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BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	**516 WALL STREET WAYNESVILLE, NC 28786**

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record reviews the facility failed to honor food preferences for 2 of 3 residents reviewed for choices (Resident # 95 and Resident #115). The findings included: 1. Resident #95 was admitted to the facility 09/04/14 with diagnoses which included nutrition deficiency, diabetes, renal disease, dialysis and depression. The most recent Minimum Data Set (MDS) 30 day admission assessment dated 12/12/14 revealed resident #95 was cognitively intact and able to make decisions of daily living. Review of Resident #95's tray card on 02/23/15 at 12:29 PM revealed no dislikes recorded on the tray card. Review of Resident #95's care conference notes revealed he was invited and attended care conferences and was involved in the plan of care. The weight loss and nutritional care plan dated 09/15/14 identified the potential risk for weight loss related to chronic illness with approaches	F 242	F242 1. Corrective action has been accomplished for the alleged deficient practice for Resident #95 and Res#115 by assessing the resident□s likes and dislikes related to food preferences and updating the information in the facility□s meal card system. Resident #95□s and Res #115□s food preferences are honored. 2. Facility residents have the potential to be affected by the same alleged deficient practice. Therefore, the Dietary Manager has conducted an audit of current residents□ food preferences to validate that tray cards reflect the residents□ current food likes/dislikes. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Director of Nursing or Administrator will provide in-service/re-education for nursing and dietary staff, including the Dietary Manager, regarding the resident□s right to make choices related to areas of life in	3/27/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/20/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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which included provide diet as ordered and determine the resident's individual likes and dislikes.

The food preference list in the medical record of Resident #95 dated 09/05/14 noted Resident #95 was on a consistent carbohydrate, no added salt diet and that he disliked liver, and cooked or raw onions. A follow up preference list dated 02/26/15 revealed Resident #95 also indicated he disliked carrots, corn and peas.

On 02/23/15 at 12:29 PM Resident #95's lunch tray and tray card were observed. The tray card revealed no dislikes and the lunch meal consisted of turkey, mashed potatoes, peas and fruit cocktail. Resident #95 stated, "see here they gave me peas again, I hate peas and I have told them that." Resident #95 did not eat the peas served with the lunch meal on 02/23/15.

On 02/25/15 at 12:25 PM Resident #95's lunch tray and tray card were observed. The tray card revealed no dislikes and the meal consisted of ham, macaroni and cheese and peas. Resident #95 stated, "I will tell you right now I won't eat these peas, they give them to me all the time and I don't like peas."

On 02/26/15 at 12:28 PM Resident #95's lunch tray and tray card were observed. The tray card revealed no dislikes and the meal consisted of cooked cabbage, corn bread, and a bowl of ground meat with kidney beans and onions in a tomato sauce. Resident #95 stated, "I don't eat onions raw or cooked and they know this. It was reviewed during the admission when they filled out a preference list. See this bowl of meat and beans, it has cooked onions in it, I will not eat this

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the facility that are important to them; specifically, each resident should be interviewed for their food preferences, likes, and dislikes so that the information can be entered into the facility□s meal tray system to ensure that the resident does not receive items they do not like. This education will also include that when a resident voices a like/dislike, the staff should ensure that this information is provided to the Dietary Manager in a timely manner in order to honor the resident□s preference. The Health Information Manager or Dietary Manager will review new admission charts weekly to identify that likes/dislikes have been documented and are transcribed to the meal tray system. The Director of Nursing, Unit Coordinator, or Social Services Director will conduct random interviews with at least three interviewable residents weekly for four weeks, then at least three interviewable residents per month for three months to ensure continued compliance with providing foods that are compatible with the residents□ likes and dislikes. The Administrator will review Resident Council Meeting minutes monthly to identify concerns related to preferences such as food likes/dislikes and ensure that concerns are addressed.
4. The Administrator or Social Services Director will review data obtained during the audits, interviews, and Resident Council Meetings, analyze the data and report patterns/trends to the QAPI committee every other monthly for four months. The QAPI committee will evaluate the effectiveness of the above

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F 242	Continued From page 2 and they know I don't eat onions." Resident 95# stated his food likes and dislikes were reviewed when he was admitted and it was upsetting that he kept receiving food he disliked at his meals. Resident #95 revealed he spoke to someone in the dietary department about a month ago and told them then he did not like raw or cooked onions, and peas and carrots. Resident #95 stated he was told they would fix it so he would not be given these foods. On 02/27/15 at 10:14 AM the District Dietary Manager (DDM) confirmed peas and carrots were not on Resident #95's preference list but that raw and cooked onions were on the list. The DDM revealed that dislikes are not listed on each individual residents tray card that the dietary staff use to prepare meal trays. The DDM stated preferences for likes and dislikes were listed in each residents profile in the computer. The DDM explained tray cards were generated for each meal based on each residents profile and preferences with alternates substituted for any known dislikes. The DDM stated she was not aware of a problem of Resident #95 receiving food he did not like. The DDM confirmed it was her expectation that any time a preference or dislike was communicated it should be documented and placed in the meal tracker system so residents food preferences were honored. On 02/27/15 at 1:35 PM the Dietary Manager (DM) confirmed that residents dislikes are not listed on the tray cards which dietary staff use to prepare resident meal trays. The DM stated the meal tracker system was a new system put into place and was a work in progress. The DM stated resident food preferences were noted in the	F 242	plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	

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system under each residents profile and used to generate the tray card. The DM revealed she was not aware Resident #95 was served items he did not like. The DM explained that food preferences were reviewed at the time of a residents admission, yearly and as needed. The DM further explained her expectation was that resident food preferences were honored and items residents did not like were not served. The DM confirmed because Resident #95 received food he had communicated as a dislike, the facility was not honoring his food preferences.

An interview was conducted on 02/26/15 at 4:49 PM with the Director of Nursing (DON). The DON stated she expected residents food preferences were reviewed on admission, updated yearly and as needed. The DON stated residents should receive the foods they like and dietary staff should ensure resident food preferences were honored and the correct foods were served on their meal tray.

2. Resident #115 was re-admitted to the facility on 01/22/15 with diagnoses which included nutrition deficiency, renal disease, diabetes, dialysis and depression. The most recent Minimum Data Set (MDS) 5 day admission assessment dated 02/02/15 revealed resident #115 was cognitively intact and able to make decisions of daily living.

Review of Resident #115's tray card on 02/23/15 at 12:29 PM revealed no dislikes recorded on the tray card.

Review of Resident #115's individual preferences care plan dated 02/18/15 identified his choice to be highly involved in daily care decisions regarding suggested or recommended

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interventions and specific preferences. The goal was for Resident #115 to have his preferences honored after individual consultation throughout the review. The approaches listed revealed recommended treatments of interventions to allow his individual preferences and choices, and to honor his individual choices and preferences as able within parameters of the facility. The weight loss and nutritional care plan dated 02/18/15 identified the potential risk for weight loss related to chronic illness with approaches which included providing diet as ordered and determining Resident #115's individual likes and dislikes.

Review of the 10/10/14 food preference list in the medical record of Resident #115 revealed a dislike for rice. The updated preference list dated 01/23/15 revealed the resident interview for likes and dislikes was completed with no other documented changes. The preference list revealed Resident #115 was on a consistent carbohydrate renal diet.

Review of the Group food item detail list provided by the District Dietary Manager (DDM) on 02/27/15 at 10:14 AM revealed macaroni and cheese should not be served on a renal diet.

During an observation on 02/23/15 at 12:29 PM Resident #115 was observed eating his lunch which consisted of turkey, mashed potatoes,stuffing and peas and carrots. Resident #115 only ate the turkey and potatoes and stated, I don't like the carrots and they know this.

During an observation on 02/26/15 at 12:48 PM Resident #115 was observed with his lunch tray which consisted of the alternate menu item of

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chicken with peas/carrots/biscuit dumpling and spiced apple dessert. Resident #115 stated, "see look at this again they give me this alternative but it has carrots in it which I told them I do not like. I get frustrated by having to tell this all the time so I either don't eat or I order grilled cheese sandwiches." Resident #115 was observed to eat only the spiced apple dessert.

An interview was conducted on 02/25/15 at 12:25 PM with Resident #95 (the roommate of Resident #115). Resident #95 was observed eating his lunch of ham and macaroni and cheese. Resident #95 stated, "you see this macaroni and cheese? My roommate will be glad he was at dialysis today because he hates mac and cheese. I can tell you right now he gets it on his plate all the time, he gets mad about it and he won't eat it. I know because I heard him tell the dietary people he doesn't like it."

An interview was conducted on 02/25/15 at 3:37 PM with Nurse #2 who was familiar with Resident #115. Nurse #2 stated Resident #115 was very independent and was cognitively able to make his own choices and voice his concerns. Nurse #2 revealed Resident #115 had complained about being given foods that he did not prefer which were communicated to the dietary department. Nurse #2 further revealed that Resident #115 frequently requested grilled cheeses sandwiches because he wasn't given foods that he liked.

An interview was conducted on 02/26/15 at 12:34 PM with Resident #115. He stated that he talked to the dietary staff when he was admitted to the facility and they came and did updates to his preference list. Resident #115 stated he told them he did not like rice, carrots, and macaroni and

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cheese. Resident #115 revealed the dietary staff assured him he would not receive food items he did not like on his meal plates.

On 02/27/15 at 10:14 AM the DDM stated Resident #115 received a Consistent Carbohydrate Diet (CCD) renal diet. The DDM explained the diet he received was a more liberalized diet for quality of life and that it included some of the renal diet restrictions. The DDM confirmed that rice was on the food preference list of Resident #115 but that macaroni and cheese was not on the list. The DDM stated dislikes were not listed on individual resident tray cards that the dietary staff use to prepare meal trays. The DDM further revealed preferences for likes and dislikes were listed in each residents profile in the computer. The DDM explained tray cards were generated for each meal based on each residents profile and preferences with alternates substituted for any known dislikes. The DDM further stated she was not aware Resident #115 received food he did not like. The DDM confirmed it was her expectation that any time a preference or dislike was communicated it should be documented and placed in the meal tracker system so residents food preferences were honored.

On 02/27/15 at 1:35 PM the Dietary Manager (DM) confirmed that residents dislikes were not listed on the tray cards which dietary staff used to prepare residents meal trays. The DM stated the meal tracker system was a new system put into place and was a work in progress. The DM stated that resident food preferences were in the system under each residents profile. The DM revealed she was not aware Resident #115 was served items he did not like. The DM explained that food

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F 242	Continued From page 7 preferences were reviewed at the time of a residents admission, yearly and as needed. The DM further explained her expectation was that resident food preferences were honored and items they did not like were not served at meals. The DM further confirmed that based on this and the fact that Resident #115 was still receiving foods that were on his dislike list, the facility was not honoring his food preferences. On 02/26/15 at 4:49 PM the Director of Nursing (DON) stated she expected residents preferences were reviewed on admission, updated yearly and as needed. The DON stated residents should receive food they like and dietary staff should ensure all residents likes and dislikes were honored and the correct foods were served on their trays.	F 242		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to provide a homelike environment with sensory stimulation for 1 of 35 residents reviewed for homelike environment (Resident #57). The findings included:	F 252	F252 1. Corrective action for the alleged deficient practice with regarding to Resident #57 has been accomplished by providing a television for viewing, placing personal pictures in frames in his room, and encouraging participation in activities of interest.	3/27/15

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F 252	Continued From page 8 Resident #57 was admitted to the facility on 10/13/10 with diagnoses which included generalized muscle weakness, difficulty walking, Alzheimer's, delusional disorder, anxiety, depression and senile dementia. A review of the most recent quarterly Minimum Data Set (MDS) dated 12/09/14 revealed Resident #57 had short term and long term memory problems and was severely impaired in cognition for daily decision making skills. The MDS further revealed Resident #57 required extensive assistance with activities of daily living (ADLs) which included mobility, transfers, walking, toileting and personal hygiene. The MDS coded Resident #57 with behavior symptoms of inattention, disorganized thinking, and decreased level of activity. The MDs further coded Resident #57 as not exhibiting behaviors of rejected care. A review of a care plan dated 07/08/14 last revised on 12/09/14 revealed Resident #57 required assistance with ADLs related to his progressing dementia. The goals indicated Resident #57 would have his daily needs met with staff support and with interventions to assist as needed with ADLs. The care plan for altered communication related to dementia dated 07/08/14 included interventions to provide a calm environment, to promote effective communication and attempt to keep the resident occupied in activities. The care plan for activities dated 10/08/14 identified Resident #57' s potential for decreased participation in activities related to his choice to spend time in his room. The goals indicated Resident #57 enjoyed TV, music and special events. The interventions were designed to draw on Resident #57's strengths and provide 1 on 1 activities as needed throughout the week.	F 252	2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Activities Director has completed an audit of the current population to identify that the residents have items in their rooms, such as photos, framed pictures, televisions or radios, that aid in making their rooms home-like and personalized. Responsible parties will be contacted to assist in supplying personal items as needed. 3. Measures put in place to ensure the alleged deficient practice does not recur include: The Administrator or Activities Director will conduct in-service education for facility staff regarding the provision of a safe, clean, home-like environment, allowing the resident to use his/her personal belongings when possible; specifically, if a resident is noted to have a need for items that will enhance their environment, such as access to music, photos, etc., the staff should notify the Activities Director or Administrator to contact the resident□s Responsible Party for assistance. The facility□s Ambassadors (Interdisciplinary Team) will conduct visits at least weekly to assigned residents to identify concerns with the resident□s environment. The concerns, as identified, will be brought to the morning stand up meeting for discussion and resolution. The Activities Director will discuss personalization of a resident□s room with the resident and/or responsible party during care plan meetings at least annually or when a concern is identified. 4. The Administrator or Activities	

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F 252	Continued From page 9 The care plan dated 10/08/14 identified the problem area of potential for wandering related to dementia. The interventions revealed offering emotional and psychological support, provide and involve the resident in activities directed at his specific interests, provide supervised walks, and to observe for increased safety risks. A review of the physician progress notes dated 01/08/15 revealed an exam of Resident #57 with significant dementia, anxiety, depression and debility which required a lot of help with ADLs. The exam and observations further revealed Resident #57 was in no acute distress, sitting in his chair uninterested in any interactions except wanting to watch and listen to his TV. During an observation on 02/23/15 at 11:56 AM Resident #57 was sitting in his chair, beside the bed, looking at the floor. His wheelchair and walker were noted to be on the opposite side of the room. No personal objects were noted in room, on his tables or on the walls. There was no radio or TV in the room and no pictures on the walls. There was no bird feeder or anything outside the window beside his bed. During an observation on 02/25/15 at 11:54 AM Resident #57 was sitting in his chair, beside his bed. There were 4 photos on his side table across the room from where he was sitting. His wheelchair and walker remained on the opposite side of the room next to the table with the photos. There was no radio or TV in the room and no pictures on the walls. There was no bird feeder or anything outside the window beside his bed. During an observation on 02/26/15 at 9:43 AM Resident #57 was sitting in his chair, next to his	F 252	Director will review the results of Ambassador visits, concerns, and care plan meetings, analyze the data for patterns/trends and report to the QAPI committee every other month for four months. The QAPI committee will evaluate the effectiveness of the plan and may amend the plan based on identified outcomes to ensure continued compliance	

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bed, looking at the floor. Resident #57 had a tray table in front of him with 2 wildlife bird magazines one dated March 2007 and one dated Jan 2011. There was no bird feeder outside the window beside his bed. His wheelchair and walker were noted to be on the opposite side of the room . No personal objects were noted in room, on his tables or on the walls. There was no radio or TV in the room and no pictures on the walls.

An interview was conducted on 02/25/15 at 2:51 PM with NA #1. NA#1 stated Resident #57 stayed in his room most days but sometimes he would get up and walk out into the halls. NA#1 further stated Resident #57 rarely attended any activities

An interview was conducted on 02/26/15 at 4:49 PM with the Director of Nursing (DON). The DON revealed Resident #57 rarely attended activities out of his room. The DON further stated the Activity Director normally visited with residents in their rooms. The DON confirmed Resident #57 needed a more homelike environment and some sensory stimulation. The DON stated it was her expectation that residents were provided in room stimulation and activities that met their interest.

An interview was conducted on 02/26/15 at 5:26 PM with the Activities Director (AD). The AD stated that Resident #57 enjoyed watching TV and listening to music. The AD further stated Resident #57 enjoyed listening and watching the gospel music channel on TV. The AD revealed Resident #57 had attended music group activities in the past. The AD confirmed he was unaware Resident #57 did not have a TV or a radio in his room.

F 253	483.15(h)(2) HOUSEKEEPING &	F 253		3/27/15

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(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 253 SS=D	Continued From page 11 MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to repair furniture in a resident's room for 1 of 35 residents reviewed for safe environment and furniture in good repair (Resident #57). The findings included: Resident #57 was admitted to the facility on 10/13/10 with diagnoses which included generalized muscle weakness, difficulty walking, Alzheimer's, delusional disorder, anxiety, depression and senile dementia. A review of the most recent quarterly Minimum Data Set (MDS) dated 12/09/14 revealed Resident #57 had short term and long term memory problems and was severely impaired in cognition for daily decision making skills. The MDS further revealed Resident #57 required extensive assistance with activities of daily living (ADLs) which included mobility, transfers, walking, toileting and personal hygiene. The MDS coded Resident #57 with behavior symptoms of inattention, disorganized thinking, and decreased level of activity. The MDs further coded Resident #57 as not exhibiting behaviors of rejected care. A review of a care plan dated 07/08/14 last revised on 12/09/14 revealed Resident #57	F 253	F253 1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident #57 by completing repairs of the identified bureau drawer handles and the veneer on the wardrobe closet. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Maintenance Director has completed an audit of resident rooms to identify repair needs. Repairs have been prioritized based on urgency and safety needs. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: the Administrator will conduct in-service education for the Maintenance Director, Ambassadors, and facility staff regarding the maintenance of a sanitary, orderly, and comfortable environment; specifically, items that are noted to be broken or in need of repair should be reported to the Maintenance Director via the Maintenance Request Log unless it is considered urgent for the safety of the resident. In this case, the repair is to be reported to the Maintenance Director or Administrator as soon as possible so that repairs can be	

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required assistance with ADLs related to his progressing dementia. The goals indicated Resident #57 would have his daily needs met with staff support and with interventions to assist as needed with ADLs. The care plan dated 10/08/14 identified the problem area of potential for wandering related to dementia. The interventions revealed offering emotional and psychological support, provide and involve the resident in activities directed at his specific interests, provide supervised walks, and to observe for increased safety risks.

During an observation on 02/23/15 at 11:56 AM Resident #57 was sitting in his chair, beside the bed, looking at the floor. His wheelchair and walker were noted to be on the opposite side of the room. The drawer handle on the bedside table and on the closet drawer was broken and hanging from one screw on the bottom drawers that was 6-8" from the floor. The veneer was peeling off the closet door at waist height on the right hand side of the door and on the right hand side of the base of the closet unit.

During an observation on 02/25/15 at 11:54 AM Resident #57 was sitting in his chair, beside his bed. His wheelchair and walker remained on the opposite side of the room. The drawer handle on the bedside table and on the closet drawer was broken and hanging from one screw on the bottom drawers that was 6-8" from the floor. The veneer was peeling off the closet door at waist height on the right hand side of the door and on the right hand side of the base of the closet unit.

During an observation on 02/26/15 at 9:43 AM Resident #57 was sitting in his chair, next to his bed, looking at the floor. His wheelchair and

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accomplished timely. The Maintenance Director will check the Maintenance Request Log daily, Monday through Friday, and complete repairs based on priority and equipment availability. Those items that cannot be immediately repaired will be denoted and arrangements made for repair in a timely manner. The Maintenance Director and Administrator will conduct weekly facility rounds for four (4) weeks to identify repair needs and document the needs in the Maintenance Request Log. After four (4) weeks, these rounds will be conducted at least monthly. The Administrator will review concerns related to Maintenance issues daily Monday through Friday during the morning meeting and assure timely resolution. The facility□s Ambassadors will conduct rounds at least weekly to include monitoring for issues related to maintenance or repairs to ensure continued compliance.

4. The Administrator or Maintenance Director will review data obtained during rounds, analyze the data and report patterns/trends to the QAPI committee every other month for four months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified outcomes to ensure continued compliance.

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F 253	Continued From page 13 walker were noted to be on the opposite side of the room. The drawer handle on the bedside table and on the closet drawer was broken and hanging from one screw on the bottom drawers that was 6-8" from the floor. The veneer was peeling off the closet door at waist height on the right hand side of the door and on the right hand side of the base of the closet unit. An interview was conducted on 02/26/15 at 4:49 PM with the Director of Nursing (DON). The DON verified the drawer handles were broken and needed to be repaired. The DON further verified the closet veneer was in need of repair. The DON stated it was her expectation that residents were provided an environment that was safe and she expected furniture in good working order to prevent injuries. An interview was conducted on 02/26/15 at 4:21 PM with the Maintenance Manager (MM). The MM explained that staff and residents and their family members report any maintenance problems to him directly or they are written on a maintenance log that is kept at the nurse's station. The MM further explained he reviewed the repair log daily and prioritized the jobs according to urgency and safety. The MM stated he was unaware of the repairs needed in Resident #57's room to the drawer handles and the veneer on the closet. The MM verified the drawer handles were broken and needed to be repaired and the closet veneer was in need of repair. The MM stated it was his expectation that residents were provided an environment that was safe and he expected to be notified of needed repairs in order to provide maintenance to prevent injuries.	F 253		

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F 312	Continued From page 14	F 312		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to provide nail care for 1 of 2 dependent residents reviewed for activities of daily living (Resident #57). The findings included: Resident #57 was admitted to the facility on 10/13/10 with diagnoses which included generalized muscle weakness, difficulty walking, Alzheimer's, delusional disorder, anxiety, depression and senile dementia. A review of the most recent quarterly Minimum Data Set (MDS) dated 12/09/14 revealed Resident #57 had short term and long term memory problems and was severely impaired in cognition for daily decision making skills. The MDS further revealed Resident #57 required extensive assistance with activities of daily living (ADLs) which included mobility, transfers, walking, toileting and personal hygiene. The MDS coded Resident #57 with behaviors and symptoms of inattention, disorganized thinking, and decreased level of activity. The MDs also coded Resident #57 with no behaviors of rejected care.	F 312	F312 1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident # 57 by providing nail care and trimming the resident□s finger nails. The Resident□s grooming/personal hygiene needs are provided for during routine care by assigned nursing staff and as needed based on the plan of care. 2. Facility residents who are unable to carry out activities of daily living have the potential to be affected by this alleged deficient practice. The Director of Nursing and Unit Coordinators have completed an audit of current residents□ nail care needs. Any concerns regarding nail care needs were resolved upon identification. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Director of Nursing or Unit Coordinator will conduct In-service for Nursing Staff regarding provision of ADL care for dependent residents; specifically, that nail care is to be during the resident□s shower and as needed, including checking for jagged edges and	3/27/15

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A review of a care plan dated 07/08/14 and last revised 12/09/14 revealed Resident #57 required assistance with ADLs related to progressing dementia. The goals indicated Resident #57 would have his daily needs met with staff support and with interventions as needed to assist Resident #57 with ADLs. The behavior care plan dated 07/08/14 identified the problem of Resident #57 eating with his hands and addressed interventions for staff to wash his hands before and after meals.

A review of an ADL sheet (which was identified as the daily care guide for Nurse Aides (NAs) to provide resident care) indicated Resident #57 required assistance with grooming. The special instructions section on the ADL sheet did not indicate that Resident #57 had refused nail care.

On 02/23/15 at 11:56 AM, 2/23/15 at 4:04 PM and 2/24/15 at 2:53 PM Resident #57 was observed seated in a chair, in his room, and all ten fingernails were noted to be long with ragged edges. The fingernails extended approximately ¼ inch at the end of each finger and had whitish/brown debris under the nails on both hands.

On 02/25/15 at 8:17 AM Resident #57 was observed seated in a chair, in his room, eating breakfast which consisted of eggs, ground meat and oatmeal. Resident #57 was observed using his fingers to eat the oatmeal and the fingernails on both hands were long with ragged edges. The resident's fingernails extended approximately ¼ inch at the end of each finger and had whitish/brown debris under the nails on both hands. In addition there was oatmeal observed

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clipping finger nails to reduce the potential for injury. Nail care and grooming needs will be provided during routine daily care and as needed by assigned Resident Care Specialists and/or Licensed Nurses. Nail care needs will be evaluated by the Licensed Nurse at least weekly as part of the Weekly Skin Checks. Care rounds will be conducted by the Director of Nursing or Unit Coordinators at least 3 times per week for four (4) weeks, then at least weekly thereafter to monitor for nail care needs.

4. The Director of Nursing or Unit Coordinator will review the results of care rounds, analyze the results, and report patterns/trends to the QAPI committee every other month for four months. The QAPI committee will evaluate the effectiveness of the plan and may amend the plan based on patterns/trends to ensure continued compliance.

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on the thumb and index finger of his right hand.

On 02/26/15 at 12:45 PM Resident #57 was observed seated in a chair, in his room, eating lunch. The lunch meal consisted of a mechanical soft meal which included ground cabbage. Resident #57 was observed holding a spoon in his right hand and pushed the food onto the spoon with his left hand. The fingernails on both of Resident #57's hands were long with ragged edges. The resident's fingernails extended approximately ¼ inch at the end of each finger and had whitish/brown debris under the nails on both hands.

An interview was conducted on 02/26/15 at 2:51 PM with Nurse Aide (NA) #1. NA #1 stated she had taken care of Resident #57 in the past and was familiar with his needs. NA #1 stated NAs were expected to check residents' nails every day and to clean and trim them not only during their shower but on a daily basis as needed. NA #1 confirmed Resident #57 was cooperative with his care but she had not trimmed his nails during her shift on 02/26/15. NA # 1 further explained they were provided a daily duty paper listing the residents and their needed care. NA # 1 revealed that Resident #57 required total care for most ADLs, but that he ate well without assistance and needed only tray set-up. NA # 1 further revealed Resident #57 ate using his hands at times.

An interview was conducted on 02/25/15 at 3:37 PM with Nurse # 2 who was familiar with the care required for Resident #57. Nurse # 2 confirmed Resident #57 required total care for most ADLs but was able to feed himself with tray set up. Nurse #2 revealed nail care was provided for residents on their shower days, and as needed

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F 312	Continued From page 17 before and after meals. An interview was conducted on 02/26/15 at 4:49 PM with the Director of Nursing (DON). The DON revealed Resident #57 required total assistance for most ADLs but he was able to feed himself with tray set-up only. The DON further revealed she was aware that Resident #57 often ate with his hands. The DON stated it was her expectation that nail care was provided for residents on their shower days and as needed. The DON further stated that Resident #57 should have his nails and hands cleaned before and after each meal due to his eating with his hands.	F 312		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility medication error rate was greater than 5 percent (%) as evidenced by 4 medication errors out of 26 opportunities for error which resulted in a medication error rate of 15.38% for 2 of 9 residents observed during medication administration who were administered sliding scale insulin without current physician's orders (Residents # 31 and # 125). The findings include: 1. Resident # 31 was admitted to the facility on 11/26/13 with diagnoses which included diabetes	F 332	F332 1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident #31 by obtaining a clarification of the physician's order for capillary glucose testing and sliding scale insulin administration. Testing results and administration of insulin is documented by the licensed nurse on the Medication Administration Record. Resident #125's order for capillary blood glucose testing and sliding scale insulin has been clarified to include the administration scale. testing results	3/27/15

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mellitus and congestive heart failure. His most recent care plan dated 12/26/14 addressed his need for monitoring of blood glucose levels with daily capillary blood glucose (CBG)) tests and sliding scale insulin as ordered.

Review of Resident # 31's medical record revealed a document titled "Blood Glucose Tracking/Sliding Scale Insulin Administration Record" dated February 2015 which indicated Resident # 31 received daily CBG tests before meals and at bedtime and sliding scale insulin injections. Instructions were written at the top of the document to administer sliding scale Novolog insulin before meals and at bedtime with the following parameters: "0 - 150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units and 351 - 400 = 10 units. Nursing documentation on the record revealed Resident # 31 had received sliding scale insulin injections four times every day in February 2015. There was no place designated on the document for a physician signature to indicate the dosage parameters were reviewed and approved by the physician.

Review of Resident # 31's January and February 2015 summary of physician's orders, which were signed as approved by the physician, revealed there were no orders for CBG tests or sliding scale insulin before meals and at bedtime. Further review of the medical record did not reveal any orders on the current chart for CBG tests or sliding scale insulin before meals and at bedtime.

Nurse # 1 was observed on 02/26/15 at 11:41 AM performing a CBG test on Resident # 31 and obtained a result of 246. Nurse # 1 was observed

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and administration of insulin is documented by the licensed nurse on the Medication Administration Record. Medications are delivered per the physician's order for the identified residents.

2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing and Unit Coordinators have completed an audit of current residents who require capillary blood glucose testing and sliding scale insulin administration to determine accuracy of transcription. Any discrepancies were corrected upon identification.

3. Measures put in place to ensure the alleged deficient practice does not recur include:
The Director of Nursing will conduct in-service re-education for Licensed Nurses and Health Information Manager regarding the residents right to be free from medication errors, specifically, when an order for capillary blood glucose testing and sliding scale insulin are received, the Licensed Nurses are transcribe physician's orders accurately and validate the accuracy of the information provided on the Medication Administration Record. The Health Information Manager is to enter physician's orders for capillary blood glucose testing and sliding scale insulin parameters accurately and timely to facilitate licensed nurses review of medication recapitulations on a monthly basis.

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F 332	Continued From page 19 checking the dosage parameters on the Sliding Scale Insulin Administration Record, then administering Novolog insulin 4 units to Resident # 31 and documenting the CBG and insulin administration on the record. An interview with Unit Coordinator (UC) # 1 on 02/26/15 at 3:01 PM revealed she was unable to locate a signed physician's order on Resident # 31's chart for CBG tests or sliding scale insulin. UC # 1 stated the parameters for the sliding scale insulin were listed on the Blood Glucose Tracking/Sliding Scale Insulin Administration Record. When asked if the physician reviewed the document and approved the dosage parameters, UC # 1 stated the physician didn't review or sign the document to approve the dosage parameters. An interview with the Medical Records coordinator on 02/26/15 at 3:20 PM revealed she located a telephone order dated 05/22/14 for CBG's and sliding scale insulin in Resident # 31's archived records, which was signed by the physician. When asked why the order for CBG's and sliding scale insulin was not included in the January or February 2015 summary of current physician orders, she stated the facility stopped including the CBG and sliding scale insulin orders on the monthly summary of orders about 6 months ago. When asked what the system was for the physician reviewing and approving those orders, she acknowledged there was not a system in place for the physician to review the orders. An interview with the Director of Nursing (DON) on 02/27/15 at 2:45 PM revealed the monthly summary of physician's orders was considered	F 332	The Director of Nursing and Unit Coordinator will review new physician's orders during the morning clinical meeting and validate that the order has been correctly transcribed to the MAR. On a monthly basis, The Director of Nursing, Unit Coordinators, and assigned Licensed Nurses will review the monthly recapitulation of physician's orders will be reviewed by the Director of Nursing and Unit Coordinators during the morning meeting to validate accuracy of transcription. The Director of Nursing and Area Staff Development Manager will complete a total of at least two Medication Pass Observations weekly for Licensed Nurses and Certified Medication Aides until all have been observed. Thereafter, the Director of Nursing and Area Staff Development Manager will conduct a total of two observations per month to ensure accuracy of medication delivery. 4. The Director of Nursing will review the results of audits, medication pass observations, and monthly recapitulations, analyze the data to identify patterns/trends monthly for four months and report findings to the QAPI committee. The QAPI committee will evaluate the effectiveness of the plan and may amend the plan based on identified outcomes to ensure continued compliance.	

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the currently approved orders after they were signed by the physician and should include all current orders for medication and treatment. The DON stated the nurses were not instructed to omit orders for CBG's and sliding scale insulin from the monthly summary of physician's orders and those orders should have been included on the January and February 2015 orders.

2. Resident # 125 was admitted to the facility on 12/19/14 with diagnoses including diabetes mellitus and chronic ischemic heart disease. His most recent care plan dated 12/31/14 addressed his need for monitoring of blood glucose levels with daily capillary blood glucose (CBG)) tests and sliding scale insulin as ordered.

Review of Resident # 125's medical record revealed a document titled "Blood Glucose Tracking/Sliding Scale Insulin Administration Record" dated February 2015 which indicated Resident # 125 received daily CBG tests before meals and at bedtime and sliding scale insulin injections. Instructions were written at the top of the document to administer sliding scale Novolog insulin before meals and at bedtime with the following parameters: "0 - 150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units and 351 - 400 = 10 units. Nursing documentation on the record revealed Resident # 125 had received sliding scale insulin injections usually three times every day in February 2015. There was no place designated on the document for a physician signature to indicate the dosage parameters were reviewed and approved by the physician.

Review of Resident # 125's January and February 2015 summary of physician's orders, which were

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signed as approved by the physician, revealed there were no orders for CBG tests or sliding scale insulin before meals and at bedtime. Further review of the medical record revealed an admission order dated 12/19/14 which listed "Insulin Aspart sliding scale before meals and at bedtime" but did not include the type of insulin or dosage parameters for the sliding scale insulin.

Nurse # 3 was observed on 02/25/15 at 4:28 PM performing a CBG test on Resident # 125 and obtained a result of 296. Nurse # 3 was observed checking the dosage parameters on the Sliding Scale Insulin Administration Record, then administering Novolog insulin 6 units to Resident # 125 and documenting the CBG and insulin administration on the record.

Nurse # 2 was observed on 02/26/15 at 12:00 PM performing a CBG test on Resident # 125 and obtained a result of 284. Nurse # 2 was observed checking the dosage parameters on the Sliding Scale Insulin Administration Record, then administering Novolog insulin 6 units to Resident # 125 and documenting the CBG and insulin administration on the record.

An interview with Unit Coordinator (UC) # 1 on 02/26/15 at 3:01 PM revealed she was unable to locate a signed physician's order on Resident # 125's chart that listed specific parameters for sliding scale insulin. UC # 1 stated the parameters for the sliding scale insulin were listed on the Blood Glucose Tracking/Sliding Scale Insulin Administration Record. When asked if the physician reviewed the document and approved the dosage parameters, UC # 1 stated the physician didn't review or sign the document to approve the dosage parameters. UC # 1 stated

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F 332	Continued From page 22 the specific dosage parameters for the sliding scale insulin should have been included on the admission orders. An interview with the Medical Records coordinator on 02/26/15 at 3:20 PM revealed she located a hospital discharge summary for Resident # 125 with a discharge medication list dated 12/19/14 which included CBG's and sliding scale insulin. She was unable to locate a signed physician's order for administration of sliding scale insulin that included dosage parameters. When asked why the order for CBG's and sliding scale insulin was not included in the January or February 2015 summary of current physician orders, she stated the facility stopped including the CBG and sliding scale insulin orders on the monthly summary of orders about 6 months ago. When asked what the system was for the physician reviewing and approving those orders, she acknowledged there was not a system in place for the physician to review the orders. An interview with the Director of Nursing (DON) on 02/27/15 at 2:45 PM revealed the monthly summary of physician's orders was considered the currently approved orders after they were signed by the physician and should include all current orders for medication and treatment. The DON stated the nurses were not instructed to omit orders for CBG's and sliding scale insulin from the monthly summary of physician's orders and those orders should have been included on the January and February 2015 orders.	F 332		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333		3/27/15

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F 333	Continued From page 23 any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to accurately transcribe physician's orders which resulted in 3 of 6 residents not receiving the correct dosage of medication (Residents #24, #80 and #130). The findings included: 1. Resident #24 was admitted to the facility 07/12/13 with diagnoses which included anxiety, depression and esophageal reflux. The current care plan for Resident #24 last updated 01/14/15 included the following problem area: -Resident on Proton Pump Inhibitor (Omeprazole) due to associated diagnosis or treatment regime. Approaches to address this problem area included to administer medication per order. Review of physician orders in the medical record of Resident #24 noted Omeprazole (a medication used to treat esophageal reflux) had been ordered 20 milligrams (mg) twice a day on 03/20/14. A physician's progress note dated 03/20/14 noted Resident #24 was having continual issues with abdominal pain and nausea and had been on multiple medications to treat this, including Omeprazole. The note referenced a recent gastrointestinal consult with recommendation to increase the dose of the Omeprazole secondary to the continued symptomatology. The physician	F 333	F333 1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident #24 by clarifying the physician□s order for Omeprazole. Resident #130□s order for Pepcid has been corrected to include the ordered administration times. Resident #80 receives Tramadol as ordered by the physician. Medication Variances were completed for each identified resident. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing and Unit Coordinators have completed an audit of current physician□s orders and Medication Administration Records to determine accuracy of transcription. Any discrepancies were corrected upon identification. 3. Measures put in place to ensure the alleged deficient practice does not recur include: The Director of Nursing will conduct in-service re-education for Licensed Nurses, Certified Medication Aides, and Health Information Manager regarding the resident□s right to be free from significant medication errors, specifically, Licensed Nurses are to transcribe physician□s orders accurately and validate the accuracy of the information provided on the Medication Administration Record (MAR). Certified Medication Aides are to	

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wrote an order on 03/20/14 for Omeprazole 20 mg, twice a day.

Review of Medication Administration Records (MARs) from March 2014-November 2014 noted the Omeprazole was administered to Resident #24 twice a day as ordered. On 12/09/14 a handwritten entry on the December 2014 MAR for Resident #24 noted a change in the Omeprazole from twice a day to once a day. There was not a subsequent physician order in the medical record of Resident #24 to correspond with the decrease in the Omeprazole.

On 02/27/15 at 10:30 AM Unit Coordinator #2 reviewed the medical record of Resident #24 and found a pharmacy Consultation Report dated 12/01/14 with a recommendation to decrease the Omeprazole from 20 mg twice a day to 20 mg once a day. A handwritten response by the Geriatric Nurse Practitioner (GNP) for Resident #24 dated 12/05/14 noted a decline in the recommendation noting the resident "has severe gastroesophageal reflux disease and needs this for treatment management." Unit Coordinator #2 stated that Nurse #2 noted this recommendation on 12/09/14 and felt Nurse #2 mistakenly read the response as an approval and changed the order on the MAR from twice a day to once a day. Unit Coordinator #2 stated the Omeprazole order should not have been changed, that it was a medication error and would be reported to the resident's GNP. Attempts were made to contact Nurse #2 for a phone interview but the attempts were unsuccessful.

On 02/27/15 at 12:50 PM the GNP for Resident #24 stated she had declined the order to decrease the Omeprazole when requested by the

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bring to the nurse□s attention any discrepancies identified during medication administration passes so that the Five Rights of Medication Administration are followed. The Health Information Manager is to enter physician□s orders accurately and timely to facilitate licensed nurse review of medication recapitulations on a monthly basis.
The Director of Nursing and Unit Coordinator will review new physician□s orders daily during the morning clinical meeting and validate that the order has been correctly transcribed to the MAR. On a monthly basis, the Director of Nursing, Unit Coordinators, and assigned Licensed Nurses will review the monthly recapitulation of physician□s orders to validate accuracy of transcription. Discrepancies will be corrected at the time of discovery. Newly admitted residents□ physician□s orders will be reviewed by the Director of Nursing and Unit Coordinator during the morning clinical meeting to validate accuracy of transcription.
The Director of Nursing and Area Staff Development Manager will complete a total of at least two Medication Pass Observations at least twice weekly for Licensed Nurses and Certified Medication Aides until all have been observed. Thereafter, the Director of Nursing and Area Staff Development Manager will conduct two observations per month to ensure accuracy of medication delivery.
4. The Director of Nursing will review the results of audits, medication pass observations, and monthly recapitulations, analyze the data to identify patterns/trends

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consultant pharmacist 12/01/14. The GNP stated she had just been informed of the medication error and increased the Omeprazole dose back to twice a day for Resident #24.

On 02/27/15 at 1:30 PM the Director of Nursing (DON) stated the Omeprazole should not have been decreased for Resident #24 on 12/09/14. The DON stated that it was most likely not identified by staff when the January 2015 MAR/physician orders were reconciled. The DON stated she suspected the staff member that typed the January 2015 physician orders and January 2015 MAR for Resident #24 used the December MAR as a guide and did not verify if there was a physician's order to decrease the Omeprazole on 12/09/14.

2. Resident # 130 was admitted to the facility on 02/11/15 with diagnoses which included relapsed non-Hodgkin's lymphoma, hypertension and gastroesophageal reflux disease (GERD). Her most recent care plan dated 02/24/15 addressed her need for a proton pump inhibitor for treatment of GERD. The interventions included: administer medication per order and monitor for abdominal pain, nausea and vomiting, diarrhea, increased flatulence and headache.

Admission physician's orders for Resident # 130 dated 02/11/15 included Pepcid (a proton pump inhibitor) 20 milligrams (mg) one tablet twice a day. Review of the February 2015 Medication

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monthly for four months and report findings to the QAPI committee. The QAPI committee will evaluate the effectiveness of the plan and may amend the plan based on identified outcomes to ensure continued compliance.

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Administration Record (MAR) for Resident # 130 revealed Pepcid 20 mg one tablet twice a day was listed on the MAR but the administration time was listed for once a day at 5:00 PM. Nursing documentation on the MAR indicated the Pepcid was administered once a day from 02/11/15 through 02/26/15, which was verified by Unit Coordinator # 1 when brought to her attention.

Visual inspection of the medication package of Pepcid 20 mg for Resident # 130 revealed it was labeled as dispensed from the pharmacy on 02/11/15 and the package label indicated the medication was to be administered twice a day.

An interview on 02/26/15 at 4:07 PM with Unit Coordinator (UC) # 1 about the process for transcribing physicians orders revealed the charge nurse transcribed new orders onto the MAR. When asked if the facility had a system for verifying accuracy of the transcription of orders, UC # 1 stated the facility did not have a formal system for double checking the accuracy of transcription of physicians orders. UC # 1 stated she checked the transcription of orders when requested by the charge nurse but didn't verify the accuracy of transcription on a routine basis.

During an interview on 02/27/15 at 1:33 PM with the Geriatric Nurse Practitioner (GNP), the GNP was asked if there was any adverse effect on Resident # 130 from receiving half the prescribed dosage of Pepcid for the first 15 days of her admission to the facility. The GNP stated she didn't think Resident # 130 suffered any harm but she expected the medication to be administered as prescribed.

An interview on 02/27/15 at 3:18 PM with the

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Director of Nursing (DON) about the facility's process for verifying the accuracy of transcription of medication orders for newly admitted residents revealed a chart audit was completed the day after a resident was admitted but failed to identify the error on Resident # 130's MAR.

3. Resident # 80 was admitted to the facility on 11/05/12 with diagnoses which included depression, dementia, chronic lumbago, hypertension and chronic pain syndrome. A quarterly Minimum Data Set (MDS) assessment dated 11/07/14 indicated she had moderately impaired cognitive skills for daily decision making and impaired short term and long term memory. Her most recent care plan dated 11/12/14 addressed the resident's chronic pain with need for administration of Tramadol, a medication used to treat pain, on an as needed (PRN) basis.

Review of Resident # 80's October 2014 summary of physician's orders, which was signed as reviewed by Unit Coordinator (UC) # 1 on 09/30/14, revealed the list of medications included Tramadol 50 milligrams (mg) by mouth every 6 hours PRN pain with an origination date of 11/05/12.

Review of Resident # 80's October 2014 Medication Administration Record (MAR) revealed the following entry: Tramadol 50 mg one tablet by mouth every 6 hours PRN pain. Nursing documentation on the MAR indicated the Tramadol had been given all but 5 days in October 2014 and was given twice on 10/01/14.

Review of Resident # 80's November 2014 summary of physician's orders, which was signed

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as reviewed by UC # 1 on 10/31/14, revealed Tramadol was not included with the medications listed. The summary of orders was signed by the physician on 11/06/14.

Review of Resident # 80's November 2014 MAR revealed Tramadol was not listed on the MAR.

Review of Resident # 80's December 2014 summary of physician's orders, which was signed as reviewed by UC # 1 on 11/30/14, revealed Tramadol was not included with the medications listed. The summary of orders was signed by the physician on 12/08/14.

Review of Resident # 80's December 2014 MAR revealed the following entry: Tramadol 50 mg one tablet by mouth every 6 hours PRN pain. Nursing documentation on the MAR indicated the Tramadol had been given all but 3 days in December 2014 and was given twice on 12/19/14 and 12/28/14.

Review of Resident # 80's January 2015 summary of physician's orders, which was signed as reviewed by UC # 1 on 12/31/14, revealed Tramadol was not included with the medications listed. The summary of orders was signed by the physician on 01/11/15.

Review of Resident # 80's January 2015 MAR revealed the following entry: Tramadol 50 mg one tablet by mouth every 6 hours PRN pain. Nursing documentation on the MAR indicated the Tramadol had been given all but 3 days in January 2015 and was given twice on 01/04/15 and 01/07/15.

Further review of Resident # 80's physician's

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orders revealed a telephone order dated 01/28/15 for Tramadol 50 mg one tablet by mouth every 6 hours as needed for back pain.

Review of Resident # 80's February 2015 summary of physician's orders, which was signed as reviewed by UC # 1 on 01/31/15, revealed Tramadol was not included with the medications listed.

Review of Resident # 80's February 2015 MAR revealed the following entry: Tramadol 50 mg one tablet by mouth every 6 hours PRN pain. Nursing documentation on the MAR indicated the Tramadol had been given all but 3 days in February 2015 beginning 02/01/15.

Further review of Resident #80's medical record revealed there was not a physician's order to discontinue the Tramadol after it was ordered on 11/05/12. There was also not an order to resume the Tramadol after it was omitted from the November 2014 summary of physician's orders and the November 2014 MAR as well as the December 2014 andJanuary 2015 summary of physician's orders until the order obtained on 01/28/15. Review of the February 2015 summary of physician orders revealed the Tramadol 50 mg one tablet by mouth every 6 hours PRN pain was not included on the summary.

An interview with the Director of Nursing (DON) on 02/17/15 at 2:45 PM revealed she did not have an explanation for the Tramadol being omitted from November 2014 through February 2015 summary of physician's orders and from the November 2014 MAR. The DON stated once the physician signed the monthly summary of physician's orders they were considered the

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F 333	Continued From page 30 current orders unless another order was written after that date. The DON stated the Medical Records coordinator entered physician's orders into the computer program that was used to generate the monthly summary of physician's orders and MARs and she must have overlooked the Tramadol.	F 333		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		3/27/15

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F 441	Continued From page 31 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to sanitize contaminated wound care supplies before placing them in a common storage area for 1 of 1 residents. (Resident #70) The findings included: Wound care was observed being performed by Nurse #4 on Resident #70 on 02/25/2015 at 3:57 PM. Nurse #4 cleansed the wound with normal saline and applied medicated cream to the wound bed with gloved hands then handled the tube of medicated cream and container of normal saline without changing gloves or washing hands. Nurse #4 did not sanitize the tube of medicated cream or container of normal saline after the tube of medicated cream and container of normal saline were handled by Nurse #4's gloved hands while she was performing wound care, applying medicated cream on resident's wound and dressing resident's wound prior to replacement in wound care supply cart. Nurse #4's gloved hands had been in contact with the bed of Resident #70's wound which was described as a stage 3 pressure ulcer in the medical record. The wound bed was beefy red. No drainage, bleeding or odor related to Resident #70's wound was observed.	F 441	F441 1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident # 70 by providing wound care using clean technique. Nurse #4 has been provided with one-to-one education regarding infection control practices related to when to change gloves, wash hands, and how to store treatment creams and other items to reduce the potential for the spread of infection. Treatment carts were cleaned and treatment items, such as tubes of medication and bottles, are stored appropriately. 2. Facility residents who receive wound treatments have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing has audited the facility□s treatment carts to ensure that items are separated appropriately and infection control practices are in place. 3. Measures put in place to ensure that the alleged deficient practice does not recur include: The Director of Nursing and Area Staff Development Manager will conduct	

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F 441	Continued From page 32 Nurse #4 verbalized that she does not sanitize wound care supplies prior to placing them back in the wound care supply cart during a staff interview immediately following wound care procedure. On 02/25/2015 at 4:19 PM Nurse #4 was observed placing the wound care supplies which had just been used to treat Resident #70 in a wound care cart drawer with supplies for use with other residents. Nurse #4 was observed placing the tube of contaminated, unlabeled medicated cream into an unlabeled box with other tubes of the medicated cream. Nurse #4 was observed placing the contaminated container of normal saline into a drawer with wound care supplies intended for use treating other residents. Nurse #4 had not labeled the container of normal saline with the resident's name or dated the container of normal saline after she had opened it in preparation to perform wound care. A staff interview was conducted with Director of Nurses and Unit Coordinator #2 on 02/25/2015 at approximately 5:00 PM. The Director of Nurses and Unit Coordinator #2 both verbalized that the facilities in-service and training materials did not instruct staff to sanitize wound care supplies and equipment prior to placing them back into the wound care cart and that resident's wound care supplies and equipment were commonly stored together in the wound care carts throughout the facility.	F 441	in-service education for licensed nurses regarding infection control practices that reduce the potential for the spread of disease or infection; specifically, wound care supplies are to be handled with clean gloves/hands and if treatment supplies are touched with soiled hands/gloves, then the vessel must be wiped down with an appropriate disinfecting agent and labeled prior to returning the item to the central treatment cart. In addition, treatment medications that are specific to an individual are to be kept in separate plastic bags and housed in the treatment cart away from common supplies such as gauze pads, saline bottles, or other wound care supplies. The Director of Nursing and Area Staff Development Manager will complete skill observations for clean dressing changes for three licensed nurses per week until all nurses have been observed. Thereafter, the Director of Nursing and Area Staff Development Manager will conduct a total of two wound care observations per month for four months to validate that proper infection control techniques are being employed. The Director of Nursing and Unit Coordinator will audit the contents of the treatment carts weekly for four weeks, then monthly for four months to ensure that treatment items are stored appropriately to reduce the potential for infection. 4. The Director of Nursing will review the results of audits and observations, analyze the data to determine patterns/trends and report to the QAPI committee every other month. The QAPI	

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F 441	Continued From page 33	F 441	committee will evaluate the effectiveness of the plan and may amend the plan based on identified outcomes to ensure continued compliance.	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure physician's orders and Medication Administration Records (MARs) were complete and accurate for 5 of 6 residents reviewed for unnecessary medications (Residents # 31, 53, 80, 125 and 130). The findings included: 1. Resident # 31 was admitted to the facility on 11/26/13 with diagnoses including diabetes mellitus and congestive heart failure. His most recent care plan dated 12/26/14 addressed his need for monitoring of blood glucose levels with	F 514	F514 1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident #31 by obtaining a signed clarification order for Capillary Blood Glucose testing and Sliding Scale Insulin administration and placing the orders on the Medication Administration Record (MAR). Resident #53s order for Artificial Tears was clarified on 2/26/15 and the MAR was updated to reflect the change. Resident #80s order for Tramadol has been reviewed for accuracy and the MAR is	3/27/15

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daily capillary blood glucose (CBG) tests and sliding scale insulin as ordered.

Review of Resident # 31's January and February 2015 summary of physician's orders, which were signed as approved by the physician, revealed there were no orders for CBG tests or sliding scale insulin before meals and at bedtime. Further review of the medical record did not reveal any orders on the current chart for CBG tests or sliding scale insulin before meals and at bedtime.

Nurse # 1 was observed on 02/26/15 at 11:41 AM performing a CBG test on Resident # 31 and obtained a result of 246. Nurse # 1 was observed checking the dosage parameters on the Sliding Scale Insulin Administration Record, then administering Novolog insulin 4 units to Resident # 31 and documenting the CBG and insulin administration on the record.

An interview with Unit Coordinator (UC) # 1 on 02/26/15 at 3:01 PM revealed she was unable to locate a signed physician's order on Resident # 31's chart for CBG tests or sliding scale insulin. UC # 1 stated the parameters for the sliding scale insulin were listed on the Blood Glucose Tracking/Sliding Scale Insulin Administration Record. When asked if the physician reviewed the document and approved the dosage parameters, UC # 1 stated the physician didn't review or sign the document to approve the dosage parameters.

An interview with the Medical Records coordinator on 02/26/15 at 3:20 PM revealed the facility stopped including the CBG and sliding scale insulin orders on the monthly summary of

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reflective of the correct administration order. Resident #130s order for Pepcid has been corrected to include the ordered administration times.

2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing and Unit Coordinators have completed an audit of current physicians orders and Medication Administration Records to determine accuracy of transcription. Any discrepancies were corrected upon identification.

3. Measures put in place to ensure the alleged deficient practice does not recur include:

The Director of Nursing amd Area Staff Development Manager will conduct in-service re-education for Licensed Nurses, Certified Medication Aides, and Health Information Manager regarding accuracy of the clinical record to include accuracy of transcription of physicians orders using the Five Rights of Medication Administration; specifically, a review of the facilitys practice of monthly recapitulation of orders and how to transcribe a physicians order. Licensed Nurses are to transcribe physicians orders accurately, physicians orders are to be validated by the licensed nurse to contain all necessary components of a medication order, and Licensed Nurses are to validate the accuracy of the information provided on the Medication Administration Record (MAR). Certified Medication Aides are to bring to the nurses attention any discrepancies identified during medication administration

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BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	516 WALL STREET WAYNESVILLE, NC 28786

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orders about 6 months ago. When asked what the system was for the physician reviewing and approving those orders, she acknowledged there was not a system in place for the physician to review the orders.

An interview with the Director of Nursing (DON) on 02/27/15 at 2:45 PM revealed the monthly summary of physician's orders was considered the currently approved orders after they were signed by the physician and should include all current orders for medication and treatment. The DON stated the nurses were not instructed to omit orders for CBG's and sliding scale insulin from the monthly summary of physician's orders and those orders should have been included on the January and February 2015 orders.

2. Resident # 53 was originally admitted to the facility on 05/02/14 and readmitted on 02/03/15 with diagnoses including congestive heart failure, hypertension and diabetes mellitus.

Review of Resident # 53's readmission orders dated 02/03/15 revealed an order for "artificial tears 1 drop three times a day" and did not specify the eye(s) to which they were to be administered.

Review of Resident # 53's February 2015 Medication Administration Record (MAR) revealed an entry which read: "artificial tears 1 drop three times a day" and did not specify the eye(s) to which they were to be administered.

During observation of administration of Resident #53's medication on 02/26/15 at 2:25 PM, Certified Medication Aide (CMA) # 1 removed a bottle of artificial tears labeled for Resident # 53

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passes so that the Five Rights of Medication Administration are followed.
The Health Information Manager is to enter physician□s orders accurately and timely to facilitate licensed nurse review of medication recapitulations on a monthly basis.
The Director of Nursing and Unit Coordinator will review new physician□s orders daily, Monday through Friday, during the morning clinical meeting and validate that the order has been correctly transcribed to the MAR. Orders for sliding scale insulin will be included in the physician□s order summary and on the MAR. On a monthly basis, the Director of Nursing, Unit Coordinators, and assigned Licensed Nurses will review the monthly recapitulation of physician□s orders to validate accuracy of transcription. Discrepancies will be corrected at the time of discovery. Newly admitted residents□ physician□s orders will be reviewed by the Director of Nursing during the morning clinical meeting to validate accuracy of transcription.
4. The Director of Nursing will review the results of audits and monthly recapitulations, analyze the data to identify patterns/trends monthly for four months and report findings to the QAPI committee. The QAPI committee will evaluate the effectiveness of the plan and may amend the plan based on identified outcomes to ensure continued compliance.

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from the medication cart. CMA # 1 read the MAR and stated: "he's always gotten drops in both eyes but it doesn't list it on the MAR. CMA then approached Unit Coordinator (UC) # 2 to ask for clarification.

UC # 2 checked the readmission orders for Resident # 53 dated 02/03/15 and confirmed the order did not specify the eye(s) to which the drops were to be administered. UC # 2 then checked the list of discharge medications on the hospital discharge summary which indicated 1 drop was to be administered to each eye. UC # 2 stated she wrote the readmission orders for Resident # 53 on 02/03/15 and overlooked including on the order that the drops were to be administered to both eyes. UC # 2 then wrote a clarification order and added the instructions to the MAR.

3. Resident # 80 was admitted to the facility on 11/05/12 with diagnoses including depression, dementia, chronic lumbago, hypertension and chronic pain syndrome. A quarterly Minimum Data Set (MDS) assessment dated 11/07/14 indicated she had moderately impaired cognitive skills for daily decision making and impaired short term and long term memory. Her most recent care plan dated 11/12/14 addressed the resident's chronic pain with need for administration of Tramadol, a medication used to treat pain, on an as needed (PRN) basis.

Review of Resident # 80's October 2014 summary of physician's orders revealed the list of medications included Tramadol 50 milligrams (mg) by mouth every 6 hours PRN pain with an origination date of 11/05/12.

Review of Resident # 80's October 2014

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Medication Administration Record (MAR) revealed the following entry: Tramadol 50 mg one tablet by mouth every 6 hours PRN pain. Nursing documentation on the MAR indicated the Tramadol had been given all but 5 days in October 2014 and was given twice on 10/01/14.

Review of Resident # 80's November 2014 summary of physician's orders revealed Tramadol was not included with the medications listed. The summary of orders was signed by the physician on 11/06/14.

Review of Resident # 80's November 2014 MAR revealed Tramadol was not listed on the MAR.

Review of Resident # 80's December 2014, January and February 2015 summary of physician's orders revealed Tramadol was not included with the medications listed.

Review of Resident # 80's December 2014 MAR revealed the following entry: Tramadol 50 mg one tablet by mouth every 6 hours PRN pain. Nursing documentation on the MAR indicated the Tramadol had been given all but 3 days in December 2014 and was given twice on 12/19/14 and 12/28/14.

Review of Resident # 80's January 2015 MAR revealed the following entry: Tramadol 50 mg one tablet by mouth every 6 hours PRN pain. Nursing documentation on the MAR indicated the Tramadol had been given all but 3 days in January 2015 and was given twice on 01/04/15 and 01/07/15.

Further review of Resident # 80's physician's orders revealed a telephone order dated 01/28/15

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for Tramadol 50 mg one tablet by mouth every 6 hours as needed for back pain.

Review of Resident # 80's February 2015 MAR revealed the following entry: Tramadol 50 mg one tablet by mouth every 6 hours PRN pain. Nursing documentation on the MAR indicated the Tramadol had been given all but 3 days in February 2015 beginning 02/01/15.

Further review of Resident #80's medical record revealed there was not a physician's order to discontinue the Tramadol after it was ordered on 11/05/12. There was also not an order to resume the Tramadol after it was omitted from the November 2014 summary of physician's orders and the November 2014 MAR as well as the December 2014, January 2015 and February 2015 summary of physician's orders.

An interview with the Director of Nursing (DON) on 02/17/15 at 2:45 PM revealed she did not have an explanation for the Tramadol being omitted from November 2014 through February 2015 summary of physician's orders and from the November 2014 MAR. The DON stated once the physician signed the monthly summary of physician's orders they were considered the current orders unless another order was written after that date. The DON stated there should have been an order to discontinue the Tramadol before it was omitted from the November 2014 summary of physician's orders and MAR. She stated there should have been an order to resume the Tramadol before it was added to the December 2014 MAR. The DON stated she expected the physician's orders to correspond with the medications listed on the MAR and for both documents to be complete and accurate.

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4. Resident # 125 was admitted to the facility on 12/19/14 with diagnoses including diabetes mellitus and chronic ischemic heart disease. His most recent care plan dated 12/31/14 addressed his need for monitoring of blood glucose levels with daily capillary blood glucose (CBG)) tests and sliding scale insulin as ordered.

Review of Resident # 125's January and February 2015 summary of physician's orders, which were signed as approved by the physician, revealed there were no orders for CBG tests or sliding scale insulin before meals and at bedtime. Further review of the medical record revealed an admission order dated 12/19/14 which listed "Insulin Aspart sliding scale before meals and at bedtime" but did not include the type of insulin or dosage parameters for the sliding scale insulin.

Nurse # 3 was observed on 02/25/15 at 4:28 PM performing a CBG test on Resident # 125 and obtained a result of 296. Nurse # 3 was observed checking the dosage parameters on the Sliding Scale Insulin Administration Record, then administering Novolog insulin 6 units to Resident # 125 and documenting the CBG and insulin administration on the record.

Nurse # 2 was observed on 02/26/15 at 12:00 PM performing a CBG test on Resident # 125 and obtained a result of 284. Nurse # 2 was observed checking the dosage parameters on the Sliding Scale Insulin Administration Record, then administering Novolog insulin 6 units to Resident # 125 and documenting the CBG and insulin administration on the record.

An interview with Unit Coordinator (UC) # 1 on

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F 514	Continued From page 40 02/26/15 at 3:01 PM revealed she was unable to locate a signed physician's order on Resident # 125's chart that listed specific parameters for sliding scale insulin. UC # 1 stated the parameters for the sliding scale insulin were listed on the Blood Glucose Tracking/Sliding Scale Insulin Administration Record. When asked if the physician reviewed the document and approved the dosage parameters, UC # 1 stated the physician didn't review or sign the document to approve the dosage parameters. UC # 1 stated the specific dosage parameters for the sliding scale insulin should have been included on the admission orders. An interview with the Medical Records coordinator on 02/26/15 at 3:20 PM revealed the facility stopped including the CBG and sliding scale insulin orders on the monthly summary of orders about 6 months ago. When asked what the system was for the physician reviewing and approving those orders, she acknowledged there was not a system in place for the physician to review the orders. An interview with the Director of Nursing (DON) on 02/27/15 at 2:45 PM revealed the monthly summary of physician's orders was considered the currently approved orders after they were signed by the physician and should include all current orders for medication and treatment. The DON stated the nurses were not instructed to omit orders for CBG's and sliding scale insulin from the monthly summary of physician's orders and those orders should have been included on the January and February 2015 orders. 5. Resident # 130 was admitted to the facility on 02/11/15 with diagnoses which included relapsed	F 514		

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F 514	Continued From page 41 non-Hodgkin's lymphoma, hypertension and gastroesophageal reflux disease (GERD). Her most recent care plan dated 02/24/15 addressed her need for a proton pump inhibitor for treatment of GERD. The interventions included: administer medication per order and monitor for abdominal pain, nausea and vomiting, diarrhea, increased flatulence and headache. Her admission physician's orders dated 02/11/15 included Pepcid (a proton pump inhibitor) 20 milligrams (mg) one tablet twice a day. Review of the February 2015 Medication Administration Record (MAR) revealed Pepcid 20 mg one tablet twice a day was listed on the MAR but the administration time was listed for once a day at 5:00 PM. Nursing documentation on the MAR indicated the Pepcid was administered once a day from 02/11/15 through 02/26/15 when the surveyor brought the medication error to staff's attention. Visual inspection of the medication package for Pepcid 20 mg revealed it was labeled as dispensed from the pharmacy on 02/11/15 and the package label indicated the medication was to be administered twice a day. An interview on 02/26/15 at 4:07 PM with Unit Coordinator (UC) # 1 about the process for transcribing physicians orders revealed the charge nurse transcribed new orders onto the MAR. When asked if the facility had a system for verifying accuracy of the transcription of orders, UC # 1 stated the facility did not have a formal system for double checking the accuracy of transcription of physician's orders. UC # 1 stated she checked the transcription of orders when requested to do so by the charge nurse but didn't	F 514		

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verify the accuracy of transcription on a routine basis.

During an interview on 02/27/15 at 1:33 PM with the Geriatric Nurse Practitioner (GNP), the GNP was asked if there was any adverse effect on Resident # 130 from receiving half the prescribed dosage of Pepcid for the first 15 days of her admission to the facility. The GNP stated she didn't think Resident # 130 suffered any harm but she expected the medication to be administered as prescribed.

An interview on 02/27/15 at 3:18 PM with the Director of Nursing (DON) about the facility's process for verifying the accuracy of transcription of medication orders for newly admitted residents revealed the facility protocol was to complete a chart audit the day after a resident was admitted but the person who did the audit failed to identify the error on Resident # 130's MAR.