STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345278	A. BUILDING _____ B. WING _____	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN SURRY SNF	830 ROCKFORD STREET MOUNT AIRY, NC 27030

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain the medical confidentiality for 7 of 8 residents (Resident #1, #3, #11, #19, #23, #26, and #33) who received a physician order for Tamiflu.	F 164	Immediately medical information for residents, #1 #3 #11 #19 #23 #26 and #33 was removed from charts, other than their own. Physician order shows only name of each resident. One copy on each chart. Remedial education and counseling	5/14/15

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

Electronically Signed | 05/14/2015

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F 164	Continued From page 1 The findings included; Medical record review of Resident #1 revealed a physician order dated 1/21/15 that stated please administer Tamiflu 75miligrams (mg) one capsule daily x 14 days to residents #1 #3, #11, #19, #23, #26, and #33. The physician order was observed to be signed by the MDS coordinator (nurse # 2). Further review of Resident #1, #3, #11, #19, #23, #26, and #33 physician orders revealed a photo copy of the same order dated 1/21/15 for the administration of the medication Tamiflu 75mg one capsule daily x 14 days. Interview with Nurse #2 on 4/23/15 at 9:30 am revealed he was unaware that he could not put multiple residents' names on one physician order when multiple residents were being prescribed the same medication or treatment. Interview with the Director of Nursing on 4/23/15 at revealed it was her expectation that resident files not contain personal information about other residents.	F 164	provided to the staff, concerning privacy issues on 5/6/15. A plan was implemented to audit 100% of charts monthly, and correct any deficiency. Monitoring will be ongoing and reported to quality assurance quarterly.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review wht facility failed to identify, assess, care plan and provide medical justification prior to	F 221	Physician order obtained for restraint on resident #18. A breakaway belt, with Velcro closure is used. Resident will use	5/18/15

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F 221	Continued From page 2 using a soft belt restraint one of one sampled residents with a restraint. Resident #18. The findings included: Resident # 18 was admitted to the facility on 3/3/15 with diagnosis of fall with hematoma, late effects of stroke and dementia. Review of the social work note dated 3/10/15 revealed the resident had long and short term memory problems which impaired his decision making abilities. Resident #18 had a chair fall alert monitor to alert staff when "he tries to get up unassisted which he does often." Nurse's note dated 3/31/15 indicated Resident #18 had "stood up several times tonight sounding chair alarm." The Minimum Data Set dated 3/16/15 indicated the resident had severe impairment with cognition, required extensive assistance of one person for transfer, ambulation, toileting and personal hygiene. Human assistance was required to enable the resident to maintain balance when transferring and/or standing. There was no limitation in movement of his extremities. This MDS indicated he was continent of bowel and occasionally incontinent of bladder. Falls were indicated as occurring prior to the MDS and no restraints were in use for the resident. The incident/accident reports indicated Resident #18 had a fall on 4/1/15 and 4/7/15 while standing without assistance from the wheelchair. Review of the physician's orders dated 4/8/15	F 221	while in wheelchair only. Resident is able to remove at will. Resident will be able to move in wheelchair about unit. Restraint will prevent falls as he sometimes forgets he is unable to walk unassisted. Interventions in place showing restraint to be removed every 2 hrs. to assist with ADL□s. Restraint use added to the care plan. Initial restraint form completed. To ensure that the deficient practice will not reoccur and to address those residents having potential to be affected, education and counseling were provided to all staff regarding restraint use; including the use of breakaway belts and when they are considered a restraint and documentation required such as an order, restraint interventions, care plan, and quarterly restraint assessment. Monitoring will include any residents in breakaway belts every 2 hours daily to determine if the belt is considered a restraint and the presence of applicable orders and documenation. Restraint use is reported and reviewed quarterly in the Quality Assurance meeting.	

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F 221	Continued From page 3 indicated a soft belt was to be used while Resident #18 was in the wheelchair. The physician ' s order did not address the use of the soft belt as a restraint or indicate the medical diagnosis or physical symptoms that required the soft belt. Review of the care plan indicated the soft belt was not included as a problem or an intervention. . The nurse's note of 4/18/15 indicated the resident was alert and confused. He was incontinent and used pull ups. He propelled himself in the hallway in a wheelchair. A "break away belt and chair alarm" was in use. The resident "continues to attempt to get up unassisted at times." Observations on 4/21/15 at 2:30 PM revealed Resident #18 had a soft belt restraint in place around his waist while in a wheelchair. The back ties were secured by the end loops onto the bottom of the wheelchair base. The front of the belt was fastened by Velcro. Resident #18 was observed pulling at the soft belt, but did not remove it or unfasten it. Observations on 4/22/15 at 12:30 PM revealed the resident was in a wheelchair, soft belt restraint fastened and at a table eating lunch. A staff member was seated at his table. The soft belt was not released during the meal. Interview with MDS nurse on 04/22/2015 2:52 PM revealed the facility did not have any residents with a restraint at the present time. Interview on 04/22/2015 3:07 PM with the Director of Nursing (DON) revealed they were a restraint free facility. Resident #18 had a " break	F 221		

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F 221	Continued From page 4 away belt and could remove the belt." It was explained the belt was not considered a restraint since he could remove it at times. Further interview revealed Resident #18 was not consistent in removing the soft belt restraint on command. 04/22/2015 4:50 PM interview with aide #1 and aide #2 indicated Resident #18 would usually remove his belt when asked. Aide #1 explained it would depend "if he has had his meds or not." Aide #1 was asked to request Resident #18 to remove the soft belt. Observations of aide #1 and Resident #18 revealed he was asked to remove his belt and he would not remove it.	F 221		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		5/18/15

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F 279	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to develop a care plan for 1 of 4 sampled residents with existing contractures (Resident #20) and 1 of 1 sampled residents with restraints (Resident #18). The findings included: 1. Resident #20 was admitted to the facility on 10/13/2006 with diagnoses that included dementia. The most recent Minimum Data Set dated 2/3/15 revealed Resident #20 was totally dependent on staff for all activities of daily living with impairments to upper and lower extremities. Resident #20 was coded as being cognitively impaired for daily decision making. Review of Resident #20's care plan revised 2/24/15 revealed a "focus" of Resident #20 had an ADL self-care performance deficit. Resident is total care, no communication, and bed bound. The goal stated Resident #20 will maintain current level of function in though the review date. The interventions included, bathing/showers. The resident is totally dependent on 2 staff to provide bathing/shower 2 times a week as necessary. The interventions did not include Resident #20's contractures. Observations of Resident #20 on 4/22/15 at 8:30am revealed the resident to be lying in bed. The resident ' s left hand and arm was observed to be held tight to Resident #20 ' s chest with thumb protruding between clenched fists. The resident ' s right hand and right arm were	F 279	Care plan updated for resident #20 to include contractures. Remedial education given to staff regarding resident #20 to minimizing pain during ADLs, use of assistive devices, preventing or worsening of contractures, and monitoring decline. Education included documentation on residents with contractures. To ensure that the deficient practice will not reoccur and to address those residents having potential to be affected by the same deficient practice, remedial education was provided to all staff related to prevention of or worsening of contractures in residents, including minimizing pain during ADLs, use of assistive devices, and monitoring decline. Education to staff included documentation and update of the resident care plan. Monitoring will consist of weekly nursing assessments, and notes on all residents. Monitoring will be ongoing and reviewed at quarterly quality assurance meeting.	

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F 279	Continued From page 6 observed to be held tight to resident #20's chest. . Observations of Resident #20 on 4/23/15 at 11:00 am revealed the resident to be lying in bed with arms drawn upward toward Resident #20's chest. A blue carrot (device used for preventing further contracture and maintain healthy skin integrity) was observed to be in resident's right hand. Resident's left hand was observed to be closed as evidenced by resident's thumb protruding between middle finger and ring finger. Observation of Resident #20 on 4/23/15 at 1:50 pm revealed the resident to be lying in bed. Resident #20 was observed to be holding a blue carrot in her right hand. Resident #20 had no additional splinting device applied. Interview with NA#1 on 4/23/15 at 1:54 pm revealed Resident #20 was very tight in her upper arms and hands. NA#1 indicated that occasionally staff used a wash cloth and sometimes they used a blue carrot. NA#1 indicated she did not receive specifics in regards to how long resident #20 was to hold the carrot. NA#1 further indicated Resident #20 did not receive any range of motion services. Interview with NA#2 on 4/23/15 at 2:38 pm revealed Resident #20 was very stiff in her upper arms and elbows. The resident is very difficult to bath due to her hands and arms being so stiff. The resident typically and grimaced and moaned when bathing or personal care is provided. NA#2 stated that occasionally she will massage Resident #20's arm because she didn't want to hurt her. NA#2 further indicated there was slight tightness in Resident #20's knees. Resident #20's fingers do dig in her hand and a family	F 279		

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F 279	Continued From page 7 member preferred to cut the nails and the carrot prevented fingers to skin. Powder was occasionally used to make it easier to get the blue carrot into the right hand. NA#2 could not recall being provided directions for which hand the blue carrot was supposed to go in or how long. Sometimes it is put in the right hand and occasionally it is placed in the left. The NA indicated the named resident was not capable of moving any of her upper extremities. Interview with the Physical Therapy assistant (OT therapist unavailable) revealed she could only locate an Occupational therapy summary dated that indicated Resident #20 was to wear a carrot. The Physical therapy assistant was able to locate an order dated 12/2/10 that indicated Resident #20 had a right hand contracture. The plan of care stated discharge from OT. The progress note comment indicated that Resident #20 was to wear an orthopedic fitting on right hand splint and staff were educated on correct splint wear. Interview with the Director of Nursing (DON) on 4/23/15 at 2:56 pm revealed she was responsible for the development of resident care plans. The DON stated she did not care plan or devleop interventions in regards to Resident #20's contractures. 2. Resident # 18 was admitted to the facility on 3/3/15 with diagnosis of fall with hematoma, late	F 279		

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F 279	Continued From page 8	F 279		

effects of stroke and dementia.

Review of the social work note dated 3/10/15 revealed the resident had long and short term memory problems which impaired his decision making abilities. Resident #18 had a chair fall alert monitor to alert staff when "he tries to get up unassisted which he does often."

Nurse"s note dated 3/31/15 indicated Resident #18 had "stood up several times tonight sounding chair alarm."

The Minimum Data Set dated 3/16/15 indicated the resident had severe impairment with cognition, required extensive assistance of one person for transfer, ambulation, toileting and personal hygiene. Human assistance was required to enable the resident to maintain balance when transferring and/or standing. There was no limitation in movement of his extremities. This MDS indicated he was continent of bowel and occasionally incontinent of bladder. Falls were indicated as occurring prior to the MDS and no restraints were in use for the resident.

The incident/accident reports indicated Resident #18 had a fall on 4/1/15 and 4/7/15 while standing without assistance from the wheelchair.

Review of the physician's orders dated 4/8/15 indicated a soft belt was to be used while Resident #18 was in the wheelchair. The physician's order did not address the use of the soft belt as a restraint or indicate the medical diagnosis or physical symptoms that required the soft belt.

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F 279	Continued From page 9 Review of the care plan indicated the soft belt was not included as a problem or an intervention. Observations on 4/21/15 at 2:30 PM revealed Resident #18 had a soft belt restraint in place around his waist while in a wheelchair. The back ties were secured by the end loops onto the bottom of the wheelchair base. The front of the belt was fastened by Velcro. Resident #18 was observed pulling at the soft belt, but did not remove it or unfasten it. Observations on 4/22/15 at 12:30 PM revealed the resident was in a wheelchair, soft belt restraint fastened and at a table eating lunch. A staff member was seated at his table. The soft belt was not released during the meal. Interview with MDS nurse on 04/22/2015 2:52 PM revealed the facility did not have any residents with a restraint at the present time. Interview on 04/22/2015 3:07 PM with the Director of Nursing (DON) revealed they were a restraint free facility. Resident #18 had a "break away belt and could remove the belt." It was explained the belt was not considered a restraint since he could remove it at times. Further interview revealed Resident #18 was not consistent in removing the soft belt restraint on command. 04/22/2015 4:50 PM interview with aide #1 and aide #2 indicated Resident #18 would usually remove his belt when asked. Aide #1 explained it would depend "if he has had his meds or not." Aide #1 was asked to request Resident #18 to remove the soft belt. Observations of aide #1 and Resident #18 revealed he was asked to	F 279		

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F 279	Continued From page 10 remove his belt and he would not remove it.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to include interventions implemented to prevent falls on the care plan after falls occurred for one of two sampled residents with falls. Resident #18. The findings included: Resident admitted to the facility on 3/3/15 with diagnosis of fall with hematoma, late effects of	F 280	Care plan was updated on resident # 18 to include falls. For those residents having potential to be affected by the same deficient practice and to ensure that the deficient practice will not reoccur, a plan was implemented to update care plans within 72 hrs of any resident fall. Two nurses will review care plans to insure all interventions are in place to prevent future falls. A fall report will be	5/18/15

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F 280	Continued From page 11 stroke and dementia. The Minimum Data Set dated 3/16/15 indicated the resident required extensive assistance of one person for transfer, ambulation, toileting and personal hygiene. Human assistance was required to enable the resident to maintain balance when transferring and/or standing. There was no limitation in movement of his extremities. This MDS indicated he was continent of bowel and occasionally incontinent of bladder. Falls were indicated as occurring prior to the MDS completion. The care plan included a focus for high risk for falls related to the resident was unaware of safety needs, confusion, and gait and balance problems. The stated goals included the resident would be free of falls through the next review date, free of minor injury and not sustain serious injury. The interventions included staff were to anticipate and meet resident's needs, the call light to be within reach, encourage use and ask for assistance, the resident needed prompt response to all requests for assistance and follow fall protocol. The use of a seat alarm and soft belt while in the wheelchair were not included on the care plan. Review of the incident reports for falls were as follows: - 4/1/15 in PM. Resident #18 was alert, disoriented and high risk for falls. Resident #18 was in the wheelchair (w/c). He stood up without assistance and fell to floor landing on his bottom. There were no injuries. - 4/7/15 at 830 PM alert, high risk for falls. Resident #18 was standing in the hall, had just	F 280	sent to DON who will update the care plan. The report will be forwarded to the chairman of the fall committee, and Quality Assurance Director. Monitoring will be ongoing and all fall reports will be discussed quarterly in the Quality Assurance Committee.	

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F 280	Continued From page 12 gotten out of w/c when another resident had spoken loudly to him. That startled him and he fell trying to sit back in the w/c. There were no injuries. - 4/12/15 at 5:20 PM disoriented, in dining room, removed break away belt and chair alarm was sounding. Staff found resident sitting in the floor in dining room beside of the sink. The resident had stated he need to go to the bathroom. His wife was in the dining room with the resident. The area on the finger was cleaned with betadine and a bandaid applied. Interview with the Director of Nursing on 04/22/2015 at 3:34 PM revealed she did the care plans and updates to care plan. Interventions to prevent falls that were initiated after he had fallen included use of a seat alarm on the w/c and use of break-away seat belt. She explained the alarm and belt should have been on the care plan and she "just missed it."	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, hospice interview and record review the facility failed to	F 309	Physician order obtained on resident #19 for a swallowing evaluation. Education	5/14/15

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F 309	Continued From page 13 assess a resident with problems swallowing for the need of thickened liquids for one of one sampled residents with swallowing problems. Resident #19. The findings included: Resident #19 was admitted to the facility on 10/5/13 with diagnosis of depressive disorder, dementia without behavioral disturbance and anxiety. Review of the Minimum Data Set (MDS) dated 2/9/15 indicated the resident had no swallowing problems and required total assistance of staff with eating. The care plan dated 2/9/15 included interventions for staff to provide total assistance for meals and provide liquids in a Sippy cup to allow her to self-administer as possible. Review of the April monthly orders included a puree diet with regular liquids. Review of the hospice nurse's notes dated 3/31/15 revealed Resident #19 had swallowing problems and was pocketing food. Hospice notes dated 4/8/15 and 4/13/15 included the use of thickened liquids and assessed the resident as "strangled on thin liquids." This note indicated the staff added thickener to the liquids. Observations on 4/21/15 at 12:38 PM Resident #19 had pre-thickened liquids of nectar consistency at bedside. The lunch tray had regular thin liquids. Aide #3 provided the thin liquids from a glass. Interview with aide #3 at that time revealed she did not know if the resident	F 309	provided to staff regarding consistency of liquids, including how to determine if resident has order for specific diet, or thickened liquids. Also if staff observes any resident with difficulty swallowing, advise nurse. She will then obtain order for swallowing evaluation. Any changes will be added to care plan. Staff to read and sign copy of care plan located in care plan book provided at nurses desk. Care plan will be updated with any changes in resident diet. MDS nurse will monitor care plan book, making sure staff is reading and signing. Monitoring will be weekly by the MDS nurse and reviewed quarterly at the Quality Assurance Committee.	

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F 309	Continued From page 14	F 309		

required thickened liquids or not and proceeded to give the thin liquids. Resident #19 was not observed coughing when provided thin liquids.

Interview with the registered dietician on 4/21/15 at 12:45 PM revealed Resident #19 did not have an order for thickened liquids and she was not aware of any swallowing problems.

On 04/23/2015 at 10:17 AM an interview with the hospice nurse was conducted. The Hospice nurse had written the notes on 3/31/15, 4/8/15 and 4/18/15. During the interview she explained if the resident had swallowing problems, the "hospice aide must have reported to her about swallowing problems." She indicated it was an intermittent problem for Resident #19. The Hospice nurse explained she or the aides would report to the facility staff any concerns or problems observed while providing care. The Hospice nurse did not remember who she reported the swallowing problems to in the facility.

On 04/23/2015 at 10:26 AM an interview with nurse #1 who was responsible for Resident #19's care, revealed she gave the resident thickened liquids at times. At times she had problems swallowing and sometimes she didn't. The electronic record for Resident #19 was reviewed by nurse #1 for referrals to speech therapy. Nurse #1 reported there had not been a speech referral or evaluation completed for this resident for safe swallow.

Interview on 04/23/2015 at 10:28 AM with aide #3 revealed she provided care for Resident #19 since she had been in facility. During the interview, aide #3 explained Resident #19 drank "really good with a Sippy cup." Further interview

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F 309	Continued From page 15 revealed she was not aware of swallowing problems with thin liquids. She had received no reports from a hospice aide regarding swallowing problems or pocketing food in her mouth. Thickened liquids were on her tray that morning. Aide #3 explained she had asked the dietician about the thickened liquids and was informed there was not an order for thickened liquids. Interview with the Registered Dietician on 4/23/15 at 10:45 AM revealed the diet slip indicated thickened liquids were to be sent to the resident on her tray. Further interview revealed that was a mistake on the diet slip. Resident #19 did not have orders for thickened liquids. The Registered Dietician was not aware of any swallowing problems for Resident #19. Interview with the Director of Nursing (DON) on 04/23/2015 at 10:51 AM revealed she would expect the nurse to inform the physician if a resident had swallowing problems. The physician would then order a speech evaluation. The speech therapist would determine what consistency of liquids would be appropriate. The DON explained she was not aware the nurses were giving thickened liquids without an order or informing the physician.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		5/14/15

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F 318	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to assess existing contractures, make referral and provide a plan of care for 1 of 4 sampled residents (Resident #20) who had an existing contractures. The findings included: Resident #20 was admitted to the facility on 10/13/2006 with diagnoses that included dementia. The most recent Minimum Data Set dated 2/3/15 revealed Resident #20 was totally dependent on staff for all activities of daily living with impairments to upper and lower extremities. Resident #20 was coded as being cognitively impaired for daily decision making. Review of Resident #20's care plan revised 2/24/15 revealed a "focus" of Resident #20 had an ADL self-care performance deficit. Resident is total care, no communication, and bed bound. The goal stated Resident #20 will maintain current level of function in though the review date. The interventions included, bathing/showers. The resident is totally dependent on 2 staff to provide bathing/shower 2 times a week as necessary. The interventions did not include Resident #20's contractures. Observations of Resident #20 on 4/22/15 at 8:30am revealed the resident to be lying in bed. The resident's left hand and arm was observed to be held tight to Resident #20's chest with thumb protruding between clenched fists. The resident ' s right hand and right arm were observed to be	F 318	A Physician order was obtained on resident #20 for OT/PT screening. Plan is being followed as outlined by therapy to prevent worsening of contractures, and improve range of motion. Physician orders were obtained for therapy screening on all residents at risk for contractures. Education provided to staff regarding therapy plan. Contractures implemented into care plans. Completed 5/14/15. Monitoring will be ongoing weekly and reported quarterly at Quality Assurance Committee.	

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F 318	Continued From page 17 held tight to resident #20's chest. Observations of Resident #20 on 4/23/15 at 11:00 am revealed the resident to be lying in bed with arms drawn upward toward Resident #20's chest. A blue carrot (device used for preventing further contracture and maintain healthy skin integrity) was observed to be in resident's right hand. Resident ' s left hand was observed to be closed as evidenced by resident's thumb protruding between middle finger and ring finger. Observation of Resident #20 on 4/23/15 at 1:50 pm revealed the resident to be lying in bed. Resident #20 was observed to be holding a blue carrot in her right hand. Resident #20 had no additional splinting device applied. Interview with NA#1 on 4/23/15 at 1:54 pm revealed Resident #20 was very tight in her upper arms and hands. NA#1 indicated that occasionally staff used a wash cloth and sometimes they used a blue carrot. NA#1 indicated she did not receive specifics in regards to how long resident #20 was to wear the carrot. NA#1 further indicated Resident #20 did not receive any range of motion services. Interview with NA#2 on 4/23/15 at 2:38 pm revealed Resident #20 was very stiff in her upper arms and elbows. The resident is very difficult to bath due to her hands and arms being so stiff. The resident typically and grimaced and moaned when bathing or personal care is provided. NA#2 stated that occasionally she will massage Resident #20's arm because she didn't want to hurt her. NA#2 further indicated there was slight tightness in Resident #20's knees. Resident #20's fingers do dig in her hand and a family	F 318		

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member preferred to cut the nails and the carrot prevented fingers to skin. Powder was occasionally used to make it easier to get the blue carrot into the right hand. NA#2 could not recall being provided directions for which hand the blue carrot was supposed to go in or how long. Sometimes it is put in the right hand and occasionally it is placed in the left. The NA indicated the named resident was not capable of moving any of her upper extremities.

Interview with the Physical Therapy assistant (OT therapist unavailable) revealed she could only locate an Occupational therapy summary dated that indicated Resident #20 was to wear a carrot. The Physical therapy assistant was able to locate an order dated 12/2/10 that indicated Resident #20 had a right hand contracture. The plan of care stated discharge from OT. The progress note comment indicated that Resident #20 was to wear an orthopedic fitting on right hand splint and staff were educated on correct splint wear.

Interview with the Director of Nursing (DON) on 4/23/15 at 2:56 pm revealed residents are referred to Occupational Therapy or Physical therapy by the nursing or the physician. Nursing staff would ensure the physician was aware of changes in range of motion and the physician would write an order for a resident to be referred to therapy. The DON was unable to provide therapy orders for review in regards to Resident #20's contractures or any device application. The DON stated it was her expectation that nursing communicate with the physician and the therapy department in regards to residents with contractures so changes in contractures are monitored and interventions could be put into place.

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F 329 SS=D	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 drugs. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, pharmacist and physician interview the facility failed to obtain valporic acid levels for 1 of 5 residents (Resident #36) who received divaloproex sodium ER (immediate release) 500mg (milligrams) 2 times daily for the management of seizure disorder. The findings included:	F 329	A laboratory audit of medications was completed for all existing residents of our nursing center, including resident #36. Medications were identified by registered pharmacist upon review of current MAR printouts. This was compared with laboratory data compiled in the electronic medical record. Upon review of the consultant pharmacist, individual	5/14/15

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F 329	Continued From page 20 Resident #36 was admitted to the facility on 4/7/14 with a diagnoses that included; hypertension, History of Residual left hemiparesis, coronary Artery disease, and seizure disorder. Review of Resident #36 physician order sheet for the month of April 2015 revealed divalproex sodium ER 500mg 2 times daily for seizure disorder. Review of Resident #36 labs from 4/21/14 through 4/14/15 revealed no labs in regards to valporic acid level testing for the use of divaloproex sodium ER for seizure disorder. Interview with the Director of Nursing (DON) on 4/23/15 at 9:57am revealed the facility obtained valporic acid levels according to physician orders. The DON indicated she could not locate a lab in which Resident #36 had valporic acid level test completed within the year. Interview with the facilities Medical Director on 4/23/15 at 9:57am revealed valporic acid level testing is ordered depending on the resident. The medical director indicated he wouldn't recommend going over 6 months without checking a resident's valporic acid level. The Medical Director revealed labs would be drawn as to the specification of Resident #36's primary medical decides. Interview with Resident #36's primary medical doctor on 4/23/15 at 11:00pm stated generally he would order a valporic acid level once a year. The physician indicated that valporic acid levels should have been ordered if they had not been	F 329	recommendations were made to physician providers for laboratory follow-up. A laboratory protocol for medication monitoring has been developed and approved. The laboratory protocol has been provided to the attending physician for signature on each existing residents. Going forward, facility nursing administration will send the laboratory protocol to the admitting provider for signature for newly admitted residents. Once the laboratory protocol is approved by the resident□s attending physician, the affected laboratory schedule will be printed on the Physician Order Sheets or otherwise denoted in the electronic medical record for monthly review by the consultant pharmacist As new medications are added to the medication profile the laboratory schedule printed on the Physician Order Sheet or denoted in the electronic medical record by the nurse transcribing the orders and will be reviewed monthly by the Consultant Pharmacist. Monitoring of the laboratory protocol for medication monitoring will be monthly and reported quarterly to the Quality Assurance committee.	

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F 329	Continued From page 21 completed within a year. The Primary medical physician further indicated it was not his experience that pharmacy remind him that valporic acid levels be conducted. Due to the valporic acid levels not being drawn within the year the physician would order the valporic acid levels to be dawn. Interview with the facility pharmacist on 4/23/15 at 11:14 pm indicated if a resident's seizure disorder is stable once a year valpoirc acid level testing was sufficient. During observation of Resident #36's medical record the pharmacist revealed the Resident #36 received divaloproex sodium ER 500mg 2 x a day. The pharmacist stated that usually due to receiving 500mg of divalopoex sodium 2 times daily valporic acid testing should have brought to the physician attention. The pharmacist could not locate communication in which valpoirc levels had been recommended.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and	F 334		5/18/15

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F 334	Continued From page 22 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment	F 334		

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F 334	Continued From page 23 and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to provide education information to responsible parties and/or residents prior to administration of the influenza vaccination for three of five sampled residents for immunizations. (Residents #15, 39, and 4) The findings included: Review of the facility policy "Pneumococcal and Influenza Immunization Assessment and Administration" included "H. The nurse will assure the patient has been provided information regarding this vaccine, administer the vaccine, and document the administration on the patient eMAR (electronic medication administration record)." Record reviews for Residents #15, 39 and 4 revealed the influenza vaccine was administered on 11/4/14. Documentation of the education provided to the responsible party and/or resident was not located in the medical record. Interview with nurse #2 on 04/21/2015 11:54 AM revealed she was unable to locate education documentation for the influenza in the medical	F 334	Flu vaccine consent- Immediately supplied current vaccine information to residents/responsible party #15, #39, and #4. Documentation of receipt of information placed in chart of resident #15, #39, and #4. Corrective action for those residents having potential to be affected by the same deficient practice and to ensure tha the deficient practice will not occur, the consent form for vaccines was reviewed and changed for future use to reflect that the resident/responsible party may receive a copy of vaccine information/education upon request. Education was provided to nursing staff regarding explanation of consent form to resident/responsible party, including presentation of vaccine information to resident/responsible party. The consent will also state information is available upon request. Upon signing of consent, the resident/responsible party will be told information regarding vaccine is available, and given a copy if requested. The consent form will indicate if the resident/responsible party requested and received vaccination information.	

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F 334	Continued From page 24 records for Residents #15, 39 and 4. An interview with the Director of Nursing (DON) on 04/21/2015 at 11:55 AM revealed the process for immunization of residents included sending a fax to the physician for the resident to have the immunization. The physician would give an order to administer the vaccine. The responsible party/resident would be given a form to sign agreeing to receive the vaccine. The educational information was not given to the responsible party/resident along with the consent form. The consent form was placed on the medical record. Interview with the MDS nurse on 04/21/2015 at 12:11 PM revealed the consent form was kept in a folder with the influenza educational information. The nurse on the floor kept the folder. The consent form was handed to the responsible party/resident to sign the consent. The information was not presented to the family/RP/resident. The influenza educational information was in the folder for use by the nurse to answer any questions asked by the responsible party/resident.	F 334	Signed consent forms will be kept on each residents chart. Monitoring will include an annual review of all influenza consent forms to determine if residents requested and recieved vaccination literature/information. Monitoring will be reported to the quarterly Quality Assurance committee.	
F 428 SS=D	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.	F 428		5/18/15

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F 428	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview pharmacist failed to address the lack of a valporic acid level test for 1 of 5 residents (Resident #36) who received divaloproex sodium ER (immediate release) 500mg (milligrams) 2 times daily for the management of seizure disorder. The findings included: Resident #36 was admitted to the facility on 4/7/14 with a diagnoses that included; hypertension, History of Residual left hemiparesis, coronary Artery disease, and seizure disorder. Review of Resident #36 Medication Administration Record (MAR) for the month of April 2015 revealed divalproex sodium ER 500mg 2 times daily for seizure disorder. Review of Resident #36 pharmacy reviews from 4/21/14 through 4/14/15 revealed no labs in regards to valporic acid level testing for the use of Depakote Sodium ER for seizure disorder. Review of Resident #36 labs from 4/21/14 through 4/14/15 revealed no labs in regards to valporic acid level testing for the use of divaloproex Sodium ER for seizure disorder Review of Resident #36 physician orders revealed no orders in regards to obtaining valporic acid levels. Interview with the Director of Nursing (DON) on 4/23/15 at 9:57am revealed the facility obtained valporic acid levels according to physician orders.	F 428	A laboratory audit of medications was completed for all existing residents of our nursing center, including resident #36. Medications were identified by registered pharmacist upon review of current MAR printouts. This was compared with laboratory data compiled in the electronic medical record. Upon review of the consultant pharmacist, individual recommendations were made to physician providers for laboratory follow-up. A laboratory protocol for medication monitoring has been developed and approved. The laboratory protocol has been provided to the attending physician for signature on each existing residents. Going forward, facility nursing administration will send the laboratory protocol to the admitting provider for signature for newly admitted residents. Once the laboratory protocol is approved by the resident□s attending physician, the affected laboratory schedule will be printed on the Physician Order Sheets or otherwise denoted in the electronic medical record for monthly review by the consultant pharmacist As new medications are added to the medication profile the laboratory schedule printed on the Physician Order Sheet or denoted in the electronic medical record by the nurse transcribing the orders and will be reviewed monthly by the Consultant Pharmacist.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345278	A. BUILDING _____ B. WING _____	04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN SURRY SNF	830 ROCKFORD STREET MOUNT AIRY, NC 27030

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F 428	Continued From page 26 The DON indicated she could not locate a lab in which Resident #36 had valporic acid level test completed beyond the year. Interview with the facilities medical director on 4/23/15 at 9:57am revealed valporic acid level testing is ordered depending on the resident. The medical director indicated he wouldn't recommend going over 6 months without checking a resident ' s valporic acid level. The Medical Director revealed labs would be drawn as to the specification of Resident #36's primary medical decides. Interview with Resident #36's primary medical doctor on 4/23/15 at 11:00pm stated generally he would order a valporic acid level once a year. The physician indicated that Valporic acid levels should have been ordered if they had not been completed within a year. The Primary medical physician further indicated it was not his experience that pharmacy remind him that valporic acid levels be conducted. Due to the valporic acid levels not being drawn within the year the physician would order the valporic acid levels to be dawn. Interview with the facility pharmacist on 4/23/15 at 11:14 pm indicated if a resident's seizure disorder was stable once a year valpoirc acid level testing was sufficient in the instance the resident seizure disorder was stable or was receiving a low dose of the medication. During an observation of Resident #36's medical record the pharmacist revealed the Resident #36 received divaloproex sodium ER 500mg 2 times a day and indicated a valorpic acid level should have been drawn. The pharmacist further stated valporic acid testing should have brought to the physician attention. The pharmacist could not locate communication in which valpoirc levels had been recommended.	F 428	Monitoring will consist of an annual laboratory audit of medications for all residents for laboratory protocol compliance by the Director of Pharmacy. The results of the annual monitoring will be reported to the Quality Assurance committee.	