STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOWING ROCK REHAB DAVANT EXTENDED CARE CTR	418 CHESTNUT STREET BLOWING ROCK, NC 28605

(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 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		4/27/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/27/2015

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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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews the facility failed to report within 24 hours and failed to submit a 5 working day report for an allegation of abuse to the North Carolina Health Care Personnel Registry for 1 of 1 resident sampled for abuse. (Resident #41). The findings included: Resident #41 was re-admitted to the facility on 09/02/14 with diagnoses which included lung disease, difficulty swallowing, high blood pressure, thyroid disease and heart disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 03/10/15 indicated Resident #41's cognition was moderately impaired and required extensive assistance by staff for activities of daily living. During an interview with Resident #41 on 03/31/15 at 12:25 PM she replied yes when questioned if staff, a resident or anyone else had abused her. She explained it wasn't that long ago when it happened but she could not recall the date or day of week. She further explained it happened one evening at supper time when she dropped a soda in the floor and spilled it and a nurse aide (NA) made her eat her supper in her room. She confirmed she had reported it to a nurse but could not remember a name. A review of abuse investigations conducted by the facility revealed there were no 24 hour reports or 5 working day reports to the North Carolina Healthcare Personnel Registry regarding Resident #41.	F 225	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance with the State and Federal regulations as outlined. To remain in compliance with all Federal and State regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been completed by 04/27/15. How the corrective action will be accomplished for the resident(s)affected. The incident for Resident #41 dated 02/09/15 was immediately investigated and a 24 Hour/5 Day report submitted to the Health Care Registry on 04/02/15. The investigation was determined unintentional and unsubstantiated. The CNA was interviewed by the Social Services Director, the Administrator, and the Consultant on 04/02/15. The Social Services director spoke with Resident #41 again on 04/02/15. Education on the facility Abuse policy, and the Federal and State regulations, and the definition of Abuse and Neglect was provided the Administrator and the DON including reporting and the definition of seclusion by the Consultant on 04/02/15. How the corrective action will be	

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F 225	Continued From page 2 A review of an electronic mail (email) document dated 02/11/15 at 7:20 AM from Nurse #7 who worked the 11:00 PM to 7:00 AM shift and routinely provided care to Resident #41 indicated he sent information to the Director of Nursing (DON) and Administrator that Resident #41 had asked to speak with him about something important. The document revealed Resident #41 stated the day before yesterday on Monday 02/09/15 she dropped a soda on the floor in the lobby, then a NA took her to her room, cleaned her up, put her in a hospital gown, and made her eat dinner in her room. The document indicated Nurse #7 was not a witness to these events, and could not attest to the accuracy of the statements, but he assured Resident #41 that he would inform the DON and Administrator of what she had told him. A review of a facility document titled Complaint Monitoring Tool dated 02/11/15 at 8:46 AM indicated a complaint was received by the Social Worker (SW) related to Resident #41 and the type of complaint was listed as quality of care. A handwritten note on the tool indicated to see attached and the attached document was the email from Nurse #7. During an interview on 04/02/15 at 4:14 PM the SW confirmed Nurse #7 had sent the email to the DON and Administrator and then it was forwarded to her. She explained she printed the email and attached it to a Complaint Monitoring Tool and then she talked with Resident #41. She stated she informed Resident #41 they had received an email from Nurse #7 and reviewed it with her. The SW explained she did not realize Resident #41 was upset about being made to eat supper in her room. She further explained she thought	F 225	accomplished for those residents with the potential to be affected by the same practice. An audit of other incidents and complaints from 01/01/15 until the current date was completed on 04/27/15. There were no other incidents that required investigation and reporting. Measures put in place to ensure practices will not occur. The Administrator and DON were educated on 04/02/15 by the Corporate Consultant on timely reporting to other officials in accordance with the Federal and State regulations. All current staff completed Abuse and Neglect education inculding mandated reporting via the TEDs module and virtual orientation with a scenario on seclusion requiring successful pass of the test questions on 04/24/15. All current Nurses and Department Heads completed TEDs education on "A Simple Approach to Investigation" on 04/24/15. Education on Abuse and Neglect will be added into the general orientation for all new hires and then required quarterly via the TEDs modules for all employees. Completion of the first general orientation was on 04/27/15 and then will be ongoing. How the facility plans to monitor and ensure correction is achieved and sustained. All complaints and incidents will be reported to and reviewed by the	

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F 225	Continued From page 3 Resident #41 was upset because she was put in a hospital gown after she had spilled her soda and was told by the NA she could not be in the hallway with pajamas on. She stated she talked with the NA after she had talked with Resident #41 but did not write down what the NA said. She stated the former Administrator told her not to classify it as an investigation for abuse but to classify the incident as a complaint and since the Administrator made the final decisions she did not pursue it further. She confirmed there was no 24 hour or 5 working day reports sent to the North Carolina Health Care Personnel Registry. During an interview on 04/02/15 at 5:28 PM the DON stated after she received the email from Nurse #7 it was given to the SW and then they met with the former Administrator and discussed it. She confirmed she did not interview Resident #41 after she received the email dated 02/11/15 because the former Administrator told her the SW should interview the resident. She explained the Administrator made the final decision and told them to classify the incident as a complaint instead of an allegation of abuse and verified there was no 24 hour or 5 working day reports filed with the North Carolina Healthcare Personnel Registry. During an interview on 04/02/15 at 6:15 PM the current facility Administrator and a Consultant confirmed they were unaware of Resident #41's concerns about being made to eat supper in her room after she spilled her soda and a 24 hour and 5 working day report should have been submitted when the incident occurred.	F 225	Administrator, DON, and Social Workers and assessed within 24 hours of the incident to ensure timely investigation and reporting. Failure to report will result in immediate action to include education and/or disciplinary action. The 24 hour/5 day report will be reviewed in the weekly Risk Agenda. The Administrator presented to the hospital Performance Improvement Leadership on 04/22/15 the survey deficiencies, the Federal Guidelines of each deficiency, and the facility actions. The Administrator/designee will present all 24 hour/5 day reports in the facility Quality Assurance Meedting monthly X 4. The Administrator/designee will report to the hospital Performance Improvement Committee quarterly X 3 on the survey deficiencies and actions for revision/resolution to ensure compliance.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		4/27/15

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F 226	Continued From page 4 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews the facility failed to investigate an allegation of abuse and failed to submit a 24 hour and 5 working day report for an allegation of abuse to the North Carolina Health Care Personnel Registry for 1 of 1 resident sampled for abuse. (Resident #41). The findings included: A review of a facility policy titled Abuse Prevention and Reporting with a revised date of 08/24/13 indicated in part a definition of abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. A section titled Internal Reporting Requirements and Identification of Allegations indicated in part supervisors shall immediately inform the social worker (SW), chief clinical officer or nursing administrator on call of all reports of potential mistreatment and upon learning of the report the SW or designee shall initiate an incident investigation. The policy also indicated the notified individual will complete the 24 Hour Initial Report Notification of Facility Allegation and fax to the Division of Health Service Regulation within 24 hours. The policy further indicated all investigations would be completed and faxed	F 226	How the corrective action will be accomplished for the resident(s)affected. The incident for Resident #41 dated 02/09/15 was immediately investigated and a 24 Hour/5 Day report submitted to the Health Care Registry on 04/02/15. The investigation was determined unintentional and unsubstantiated. The CNA was interviewed by the Social Services Director, the Administrator, and the Consultant on 04/02/15. The Social Services director spoke with Resident #41 again on 04/02/15. Education on the facility Abuse policy, and the Federal and State regulations, and the definition of Abuse and Neglect was provided the Administrator and the DON including reporting and the definition of seclusion by the Consultant on 04/02/15. How the corrective action will be accomplished for those residents with the potential to be affected by the same practice. An audit of other incidents and complaints from 01/01/15 until the current date was completed on 04/27/15. There were no	

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F 226	Continued From page 5 within 5 working days to the Division of Health Service Regulation and the investigator would report the conclusion of the investigation in writing to the Administrator and notify the North Carolina Health Care Personnel Registry if the allegation was determined to be valid and involved the mistreatment of a resident by a health care worker. Resident #41 was re-admitted to the facility on 09/02/14 with diagnoses which included lung disease, difficulty swallowing, high blood pressure, thyroid disease and heart disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 03/10/15 indicated Resident #41's cognition was moderately impaired and required extensive assistance by staff for activities of daily living. During an interview with Resident #41 on 03/31/15 at 12:25 PM she replied yes when questioned if staff, a resident or anyone else had abused her. She explained it wasn't that long ago when it happened but she could not recall the date or day of week. She further explained it happened one evening at supper time when she dropped a soda in the floor and spilled it and a nurse aide (NA) made her eat her supper in her room. She confirmed she had reported it to a nurse but could not remember a name. A review of abuse investigations conducted by the facility revealed there were no investigations related to Resident #41 and there were no 24 hour reports or 5 working day reports to the North Carolina Health Care Personnel Registry. A review of an electronic mail (email) document dated 02/11/15 at 7:20 AM from Nurse #7 who	F 226	other incidents that required investigation and reporting. Measures put in place to ensure practices will not occur. The Administrator and DON were educated on timely reporting to other officials in accordance with the Federal and State regulations by the Consultant on 04/02/15. All staff completed Abuse and Neglect education inculding mandated reporting via the TEDs module and virtual orientation with a scenario on seclusion requiring successful pass of the test questions on 04/24/15. All Nurses and Department Heads completed TEDs education on "A Simple Approach to Investigation" on 04/24/15. Education on Abuse and Neglect will be added into the general orientation for all new hires and then required quarterly via the TEDs modules for all employees. Completion of the first general orientation was on 04/27/15 and then will be ongoing. How the facility plans to monitor and ensure correction is achieved and sustained. All complaints and incidents will be reported to and reviewed by the Administrator, DON, and Social Workers and assessed within 24 hours of the incident to ensure timely investigation and reporting. Failure to report will result in immediate action to include education and/or disciplinary action. The 24 hour/5 day report will be reviewed in the weekly	

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F 226	Continued From page 6 worked the 11:00 PM to 7:00 AM shift and routinely provided care to Resident #41 indicated he sent information to the Director of Nursing (DON) and Administrator that Resident #41 had asked to speak with him about something important. The document revealed Resident #41 stated the day before yesterday on Monday 02/09/15 she dropped a soda on the floor in the lobby, then a NA took her to her room, cleaned her up, put her in a hospital gown, and made her eat dinner in her room. The document indicated Nurse #7 was not a witness to these events, and could not attest to the accuracy of the statements, but he assured Resident #41 that he would inform the DON and Administrator of what she had told him. A review of a facility document titled Complaint Monitoring Tool dated 02/11/15 at 8:46 AM indicated a complaint was received by the Social Worker (SW) related to Resident #41 and the type of complaint was listed as quality of care. A handwritten note on the tool indicated to see attached and the attached document was the email from Nurse #7. During an interview on 04/02/15 at 4:14 PM the SW confirmed Nurse #7 had sent the email to the DON and Administrator and then it was forwarded to her. She explained she printed the email and attached it to a Complaint Monitoring Tool and then she talked with Resident #41. She stated she informed Resident #41 they had received an email from Nurse #7 and reviewed it with her. The SW explained she did not realize Resident #41 was upset about being made to eat supper in her room. She further explained she thought Resident #41 was upset because she was put in a hospital gown after she had spilled her soda	F 226	Risk Agenda. The Administrator presented to the hospital Performance Improvement Leadership on 04/22/15 the survey deficiencies, the Federal Guidelines of each deficiency, and the facility actions. The Administrator/designee will present all 24 hour/5 day reports in the facility Quality Assurance Meedting monthly X 4. The Administrator/designee will report to the hospital Performance Improvement Committee quarterly X 3 on the survey deficiencies and actions for revision/resolution to ensure compliance.	

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F 226	Continued From page 7	F 226		

and was told by the NA she could not be in the hallway with pajamas on. She stated she talked with the NA after she had talked with Resident #41 but did not write down what the NA said. She stated the former Administrator told her not to classify it as an investigation for abuse but to classify the incident as a complaint. She stated she did what the Administrator told her to do and confirmed there was no investigation done for possible abuse. The SW further stated there was no 24 hour or 5 working day reports sent to the North Carolina Health Care Personnel Registry.

During an interview on 04/02/15 at 5:28 PM the DON stated after she received the email from Nurse #7 she gave it to the SW and they met with the former Administrator and discussed it. The DON confirmed she did not interview Resident #41 after she received the email dated 02/11/15 because the former Administrator told her the SW should interview the resident. She explained the Administrator made the final decisions and told them to classify the incident as a complaint instead of an allegation of abuse and there were no 24 hour or 5 working day reports filed with the North Carolina Health Care Personnel Registry. The DON stated she felt there was a misunderstanding because staff thought Resident #41 was upset because she could not wear her pajamas in the hallway but the resident's concern about being made to eat dinner in her room was not investigated as possible abuse.

During an interview on 04/02/15 at 6:15 PM the current facility Administrator and a Consultant confirmed they were unaware of Resident #41's concerns about being made to eat supper in her room after she spilled her soda. They further

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F 226	Continued From page 8 stated the 24 hour and 5 working day reports should have been submitted when the incident occurred and an investigation should have been done.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to adjust medication administration times to avoid waking a resident for a respiratory inhaler at scheduled hours during the night and failed to dress residents in personal clothing instead of hospital gowns for 3 of 4 residents sampled for dignity. (Resident #37, #57 and #38). The findings included: 1. Resident #37 was re-admitted to the facility on 04/04/14 with diagnoses which included chronic lung disease, high blood pressure, thyroid disease, chronic pain, heart failure, anemia, anxiety and Parkinson's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 01/08/15 indicated Resident #37 was cognitively intact and required limited assistance with Activities of Daily Living. A review of monthly Medication Administration Records from October 2014 through March 2015	F 241	How the corrective action will be accomplished for the resident(s) affected. Resident(s) #37,57,and #38 were immediately provided clean clothing on 04/02/15. A physician order was obtained for clarification for Resident #37's inhaler to be PRN at night per Resident choice on 04/02/15. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. An audit of all current residents was completed on 04/27/15 to ensure clean clothing of a proper fit was available. An audit of physician orders for night administration of medications was completed on 04/27/15.	4/27/15

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F 241	Continued From page 9 indicated Duoneb (respiratory inhaler) 2.5/0.5 milligrams (mg)/3 milliliters (ml) was given daily every 4 hours at 2:30 AM, 6:30 AM, 10:30 AM, 2:30 PM, 6:30 PM and 10:30 PM. A review of monthly physician's orders dated March 2015 indicated Duoneb 2.5/0.5 mg/ 3 ml every 4 hours at 2:30 AM, 6:30 AM, 10:30 AM, 2:30 PM, 6:30 PM and 10:30 PM. During an interview on 04/02/15 at 6:48 AM with Nurse #7 he confirmed Resident #37 had a Duoneb inhaler routinely scheduled every 4 hours because of chronic lung disease. He explained he was allowed to give resident medications 1 hour before or 1 hour after they were scheduled to be given and he usually went into Resident #37's room around 9:00 PM or 9:30 PM and gave him his Duoneb inhaler and most of the time Resident #37 was awake. He further explained he woke Resident #37 for the 2:30 AM dose and asked him if he wanted it and sometimes he did and sometimes he refused it. Nurse #7 stated he also woke Resident #37 for the 6:30 AM dose and he usually did not refuse that dose. He stated he felt bad about waking Resident #37 to give him medication at night but it couldn't be done any other way or he didn't know of any other way to do it. During an interview on 04/02/15 at 9:50 AM with Resident #37 he confirmed nurses woke him up during the night to give him a respiratory inhaler. When asked how it made him feel to be woke up during the night he stated "it don't." When asked to clarify he stated he didn't like it and when the nurses woke him up he couldn't go back to sleep and if he was at home he would not get up during the night to use his inhaler. He stated he would	F 241	Measures in place to ensure practices will not occur The DON/designee educated on 04/27/15 the physicians and current nursing staff that each resident has a right to make choices about his or her life in the facility and the right not to be awakened at night while asleep for medicaions. Nursing was educated by the DON/designee that each resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. Medication will be scheduled PRN during the night shift to ensure the resident receives undisturbed sleep and/or has the medications scheduled while awake. the resident has the right to refuse the medication and request not to be awakened. The administration time will be clarified with the physician the next day. Completed 04/27/15. The Dining Manager educated staff on Dignity with the Dining Process on 03/27/15. Education of all current staff by the Social Services Director was completed on 04/27/15 and included the definition of dignity, Resident Rights, choices, hygiene, and grooming as defined by the State and Federal regulations. Resident Rights, choices,Dignity, oral and hygiene education will be added into the general orientation for all new hires and then required quarterly via the TEDs modules. How the facility plans to monitor and	

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F 241	Continued From page 10 rather be able to call the nurse for his inhaler when he needed it. During an interview on 04/02/15 at 5:21 PM the Director of Nursing (DON) stated it was her expectation for medications to be scheduled during resident's waking hours. She confirmed she was unaware Resident #37 received a Duoneb inhaler routinely every 4 hours and was awakened during the night for the medication. She stated she was not sure if this was something Resident #37 wanted or if it worked for him and the physician should be consulted to determine what times the medication was reasonable for the resident's condition. 2) Resident #57 was admitted to the facility on 11/03/14 with diagnoses which included aphasia (speechless), epileptic seizure disorder, and multiple joint contractures. The Quarterly Minimum Data Set (MDS) dated 01/23/15 coded Resident #57's cognition as severely impaired and was totally dependent on staff for bed mobility, transfers, dressing, eating, bathing, personal hygiene, and always incontinent of bowel and bladder. Resident #57 was observed on 04/01/15 at 6:32 AM laying in his bed asleep, wearing a hospital gown, bed covers up to his waist area, the TV on a cartoon channel, and the door was opened. On 04/01/15 at 7:02 AM, nurse aide (NA) #1 was observed to enter Resident #57's room. She was observed to wake the resident, she spoke to him, raised the head of his bed to a 35 to 45 degree angle, left the TV playing on the cartoon channel, left the resident in a hospital gown, and left the room.	F 241	ensure correction is achieved and sustained. The Department Heads will audit 10 residents each daily for oral care, to ensure fresh clothing is offered and available, to verify the nails are trimmed and clean, hair combed, facil hair trimmed per resident choice, privacy provided with care, knocking occuring prior to room entry, and minimal signage posting. The DON/designee will audit (10) residents weekly X (3) weeks for for oral care, to ensure fresh clothing is offered and available, to verify the nails are trimmed and clean, hair combed, facil hair trimmed per resident choice, privacy provided with care, knocking occuring prior to room entry, and minimal signage posting. The Administrator/designee will audit (10) ten random residents monthly for for oral care, to ensure fresh clothing is offered and available, to verify the nails are trimmed and clean, hair combed, facil hair trimmed per resident choice, privacy provided with care, knocking occuring prior to room entry, and minimal signage posting. The Administrator/DON/designee will report the results for for oral care, to ensure fresh clothing is offered and available, to verify the nails are trimmed and clean, hair combed, facil hair trimmed per resident choice, privacy provided with care, knocking occuring prior to room entry, and minimal signage posting to the	

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F 241	Continued From page 11 Resident #57 was observed on 04/01/15 at 11:43 AM in his bed, with the head of his bed at a 35 to 45 degree angle, wearing the hospital gown, and the TV was on a cartoon channel. Resident #57 was observed on 04/01/15 at 3:34 PM, the door to his room was open, he was wearing a hospital gown, and laying in his bed with his eyes opened. Resident #57 was observed on 04/02/15 at 10:33 AM, the door to his room was opened, he was wearing a hospital gown, and laying in his bed with his eyes opened. Resident #57 was observed on 04/02/15 at 12:23 PM, with the door to his room opened, he was laying in his bed with his eyes opened, wearing a hospital gown, and the TV was on a cartoon channel. On 04/02/15 at 1:48 PM, NA #1 was observed coming out of Resident #57's room. The door was opened, the TV was on a cartoon channel, the resident was in his bed with his eyes opened, and he was wearing a hospital gown. An interview was conducted on 04/02/15 at 2:09 PM with NA #1. She stated she was expected to put a shirt or a sweatshirt on Resident #57 every day. She indicated she had not dressed him in his own clothes because some of his clothes had gotten too small. She further stated she had not advised the nurse or the social worker of his clothes being too small. An interview was conducted on 04/02/15 at 2:50 PM with Nurse #5. She indicated she had	F 241	Quality Assurance Committee monthly X (3) months. Failure to achieve compliance will result in education and/or disciplinary action. The Administrator will report the results of the Quality Assurance Committee to the Performance Improvement Committee quarterly X (3) three to ensure compliance.	

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administered the resident's medications earlier in the morning and noted he was wearing a hospital gown. She stated she would have expected the NAs to have dressed him in his own clothes and to have informed her if his clothes were too small. She indicated she was unaware Resident #57's clothes to be too small and he was to be dressed in his own clothes every day as that was the preference of his family.

An interview was conducted on 04/02/15 at 3:37 PM with NA #2. She stated she was aware Resident #57 was supposed to be dressed in his own clothes every day and she had no answer as to why he was in a hospital gown. She indicated she was unaware of his clothes being too small.

An interview was conducted on 04/02/15 at 3:44 PM with the Social Worker. She stated she was unaware of Resident #57's clothes being too small. She indicated it was almost impossible to contact Resident #57's family member because they were in the military and out of the state. She further indicated had she known about the resident's clothes to be too small she would have contacted the family, would have left a message, and they would have sent bigger clothes for him. She stated she would have expected the NAs to have dressed Resident #57 in his own clothes every day. She further stated she was aware the preference of the family was to have him dressed every day.

An interview was conducted on 04/02/15 at 5:39 PM with the Director of Nursing (DON). She stated Resident #57 had clothes hanging in his closest and she would have expected the NAs to have dressed him in his own clothes every day. She further stated she was unaware of Resident

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F 241	Continued From page 13 #57's clothes being too small. 3) Resident #38 was admitted to the facility on 10/26/09 with diagnoses which included Alzheimer's disease, dementia, osteoporosis, anemia, and cardiac dysrhythmias. The Quarterly MDS dated 03/17/15 coded Resident #38's cognition as severely impaired but capable of making her needs known. Resident #38 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene, and was totally dependent on staff for transfers and bathing. The resident was frequently incontinent of bladder and always incontinent of bowel. Further review of the MDS coded Resident #38's preferences for customary routine as to be very important for her to choose her own clothes to wear. Resident #38 was observed on 04/01/15 at 6:34 AM laying in her bed asleep, wearing a hospital gown, the bed covers up to her neck, and the door to be opened about 6 inches. On 04/01/15 at 8:03 AM, a nurse aide (NA) #2 was observed to enter Resident #38's room. She was observed to wake the resident up, she spoke to the resident, raised the head of her bed to a 45 degree angle, turned on the resident's TV, she left the resident in a hospital gown, and left the room. Resident #38 was observed on 04/01/15 at 11:53 AM lying in her bed, with the head of her bed at a 30 degree angle, and to be wearing a hospital gown. Resident #38 was observed on 04/01/15 at 4:34	F 241		

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PM, with the door to her room opened, lying in bed with her eyes opened, and to be wearing a hospital gown.

An interview was conducted on 04/01/15 at 4:36 PM with Resident #38. She stated she preferred to be in her own gown or her own clothes. She indicated "they just put on me whatever they can find and I don't like it but what can I do about it." She further indicated on her shower days the NAs would dress her in her own clothes and if she soiled her own clothes the NAs would dress her in a hospital gown.

Resident #38 was observed on 04/02/15 at 11:33 AM, with the door to her room opened, laying in her bed with her eyes opened, and to be wearing a hospital gown.

An interview was conducted on 04/02/15 at 2:09 PM with NA #1. She stated she was expected to put Resident #38 in her own gown or her own clothes every day. She further stated out of habit she would pick up a hospital gown with the towels and washcloths before going into a resident's room to assist them with a bath. She stated she occasionally asked Resident #38 what she wanted to wear but there were times without thinking she dressed Resident #38 in a hospital gown out of convenience.

An interview was conducted on 04/02/15 at 2:50 PM with Nurse #5. She indicated she had been in and out of Resident #38's room and noted she was wearing a hospital gown but had not thought anything about it since the resident could make her needs known. She further stated she would have expected the NAs to have dressed Resident #38 in her own clothes.

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F 241	Continued From page 15 An interview was conducted on 04/02/15 at 3:37 PM with NA #2. She stated Resident #38 was supposed to be dressed in her own clothes every day and she had no answer as to why the resident was dressed in a hospital gown. An interview was conducted on 04/02/15 at 5:39 PM with the DON. She stated she would have expected the NAs to have dressed Resident #38 in her own gown and/or her own street clothes based on the resident's preference. She further stated Resident #38 was capable to voice her own needs and/or wants and that the NAs were expected to ask the resident's what they preferred.	F 241		
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 record review, observation, staff interview and family interview, the facility failed to carry out good grooming, oral hygiene and fingernail care for 2 of 3 residents sampled for activities of daily living (Resident #7 & #118). Findings included: 1. The 5/12/14 significant change Minimum Data Set for Resident #7 revealed he had diagnoses	F 312	How the corrective action will be accomplished for the resident(s) affected. On 04/01/15, oral care was immediately provided Resident #37 after a brief in-service on prividing Oral Care Without a Battle. Resident #118 received nail care immediately on 04/02/15. How corrective action will be	4/27/15

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F 312	Continued From page 16 including hypertension, cerebrovascular accident, dementia, hemiplegia, seizure disorder, anxiety, depression and psychotic disorder other than dementia. Resident #7 was seen by a dentist on 9/15/14 for an annual exam. The dentist wrote in his consultation notes, "Has teeth. Combative. Unable to exam. Resident #7 was assessed on the 2/9/15 quarterly review Minimum Data Set as being totally dependent for dressing and personal hygiene, including oral care. His care plan dated 3/25/15 indicated that he "Requires extensive to dependent assistance with ADLs (Activities of Daily Living)." The goal was, "Will be clean and well-groomed through next review." Approaches included, "Staff to assist with dressing daily & prn (as needed)." Another care plan problem was "Aspiration risk for related dysphagia." The goal was resident will have no complications of aspiration through next review. One approach included, "Assist with oral care as resident allows." The care plan also provided approaches for how to deliver care to Resident #7. These included, " Be patient/allow ample time/DO NOT rush ... Approach resident slowly, strike up conversation before starting care. If resident becomes combative leave and try to approach later." Review of the Care Guide revealed that oral care was not included on the sheet of instructions. Review of the ADL Flow Sheet for March 2015 revealed Resident #7 received a bath on 3/30/15. Family interview on 3/30/15 at 8:15 P.M. and 9:08 P.M. said, "It looks like his clothes are dirty all of the time" and " His teeth are awful." Observations on 3/31/15 at 8:16 A.M. revealed Resident #7 was wearing a dark blue sweat shirt that was dirty with flaky looking material on it. On	F 312	accomplished for those residents with the potential to be affected by the same practice. Oral Care was provided to all current residents on 04/02/15. An audit was conducted on 04/27/15 of all current resident's nails to ensure all nails were clean and trimmed. Measures in place to ensure practices will not occur. Education on Oral Care Without a Battle was completed on 04/27/15 for all current staff. All current staff completed education through TEDs on Resident Rights, Respect, and Dignity by the TEDs modules on 04/27/15. All current staff completed education on the facility policy on hygiene and oral care on 04/27/15. The Department Heads will visually audit (10) ten Residents daily for oral care and nail care. Weekly, the Team Leaders will audit (10) ten Residents for completion of oral care. any refusals will be reported to and documented by the Charge Nurse. Refusals of oral care and nail care will be reported to the DON/Administrator/designee. The staff will attempt to have the Resident participate with oral and nail care. Any continued refusals will be reported and discussed during Morning Meeting for possible resolutions/interventions. Oral Care Without a Battle DVD education	

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F 312	Continued From page 17 3/31/15 at 3:54 P.M., the resident was wearing the same sweat shirt with flaky substances on it. On 3/31/15 at 3:56 P.M. Resident #7's teeth were observed from an arm's length distance and looked okay. On 3/31/15 the ADL flow sheet for dressing was coded "4/3" meaning he was totally dependent on two or more staff for ADL Assistance and Support even though his sweat shirt was not changed. Oral care was not on the ADL flow sheet. On 4/1/15 at 8:23 A.M., the Director of Nurses was observed feeding Resident #7. The resident was wearing the same soiled sweat shirt. NA #2 and NA #3 were observed providing incontinence care on 4/1/15 at 9:26 A.M. The NAs changed his brief. They did not change his sweat shirt. The resident was not wearing pants. The resident was observed again on 4/1/15 at 2:39 P.M. wearing the same dirty sweat shirt. NA #2 was interviewed at this time and said, "I have not done anything for Resident #7 yet. Someone else fed him. We won't do anything until we finish with trays." On 4/1/15 at 3:14 P.M. Nurse #3 said, "When we try (to brush his teeth), he clenches his teeth. It is not on the care guide. I would assume they do it when they round." She confirmed that he was scheduled for showers on Monday and Friday. On 4/1/15 at 3:22 P.M. the Director of Nurses said, "I did not brush his teeth after breakfast." Interview with NA #2 on 4/1/15 at 3:50 P.M. revealed, "Oral care is done after meals. I did not feed him and I don't know who did." An interview with NA #1 on 4/1/15 at 4:57 P.M. revealed, she fed Resident #7 lunch today, but did not give any ADL care except for wiping his mouth after lunch. On 4/1/15 the ADL flow sheet for dressing was coded "4/3" meaning he was totally dependent on two or more staff for	F 312	will be added into the general orientation for all new hires and then required quarterly via the TEDs modules on good hygiene including oral and nail care. How the facility plans to monitor and ensure correction is achieved and sustained. The Administrator/DON/designee will conduct random audits of oral and nail hygiene on (15) fifteen Residents daily X (1) one week; random audits of oral and nail hygiene on (15) fifteen Residents weekly X (2) two weeks; and random audits of oral and nail hygiene on (15) fifteen Residents monthly X (2) two months. Failure of compliance will result in immediate action to include education and/or disciplinary action. The Administrator/DON/designee will report the results of the audits to the Qualtiy Assurance committee monthly X (3) three months. The Administrator will report the results of the audits to the Performance Improvement Committee quarterly X (3) three.	

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ADL Assistance and Support even though his sweat shirt was not changed.

On 4/2/15 at 8:05 A.M. the Administrator reported that staff reviewed the Mouth Care without a Battle educational material and provided mouth care last night. Nurses' notes on 4/1/15 at 6:07 P.M. included, "Resident became combative during evening care, swinging at staff and trying to bite CNA providing mouth care. Resident bit the end off mouth swab and had a difficult time getting him to spit it out. Will attempt later." On 4/1/15 at 7:24 P.M. notes included, "RN approached resident after supper to do mouth care. Resident was in a calm pleasant mood at this time and opened mouth upon command. Two nurses in at this time; one to distract; one to clean teeth. We were able to clean mouth with mouthwash and water on a pink swab but some food and debris remains that will need to be removed with routine cleanings."

On 4/2/15 at 7:40 A.M. and at 8:36 A.M. when the resident was fed breakfast, he had the same soiled sweat shirt on.

2. Resident #118 was admitted to the facility on 03/17/15 with diagnoses which included depression and Alzheimer's dementia. A review of admission Minimum Data Set (MDS) worksheets dated 03/20/15 indicated Resident #118 had short and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS worksheets also indicated Resident #118 required extensive assistance for activities of daily living (ADLs) which included hygiene but was totally dependent on staff for bathing.

A review of a care plan dated 03/30/15 revealed a

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problem statement that Resident #118 required staff assistance for all activities of daily living and the goal indicated he would be able to participate in part of ADLs through next review. The approaches were listed in part to provide 1 staff to assist resident with bathing and give baths in the morning as Resident #118 got more agitated in the evening and if Resident #118 was resistant to attempt later.

A review of shower and bath schedules indicated Resident #118 was to receive a bath or shower on Wednesday and Sunday of each week.

During an observation on 03/31/15 at 9:57 AM Resident #118 was lying in bed in his room and his fingernails on his left hand were uneven and long with brown debris under each of the nails. His right hand was under the sheet and not visible.

During an observation on 04/01/15 at 2:45 PM Resident #118 was lying in bed in his room and had his hands lying across the top of his stomach. The fingernails on his left hand were approximately ¼ inch beyond the fingertips and uneven with dark brownish debris under each of the nails. The fingernails on his right hand were long and approximately ¼ inch beyond the fingertips except 1 fingernail was broken with jagged edges and the nail on the middle finger was bluish/black in color.

During an observation on 04/02/15 at 12:10 PM Resident #118 was sitting on the side of his bed eating lunch and picked up food with his fingers and placed it in his mouth. The fingernails on his left hand were approximately ¼ inch beyond the fingertips and uneven with dark brownish debris

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under each of the nails. The fingernails on his right hand were long and approximately ¼ inch beyond the fingertips except 1 fingernail was broken with jagged edges and the nail on the middle finger was bluish/black in color.

During an interview on 04/02/15 at 2:16 PM with Nurse Aide (NA) #1 she confirmed she gave Resident #118 a bath last night. She explained Resident #118 couldn't do anything for himself and she gave him a bath in the whirlpool tub.

During an interview on 04/02/15 at 2:17 PM with NA #2 she stated she was assigned to care for Resident #118 with NA #1 but had only been assigned to Resident #118's care for a couple of days. She further stated she had not cleaned or trimmed his nails.

During a follow up interview on 04/02/15 at 2:51 PM with NA #1 she explained when she gave Resident #118 his bath last night she washed his hands but did not trim his nails.

During an observation and interview on 04/02/15 at 3:00 PM with Nurse #2 she went into Resident #118's room and examined his fingernails on both hands. She confirmed Resident #118's fingernails needed to be cleaned under each of them and they needed to be trimmed or filed. She described the nails on Resident #118's left hand as uneven, long and dirty with brownish debris underneath each nail. She then described the nails on Resident #118's right hand as uneven, long and dirty with brownish debris underneath each nail except the middle finger on his right hand had a bluish/black nail bed. Nurse #2 stated the NAs should have done nail care when he had his bath and she would have

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F 312	Continued From page 21 expected for NAs to tell her if Resident #118 had refused to have his nails cleaned or trimmed. She further stated no one had reported to her Resident #118 had refused to have his nails cleaned or trimmed but they needed to be cleaned and trimmed. During an interview on 05/04/15 at 5:01 PM the Director of Nursing (DON) stated it was her expectation for NAs to clean under resident ' s nails and trim and file them as needed when residents received their bath or shower. She further stated she expected for NAs to report to the nurse if a resident refused to have their nails cleaned or trimmed.	F 312		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		4/27/15

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	345045	A. BUILDING _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 22 drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, pharmacy, and staff interviews, for 8 months the facility failed to respond to a pharmacy recommended dose reduction (RDR) of the medication Temazepam, a benzodiazepine hypnotic used for sleep disorder, for 1 of 5 residents sampled for maintaining a drug regimen free of unnecessary medications (Resident #65). The findings included: Resident #65 was admitted to the facility on 04/11/14 with diagnoses which included anxiety disorder and depression. Review of the most recent quarterly Minimum Data Set (MDS) dated 02/06/15 coded Resident #65's cognition as moderately impaired and capable of making her needs known. Further review of the MDS revealed Resident #65 required extensive assistance with bed mobility, transfers, dressing, and was totally dependent on staff for toileting, personal hygiene, and bathing. The MDS further revealed Resident #65 received a hypnotic medication 7 out of 7 days a week. Resident #65 was observed on 04/02/15 at 7:12 AM to be in her bed at a 45 degree angle, the overhead light on, her eyes closed, and was unable to be awakened by a knock on her door. Resident #65 was observed on 04/02/15 at 12:02	F 329	How the corrective action will be accomplished for the resident(s) affected. The Pharmacy Recommendations for Resident #65 were addressed by the physician on 02/01/15. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. All current resident pharmacy recommendations were reviewed and addressed by each treating physician for March and April of 2015 and completed on 04/24/15. Measures in place to ensure practices will not occur. The Administrator completed physician education on 04/23/15 concerning the regulations for Pharmacy Recommendations, Gradual Dose Reduction, the rationale, and the prevention of unnecessary medications. How the facility plans to monitor and ensure correction is achieved and sustained.	

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F 329	Continued From page 23 PM, with her lunch tray on the over bed table across her body in front of her, her eyes heavy, and was unable to eat her lunch without nodding off to sleep. Resident #65 was observed on 04/02/15 at 2:23 PM to be in her bed and unable to have a conversation without nodding off to sleep. Review of the medical record revealed a physician's order dated 04/11/14 for Temazepam 30 milligrams (mg) by mouth every night (QHS). Review of the Medication Administration Records (MARs) for the past 6 months dated September 2014 to February 2015 revealed the orders were transcribed for Resident #65 to be started on Temazepam 30 mg by mouth every night on 04/11/14. Further review of the MARs indicated the 30 mg was documented to have been given every night since 04/11/14 through 02/10/15. Review of a document titled "Pharmacist's Monthly Medication Regimen Review" dated 04/24/14 indicated a Pharmacy RDR of the current dose Temazepam 30 mg one capsule by mouth every night exceeded the recommended geriatric limit of Temazepam 15 mg one capsule by mouth every night. Further review of the document revealed no indication of a physician's review. Review of the Pharmacy RDR dated 05/21/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of a physician's review.	F 329	The DON/designee will ensure the Pharmacy Recommendations are flagged and placed on the charts for the physicians by the last week of each month. The DON/designee will audit Pharmacy Recommendations for completion by the 8th of each month. The Pharmacist will monitor Pharmacy Recommendation completion and report monthly to the DON/Administrator/designee unaddressed recommendations. Failure of compliance will result in immediate action to include education and/or disciplinary action. The Medical Director will be notified of physicians not completing the recommendations in a timely manner and ensure physician recommendations are addressed immediately. The Administrator/designee will report the results to the Qualtiy Assurance Committee monthly X (3) three months. The Pharmacy consultant will provide a report during the Performance Improvement Committee meeting on a total number of Pharmacy recommendations and the number that were accepted, denied, and incomplete. The Pharmacist will also report to the Performance Recommendations for Gradual Dose Reductions that were accepted, denied, or incomplete.	

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F 329	Continued From page 24	F 329		

Review of the Pharmacy RDR dated 06/18/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of a physician's review.

Review of the Pharmacy RDR dated 07/15/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of a physician's review.

Review of the Pharmacy RDR dated 08/12/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of a physician's review.

Review of the Pharmacy RDR dated 09/08/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of a physician's review.

Review of the Pharmacy RDR dated 10/14/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of a physician's review.

Review of a Physician's order dated 11/06/14 indicated Temazepam 30 mg by mouth QHS.

Review of the Pharmacy RDR dated 11/20/14

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F 329	Continued From page 25	F 329		

indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of a physician's review.

Further review of the Pharmacy RDR dated 12/09/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR was reviewed, signed by a physician, and dated 01/26/15.

A Physician's order dated 02/10/15 indicated Temazepam 15 mg by mouth QHS.

An interview was conducted on 04/02/15 at 4:24 PM with Nurse #1. She stated she had been the liaison for the pharmacy/physician recommendations since February 2015. She indicted the Pharmacist brought the RDR sheets to her weekly and her expectation was for the physician's to review, sign, and date the RDR sheets at least monthly but her goal was to have the RDR sheets reviewed bi-weekly. She further indicated the RDR sheets should have been reviewed by the physician.

An interview was conducted on 04/02/15 at 4:42 PM with the Pharmacist. She stated she had spoken with the physician related to the maximum dose of Temazepam 30 mg and had received no response from the physician prior to 01/26/15. She further stated she would have expected the physician to review and communicate his recommendation in more of a timely manner.

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F 329	Continued From page 26 The facility physician was unavailable for an interview. An interview was conducted on 04/02/15 at 5:39 PM with the Director of Nursing (DON). She stated the facility had a system in place for the RDR sheets to be reviewed in more of a timely manner. She further stated it was her expectation for the process to be followed each month and it was not done in this case.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to prevent two significant medication errors by not administering OxyContin as ordered and not obtaining a pulse prior to the administration of Levothyroxine for 2 of 8 residents observed during medication administration (Resident #80 and #77). The findings included: 1) Resident #80 was re-admitted to the facility on 02/18/15 with diagnoses which included a history of falls and back pain. The Admission Minimum Data Set (MDS) dated 02/25/15 coded Resident #80's cognition as moderately impaired and capable of making her needs known. On 04/02/15 at 8:52 AM Nurse #6 was observed during medication pass observation to pull from	F 333	How the corrective action will be accomplished for the resident(s) affected. The pulse for Resident #77 was taken after the Synthroid administration during the Med Pass observation on 04/01/15. The Oxycontin blister pack was immediately re-labeled for Resident #80 to reflect the dose change on 04/02/15. How the corrective action will be accomplished for those resident(s) with the potential to be affected by the same practice. An audit of all Synthroid medications was completed on 04/17/15 for accuracy and parameter monitoring. An audit of all	4/27/15

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F 333	Continued From page 27 the narcotic drawer the pharmacy bubble packed card with the label affixed on the card which read in part OxyContin 20 milligrams (mg) tablet, take one tablet by mouth every 12 hours. On the facility document titled "Control Drug Count Sheet" read in part OxyContin 20 mg tablet, take 1 tablet by mouth every 12 hours and on the pharmacy printed label affixed to the drug sheet the "12 Hours" was noted to have a line marked through it and next to the 12 hours was hand written, AM (morning) changed 02/2015. A review of Resident #80's medical record for medication reconciliation the physician's order dated 02/18/15 read OxyContin 20 mg extended release by mouth every 12 hours for pain. A review of Resident #80's Medication Administration Record (MAR) dated 02/18/15 through 02/25/15 revealed the order had been correctly transcribed for administration of OxyContin 20 mg by mouth every 12 hours according to the physician's order. An interview was conducted with Nurse #6 on 04/02/15 at 9:12 AM. She stated the medication label on the bubble pack was wrong and should have read for the OxyContin 20 mg to be administered every morning and not every 12 hours. She further stated the facility had stickers that should have been placed on the bubble pack that would have indicated the physician's change in the medications frequency. Nurse #6 had no explanation as to why the label had not been changed. An interview was conducted with the Director of Nursing (DON) on 04/02/15 at 5:39 PM. She stated she expected the nurses to follow the	F 333	narcotic blister packs was completed on 04/17/15 for accurate labeling. Measures in place to ensure practices will not occur. All nursing staff completed education on Medication Administration by the DON/designee to include the Seven Rights of Order Transcription, Medication Administration, Pharmacy labeling, and recommended Synthroid monitoring on 04/27/15. Education on the Seven Rights of Order Transcription, Medication Administration, Pharmacy labeling, and Synthroid monitoring will be added into the general orientation for all new hires and then required quarterly via the TEDs modules. How the facility plans to monitor and ensure correction is achieved and sustained. The DON/designee will monitor Medication Administration on all shifts for all nurses for (2) two weeks; monitor random nurse Medication Administration monthly X (1) month; and then ongoing until a Medication Pass score with <5% error is achieved. Any failure of compliance will result in immediate education and/or disciplinary action. The DON/designee will report to the monthly Quality Assurance Committee on the results of the Med Pass audits for compliance and/or re-evaluation. The Administrator/designee will report to the	

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F 333	Continued From page 28 physician's orders and to administer medications at the correct times and frequency. She further stated she would have expected the nurse and/or nurse's to have changed the label to have reflected the change in frequency from the administration of every 12 hours to every morning for Resident #80's medication. 2) Resident #77 was admitted to the facility on 09/26/14 with diagnoses which included hypothyroidism. On 04/01/15 at 6:42 AM Nurse #7 was observed during medication pass observation to administer Levothyroxine (thyroid medication) 50 micrograms (mcg) by mouth to Resident #77 and no pulse was checked prior to the administration of the medication. A review of Resident #77's medical record for medication reconciliation the physician's order dated 09/26/14 read in part Levothyroxine 50 mcg tablet 1 by mouth every morning at 6:30 AM, check pulse prior to administration. A review of Resident #77's Medication Administration Records (MARs) dated 03/01/15 through 04/01/15 revealed the order had been correctly transcribed for the pulse to be checked prior to the administration of Levothyroxine 50 mcg every morning at 6:30 AM and there was a pulse documented for every day except for 04/01/15. An interview was conducted with Nurse #7 on 04/02/15 at 6:48 AM. He stated he was aware of the side effects being that of a fast or irregular heart rate and difficulty in breathing and the importance to have checked the pulse prior to the	F 333	Performance Improvement Committee on the results of the Med Pass audits quarterly X (3) three to ensure compliance.	

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F 333	Continued From page 29 administration of the Levothyroxine. He further stated he was in a hurry and had forgot to check Resident #77's pulse before he had given the resident the Levothyroxine medication. An interview was conducted with the Director of Nursing (DON) on 04/02/15 at 5:39 PM. She stated she expected the nurses to follow the physician's orders. She further stated her expectation was for the nurse's to always check Resident #77's pulse prior to the administration of the Levothyroxine medication.	F 333		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record reviews, pharmacy, and staff interviews, the facility failed to respond to a pharmacist recommendation for a dose reduction of the medication Temazepam, a benzodiazepine hypnotic used for sleep disorder, for 1 of 5 residents reviewed for unnecessary medications (Resident #65). The findings included:	F 428	How the corrective action will be accomplished for the resident(s) affected. The Pharmacy Recommendations for Resident #65 were addressed by the physician on 02/01/15. How corrective action will be accomplished for those residents with the	4/27/15

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F 428	Continued From page 30 Resident #65 was admitted to the facility on 04/11/14 with diagnoses which included anxiety disorder and depression. Review of the most recent quarterly Minimum Data Set (MDS) dated 02/06/15 coded Resident #65's cognition as moderately impaired and capable of making her needs known. Further review of the MDS revealed Resident #65 required extensive assistance with bed mobility, transfers, dressing, and was totally dependent on staff for toileting, personal hygiene, and bathing. The MDS further revealed Resident #65 received a hypnotic medication 7 out of 7 days a week. Review of the medical record revealed a physician's order dated 04/11/14 for Temazepam 30 milligrams (mg) by mouth every night (QHS). Review of the Medication Administration Records (MARs) for the past 6 months dated September 2014 to February 2015 revealed the orders were transcribed for Resident #65 to be started on Temazepam 30 mg by mouth every night on 04/11/14. Further review of the MARs indicated the 30 mg was documented to have been given every night since 04/11/14 through 02/10/15. Review of a document titled "Pharmacist's Monthly Medication Regimen Review" dated 04/24/14 indicated a Pharmacy RDR of the current dose Temazepam 30 mg one capsule by mouth every night exceeded the recommended geriatric limit of Temazepam 15 mg one capsule by mouth every night. Further review of the document revealed no indication of the facility's review and/or a physician's review. Review of the Pharmacy RDR dated 05/21/14	F 428	potential to be affected by the same practice. All current resident pharmacy recommendations were reviewed and addressed by each treating physician for March and April of 2015 and completed on 04/24/15. Measures in place to ensure practices will not occur. The Administrator completed physician education on 04/23/15 concerning the regulations for Pharmacy Recommendations, Gradual Dose Reduction, the rationale, and the prevention of unnecessary medications. How the facility plans to monitor and ensure correction is achieved and sustained. The DON/designee will ensure the Pharmacy Recommendations are flagged and placed on the charts for the physicians by the last week of each month. The DON/designee will audit Pharmacy Recommendations for completion by the 8th of each month. The Pharmacist will monitor Pharmacy Recommendation completion and report monthly to the DON/Administrator/designee unaddressed recommendations. Failure of compliance will result in immediate action to include education and/or disciplinary action.	

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F 428	Continued From page 31 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of the facility's review and/or a physician's review. Review of the Pharmacy RDR dated 06/18/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of the facility's review and/or a physician's review. Review of the Pharmacy RDR dated 07/15/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of the facility's review and/or a physician's review. Review of the Pharmacy RDR dated 08/12/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of the facility's review and/or a physician's review. Review of the Pharmacy RDR dated 09/08/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of the facility's review and/or a physician's review.	F 428	The Medical Director will be notified of physicians not completing the recommendations in a timely manner and ensure physician recommendations are addressed immediately. The Administrator/designee will report the results to the Qualtiy Assurance Committee monthly X (3) three months. The Pharmacy consultant will provide a report during the Performance Improvement Committee meeting on a total number of Pharmacy recommendations and the number of recommendations that were accepted, denied, or incomplete. The Pharmacist will also report to the Performance Improvement Committee on the Pharmacy Recommendations for Gradual Dose Reductions that were accepted, denied, or incomplete.	

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F 428	Continued From page 32	F 428		

Review of the Pharmacy RDR dated 10/14/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of the facility's review and/or a physician's review.

Review of a Physician's order dated 11/06/14 indicated Temazepam 30 mg by mouth QHS.

Review of the Pharmacy RDR dated 11/20/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR revealed no indication of the facility's review and/or a physician's review.

Further review of the Pharmacy RDR dated 12/09/14 indicated the recommended maximum dose for Temazepam in geriatric residents would be 15 mg per day and Resident #65's current dose was Temazepam 30 mg per day. The Pharmacy RDR was reviewed, signed by a physician, and dated 01/26/15.

A Physician's order dated 02/10/15 indicated Temazepam 15 mg by mouth QHS.

An interview was conducted on 04/02/15 at 4:24 PM with Nurse #1. She stated she had been the liaison for the pharmacy/physician recommendations since February 2015. She indicted the pharmacist brought the RDR sheets to her weekly and her expectation was for the physician's to review, sign, and date the RDR sheets at least monthly but her goal was to have the RDR sheets reviewed bi-weekly. She further

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F 428	Continued From page 33 indicated the facility had a system in place for the review of the pharmacy RDR sheets to be reviewed and signed by the facility physician's monthly. An interview was conducted on 04/02/15 at 4:42 PM with the Pharmacist. She stated she had spoken with the physician related to the maximum dose of Temazepam 30 mg and had received no response from the facility and/or the physician prior to 01/26/15. She further stated she would have expected the facility and/or the physician to have reviewed and communicated the recommendation in a timely manner. The facility physician was unavailable for an interview. An interview was conducted on 04/02/15 at 5:39 PM with the Director of Nursing (DON). She stated the facility had a system in place for the RDR sheets to be reviewed in more of a timely manner. She further stated it was her expectation for the process to be followed each month and it was not done in this case.	F 428		
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. Drugs and biologicals used in the facility must be	F 431		4/27/15

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F 431	Continued From page 34 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, record review, and staff interviews, the facility failed to label the correct frequency on a bubble pack for OxyContin, a pain medication for 1 of 8 residents observed during medication administration (Resident #80). The findings included: Resident #80 was re-admitted to the facility on 02/18/15 with diagnoses which included a history of falls and back pain. The Admission Minimum Data Set (MDS) dated 02/25/15 coded Resident #80's cognition as moderately impaired and	F 431	How the corrective action will be accomplished for resident(s) affected. The Oxycontin blister pack for Resident #80 was immediately corrected with the appropriate label on 05/02/15. How the corrective action will be accomplished for those residents with the potential to be affected by the same practice. An audit of all narcotic blister packs was	

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F 431	Continued From page 35 capable of making her needs known. On 04/02/15 at 8:52 AM during medication pass observation Nurse #6 was observed to remove a pharmacy packed bubble card from the narcotic drawer to be administered to Resident #80. Further observation revealed the label on the card was identified with Resident #80's name, the name of the medication; OxyContin, how the medication was to be administered; every 12 hours, and the medication route was by mouth (PO). On the facility document titled "Control Drug Count Sheet" read in part OxyContin 20 mg tablet, take 1 tablet by mouth every 12 hours and on the pharmacy printed label affixed to the drug sheet the "12 Hours" was noted to have a line marked through it and next to the 12 hours was hand written, AM changed 02/2015. A review of Resident #80's medical record for medication reconciliation the physician's order dated 02/18/15 read OxyContin 20 mg extended release (ER) by mouth (PO) every 12 hours (Q12Hrs) for pain. A review of Resident #80's Medication Administration Record (MAR) dated 02/18/15 through 02/25/15 revealed the order had been correctly transcribed for administration of OxyContin 20 mg PO Q12Hrs according to the physician's order. An interview was conducted with Nurse #6 on 04/02/15 at 9:12 AM. She stated the medication label on the bubble pack was wrong and should have read for the OxyContin 20 mg to be administered every morning and not every 12 hours. She further stated the facility had stickers that should have been placed on the bubble pack	F 431	completed on 04/27/15. Measures in place to ensure practices will not occur. All current Nurses completed education on correct Pharmacy labeling on 04/24/15. Correct Pharmacy labeling education will be added into the general orientation for all new hires and then required quarterly via the TEDs modules. How the facility plans to monitor and ensure correction is achieved and sustained. The DON/designee will audit all narcotic order changes and correct blister pack labeling (3) three times per week. The DON/designee will randomly audit all narcotic order changes and correct blister pack labeling monthly X (3) three months. Failure of compliance will result in education and/or disciplinary action. The DON/designee will report the results of the narcotic order changes and correct blister pack labeling to the Quality Assurance Committee monthly X (3) three months. The Administrator/designee will report the results of the correct labeling of pharmacy blister packs to the Performance Improvement Committee quarterly X (3) three to ensure compliance.	

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F 431	Continued From page 36	F 431		

which would have indicated the frequency of the medication had changed. She indicated she should not have administered the medication without the correct frequency labeled on the medication bubble pack card.

An interview was conducted with Nurse #1 on 04/02/15 at 4:14 PM. She stated she was responsible for medication reconciliation and the MARs. She indicated should an original physician's order be changed the facility has labels that should be placed on the bubble pack cards to have indicated the change. She further indicated her expectation was for the nurses to have placed a sticker on the bubble pack card when the new frequency order was received from the physician.

An interview was conducted on 04/02/15 at 4:42 PM with the pharmacist. She confirmed the OxyContin bubble pack was to be labeled with the frequency prior to dispensing and/or the administration of the medication to Resident #80. She stated the pharmacy policy was written to allow the facility to put a sticker on the label to indicate the correct frequency provided there was a physician's order.

An interview was conducted with the Director of Nursing (DON) on 04/02/15 at 5:39 PM. She stated she expected the nurses to follow the physician's orders. She further stated she would have expected the nurse that had taken the new physician's order to have followed through with the facility process and placed the stickers on the bubble pack card to have reflected the correct frequency from every 12 hours to every morning.

An interview was conducted with Nurse #8 on

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F 431	Continued From page 37 04/02/15 at 6:13 PM. She stated she had taken the order from the physician on the change of the frequency for Resident #80's medication. She further stated she was unsure as to why she had not followed through with the process of putting a sticker on the bubble pack card and/or on the control drug count sheet for the OxyContin frequency for Resident #80.	F 431		
F 514 SS=D	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 record reviews and staff interviews the facility failed to accurately transcribe a physician's order on the monthly physician's orders for 1 of 6 residents sampled for medication review. (Resident #119) The findings included: Resident #119 was admitted to the facility on 04/04/15 with diagnoses which included chronic	F 514	How the corrective action will be accomplished for the resident(s) affected. The accurate physician monthly summary for April was reprinted for Resident #119. Resident #119 was discharged from the facility on 04/15/15. How corrective action will be accomplished for those residents with the	4/27/15

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F 514	Continued From page 38 lung disease, pneumonia, anxiety and recent abdominal surgery. The most recent admission Minimum Data Set (MDS) dated 03/11/15 indicated Resident #119 was moderately impaired in cognition for daily decision making and required extensive assistance for activities of daily living. A review of a handwritten physician's order dated 03/06/15 at 7:45 PM indicated to discontinue Lovenox (used to prevent blood clots) 30 milligrams (mg) and start Lovenox 60 mg subcutaneously (SQ) every 12 hours for 2 weeks. A review of the monthly physician's orders dated March 2015 indicated Lovenox 60 mg by mouth every 12 hours twice a week. A review of the March 2015 Medication Administration Record (MAR) for March 2015 indicated Resident #119 received Lovenox 60 mg SQ every 12 hours for 2 weeks. During an interview on 04/02/15 at 3:35 PM with Nurse #1 she explained after a physician's order was handwritten it was entered into the computer system so it would appear with medications listed on the monthly physician's order sheets. She stated Resident #119 got the medication as it was hand written on the physician's order slip but the order was not entered accurately into the computer and was therefore incorrect on the monthly physician's orders. Nurse #1 explained she and another nurse entered the orders into the computer system and the orders were supposed to be double checked to make sure they were correct but it was somehow missed during the reviews of physician's orders.	F 514	potential to be affected by the same practice. All current Nurses completed the education on the Seven Rights for Order Trasncription and the importance to maintain a complete and accurate record via the TEDs modules on 04/24/15. An audit for accuracy of the physician monthly summary and the Resident MAR/TAR was completed on 04/27/15. Measures in place to ensure practices will not occur. Each order will be reviewed by the Team Leader within 24 hours of the entered written order. The 11-7 shift will audit all new orders for accuracy. Education on the Seven Rights of Practice for Order Transcription will be added to the general orientation for new nurse hires and then required quarterly via the TEDs modules. How the facility plans to to monitor and ensure correction is achieved and sustained. The DON/designee completed an audit of the entire facility was for April checking the Monthly Medication Summary, the Medication Administration Record,and the physician order for accuracy on 04/27/15. The DON/designee will conduct random audits for accuracy of the physician monthly summary and the MAR/TAR monthly X (3) months and ongoing. The DON/designee will report the results of	

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F 514	Continued From page 39 During an interview on 04/02/15 at 5:10 PM the Director of Nursing stated it was her expectation for the nurses to transcribe handwritten physician's orders accurately to the monthly physician's orders. After a review of Resident #119's handwritten physician's orders for Lovenox and the monthly physician's orders dated March 2015 she verified the orders did not match. She stated it was her expectation for nursing staff to check orders to make sure they matched correctly.	F 514	the audits to the monthly Quality Assurance Committee X (3) months. Failure of compliance will result in immediate action to include education and/or disciplinary action. The Administrator/designee will report the results of the audits to the quarterly Performance Improvement Committee X (3) to ensure compliance.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		4/27/15

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F 520	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November 2013. This was for one recited deficiency which was originally cited in November 2013 on a recertification survey and subsequently recited in April 2015 on the current recertification survey. The deficiency was in the area of dignity. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 241 Dignity: Based on observations, record reviews and resident and staff interviews the facility failed to adjust medication administration times to avoid waking a resident for a respiratory inhaler at scheduled hours during the night and failed to dress residents in personal clothing instead of hospital gowns for 3 of 4 residents sampled for dignity. (Resident #37, #57 and #38). During the recertification survey of 11/22/13 the facility was cited for failure to ensure dignity during dining when staff failed to remove a resident's plate from the table after she coughed and vomited in it in front of residents who were eating lunch during 1 of 1 meal observation.	F 520	How the corrective action will be accomplished for the resident(s) affected. All residents have the potential to be affected by Quality Assurance determinations. Measures in place to ensure practices will not occur. Quality Assurance Committees and sub-committees have been put in place to ensure ongoing Quality Assurances practices. Survey deficiencies and audit results will be discussed in the Morning Stand-Up Meeting. A weekly Risk Meeting was established to discuss the following clinical indicators: weights,wounds,falls, and the deficiencies. A monthly Quality Assurance meeting was established to identify patterns, trends,and monitor the interventions put into place from the Quality Assurance sub-committees, Risk Meetings, and action plans. How the facility plans to monitor and ensure correction is achieved and sustained. The Administrator/designee will report to the Performance Improvement Committee the results of the Quality Assurance and	

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F 520	Continued From page 41 (Resident #36, #4 and #6). On the current recertification survey F 241 was again recited for failure to adjust medication administration times to avoid waking a resident for a respiratory inhaler at scheduled hours during the night and failed to dress residents in personal clothing instead of hospital gowns for 3 of 4 residents sampled for dignity. (Resident #37, #57 and #38). During an interview on 04/02/15 at 7:00 PM the Director of Nursing (DON) explained they had done staff in-services for staff related to dignity since the last recertification survey but did not have monitoring tools in place. During an interview on 04/02/15 at 7:15 PM the Administrator and a Corporate Consultant stated the Quality Assessment and Assurance Committee had met on a monthly basis but at the last meeting on 03/19/15 a decision was made to change the meetings to every other month. The explained they had reviewed the action plans and meeting minutes but they didn't see where issues were followed through and addressed. They confirmed in-services had been conducted but there were no action plans or monitoring to ensure residents were treated with dignity and respect as part of the QA process. They further stated they could not tell what the QA committee had addressed to look at dignity and respect to prevent repeated deficiencies.	F 520	Risk Meetings. The Performance Improvement meeting will include items outlined from the hospital and will include quarterly the Quality Assurance process as outlined by the State and Federal regulations to review systems, improvement plans, structures, and updates.	