STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING _____ B. WING _____	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

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F 222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical 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 record review, staff Nurse Practitioner and physician interview, the facility failed to keep a resident free of chemical restraints for combative and agitated behaviors medication for 1 of 5 sampled residents (Resident #14). The findings included: Resident #14 was admitted on 10/23/15 with diagnoses including urinary tract infection, dementia without behaviors and cerebral infarction. The Admission Minimum Data Set (MDS) dated 10/30/15 revealed the resident was cognitively impaired, rejected care and had been on antipsychotic medications. The Hospital Discharge Summary dated 10/23/15 revealed " On arrival the patient is confused and agitated and cannot provide any history. Even after receiving 1 mg (milligram) of Ativan (antianxiety medication) IV (intravenously) he is requiring 6 security guards to prevent him from hurting himself or the staff. Haldol (antipsychotic medication) 5 mg IV given. " The Discharge Summary also indicated due to combativeness Resident #14 was " placed on sedation precedex " which was then reduced and Depakote (a medication that can be used to treat mood disorders) was added for agitation. The resident's discharge diagnoses included " agitation and encephalopathy (brain malfunction	F 222	F-222 Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective action accomplished for resident that was affected The medical record for Resident # 14 was reviewed by the administrative nursing team on 11/19/2015 for appropriate medication orders and no other concerns were identified. The order for Haldol 5mg po now and 6pm today was a one-time order and expired on 11/17/15. Nurse #5 was reeducated on behavior assessment/monitoring/interventions and antipsychotic medication use on 11/23/2015 by the Director of Nursing. The Nurse Practitioner was re-educated by the Medical Director regarding the Long Term Care regulations regarding Psychoactive medication use and the	12/9/15

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

Electronically Signed | 12/09/2015

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F 222	Continued From page 1 characterized by altered mental status) most likely secondary to urinary tract infection and stroke " . Discharge medications included Haldol 5 mg every 6 hours as needed for agitation. On 10/23/15 the Nursing Note indicated Resident #14 was admitted at 1:24 PM. The 10/23/15 Nursing Note at 1:55 PM indicated " noted increase of agitation started yelling out and swinging hands. Asked what he wants stated ' I'm OK just leave me alone ' " . On 10/23/15 at 2 PM the Nursing Note indicated Nurse # 5 notified the Family Nurse Practitioner about the Resident's behavior and Haldol treatment orders were provided. On 10/23/15 the 2:15 PM Nursing Note indicated Resident #14 received Haldol 5 mg by mouth for agitation. On 10/23/15 at 3:00 PM the Nursing Note revealed Resident #14 had his eyes closed and was calm and quiet with family members present. Review of the Physician Orders dated 10/23/15 revealed orders for: Haldol 5 mg every 6 hours as needed for agitation an order for Haldol 5 mg twice a day. On 10/26/15 the Physician's Orders revealed the Haldol 5 mg was reduced to daily. On 10/27/15 the daily Haldol was discontinued and a Psychiatric Consultation was ordered. A Physician Note dated 10/29/15 revealed, in part, " ensure safety by intervening early signs of agitation and aggressive behavior " and further indicate that the physician should be contacted if guidance in handling residents with cognitive impairment as needed. Review of the Nurse Practitioner Note dated 10/30/15 revealed that a family member of the resident was concerned that Resident #14 was not as alert that day due to his medications. Review of the Care Plan dated 11/4/15 revealed a	F 222	regulation regarding unnecessary medications on 11/19/15. The Medical Director updated the facility standing orders to reflect the new policy for psychotropic medication use on 11/19/2015. The updated policy states that no use of physical or chemical restraints may be used unless approved by the Medical Director, unless there is an emergency situation concerning resident safety, and that the residents□ family must be notified prior to the physician. Corrective action for those residents having the potential to be affected An audit was completed by the Director of Nursing and Assistant Director of Nursing on 11/20/2015 to identify any resident receiving psychotropic medications and to ensure appropriate usage and diagnoses were in place. No other issues were identified. Measures and Systemic Changes put in place An in-service was completed for all licensed nurses 11/23/2015 to 12/8/15 by the Assistant Director of Nursing, on the updated facility standing orders for psychotropic medication use, and behavior assessment/monitoring/interventions. Any licensed nurse that has not completed the in-service will be taken off the schedule until the in-service is completed. The administrative nursing staff will review all admit orders and all new orders daily in clinical meeting to ensure the proper use and monitoring of all psychotropic medications. The Pharmacy will continue sending a list of all residents on	

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F 222	Continued From page 2 plan of care for " needs monitoring of behaviors (e.g. refusals of care/medications/treatments, combativeness-hitting/kicking, yelling/cursing at staff, etc) and depressive mood (e.g. crying/tearfulness, sad facial expressions, poor appetite, withdrawal from usual activities, etc.). " The goals of care were " decreased episodes of depressive mood " and " will not exhibit any side effects from psychotropic medication " . Interventions included " administer Haldol as ordered " , " discourage inappropriate behaviors " , " if he becomes combative/resistive during care leave him safe and attempt care at a later time " , " provide comfort measures as needed " , " encourage him to express/ventilate his feelings " and " encourage participation in out of room activities " . Review of the Nurse Practitioner readmission History and Physical dated 11/9/15 revealed " consult mental health regarding increased agitation and sun downing behavior " . On 11/9/15 a Physician's Order revealed all Haldol orders were discontinued (Haldol 5 mg every 6 hours as needed was then discontinued). Review of the Medication Administration Record (MAR) for 10/23/15 -11/9/15 revealed no as needed doses were administered to the resident. Scheduled doses of Haldol were administered 10/23/15 - 10/27/15 as ordered. On 11/17/15 at 9:50 AM the Nursing Note indicated Resident #14 was found on the floor sitting in front of his geri-chair. There was no noted injury. On 11/17/15 at 10:30 AM the Nursing Note indicated " Resident continue to display increase of agitation. He attempted multiple times to get up out from chair " . The note further indicated an order for Haldol 5 mg now and again at 6:00 PM was received from the Nurse Practitioner.	F 222	Psychoactive medications to the Director of Nursing ongoing. Any resident identified to be on Psychoactive medications will be reviewed by The administrative nursing team weekly and the Pharmacy consultant monthly to ensure appropriate medication use. Any nurse identified as failing to follow the policy regarding Psychoactive medications will be followed up with by the Director of Nursing as indicated. This review will be ongoing as long as the resident remains on a Psychoactive medication. Monitoring The daily review of physicians orders, and outcomes of the Administrative nursing team review will be presented monthly for three months to the Quality Assurance Performance Improvement Committee by the Director of Nursing for review and recommendations.	

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F 222	Continued From page 3	F 222		

According to the MAR the medication was given as ordered at 10:30 AM.
On 11/17/15 at 1:30 PM the Nursing Note revealed " Resident constantly attempted to get up out from chair or in the bed. Offered snacks and drinks, staff continue to monitor him " . The note further indicated an order for Ativan 1 mg IM (intramuscularly) was received from the Nurse Practitioner. According to the MAR the medication was given as ordered.
On 11/17/15 at 3:00 PM documentation in the Nursing Note indicated Resident #14 was calm and quiet.
On 11/17/15 at 6:00 PM documentation in the Nursing Note indicated resident #14 was calm and quiet in bed.
According to the MAR dated 11/17/15 Resident #14 received the ordered dose of Haldol 5 mg by mouth at 6:00 PM.
On 11/19/15 at 8:48 AM the Physician was interviewed. He indicated that he had not been consulted about the Haldol orders for Resident #14 and that it was his expectation in future that antipsychotic orders must be approved by the physician and have an appropriate and documented clinical indication. He added that there were many other things than could be done to address agitation and combativeness. The Physician also said that just because the resident required Haldol in the acute care hospital setting, did not mean it was appropriate for him in the facility that was his home. He added that psychotropic medications should not be used as a restraint to prevent residents from getting up.
On 11/19/15 at 8:52 a telephone interview was conducted with Nurse # 5. She had received the orders for Haldol, and administered Haldol to Resident #14 on both 10/23/15 and 11/17/15. She stated that she could not recall the events of

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F 222	Continued From page 4 10/23/15. She did recall the events of 11/17/15 and stated that the resident had been combative with staff after he had a fall. He was yelling and swinging his arms and trying to get up and she was concerned that he would fall again. She stated that she had staff members keep a closer eye on him and offered him snacks and fluids but it was not effective and he kept trying to get up out of his chair or out of the bed. Nurse #5 also said that she assessed Resident #14 after his fall and did not find any injuries but that she had not attempted any pain management strategies after his fall. On 11/19/15 at 10:20 AM a telephone interview was conducted with the Nurse Practitioner. She stated that the Haldol was ordered to treat the combative and agitated behaviors of the resident that were reported to her. She added that the clinical indication was Delirium although she acknowledged not documenting this diagnoses. In addition she said she had not ordered investigative tests as the results would take several days to come back and the Haldol would calm the resident and allow her to assess him the next time she was at the facility. She said she did not consider it a chemical restraint because she expected the facility staff had tried everything they could before calling her.	F 222		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		12/9/15

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F 278	Continued From page 5 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to accurately code hypnotic medication on the Minimum Data Set (Resident # 59) and therapy services (Resident#1) for two of twenty sampled residents. The findings included: 1. Resident #59 was admitted to the facility 11/18/10 with last readmission 9/8/15. Cumulative diagnosis included, in part, dementia and anxiety. Physician orders were reviewed and revealed the following medications ordered: Lasix (diuretic) 80 milligrams (mg) by mouth (po)	F 278	F 278 Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective action accomplished for resident that was affected	

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F 278	Continued From page 6 daily (qd) Zoloft (antidepessant) 50 mg po qd Torsemide (diuretic) 20 mg po qd Lorazepam (antianxiety) 0.5 mg po qd 9PM Novolin 70/30 (insulin) 10 units subcutaneous (SQ) every day before breakfast Ambien (hypnotic) 5 mg. 1/2 tab per tube at bedtime (hs) for insomnia An Annual Minimum Data Set (MDS) dated 8/5/15 indicated Resident #59 was cognitively intact. Medications received during the seven day assessment period included the following: 7 days of injections, 7 days of insulin, 7 days of antianxiety, antidepressant and diuretic medication. No hypnotic medication was noted as having been received during the assessment period. A review of the Medication Administration Record for July and August 2015 revealed Resident #59 received insulin and insulin injections seven days, diuretic medication seven days, antianxiety and antidepressant medication seven days and hypnotic medication seven days. On 11/17/2015 at 4:03PM, Administrative staff #2 stated she should have included the Ambien as a hypnotic for 7 days of use and it was an oversight. 2. Resident #1 was admitted to the facility on 7/9/15 with multiple diagnoses that included congenital hydrocephalus. The quarterly MDS dated 10/14/15 indicated	F 278	A modification of the MDS for resident #59 was completed by the MDS Nurse to include accurate coding for hypnotic use and was transmitted to the state database on 11/17/15. A modification of the MDS for resident #1 was completed by the MDS Nurse to include accurate coding to indicate the resident was not receiving Physical and Occupational Therapy and was transmitted to the state database on 12/8/15. Corrective action for those residents having the potential to be affected A 100% chart audit of Sections N and O of the MDS audit was completed by the Administrative Nursing Team 11/18/15 through 12/8/15 of all MDS□s completed since November 1st to ensure accuracy of the coding. Any resident requiring a modification of their assessment had such modification completed and transmitted to the state database. Measures and Systemic Changes put in place The Administrative Nursing Team was in-serviced regarding proper coding techniques for Sections N and O of the MDS, by the Director of Clinical Services on 12/8/15 and have been able to provide appropriate verbal responses related to questions regarding coding of Sections N and O of the MDS. Monitoring An audit of Sections N and O of all MDS's completed during that period will be completed weekly for four weeks, then 10 charts monthly for 2 months by 2 members of the Administrative Nursing	

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F 278	Continued From page 7 Resident #1 had significant cognitive impairment. The Special Treatments, Procedures, and Programs Section indicated Resident #1 was receiving ongoing Occupational Therapy (OT) and Physical Therapy (PT). A review of physician's orders indicated the resident was discharged from OT on 8/31/15 and PT on 9/2/15. An interview was conducted on 11/17/15 at 4:10 PM with Administrative Staff #2. She stated that she was responsible for completing the MDS. She stated that Resident #1 was not receiving ongoing OT and PT at the time of this MDS assessment. She revealed that this was an oversight and that she should have indicated the end dates for both OT and PT.	F 278	team who did not complete Sections N and O to ensure that all MDS□s completed are coded accurately before they are transmitted to the state database. These audits will be presented by the Director of Nursing for 3 months to the Quality Assurance Performance Improvement Committee for review and recommendations.	
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	F 280		12/9/15

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F 280	Continued From page 8 each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the facility failed to review and revise a care plan for one of two residents reviewed for range of motion (Resident #43) who had bilateral hand splints discontinued and one of five sampled residents reviewed for psychotropic medications (Resident#14). The findings included: 1. Resident #43 was admitted to facility 11/14/05. Cumulative diagnoses included: quadriplegia A Quarterly Minimum Data Set (Minimum Data Set) dated 8/5/15 indicated Resident #43 had short and long term memory impairment ad was severely impaired in daily decision-making. Resident required total assistance with all areas of ADL's (activities of daily living). Functional limitation in range of motion of the upper and lower extremities was noted. A care plan dated 1/10/07 and last reviewed 8/5/15 stated the following, in part, Resident #43 needed total assistance with ADL tasks secondary to quadriplegia with severe contractures of all extremities. Goal: Resident #43 will not present with any further contracture development over the next review. Approaches included, in part, apply left hand splint as ordered (6/17/14); apply right hand splint as ordered (2/24/15).	F 280	F 280 Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective action accomplished for resident that was affected The Comprehensive Care Plan for Resident #43 was reviewed by the MDS Nurse on 11/18/15 and was updated to reflect the discontinuing of the bilateral splints to the hands. The Comprehensive Care Plan for Resident #14 was reviewed by the MDS Nurse on 11/18/15 and was updated to reflect the discontinuing of the Haldol. Administrative Staff #2 was in-serviced by the Director of Clinical Services on 12/8/15 regarding how to properly document on the care plan for new onsets of conditions and orders and discontinuing interventions and problems as issues are resolved. Corrective Action for Residents With The Potential to Be Affected A one hundred percent chard audit was	

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F 280	Continued From page 9 Physician orders for November 2015 were reviewed and revealed the following in relation to splint use: Resident to wear hand splints to prevent further contracture. Assess for skin breakdown and impaired circulation under right hand splint daily. A review of the November Medication Administration Record (MAR) revealed documentation that Resident #43 had been observed for skin breakdown and impaired circulation under his right hand splint daily. An observation on 11/16/15 at 4:00PM revealed Resident #43 lying in bed with both hands in a contracted position. No splints were in place at that time. An observation on 11/17/15 at 10:51AM revealed Resident #43 lying in bed with both hands in a contracted position. No splints were in place at that time. An observation on 11/17/15 at 4:30PM revealed Resident #43 lying in bed with both hands in a contracted position. No splints were in place at that time. On 11/17/2015 at 4:49PM, Nurse #1 stated she was in charge of the restorative program. She said Resident #43 was previously in the restorative program but no longer was in the program. He was discharged from restorative PROM (passive range of motion)/ splinting program on 4/14/15. Resident #43 no longer received bilateral hand splints and was discharged from the program due to not meeting his goals of prevention of further contractures of his hands. She stated she had notified the	F 280	completed by the Administrative Nursing Team on 11/23/15 of all residents to determine which residents are identified to be at potential risk for contractures, splinting and overlooked orders. All residents that have been identified to be at risk for contractures, splinting or overlooked orders had their Care Plan reviewed for appropriate interventions by the Care Plan Team on 11/23/15 and the care plans were updated if indicated. Measures and Systemic Changes put in place The Care Plan Team for Resident #43 & #14, the Administrative Nursing Team, and the Administrator were in-serviced by the Director of Clinical Services on 12/8/15 regarding how to properly document on the care plan for new onsets of conditions and orders and discontinuing interventions and other problems as issues are resolved. Monitoring The Care Plan Team will review two Care Plans weekly for four weeks and eight Care Plans monthly for two more months to ensure the Care Plans are updated with interventions to address new onsets of conditions or discontinuing interventions, orders and other problems as issues are resolved. The Director of Nursing will present the results of those reviews to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations.	

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F 280	Continued From page 10	F 280		

physician and written a discontinuation order regarding the bilateral splints because they were not benefitting him. She showed documentation of a physician order dated 4/14/15 to discontinue the restorative program for PROM/ bilateral splints

On 1/18/15 at 8:20AM, an interview was conducted with NA #1. She stated she also worked in the restorative nursing program and Resident #43 did not have any hand splints. NA #1 said Resident #43 wore his bilateral hand splints for about six hours/ day prior to the splints being discontinued. She thought his splints had been discontinued since April 2015. NA #1 stated she would check his skin prior to having the splints applied and, even though Resident #43 no longer wore splints, she still checked for redness and skin breakdown and that was what was documented on the MAR.

On 11/18/15 at 8:27AM, Nurse #2 stated, normally, the restorative nurse would inform her when splints were initiated and/or discontinued. She stated there had been a lack of communication and she should have questioned someone about Resident #43's splints.

On 11/18/2015at 9:44AM, Administrative staff #2 stated order changes were reviewed every day in morning meeting and changes were made at that time to the care plan if needed. She stated it was her understanding they were taking him off the restorative program and nursing was to apply the splints so that why it was still on the care plan. She stated it was probably miscommunication.

On 11/18/2015 at 9:49AM, Administrative staff #1 stated the splints should have been removed

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ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

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F 280	Continued From page 11 from the care plan. 2. Resident #14 was admitted on 10/23/15 with diagnoses including urinary tract infection, dementia without behaviors and cerebral infarction. The Admission Minimum Data Set (MDS) dated 10/30/15 revealed the resident was cognitively impaired, rejected care and had been on antipsychotic medications. Review of the Care Plan dated 11/4/15 revealed a plan of care for " needs monitoring of behaviors (e.g. refusals of care/medications/treatments, combativeness-hitting/kicking, yelling/cursing at staff, etc) and depressive mood (e.g. crying/tearfulness, sad facial expressions, poor appetite, withdrawal from usual activities, etc.). " The goals of care were " decreased episodes of depressive mood ' and " will not exhibit any side effects from psychotropic medication " . Interventions included " administer Haldol as ordered . On 11/9/15 a Physician ' s Order revealed all Haldol orders were discontinued. On 11/19/15 at 10:05 AM Administrative Staff #2 was interviewed. She acknoledged that when the Haldol medication was discontinued it should have been removed from the care plan and the care plan should have been revised. She stated it was an oversight.	F 280		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,	F 325		12/9/15

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F 325	Continued From page 12 unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to serve the therapeutic diet (double portion of meat) as ordered for 1 (Resident #49)of 1 sampled resident on dialysis. Findings included: Resident # 49 was admitted to the facility on 8/8/15 with multiple diagnoses including end stage renal disease (ESRD). The quarterly Minimum Data Set (MDS) assessment dated 11/4/15 indicated that Resident #49 had intact cognition and was on dialysis. The notes of the registered dietician (RD) from the dialysis clinic were reviewed. The notes dated 8/20/15 indicated that the albumin level for Resident #49 was 3.2 (low). The goal was 4 or higher. The RD had recommended double meat portions to help meet protein needs in addition to prostat (protein supplement) twice a day. The facility's dietary notes were reviewed. The notes indicated that Resident #49 was seen by the RD at the facility on 8/26/15 and 9/16/15. The notes did not address the recommendation from the dialysis clinic regarding the double meat portion. The notes dated 10/14/15, the RD had recommended to implement the dialysis clinic recommendation for double meats. The doctor's orders were reviewed. On 10/14/15, there was an order to " add egg x (times) 2 at	F 325	F325 Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective action accomplished for resident that was affected The tray card for Resident #49 was updated by the Certified Dietary Manager (CDM) on 11/18/2015 and the resident is now receiving double portions of meats/chicken. The CDM was in-serviced and counseled regarding following dietary orders and updated the tray card as indicated on 11/24/2015. Corrective action for those residents having the potential to be affected A 100% tray card audit was completed by the Certified Dietary Manager on 11/23/2015 through 11/30/2015 to compare the tray cards against the physician orders to ensure the tray cards are accurate. No other residents were	

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F 325	Continued From page 13 breakfast and double meats with lunch and dinner. " On 11/12/15, there was an order for double portions of meat/chicken per resident's request. On 11/16/15, the albumin level for Resident #49 was 3.3 (low). On 11/17/15 at 5:40 PM, Resident #49 was observed during dinner time. Her tray contained a regular portion of chicken. Her dietary card did not indicate double portion of meat/chicken. On 11/18/15 at 5:40 PM, Resident #49 was observed during dinner time. Her tray contained a regular portion of hamburger. Her dietary card did not indicate double portion of meat/chicken. On 11/18/15 at 5:43 PM, administrative staff #3 was interviewed. She indicated that she was aware that Resident #49 had a doctor's order for double portion of meat during lunch and dinner but she was not aware that it was not written on her dietary card and therefore the double meat portion was not served.	F 325	found to have inaccurate tray cards. Measures and Systemic Changes put in place A Dietary Order Monitoring Tool was developed by the Director of Clinical Services on 12/9/15 to facilitate communication and updating of the tray cards. The tool will be utilized daily in the morning stand up meeting to verify the tray cards are updated as indicated. The Certified Dietary Manager was in-serviced on 12/9/15 by the Administrator regarding completion of the Dietary Order Monitoring Tool. Monitoring The Certified Dietary Manager will audit 3 residents with new dietary orders per week to ensure the order matches the tray card and the resident is receiving what has been ordered. The audits will continue for three months. The Certified Dietary Manager will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations	
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	F 329		12/9/15

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F 329	Continued From page 14 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 Nurse Practitioner and physician interview, the facility failed to utilize non pharmacological approaches to address behaviors, failed to evaluate the underlying cause of behaviors either before or during treatment with antipsychotic medication and failed to reassess the ongoing clinical indication for antipsychotic medication in the absence of a clinical indication for 1 of 5 sampled residents (Resident #14). The findings included: Resident #14 was admitted on 10/23/15 with diagnoses including urinary tract infection, dementia without behaviors and cerebral infarction. The Admission Minimum Data Set (MDS) dated 10/30/15 revealed the resident was cognitively impaired, rejected care and had been on antipsychotic medications. The Hospital Discharge Summary dated 10/23/15	F 329	F-329 Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective action accomplished for resident that was affected The medical record for Resident # 14 was reviewed by the administrative nursing team on 11/19/2015 for appropriate medication orders and no other concerns were identified. The order	

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F 329	Continued From page 15 revealed " On arrival the patient is confused and agitated and cannot provide any history. Even after receiving 1 mg (milligram) of Ativan (antianxiety medication) IV (intravenously) he is requiring 6 security guards to prevent him from hurting himself or the staff. Haldol (antipsychotic medication) 5 mg IV given. " The Discharge Summary also indicated due to combativeness Resident #14 was " placed on sedation precedex " which was then reduced and Depakote (a medication that can be used to treat mood disorders) was added for agitation. The resident's discharge diagnoses included " agitation and encephalopathy (brain malfunction characterized by altered mental status) most likely secondary to urinary tract infection and stroke " . Discharge medications included Haldol 5 mg every 6 hours as needed for agitation. On 10/23/15 the Nursing Note indicated Resident #14 was admitted at 1:24 PM. The 10/23/15 Nursing Note at 1:55 PM indicated " noted increase of agitation started yelling out and swinging hands. Asked what he wants stated ' I'm OK just leave me alone ' " . On 10/23/15 at 2 PM the Nursing Note indicated Nurse # 5 notified the Family Nurse Practitioner about the resident's behavior and Haldol treatment orders were provided. On 10/23/15 the 2:15 PM Nursing Note indicated Resident #14 received Haldol 5 mg by mouth for agitation. On 10/23/15 at 3:00 PM the Nursing Note revealed Resident #14 had his eyes closed and was calm and quiet with family members present. Review of the Physician Orders dated 10/23/15 revealed orders for: Haldol 5 mg every 6 hours as needed for agitation an order for Haldol 5 mg twice a day. On 10/26/15 the Physician's Orders revealed the	F 329	for Haldol 5mg po now and 6pm today was a one-time order and expired on 11/17/15. Nurse #5 was reeducated on behavior assessment/monitoring/interventions and antipsychotic medication use on 11/23/2015 by the Director of Nursing. The Nurse Practitioner was re-educated by the Medical Director regarding the Long Term Care regulations regarding Psychoactive medication use and the regulation regarding unnecessary medications on 11/19/15. The Medical Director updated the facility standing orders to reflect the new policy for psychotropic medication use on 11/19/2015. The updated policy states that no use of physical or chemical restraints may be used unless approved by the Medical Director, unless there is an emergency situation concerning resident safety, and that the residents□ family must be notified prior to the physician. Corrective action for those residents having the potential to be affected An audit was completed by the Director of Nursing and Assistant Director of Nursing on 11/20/2015 to identify any resident receiving psychotropic medications and to ensure appropriate usage and diagnoses were in place. No other issues were identified. Measures and Systemic Changes put in place An in-service was completed for all licensed nurses 11/23/2015 to 12/8/15 by the Assistant Director of Nursing, on the updated facility standing orders for psychotropic medication use, and	

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F 329	Continued From page 16 Haldol 5 mg was reduced to daily. On 10/27/15 the daily Haldol was discontinued and a Psychiatric Consultation was ordered. A Physician Note dated 10/29/15 revealed, in part, " ensure safety by intervening early signs of agitation and aggressive behavior " and further indicate that the physician should be contacted if guidance in handling residents with cognitive impairment as needed. Review of the Nurse Practitioner Note dated 10/30/15 revealed that a family member of the resident was concerned that Resident #14 was not as alert that day due to his medications. Review of the Care Plan dated 11/4/15 revealed a plan of care for " needs monitoring of behaviors (e.g. refusals of care/medications/treatments, combativeness-hitting/kicking, yelling/cursing at staff, etc) and depressive mood (e.g. crying/tearfulness, sad facial expressions, poor appetite, withdrawal from usual activities, etc.). " The goals of care were " decreased episodes of depressive mood " and " will not exhibit any side effects from psychotropic medication " . Interventions included " administer Haldol as ordered " , " discourage inappropriate behaviors " , " if he becomes combative/resistive during care leave him safe and attempt care at a later time " , " provide comfort measures as needed " , " encourage him to express/ventilate his feelings " and " encourage participation in out of room activities " . Review of the Nurse Practitioner readmission History and Physical dated 11/9/15 revealed " consult mental health regarding increased agitation and sun downing behavior " . On 11/9/15 a Physician's Order revealed all Haldol orders were discontinued (Haldol 5 mg every 6 hours as needed was then discontinued). Review of the Medication Administration Record	F 329	behavior assessment/monitoring/interventions. Any licensed nurse that has not completed the in-service will be taken off the schedule until the in-service is completed. The administrative nursing staff will review all admit orders and all new orders daily in clinical meeting to ensure the proper use and monitoring of all psychotropic medications. The Pharmacy will continue sending a list of all residents on Psychoactive medications to the Director of Nursing ongoing. Any resident identified to be on Psychoactive medications will be reviewed by The administrative nursing team weekly. The Pharmacy consultant will continue to review all residents medications monthly to ensure appropriate medication use. Any nurse identified as failing to follow the policy regarding Psychoactive medications will be followed up with by the Director of Nursing as indicated. This review will be ongoing as long as the resident remains on a Psychoactive medication. Monitoring The daily review of physicians orders, and outcomes of the Administrative nursing team review will presented monthly for three months to the Quality Assurance Performance Improvement Committee by the Director of Nursing for review and recommendations.	

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(MAR) for 10/23/15 -11/9/15 revealed no as needed doses were administered to the resident. Scheduled doses of Haldol were administered 10/23/15 - 10/27/15 as ordered.
On 11/17/15 at 9:50 AM the Nursing Note indicated Resident #14 was found on the floor sitting in front of his geri-chair. There was no noted injury.
On 11/17/15 at 10:30 AM the Nursing Note indicated " Resident continue to display increase of agitation. He attempted multiple times to get up out from chair " . The note further indicated an order for Haldol 5 mg now and again at 6:00 PM was received from the Nurse Practitioner. According to the MAR the medication was given as ordered at 10:30 AM.
On 11/17/15 at 1:30 PM the Nursing Note revealed " Resident constantly attempted to get up out from chair or in the bed. Offered snacks and drinks, staff continue to monitor him " . The note further indicated an order for Ativan 1 mg IM (intramuscularly) was received from the Nurse Practitioner. According to the MAR the medication was given as ordered.
On 11/17/15 at 3:00 PM documentation in the Nursing Note indicated Resident #14 was calm and quiet.
On 11/17/15 at 6:00 PM documentation in the Nursing Note indicated resident #14 was calm and quiet in bed.
According to the MAR dated 11/17/15 Resident #14 received the ordered dose of Haldol 5 mg by mouth at 6:00 PM.
On 11/19/15 at 8:48 AM the Physician was interviewed. He indicated that he had not been consulted about the Haldol orders for Resident #14 and that it was his expectation in future that antipsychotic orders must be approved by the physician and have an appropriate and

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documented clinical indication. He added that there were many other things than could be done to address agitation and combativeness. The Physician also said that just because the resident required Haldol in the acute care hospital setting, did not mean it was appropriate for him in the facility that was his home. He added that psychotropic medications should not be used as a restraint to prevent residents from getting up.
On 11/19/15 at 8:52 a telephone interview was conducted with Nurse # 5. She had received the orders for Haldol, and administered Haldol to Resident #14 on both 10/23/15 and 11/17/15. She stated that she could not recall the events of 10/23/15. She did recall the events of 11/17/15 and stated that the resident had been combative with staff after he had a fall. He was yelling and swinging his arms and trying to get up and she was concerned that he would fall again. She stated that she had staff members keep a closer eye on him and offered him snacks and fluids but it was not effective and he kept trying to get up out of his chair or out of the bed. Nurse #5 also said that she assessed Resident #14 after his fall and did not find any injuries but that she had not attempted any pain management strategies after his fall.
On 11/19/15 at 10:20 AM a telephone interview was conducted with the Nurse Practitioner. She stated that the Haldol was ordered to treat the combative and agitated behaviors of the resident that were reported to her. She added that the clinical indication was Delirium although she acknowledged not documenting this diagnoses. In addition she said she had not ordered investigative tests as the results would take several days to come back and the Haldol would calm the resident and allow her to assess him the next time she was at the facility. She said she did

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F 329	Continued From page 19 not consider it a chemical restraint because she expected the facility staff had tried everything they could before calling her.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that medication error rate was 5% or below by not administering the medications via gastrostomy (G) tube one at a time and by not administering a medication as ordered. There were 2 errors of 26 opportunities for error resulting in a 7.69 % error rate. Findings included: The facility's policy on " administering medications through an enteral tube " dated September, 2014 was reviewed. The policy read in part " do not mix medications together prior to administering through an enteral tube. Administer each medication separately. " 1a. On 11/18/15 at 8:11 AM, Resident #8 was observed during the medication pass. Nurse #4 was observed to prepare the medications for Resident #8 including Amlodipine (drug for hypertension), Hydrochlorothiazide (drug for hypertension), Tylenol (analgesic) and Certavite (vitamin). Nurse #4 was observed to crush all the medications, mixed them together in a medication cup and dissolved them in water. Nurse #4	F 332	F332 Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective action accomplished for resident that was affected Nurse #4 was re-educated on 11/23/2015 by Assistant Director of Nursing on the CMS guidelines for no longer administering Cocktail style medications via g-tube. Nurse #4 was also watched on a med pass by the ADON to verify proper administration of G-tube meds on 11/23/2015 prior to returning to the floor. Order for Enteric coated Aspirin qd per g-tube was clarified on 11/18/2015 and changed to Aspirin 325 mg via peg tube qd by the Unit Manager.	12/9/15

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F 332	Continued From page 20 proceeded to flush the G tube with water and poured the medications from the medication cup into the G tube. On 11/18/15 at 9:30 AM, Nurse #4 was interviewed. She stated that she was new to the facility and was not trained on how to administer medications via G tube. She added that she did not know that each medication should be administered separately if given via G tube. On 11/19/15 at 12:35 PM, administrative staff #1 was interviewed. She stated that she expected the nurses to administer medications via G tube one at a time. 1b. Resident #8 had a doctor's order dated 6/13/14 for enteric coated aspirin (pain reliever and prevents blood clot and stroke) 325 milligrams (mgs) 1 tablet per tube daily. *Do not crush* On 11/18/15 at 8:11 AM, Resident #8 was observed during the medication pass. Nurse #4 was observed to prepare the medications for Resident #8 including Amlodipine (drug for hypertension), Hydrochlorothiazide (drug for hypertension), Tylenol (analgesic) and Certavite (vitamin). Nurse #4 was not observed to prepare the enteric coated aspirin (ECASA). Nurse #4 was observed to administer the medications via G tube and then proceeded to another resident. On 11/18/15 at 9:30 AM, Nurse #4 was interviewed. She stated that she did not administer the ECASA because the order stated that it should not be crushed and she did not have the regular aspirin in her medication cart. She added that the doctor should have been called to change the ECASA to regular aspirin but it was not. Nurse #4 acknowledged the	F 332	Corrective action for those residents having the potential to be affected The medications of all residents receiving medications via G-tube were audited by the Administrative Nursing team 11/19/2015 through 12/8/2015 to ensure the medications could be crushed to be administered via G-tube. If non crushable forms of medications were identified, the physician was notified and the orders were changed to appropriate forms (crushable or liquid) of medications as indicated. Measures and Systemic Changes put in place All other nurses were re-educated on the proper administration of g-tube medications and order clarifications of medications for g-tube residents that cannot be crushed beginning on 11/23/2015 by the ADON and completed on 12/9/2015. All new nurses will receive this information in the new hire orientation. Pharmacy med pass audits to be done by the Facility Pharmacy consultant and random med pass observations to be done by Administrative nurses will be completed to ensure compliance with policy on g-tube medication administration. All new admissions and new orders including g-tube residents will have orders reviewed, verified and/or clarified as needed for proper medication route/form of administration during daily clinical meetings. Monitoring Pharmacy med pass audits to be done by the Facility Pharmacy consultant and random med pass observations to be	

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F 332	Continued From page 21 Medication Administration Records (MARs) had nurse's initials indicating that they had administered ECASA to Resident #8 via G tube. On 11/19/15 at 12:35 PM, administrative staff #1 was interviewed. She stated that the order for ECASA should have been verified with the doctor.	F 332	done by Administrative nurses to ensure compliance with policy on g-tube medication administration. The med-pass audits will be completed on at least 2 nurses on varied shifts and at least one weekend shift weekly for 4 weeks, then monthly for 2 months. The results of those audits will be presented by the Director of Nursing monthly for 3 months in the Quality Assurance Performance Improvement Committee meeting for review and recommendations.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public	F 356		12/9/15

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	345051	A. BUILDING _____ B. WING _____	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

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F 356	Continued From page 22 for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the current nurse staffing data. The findings included: A tour of the facility was conducted on 11/16/15 at 10:30 AM. The posted nurse staffing data indicated it was for 11/13/15. There was no nurse staffing data posted for 11/16/15. An interview was conducted with the Administrator on 11/17/15 at 3:15 PM. She revealed that she was unaware the nurse staffing data posting was not updated on 11/14/15, 11/15/15 or on the morning of 11/16/15. She stated that she expected the assigned RN Coordinator to post the current nurse staffing data each morning.	F 356	F356 Corrective action accomplished for resident that was affected The daily staff posting was corrected and posted the RN Unit Manager on 11/16/2015 when it was brought to the facility□s attention by the surveyor. No resident was found to be affected by the deficient practice. Corrective action for those residents having the potential to be affected No resident was found to be potentially affected by the deficient practice Measures and Systemic Changes put in place Posting of the Daily Staffing Form has been assigned the responsibility to the Receptionist which are present seven days a week. Any staff member that may be responsible for posting the Daily Staffing form was in-serviced by the Assistant Director of Nursing on 12/9/15 regarding the requirement for posting the Daily Staffing form each day. The Department Heads that serve as Manager on Duty on the weekends were in-serviced by the Assistant Director of Nursing on 12/9/15 regarding the requirement for posting the Daily Staffing	

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F 356	Continued From page 23	F 356	form each day and regarding their responsibility for checking to ensure the sheet is posted. Monitoring The Administrator or the Director of Nursing will audit the Daily Staffing form Monday through Friday and the Department Head assigned to Manager on Duty detail Saturday and Sunday, daily for one week, then weekly for three weeks, and then monthly for two months to ensure the Daily Staffing Form is posted each day. The Administrator will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations.	
F 514 SS=B	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:	F 514		12/9/15

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F 514	Continued From page 24 Based on observation, medical record review and staff interview, the facility failed to maintain complete and accurate medical records for one of two residents reviewed for range of motion (Resident #43) by not removing a physician's order for hand splints from the orders and Treatment Administration Record (TAR) when a physician's order to discontinue the splints was written in April, 2015. The findings included: Resident #43 was admitted to the facility 11/14/05. Cumulative diagnoses included: quadriplegia A Quarterly Minimum Data Set (MDS) dated 8/5/15 indicated Resident #43 had short and long term memory impairment and was severely impaired in daily decision-making. Total assistance was required with bed mobility, transfers, no ambulation occurred, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene and bathing. Functional limitation in range of motion of the upper and lower extremities was documented during the seven day assessment period. A Care Plan dated 1/10/07 and last reviewed on 8/5/15 stated the following: Resident #43 needs total assistance with ADL (activities of daily living) daily ...secondary to quadriplegia with severe contractures of all extremities. Goal: Resident #43 will not present with any further contracture development over the next review. Approaches included, in part, apply left hand splint as ordered (6/17/14); apply right hand splint as ordered (2/24/15). Physician orders for November 2015 were reviewed and revealed the following: 7/1/14	F 514	F514 Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective action accomplished for resident that was affected The Care Plan was corrected and updated by the MDS Nurse on 11/18/15 for resident #43. An order was obtained on 11/18/15 to discontinue use of hand splints and the monitoring of skin related to use of hand splints. Corrective action for those residents having the potential to be affected An audit was completed on 11/18/15 to 11/23/15 by the Administrative Nursing Team of all current residents in facility receiving restorative nursing services to ensure care plans and physician□s orders were accurate and updated if indicated. An in service was completed on 11/18/15 to 12/9/15 by the Assistant Director of Nursing for all licensed nurses regarding a second nurse is required to verify all new admission orders, monthly Medication Administration Records (MAR), and Treatment Administration Records (TAR). Both licensed nurses must review the resident□s Medical Record for new and discontinued orders to ensure all current medications and treatments are	

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F 514	Continued From page 25 Resident to wear hand splints to prevent further contracture. 10/01/14 Assess for skin breakdown and impaired circulation under right hand splint daily. A review of the November Medication Administration Record (MAR) revealed documentation that the skin had been assessed for skin breakdown and impaired circulation under the right hand splint daily. Bilateral hand splints was also noted as FYI (for your information) An observation on 11/16/15 at 4:00PM revealed Resident #43 with bilateral hands in a contracted position. No splints were in place at that time. An observation on 11/17/15 at 10:51AM revealed Resident #43 in bed with hands in a contracted position. No splints were in place at that time. An observation on 11/17/15 at 4:30PM revealed Resident #43 in bed with hands in a contracted position. No splints were in place at that time. On 11/17/2015 at 4:49PM, Nurse #1 stated she was in charge of the restorative program and stated Resident #43 was previously in the restorative program but no longer was in the program. He was discharged from restorative PROM/ splinting program on 4/14/15. He continued not to meet goals and was discharged from the program and no longer had splints to any of his extremities. She stated she had notified the physician and written the order for discontinuation of the bilateral hand splints on 4/14/15. On 11/8/15 at 8:20AM, NA #1 stated Resident	F 514	transcribed accurately on the resident□s MARs and TARs. Measures and Systemic Changes put in place Two licensed nurses will verify all new admission orders, monthly Medication Administration Records (MAR), and Treatment Administration Records (TAR). Both licensed nurses will review the resident□s Medical Record for new and discontinued orders to ensure all current medications and treatments are transcribed accurately on the resident□s MARs and TARs. The administrative nursing team will review all new admission orders and daily orders in clinical meeting to ensure continued compliance. Monitoring The administrative nursing team will audit all new admission orders and daily orders, daily, in the clinical meeting, ongoing, to ensure all current medications and treatments are transcribed accurately on the resident□s MARs and TARs and ensure continued compliance. Results of the daily review of physicians□ orders and outcomes of the Administrative nursing team review will be presented monthly by the Director of Nursing for three months to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 514	Continued From page 26	F 514		

#43 had not had any hand splints since April, 2015. She stated she signed on the MAR that she was checking for skin redness and breakdown and not that the splints were there. She stated she checked the skin even though he no longer had hand splints.

On 11/18/2015 at 9:34AM, Nurse #1 stated she, the MDS nurse and therapy met weekly and, on 4/14/15, had determined that the bilateral hand splints were not benefitting Resident #43. She stated she wrote the discontinuation order at that time and did not know why the orders for the splints continued to be on the physician orders and MAR. She stated she just must have missed discontinuing them.

On 11/18/2015 at 9:49AM, Administrative staff #1 stated she had been in the facility about 3 months. She stated the monthly orders were verified by two nurses and they checked the current physician orders and MAR with the upcoming ones. The two nurses then signed off they had verified the orders. She stated either the order wasn't discontinued on the May orders or both nurses simply didn't catch it. She expected the order should have been discontinued on the May orders/ MAR. Administrative staff stated the orders and MAR came from the pharmacy. All orders were faxed to the pharmacy and they should have also caught it and discontinued the order.