoop of the ice scoop was stored inside and came in contact with the interior of the removable insert. A trace of water was noted inside the ice scoop holder as well as black matter, concentrated in the holes of the removable insert. An ice chest on a rolling cart was stored in this room which staff was observed using to distribute ice to residents on two of the four halls in the facility. Additional observations were made on 12/02/14 at 11:13 AM, 12/03/14 at 4:55 PM, 12/04/14 at 9:54 AM and 12/05/14 at 12:00 PM. The ice scoop was stored inside this same ice scoop holder with black matter noted on the interior of the clear, ice scoop holder insert. On 12/05/14 at 12:00 PM this ice scoop holder was observed with the housekeeping supervisor. The insert was removed and the black matter was visible in the drain holes of the insert as well	F 465	The facility will provide a safe, functional sanitary and comfortable environment for the residents, staff and the public. Ice scoops and ice scoop holder in a room housing the ice machine on the 300 hall was cleaned and sanitized on 12/5/14. EVS manager educated EVS staff to clean and sanitize the scoops and holder per facility policy. Audit tool was developed for staff to document daily cleaning dates and times. The Lead EVS staff will oversee and monitor the cleaning of the ice scoops and ice scoops holders. Any identified issues will be addressed at that time. EVS Manager will monitor weekly for compliance and results of the monitoring will be shared with the Administrator or Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 465	Continued From page 31 as a clear gelatinous matter. The housekeeping supervisor stated his staff cleaned the room housing the ice machine and ice scoop holder and were responsible for cleaning the ice scoop holder. The housekeeping supervisor could not explain why the interior of the ice scoop holder had not been cleaned.	F 465		