STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	**6001 WILORA LAKE ROAD CHARLOTTE, NC 28212**

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and physician interview the facility failed to follow an order for the collection of a wound culture for 1 of 1 resident (Resident #20). Findings included: Resident #20 was admitted to the facility on 7/11/2015 and discharged to an acute care facility on 8/2/2015. Diagnoses included Ulcers of the lower limbs, Deep Venous Thrombosis, Heart Failure, Diabetes, Venous insufficiency, Noninfectious Lymphedema. The MDS dated 7/18/2015 revealed Resident #20 was cognitively intact. She required extensive assistance from two staff members for bed mobility and dressing, extensive assistance from one staff member for personal hygiene, total assistance from two staff members with toileting, and transferring (moves between surfaces) occurred only once or twice in the 7 day look back period. Resident #20 was coded on the MDS as admitted with other open lesions, no pressure ulcers, and no venous and arterial ulcers. A record review of the Care Plan for Resident #20 included a focus category of skin/wound. The etiology included the disease process of leg ulcers. The care plan approaches included obtain and monitor lab/diagnostic work as ordered. The care plan goal dated 7/11/2015 included the resident ' s wound will show signs of healing and remain free from infection through the next review.	F 281	Resident # 20 no longer resides at the facility. Residents with wounds have the potential to be affected by the alleged deficient practice. The Director of Clinical Services completed a review on 8-28-15 of current residents with wounds to validate that any wound culture orders received within the past 30 days were obtained, collected, documented and results reported to the physician with any new orders carried out as indicated by the licensed nurse. No further deficient practice was identified as a result of the audit. The Director of Clinical Services reeducated licensed nurses currently staffing the facility by 9-28-15 on the policy and procedure of obtaining, collecting, documenting and reporting wound cultures results to the prescribing physician and carrying out new orders timely as indicated by the licensed nurse. Any licensed nurse who did not receive the training by 9-28-15 will receive prior to the next scheduled shift. The Nurse Manager will maintain a log of all wound culture orders to validate that wound	9/29/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/14/2015

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F 281	Continued From page 1 A record review of a physician order dated 7/24/2015 revealed a laboratory order for a left leg wound culture and sensitivity. The wound care nurse was unavailable for an interview. On 8/21/2015 at 10:34 AM an interview with corporate staff revealed she was unable to find any addition medical records showing that the wound culture was obtained. She reported the lab was not done, the order was missed, and the lab did not have results. A nurse note dated 8/2/2015 included (in part) Resident (#20) was noted with increased confusion. Resident (#20) sent to Emergency Department for evaluation. At 10:30 PM the nurse communicated with the hospital and documented Resident (#20) was being admitted to intensive care unit (ICU) related to infection in wounds bilaterally. A record review of the hospital records dated 8/2/2015 to 8/8/2015 for Resident #20 revealed she presented to the acute care hospital with altered mental status. Resident #20 had a history of diabetes type II, chronic lower extremity edema, and lower extremity wounds with a history of multidrug resistant pathogens. Resident #20 developed lower extremity ulcerations in February and was treated at the burn center. She was discharged from the hospital and was residing in a skilled nursing facility. Per family she was not on antibiotics in the nursing facility. The Emergency Department records from 8/2/2015 included areas of green purulent thick fluid in her right leg wound. The Physician noted he did " not think that she likely had appropriate wound care at her nursing facility " . The Microbiology culture of the right thigh obtained at the hospital and resulted on 8/7/2015 included heavy growth of Pseudomonas Aeruginosa (bacteria), scant	F 281	cultures were obtained, collected, documented and results reported to the prescribing physician with any new orders carried out as indicated by the licensed nurse. The Director of Clinical Services will conduct a weekly wound meeting inclusive of a Nurse Manager, Minimum Data Set (MDS) Nurse and Dietary Manager to review residents with wounds to verify that wound cultures are completed timely and accurately per physician orders. The physicians¿ weekly wound rounding notes will also be reviewed during the weekly wound meeting to validate that all wound culture orders were accurately identified and transcribed, as indicated. The Director of Clinical Services/Nurse Manager trained Licensed nurses currently working at the facility on the a ¿Red Line¿ system (a system where the night shift audits each record for accurate transcription of orders and missed orders) by 9/28/15. The Director of Clinical Services or Unit Manager will conduct Quality Improvement monitoring of 5 resident records, MARs, and TARs for compliance with appropriate transcription and documentation of physician orders and medication/treatment documentation and the presence of the Red Line documentation 3 times a week for 4 weeks, then 3 records 3 times a week for 4 weeks, then 3 records 1 time a week for 4 weeks. The quality monitoring will be documented on a Quality Assurance and	

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F 281	Continued From page 2 growth of Acinetobacter Baumannii (pathogen), and one colony of Staphylococcus Aureus Methicillin Resistant (bacteria). She was admitted to ICU with septic shock secondary to wound infections.	F 281	Performance Improvement Monitoring Tool. The Director of Clinical Services will complete Quality Improvement monitoring of physicians¿ orders for residents with wounds 5x/week for 4 weeks, 1x/week for 2 months, then monthly for 3 months to validate that any wound cultures for residents with wounds were obtained, collected, documented and results reported to the prescribing physician with any new orders carried out as indicated by the licensed nurse. The Quality Improvement monitoring will be documented on a Quality Assurance and Performance Improvement Monitor Tool. The Director of Clinical Services will report audit results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		9/29/15

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F 309	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, physician interview, family interview and observation the facility failed to provide daily wound care as ordered by the physician for 1 of 3 residents (Resident #20) that resulted in a wound infection and hospitalization and the facility failed to administer a scheduled pain medication (OxyContin) to alleviate chronic pain, for 5 opportunities for 1 of 3 residents (Resident #10) reviewed for well-being. Findings Included: 1) Resident #20 was admitted to the facility on 7/11/2015 and discharged to an acute care facility on 8/2/2015. Diagnoses included Ulcers of the lower limbs, Deep Venous Thrombosis, Heart Failure, Diabetes, Venous insufficiency, Noninfectious Lymphedema. The MDS dated 7/18/2015 revealed Resident #20 was cognitively intact. She required extensive assistance from two staff members for bed mobility and dressing, extensive assistance from one staff member for personal hygiene, total assistance from two staff members with toileting, and transferring (moves between surfaces) occurred only once or twice in the 7 day look back period. Resident #20 was coded on the MDS as admitted with other open lesions, no pressure ulcers, and no venous and arterial ulcers. A record review of the Care Plan for Resident #20 included a focus category of skin/wound. The etiology included the disease process of leg ulcers. The care plan goal dated 7/11/2015 included 1) The resident ' s wound will show signs of healing and remain free from infection through the next review and 2) The resident will not	F 309	Resident # 20 no longer resides in the facility. A medication error report was completed by the Director of Clinical Services on 8-20-15 for resident #10 and resident will continue to have medications administered timely per physicians¿ orders. Current residents have the potential to be affected by the alleged deficient practice. A skin assessment was completed on each resident by a licensed nurse by 9-23-15 utilizing the Weekly Skin Integrity Review form. Any identified skin issues both pressure and non-pressure were assessed and documented onto the Pressure Ulcer Record or Non-Pressure Skin Condition Record by a licensed nurse and reported to the residents¿ physician and new treatment orders were obtained, implemented and documented as appropriate. Residents with pressure and non-pressure wounds were discussed at a wound meeting on 9-24-15 with the Nurse Manager, the Minimum Data Set Nurse and the Dietitian to ensure necessary treatment and services to promote healing, prevent infection and prevent new sores from developing are in place for identified residents. The Director of Clinical Services completed a review by 8-21-15 of the	

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F 309	Continued From page 4 develop additional skin integrity problems or wounds through the next review. The care plan approaches included obtain and monitor lab/diagnostic work as ordered, administer treatments as ordered, weekly skin checks, and administer medications as ordered. A record review of Resident #20 ' s treatment record for July included a treatment order to change dressings daily to both legs with Normal Saline, apply Aquacel and Santyl to both legs with Kerlix and compression bandages. The treatment record was initialed for the 12th of the month and the 14th of the month. A record review of Resident #20 ' s treatment record dated 7/16/2015 through 7/31/2015 included a wound treatment of Dakin ' s solution, Santyl, Calcium Alginate, and a dry protective dressing once daily to the 1) right shin, 2) right medial thigh, 3) left lateral shin, 4) left upper shin, and 5) left medial thigh. In addition give analgesic 30 minutes prior to wound dressing. The treatments were initialed indicating the task was completed on all 5 sites for the dates of 7/16/2015 -7/19/2015. No indication the wound care was provided on 7/20/2015. The treatments were initialed on 7/21/2015 -7/24/2015. The treatment record indicated the order and treatment was discontinued on 7/24/2015. There were no further treatment records or indication that treatment had been provided in Resident #20 ' s medical record for care from 7/25/2015 until Resident #20 ' s transfer to an acute care hospital on 8/2/2015. A record review of Resident #20 ' s treatment record dated 8/1/2015 through 8/31/2015 included an order dated 7/17/2015. Dakin ' s solution, Santyl, Calcium Alginate and dry protective dressing once daily to wounds 1) right shin, 2) right medial thigh, 3) left lateral shin, 4)	F 309	Medication Administration Records and medication storage carts to ensure physician ordered medications were available for administration. Medications were refilled as appropriate to ensure availability. Each resident residing in the facility was reassessed for pain and documented on the Pain Assessment form by a licensed nurse by 8-28-15. Any unmanaged pain identified was reported to the physician and new orders received by the licensed nurse as appropriate. A complete Medication Administration Record to medication storage cart review was also completed by the Omnicare Nurse on 9-9-15 and any needed medications were ordered to ensure compliance with medication availability. The Director of Clinical Services reeducated licensed nurses currently staffing the facility by 9-28-15 on the accurate completion of and schedule of weekly Skin Integrity Reviews and initiation of a Pressure Ulcer Record and/or a Non-Pressure Skin Condition Record for any wounds identified. The education also included timely physician notification, obtaining and starting new treatment orders and transcription onto the residents¿ Treatment Administration Record (TAR). Any nurses not reeducated by 9-28-15 will be educated prior to reporting to work for their next scheduled shift. Residents will have a weekly skin assessment completed by a licensed nurse to identify skin concerns. Any skin issues identified will be reported to the physician by the licensed nurse and	

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F 309	Continued From page 5 left upper shin, 5) left medial thigh. The order was not signature initialed for 8/1/2015 and 8/2/2015 indicating the treatment was completed and the order was marked as rewritten and no additional treatment records were found in the Resident #20 ' s medical record with the same handwriting. A record review of Physician Orders documented as a verbal order dated 7/23/2015 included to discontinue the Santyl and Dakin ' s solution to the left upper shin and the left medial thigh. Continue Calcium Alginate and apply protective dressing once daily. An additional verbal order dated 7/23/2015 included Santyl clarification. The Santyl Ointment was to be applied directly to three wounds indicted on the written verbal order as directed once daily for 30 days. A record review of a physician order dated 7/24/2014 revealed a laboratory order for a left leg wound culture and sensitivity. No results were found in the medical record. A record review of daily nurse notes dated 7/12/2015 through 7/26/2015 (the dates available in the medical record) revealed on 7/13/2015 a notation was made for treatment to areas, seen by wound doctor, Santyl, special delivery of medications. Daily notes dated 7/14/2015, 7/15/2015, 7/16/2015, 7/20/2015, 7/22/2015, and 7/25/20015 included dressing intact to bilateral legs (no notation of treatment). The daily note dated 7/17/2015 included dressing intact right and left extremities draining serous bloody drainage both dressings reinforced. The daily nurse note for 7/23/2015 included the wound physician assessed the wounds and pain medication was provided prior to the dressing change. The daily nurse note for 7/24/2015 included pain medication was provided prior to the dressing change and treatment to wound per order.	F 309	new treatment orders obtained, implemented and transcribed onto the Treatment Administration Record and Pressure Ulcer Record/Non-Pressure Skin Condition Record as appropriate. A nurse manager will make rounds each week with the wound physician to assess, measure and document the wound¿s condition on the Pressure Ulcer Record and Non-Pressure Skin Condition Record. The Director of Clinical Services, the Minimum Data Set Nurse, the Dietary Manager and Nurse Manager will discuss identified residents during a weekly wound meeting to ensure necessary treatment and services are being provided to promote healing, prevent infection and prevent new sores from developing. The Director of Clinical Services reeducated licensed nurses currently staffing the facility by 9-28-15 concerning the need to administer medications timely as prescribed. The education included the reorder process, the use of the emergency kit supply of medications, the timeliness of medication administration, the availability and use of the back up pharmacy, notifying the physician and Director of Clinical Services if a medication is not available and documentation of medications not administered per physicians order. Any licensed nurse who did not receive training by 9-28-15 will receive prior to the next scheduled shift. The licensed nurse will also evaluate residents pain upon admission, readmission, quarterly and with significant change in residents	

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F 309	Continued From page 6 No weekly skin assessments were found in Resident #20 ' s medical record. A record review of wound care specialist initial evaluation dated 7/16/2015. Five Lymphedemic wound sites were noted 1) right shin 2) right medial thigh, 3) left lateral shin, 4) left upper shin, and 5) left medial thigh. Surgical excisional debridement of subcutaneous tissue was performed on all 5 sites. A record review of a wound care specialist evaluation dated 7/23/2015 revealed no change to the five wound sites. There were treatment changes made to site 4) left upper shin and 5) left medial thigh to discontinuing the Santyl. Surgical excisional debridement of subcutaneous tissue was performed on all 5 sites. A record review of a wound care specialist evaluation dated 7/30/2015 revealed no change to wound site 1, 3, 4, or 5 and improved noted to site 2 for decreased surface area. On 8/21/2015 at 2:25 PM an interview with the wound care specialist physician revealed on 7/23/2015 Resident #20 ' s wound care was not discontinued. She discontinued the Santyl on two of Resident #20 ' s Lymphedemic wound sites. She revealed she specifically discussed with the facility wound nurse and the facility corporate nurse at Resident #20 ' s bedside why the remaining three wound sites needed the Santyl and where on the wound the nurse could apply the Santyl to conserve supply. The physician recalled there being concern from the facility about the price and need of the Santyl. The physician reported she was not at the facility enough to determine whether the nursing staff was providing daily wound care to Resident #20. The wound care nurse was unavailable for an interview. On 8/20/2015 at 5:50 PM and interview with the	F 309	condition and report any new uncontrolled pain to the physician to ensure appropriate interventions are implemented to alleviate residents pain. The Director of Clinical Services will monitor the controlled emergency kits supply weekly to ensure adequate back-up medications are available if needed. The Director of Clinical Services or Nurse Manager will complete Quality Improvement monitoring of the weekly skin assessments, Pressure Ulcer Records and/or Non-Pressure Skin Condition Records and Treatment Administration Record if indicated on 5 random residents 3x/week for 4 weeks, 1 x/week for 2 months, then 1x/month for 3 months to validate compliance with the alleged deficient practice. The Director of Clinical Services or Nurse Manager will complete a Quality Improvement monitoring of 5 residents¿ Medication Administration Records and medication storage carts. 5x/week for 4 weeks, 1 x/week for 2 months, then monthly for 3 months to ensure compliance with medication administration and availability of a2-7 day supply. Quality Improvement monitoring will be documented on a Quality Assurance and Performance Monitor Tool. The Director of Clinical Services will report audit results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The	

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F 309	Continued From page 7 interim Director of Nursing (DON) revealed her knowledge that Resident #20 had some troublesome sites over and above dry dressing. She reported after reviewing records she asked the wound nurse to start using the weekly pressure ulcer record and the pressure ulcer quality improvement log before she went on vacation. The interim DON only reports she herself had only been at the facility for 2 weeks and was not sure of facility procedure or practice. On 8/21/2015 at 11:09 PM an interview with the Regional Director of Human Resources revealed the facility was in transition with staffing and current nurse positions were being supplemented with nurses from sister facilities. The primary staff for Resident #20 during her admission was unavailable. On 8/21/2015 at 11:44 AM an interview with a corporate nurse revealed she was unable to find any addition medical records showing that daily wound care treatments were completed for Resident #20. A record review of a nursing home to hospital transfer form dated 8/2/2015 and a Situation, Background, Assessment, Recommendation communication form dated 8/2/2015 revealed Resident #20 was noted to have an altered mental status and was sent to the hospital for an evaluation. A nurse note dated 8/2/2015 included (in part) Resident (#20) was noted with increased confusion. Resident (#20) sent to Emergency Department for evaluation. At 10:30 PM the nurse communicated with the hospital and documented Resident (#20) was being admitted to intensive care unit (ICU) related to infection in wounds bilaterally. A record review of the hospital records dated 8/2/2015 to 8/8/2015 for Resident #20 revealed	F 309	QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

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F 309	Continued From page 8 she presented to the acute care hospital with altered mental status. Resident #20 had a history of diabetes type II, chronic lower extremity edema, and lower extremity wounds with a history of multidrug resistant pathogens. Resident #20 developed lower extremity ulcerations in February and was treated at the burn center. She was discharged from the hospital and was residing in a skilled nursing facility. Per family she was not on antibiotics in the nursing facility. The Emergency Department records from 8/2/2015 included areas of green purulent thick fluid in her right leg wound. The Physician noted he did " not think that she likely had appropriate wound care at her nursing facility " . The Microbiology culture of the right thigh obtained at the hospital and resulted on 8/7/2015 included heavy growth of Pseudomonas Aeruginosa (bacteria), scant growth of Acinetobacter Baumannii (pathogen), and one colony of Staphylococcus Aureus Methicillin Resistant (bacteria). She was admitted to ICU with septic shock secondary to wound infections. 2) Resident #10 was admitted to the facility on 6/6/2013. Her diagnoses included Dementia, Insomnia, Upper arm Fracture, and Chronic Pain. The Minimum Data Set dated 8/17/2015 revealed Resident #10 was severely cognitively impaired and was totally dependent on staff (two person physical assistance) for her activities of daily living. Resident #10 was assessed as frequently experiencing pain. The pain had made it hard to sleep at night and limited her day to day activities. The Physician Order Sheet dated 8/1/2015 through 8/31/2015 for Resident #10 included an order for OxyContin (narcotic pain medication) 10 mg (milligram) tablet Extended Release, every 12 hours. Take 1 tablet by mouth twice daily. It was scheduled at 9:00 AM and 9:00 PM.	F 309		

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A record review of the pharmacy controlled medication utilization record for Resident #10 ' s OxyContin revealed that the last dose on the active card stock was administered on 8/16/2015 at 9:00 AM.
The Medication Administration Record (MAR) dated 8/1/2015 through 8/31/2015 for Resident #10 revealed on 8/16/2015 the 9:00 PM dose of OxyContin was not administered, indicated by circled initials. There was no indication on the back of the MAR as to why the dose was not administered.
A Physician Order dated 8/16/2015 at midnight for Resident #10 included: May hold OxyContin 10 mg tablet ER for one dose. Follow up with Physician Assistant in the morning 8/17/2015.
The MAR dated 8/1/2015 through 8/31/2015 for Resident #10 revealed on 8/17/2015 and 8/18/2015 the 9:00 AM and the 9:00 PM doses of OxyContin were not administered indicated by circled initials. There was no indication on the back of the MAR as to why the doses were not administered.
The MAR dated 8/1/2015 through 8/31/2015 for Resident #10 revealed an as needed medication of Hydrocodone-Acetaminophen (narcotic pain medication) 5 mg-325 mg tablet take one by mouth every 4 hours as needed for pain. The record indicated by initials that on 8/17/2015 two doses were administered to Resident #10. On the back of the MAR there was one entry for 8/17/2015 that read (in part) waiting for script from MD (physician) for OxyContin.
A prescription dated 8/18/2015 for resident #10 in the physician orders was for Oxycodone 10 mg tablet ER 1 by mouth twice daily.
A grievance log revealed a concern dated 8/18/2015 for Resident #10 for medications were received late. On 8/21/2015 at 9:45 AM an

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F 309	Continued From page 10 interview with Resident #10 ' s Responsible Party (RP) revealed Resident #10 had a chronic fracture in her right shoulder that was not operable so she had chronic pain. The RP reported Resident #10 needed to be positioned for comfort and her shoulder protected in care. She reported resident #10 rubbed, guarded and covered up her right shoulder and verbalized pain in her right shoulder. The RP reported she had filed grievances for Resident #10 not receiving her medications. The RP reported she was at the facility daily and it would take up to a week to get medications ordered, in stock, and administered to Resident #10. A record review of the pharmacy controlled medication utilization record for Resident #10 ' s OxyContin revealed it was received on 8/18/2015 and the first dose administered was on 8/19/2015. On 8/20/2015 at 4:30 PM an interview with Nurse #1, a relief nurse from a sister facility, who was Resident #10 ' s nurse on 8/16/2015 reported she did know the reason the OxyContin was held on 8/16/2015. Resident #10 ' s primary nurse the evening of 8/16/2015 was unavailable for an interview. The primary nurse for day shift on 8/17/2015 was unavailable. The primary nurse on the schedule for the evening shifts for 8/17/2015 and 8/18/2015 was a contract nurse and unavailable. On 8/20/2015 at 4:40 PM an interview with Nurse #2 (a relief nurse from a sister facility) who was Resident #10 ' s nurse on 8/18/2015 reported she did not give Resident #10 her OxyContin on the 18th because it was not available. She reported Nurse #3 processed a new order on day shift 8/18/2015. She could not verify when the order was processed because she did not have access to the facility electronic pharmacy ordering	F 309		

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system. Nurse #2 reported Resident #10 will share with you she is in pain if you ask her. Nurse #3 was unavailable for an interview.
On 8/20/2015 at 11:24 PM an interview with the second shift unit manager Nurse #4 revealed when a medication was not administered the nurse was to circle her initials and write on back of the MAR the reason for not giving the medication.
On 8/20/2015 at 9:15 PM an observation of Resident #10 was made during care where she was guarding her right shoulder, verbalizing to staff to be careful with her right arm [during movement].
On 8/21/2015 at 9:34 AM an interview with the pharmacy revealed Resident #10 had a hard script (legal prescription) for OxyContin 10 mg filled on 7/21/2015. The regulatory law only allowed the pharmacy to dispense a 14 day supply of a narcotic medication, 28 tablets were provided to the facility. On 8/18/2015 a hard script was filled for OxyContin and 28 tablets were dispensed to the facility.
On 8/21/2015 at 9:30 AM an interview with Resident #10 ' s facility Nurse Practitioner (NP) revealed she was not aware that Resident #10 had not been receiving her scheduled pain medication. In reviewing the order written on 8/16/2015, the order was managed by the on call service. The NP [whose name was transcribed on the order] reported she did not personally get a call from the facility staff. She further reported she was on call on 8/16/2015. The NP shared she felt the facility had a big problem with ordering and receiving medications timely and the problem never got corrected. She reported there was no communication between nurses and other disciplines. The NP reported the residents are in a skilled nursing facility and a level of care is

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F 309	Continued From page 12 required. " It is inexcusable to be out of a scheduled pain medication for even one dose. It is not acceptable to use an as needed pain medication as a substitution for coverage of chronic pain. " On 8/21/2015 at 11:28 AM an interview with the corporate staff revealed the nursing staff was in-serviced on the procedure for ordering and receiving medications. The expectation for the nursing staff was to follow the procedure for ordering the medication timely. It was not acceptable to go 3 days without chronic pain medication. There was the expectation that the nurses write why they did not give a medication on the back of the MAR.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to promote skin integrity for 1 of 3 residents (Resident #20) that resulted in a stage 2 pressure ulcer. Findings Included: Resident #20 was admitted to the facility on 7/11/2015 and discharged to an acute care facility	F 314	Resident # 20 no longer resides in the facility. Current residents have the potential to be affected by the alleged deficient practice. A skin assessment was completed on each resident by a licensed nurse by	9/29/15

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F 314	Continued From page 13 on 8/2/2015. Diagnoses included Ulcers of the lower limbs, Deep Venous Thrombosis, Heart Failure, Diabetes, Venous insufficiency, Noninfectious Lymphedema. The MDS dated 7/18/2015 revealed Resident #20 was cognitively intact. She required extensive assistance from two staff members for bed mobility and dressing, extensive assistance from one staff member for personal hygiene, total assistance from two staff members with toileting, and transferring (moves between surfaces) occurred only once or twice in the 7 day look back period. Resident #20 was coded on the MDS as admitted with other open lesions, no pressure ulcers, and no venous and arterial ulcers. A record review of the Care Plan for Resident #20 included a focus category of skin/wound. The care plan goal dated 7/11/2015 included the resident will not develop additional skin integrity problems or wounds through the next review. A record review of Resident #20 ' s ADL report revealed she was transferred between two surfaces 8 out of 16 days between 7/14/2015 and 7/30/2015. An admission data collection form dated 7/11/2015 included a skin tear drawn in a diagram above the sacrum. A record review of wound care specialist initial evaluation dated 7/16/2015 included five Lymphedemic leg wound sites. A record review of a wound care specialist evaluation dated 7/23/2015 revealed no change to the five leg wound sites. A record review of a wound care specialist evaluation dated 7/30/2015 revealed a chief complaint of a wound on the buttocks. History: she presented with a stage 2 pressure wound of the right buttocks of at least 1 day duration. There was light serous exudate. The pressure wound of	F 314	9/23/15 utilizing the Weekly Skin Integrity Review form. Any identified skin issues both pressure and non-pressure were assessed and documented onto the Pressure Ulcer Record or Non-Pressure Skin Condition Record by a licensed nurse and reported to the residents¿ physician and new treatment orders were obtained, implemented and documented as appropriate. Residents with pressure and non-pressure wounds were discussed at a wound meeting on 9-24-15 with the Nurse Manager, the Minimum Data Set Nurse and the Dietitian to ensure necessary treatment and services to promote healing, prevent infection and prevent new sores from developing are in place for identified residents. The Director of Clinical Services reeducated licensed nurses by 9-28-15 on the accurate completion of and schedule of weekly Skin Integrity Reviews and initiation of a Pressure Ulcer Record and/or a Non-Pressure Skin Condition Record for any wounds identified. The education also included timely physician notification, obtaining and starting new treatment orders and transcription onto the residents¿ Treatment Administration Record (TAR). Any nurses not reeducated as of 9-28-15 will be educated prior to reporting to work for their next scheduled shift. Residents will have a weekly skin assessment completed by a licensed nurse to identify skin concerns. Any skin issues identified will be reported to the physician by the licensed nurse and new treatment orders obtained,	

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F 314	Continued From page 14 the right buttocks was 3.5 X 3.5 X 0.1 centimeters with light serous drainage. Dressing: Hydrogel and dry protective dressing once daily. There were no treatment records found in Resident #20 " s medical record from 7/30/2015 to 8/2/2015 when Resident #20 ' s discharge to acute care. The wound care nurse was unavailable for an interview. On 8/20/2015 at 5:50 PM and interview with the interim Director of Nursing (DON) reported after reviewing records she asked the wound nurse to start using the weekly pressure ulcer record and the pressure ulcer quality improvement log before she went on vacation. The interim DON only reports she herself had only been at the facility for 2 weeks and was not sure of facility procedure or practice. A record review of the weekly pressure ulcer record and the pressure ulcer quality improvement log for Resident #20 included one entry dated 7/16/2015 for Resident #20 ' s 5 Lymphedemic leg wound sites. The stage 2 right buttocks pressure ulcer was not added to the logs. On 8/21/2015 at 11:09 PM an interview with the Regional Director of Human Resources revealed the facility was in transition with staffing and current nurse positions were being supplemented with nurses from sister facilities. [The primary staff for Resident #20 during her admission was unavailable] On 8/21/2015 at 11:44 AM an interview with corporate staff [nursing] revealed she was unable to find any addition medical records showing that daily wound care treatments were completed for Resident #20.	F 314	implemented and transcribed onto the Treatment Administration Record and Pressure Ulcer Record/Non-Pressure Skin Condition Record as appropriate. A nurse manager will make rounds each week with the wound physician to assess, measure and document the wounds condition on the Pressure Ulcer Record and Non-Pressure Skin condition Record. The Director of Clinical Services, the Minimum Data Set Nurse, the Dietary Manager and Nurse Manager will discuss identified residents during a weekly wound meeting to ensure necessary treatment and services are being provided to promote healing, prevent infection and prevent new sores from developing. The Director of Clinical Services or Nurse Manager will complete Quality Improvement monitoring of the weekly skin assessments, Pressure Ulcer Records and/or Non-Pressure Skin Condition Records and Treatment Administration Record if indicated on 5 random residents 3x/week for 4 weeks, 1 x/week for 2 months, then 1x/month for 3 months to validate compliance with the alleged deficient practice. Quality Improvement monitoring will be documented on a Quality Assurance and Performance Monitor Tool. The Director of Clinical Services will report audit results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the	

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F 314	Continued From page 15	F 314	monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	
F 333 SS=G	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 record review, staff interview, family interview the facility failed to administer a scheduled pain medication (OxyContin), for 5 opportunities (Resident #10). Findings included: 1) Resident #10 was admitted to the facility on 6/6/2013. Her diagnoses included Dementia, Insomnia, Upper arm Fracture Chronic, and Chronic Pain. The Minimum Data Set dated 8/17/2015 revealed Resident #10 was severely cognitively impaired and was totally dependent on staff (two person physical assistance) for her activities of daily living. Resident #10 was assessed as frequently experiencing pain. The pain had made it hard to sleep at night and limited her day to day activities. Record review of a grievance log revealed a concern dated 8/18/2015 for Resident #10 for medications were received late. The Physician Order Sheet dated 8/1/2015 through 8/31/2015 for Resident #10 included an order for OxyContin (narcotic pain medication) 10 mg (milligram) tablet ER, every 12 hours. Take 1 tablet by mouth twice daily. Scheduled at 9:00 AM and 9:00 PM.	F 333	A medication error report was completed by the Director of Clinical Services for resident #10 on 8-20-15 and resident will continue to have pain medications administered timely per physicians orders. All residents with pain medication orders have the potential to be affected by the alleged deficient practice. The Director of Clinical Services completed a review on 8-21-15 of the Medication Administration Records and medication storage carts to ensure physician ordered pain medications were available for administration. Medications were refilled as appropriate to ensure availability. Each resident residing in the facility was also reassessed for pain and documented on the Pain Assessment form by a licensed nurse by 8-28-15. Any unmanaged pain identified was reported to the physician and new orders received by the licensed nurse as appropriate. A complete Medication Administration Record to medication storage cart audit was also	9/29/15

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F 333	Continued From page 16 The Medication Administration Record (MAR) dated 8/1/2015 through 8/31/2015 for Resident #10 revealed on 8/16/2015 the 9:00 PM dose of OxyContin was not administered indicated by circled initials. There was no indication on the back of the MAR as to why the dose was not administered. A Physician Order dated 8/16/2015 at midnight for Resident #10 included: May hold OxyContin 10 mg tablet ER for one dose follow up with Physician Assistant in the morning 8/17/2015. A record review of the pharmacy controlled medication utilization record for Resident #10 ' s OxyContin revealed that the last dose on the active card stock was administered on 8/16/2015 at 9:00 AM. The MAR dated 8/1/2015 through 8/31/2015 for Resident #10 revealed on 8/17/2015 and 8/18/2015 the 9:00 AM and the 9:00 PM doses of OxyContin were not administered indicated by circled signature initials. There was no indication on the back of the MAR as to why the dose was not administered. A record review of the MAR dated 8/1/2015 through 8/31/2015 for Resident #10 revealed an as needed medication of Hydrocodone-Acetaminophen (narcotic pain medication) 5 mg-325 mg tablet take one by mouth every 4 hours as needed for pain. The record indicated by signature initial that on 8/17/2015 two doses were administered to Resident #10. On the back of the MAR there was one entry for 8/17/2015 that read (in part) waiting for script from MD (physician) for OxyContin. A prescription dated 8/18/2015 for resident #10 in the physician orders was for Oxycodone 10 mg tablet ER 1 by mouth twice daily quantity #60. A record review of the pharmacy controlled medication utilization record for Resident #10 ' s	F 333	completed by the Omnicare Nurse on 9-9-15 and any needed medications were ordered to ensure compliance with medication availability. The Director of Clinical Services reeducated licensed nurses currently staffing the facility by 9-28-15 concerning the need to administer medications timely as prescribed. The education included the reorder process, the use of the emergency kit supply of medications, the timeliness of medication administration, the availability and use of the back up pharmacy, notifying the physician and Director of Clinical Services if a medication is not available and documentation of medications not administered per physicians order. The education included the need to timely reorder medications and treatment supplies when the par level is at a 2-7 day supply. Any licensed nurse who did not receive training by 9-28-15 will receive education prior to the next scheduled shift. The licensed nurse will administer pain medications timely per physicians¿ orders and document administration by initialing on the Medication Administration Record. The Director of Clinical Services and/or will monitor the controlled emergency kits supply weekly to ensure adequate back-up medication are available if needed. The Director of Clinical Services or Nurse Manager will complete a Quality Improvement monitoring of 5 residents¿ Medication Administration Records and	

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F 333	Continued From page 17 OxyContin revealed it was received on 8/18/2015 and the first dose administered was on 8/19/2015. On 8/20/2015 at 4:30 PM an interview with Nurse #1 (a relief nurse from a sister facility) who was Resident #10 ' s nurse on 8/16/2015 reported she did not know the reason the OxyContin was held on 8/16/2015. Resident #10 ' s primary nurse the evening of 8/16/2015 was unavailable for an interview. The primary nurse for day shift on 8/17/2015 was unavailable. The primary nurse on the schedule for the evening shifts for 8/17/2015 and 8/18/2015 was a contract nurse and unavailable. On 8/20/2015 at 4:40 PM an interview with Nurse #2 (a relief nurse from a sister facility) who was Resident #10 ' s nurse on 8/18/2015 reported she did not give Resident #10 her OxyContin on the 18th because it was not available. She reported Nurse #3 processed a new order on day shift 8/18/2015. She could not verify when the order was processed because she did not have access to the facility electronic pharmacy ordering system. Nurse #2 reported Resident #10 will share with you she is in pain if you ask her. Nurse #3 was unavailable for an interview. On 8/20/2015 at 11:24 PM an interview with the second shift unit manager Nurse #4 revealed the process for reordering medications was when the stock card became low the staff would re-order medications in the computer or fax a request to the pharmacy. The request for re-order should have been completed 3 to 4 days before the card stock was out of medication. If the staff sent a fax before 5:00 PM the medication order would arrive the same day. After 5:00 PM the staff would call for a stat delivery if the medication was out. The facility does not keep a record of medications ordered by fax. To know if a request was sent a	F 333	medication storage carts. 5 x/week for 4 weeks, 1 x/week for 2 months, then monthly for 3 months to ensure compliance with medication administration and availability of the 2-7 day supply. Quality Improvement monitoring will be documented on a Quality Assurance and Performance Improvement Monitor Tool. The Director of Clinical Services will report audit results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

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nurse would have to call the pharmacy. If a medication was missing for 3 days it meant the nurse did not request the order in time. The unit manager reported he did not have access to the facility electronic pharmacy ordering system, after [business] hours the nurses fax medication orders to the pharmacy. The unit manager reported when a medication was not administered the nurse was to circle her initials and write on back of the MAR the reason for not giving the medication.

On 8/21/2015 at 9:34 AM an interview with the pharmacy revealed Resident #10 had a hard script (legal prescription) for OxyContin 10 mg filled on 7/21/2015. The regulatory law only allowed the pharmacy to dispense a 14 day supply of a narcotic medication, 28 tablets were provided to the facility. On 8/18/2015 a hard script was filled for OxyContin and 28 tablets were dispensed to the facility.

On 8/21/2015 at 9:45 AM an interview with Resident #10 " s Responsible Party (RP) revealed Resident #10 had a chronic fracture in her right shoulder that was not operable so she had chronic pain. The RP reported Resident #10 needed to be positioned for comfort and her shoulder protected in care. She reported resident #10 rubs, guards, covers up, and verbalized pain to her right shoulder. The RP reported she had filed grievances for Resident #10 not receiving her medications. The RP reported she was at the facility daily and it would take up to a week to get medications ordered, in stock, and administered to Resident #10.

On 8/21/2015 at 11:09 PM an interview with the Regional Director of Human Resources revealed because of staffing changes the nurses scheduled to work at the facility were from sister facilities. Corporate policies and practices are

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consistent for all facilities. Her expectation would be the nurse on staff would be familiar with corporate policy but the building would need to provide building specific orientation. The nurses from sister facilities had building specific electronic pharmacy access. They had the ability to fax an order. There were nursing supervisors on staff who were available to order the medications. The Director of Nursing was responsible for ordering house stock medications and narcotics.

On 8/21/2015 at 9:30 AM an interview with Resident #10 ' s facility Nurse Practitioner (NP) revealed she was not aware that Resident #10 had not been receiving her scheduled pain medication. In reviewing the order written on 8/16/2015, the order was managed by the on call service. The NP [whose name was transcribed on the order] reported she did not personally get a call from the facility staff. She further reported she was on call on 8/16/2015. The NP shared she felt the facility had a big problem with ordering and receiving medications timely and the problem never got corrected. She reported there was no communication between nurses and other disciplines. The NP reported the residents are in a skilled nursing facility and a level of care is required. " It is inexcusable to be out of a scheduled pain medication for even one dose. It is not acceptable to use an as needed pain medication as a substitution for coverage of chronic pain. "

On 8/21/2015 at 11:28 AM an interview with the corporate staff revealed the nursing staff was in-serviced 7/23/2015 on the procedure for ordering and receiving medications. The expectation for the nursing staff was to follow the procedure for ordering the medication timely. When the medication tablet levels got low they

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F 333	Continued From page 20 were to notify the physician for a hard script and fax the hard script to the pharmacy. The expectation was for the new prescription to be in the building before the medication card stock was empty. It was not acceptable to go 3 days without chronic pain medication. There was the expectation that the nurses write why they did not give a medication on the back of the MAR.	F 333		
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 review and staff interview the facility failed to maintain a complete medical record by not documenting the reason for medication omissions on two medications (OxyContin and Muro) and by not documenting the reason for administering a pain medication (Hydrocodone) ordered on an as needed basis for 1 of 1 resident (Resident #10) in line with the standards of practice and the documentation tool (Medication Administration Record) provided by	F 514	Resident #10 continues to receive OxyContin twice daily as scheduled. Hydrocodone continues to be administered on an as needed basis per physicians¿ orders with the reason needed documented in the medical record. The licensed nurse received an order on 8-21-15 to discontinue Resident #10 Muro eye drops.	9/29/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 21 the facility. Findings included: Resident #10 was admitted to the facility on 6/6/2013. Her diagnoses included Dementia. Record review of a grievance log revealed a concern dated 8/18/2015 regarding Resident #10 receiving her medication late. A record review of Resident #10 ' s Medication Administration Record (MAR) dated 8/1/2015 to 8/31/2015 included an order for Muro-128 2% drops instill 1 drop both eyes twice daily (for corneal edema). On 8/17/2015 the 9:00 PM dose was not administered as indicated by circled initials. On 8/18/2015 the 9:00 AM and the 9:00 PM doses of Muro were not administered as indicated by circled initials. There was no written indication on the back of the MAR as to why the doses were missed. The Medication Administration Record (MAR) dated 8/1/2015 through 8/31/2015 for Resident #10 revealed on 8/16/2015 the 9:00 PM dose of OxyContin 10 mg (milligram) tablet Extended Release 1 tablet twice daily every 12 hours (narcotic pain medication) was not administered as indicated by circled initials. There was no indication on the back of the MAR as to why the dose was not administered. On 8/20/2015 at 4:30 PM an interview was conducted with Nurse #1 (a relief nurse from a sister facility) who was Resident #10 ' s nurse for day shift on 8/16/2015. Nurse #1 reported she did know the reason the OxyContin was held in the PM on 8/16/2015. Resident #10 ' s primary nurse during the evening of 8/16/2015 was unavailable for an interview. The MAR dated 8/1/2015 through 8/31/2015 for Resident #10 revealed on 8/17/2015 and 8/18/2015 the 9:00 AM and the 9:00 PM doses of Oxycontin were not administered as indicated by	F 514	All residents have the potential to be affected by the alleged deficient practice. A review of all Medication Administration Records (MARs) and Treatment Administration Records (TARs) for the current month was completed by the Director of Clinical Services and the Nurse Manager by 9-10-15. Other areas of missed documentation were noted and corrected when possible within current standards of practice. The Director of Clinical Services reeducated licensed nurses by 9-28-15 on the need to maintain accurate, complete medical records. This education included appropriate documentation of the reason for as needed medication administration and appropriate documentation of medication omissions. Any licensed nurse not educated by 9-28-15 will be educated prior to their next working shift. It is expectation that the licensed nurse will document administration of ordered medication by initialing on the Medication Administration Record (MAR). For as needed medications, the licensed nurse will document in the medical record the reason for administration. When a medication is not given as ordered, the licensed nurse will indicate this by circling his/her initial on the front of the MAR and document the reason for omission in the medical record. The Director of Clinical Services or Nurse Manager will conduct Quality Improvement monitoring of Medication	

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F 514	Continued From page 22 circled initials. There was no indication on the back of the MAR as to why the doses were not administered. A record review of the MAR dated 8/1/2015 through 8/31/2015 for Resident #10 revealed an order for Hydrocodone-Acetaminophen (narcotic pain medication) 5 mg-325 mg take one tablet by mouth every 4 hours as needed for pain. The record indicated, by initial, that on 8/17/2015 two doses were administered to Resident #10. On the back of the MAR there was one entry for 8/17/2015 that was transcribed (in part) as waiting for script from MD (physician) for OxyContin. The primary nurse for Resident #10 for day shift on 8/17/2015 was unavailable. The primary nurse for Resident #10 on the schedule for the evening shifts for 8/17/2015 and 8/18/2015 was a contract nurse and unavailable. On 8/20/2015 at 4:40 PM an interview was conducted with Nurse #2 a relief nurse from a sister facility who was Resident #10 ' s nurse on 8/18/2015. She reported she did not give Resident #10 her Oxycontin on the 18th because it was not available. She did not document the reason on the back of the MAR. On 8/20/2015 at 11:24 PM an interview was conducted with the second shift unit manager Nurse #4. The nurse reported when a medication was not administered the nurse was to circle her initials and write on the back of the MAR the reason for not giving the medication. On 8/21/2015 at 11:09 PM an interview with the Regional Director of Human Resources revealed because of staffing changes the nurses scheduled to work at the facility are from sister facilities. Corporate policies and practices were consistent for all facilities. Her expectation would be the nurses on staff were familiar with	F 514	Administration Records for accuracy and completeness of medication documentation 5x/ week for 4 weeks, 1x/week for 2 months, then 1x/month for 3 months. The Quality Improvement monitoring will be documented on a Quality Assurance and Performance Improvement Monitor Tool. The Director of Clinical Services will report audit results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

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F 514	Continued From page 23 corporate policy. On 8/21/2015 at 11:28 AM an interview with the corporate staff revealed there was the expectation that the nurses write why they did not give a medication on the back of the MAR.	F 514		
F 520 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to implement an appropriate plan of	F 520	The facility will follow all regulations related to the maintenance of an effective	9/29/15

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F 520	Continued From page 24 action to correct 1 of 4 identified quality deficiency in a plan of correction for failure to administer scheduled pain medication. Findings included: Cross reference F309 On 7/17/2015 the facility received a citation for failure to administer scheduled pain medication. The facility submitted a plan of correction on 8/7/2015 and set a completion date for 8/12/2015. The plan of correction included re-education of nurses currently working at the facility on 7/23/2015 on the need to follow up on resident issues affecting their wellbeing such as pain. A record review of the plan of correction in-services included (in part) Understand the need to be diligent to prevent medication errors, understand the need to be accurate to prevent errors, can verbalize the need to complete RED LINE (tool) every night, understands that the RED LINE was to be a quality check of the days ' events, each physician order are checked nightly, verbalizes understanding of the need to notify physician of changes, understand how to order and reorder medications per physician orders, understand the time in which medications must be provided, understand how to request items from the backup pharmacy, and understand that omissions are considered medication errors. On 8/21/2015 the facility was recited for F309 for failure to administer scheduled pain medication and provide wound treatments as ordered. On 8/21/2015 at 11:28 AM an interview with the corporate staff revealed the nursing staff was in-serviced on the procedure for ordering and receiving medications. The expectation for the nursing staff was to follow the procedure for ordering the medication timely. When the medication tablet levels got low they were to notify the physician for a hard script and fax the	F 520	Quality Assessment and Process Improvement committee. All residents have the potential to be affected by the alleged deficient practice. The Quality Assurance and Process Improvement (QAPI) committee; inclusive of the Executive Director, Director of Clinical Services, Medical Records Coordinator, Business Office Manager, Maintenance Director, Human Resources Director, Minimum Date Set Nurse, Recreational Director and Nurse Practitioner conducted a QAPI meeting on 8-25-15 to discuss the deficient practices identified during the survey revisit and discussed implementation of an immediate plan of correction. The facility will follow all regulations related to the maintenance of an effective quality assessment and process improvement program. The QAPI committee members were reeducated on 9-10-15 by the Regional Vice President of Operations on the need to meet regularly and to review the results and effectiveness of all audits completed and to revise the plan of correction as deemed necessary by the committee to obtain and maintain substantial compliance. The Quality Assurance and Performance Improvement Committee will meet monthly and/or more frequently as deemed necessary to review the Quality Improvement Monitoring and audit results to ensure continued substantial compliance. The Executive Director will	

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F 520	Continued From page 25 hard script to the pharmacy. The expectation was for the new prescription to be in the building before the medication card stock was empty. It was not acceptable to go 3 days without chronic pain medication. There was the expectation that the nurses write why they did not give a medication on the back of the medication administration record. In addition there was an emergency supply kit (e kit) in the building that was not utilized. QI was in process. We did the staff education for some reason there was a breakdown. The QI started with a full house audit on all resident charts and it was decreased to a random sample. The relief nurses should have been up-to-date on pharmacy procedure, using the backup pharmacy and e kit. On 8/21/2015 at 12:20 PM the corporate nurse reported the Quality Improvement (QI) committee consisted of the management team, Administrator and Medical Director. The committee met monthly. On 8/21/2015 at 12:54 PM an interview with the Administrator and chair of the QI committee reported the facility citation was in July. He reported the committee met on the last Thursday of the month. The QI committee meeting was not held on the last Thursday of July (7/30/2015) because of a conflict with the physician on the day of the meeting. The Administrator reported he did not reschedule the committee meeting because the facility was working on the Plan of Correction. He reported the staff was in-serviced on the procedure of ordering and receiving medications and the pharmacy helped facilitate the in-service. Management created memos with instructions on obtaining medications after hours. The process for obtaining medications after hours and how to use the backup pharmacy. He reported management developed an audit tool	F 520	serve as the QAPI coordinator and be responsible for the ongoing monitoring and improvement process.	

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F 520	Continued From page 26 with the original citation. The staff in-service included face to face education and return demonstration. The administrator reported his expectation was that after the plan of correction and staff training the staff would be able to follow the procedure for ordering and receiving correctly and accurately. He reported, it was not acceptable for residents to miss a dose of medication.	F 520		