| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345411 | A. BUILDING _____ B. WING _____ | C 12/04/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE | 516 WALL STREET WAYNESVILLE, NC 28786 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 176 SS=D | 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, medical record review, resident, and staff interviews, the facility failed to assess 1 of 1 resident observed with medication at the bedside for the ability to safely administer a liquid antacid (Resident #20).<br><br>The findings included:<br><br>Resident #20 was admitted to the facility on 07/12/13 with diagnoses which included dysphagia, hypertension, reflux, and nutritional deficiency.<br><br>The annual Minimum Data Set (MDS) dated 05/10/15 indicated resident had clear speech and was cognitively intact. The MDS further indicated that Resident #20 required limited assistance with bed mobility, transfers, dressing, toileting, hygiene and total dependence with bathing. Review of physician's orders indicated there was no order to self-administer any medications. Further review of nursing assessments revealed no self-administration of medications assessment had been completed.<br><br>An interview was conducted with Resident #20 on 12/02/15 at 1:56 PM. During this interview, a plastic Vitamin D container with some type of pink colored substance in the bottom was noted on | F 176 | F176<br><br>1. Corrective action has been accomplished for the alleged deficient practice for Resident #20 by removing and disposing of the over the counter medication brought into the resident by a family member without the facilities knowledge. Additionally, the facility conducted an assessment and provided education to the resident regarding self-administration of medication. The family member was also educated on the correct manner for request medications.<br><br>2. Facility residents, who want to self-administer medication have the potential to be affected by the same alleged deficient practice all resident rooms will be audited for medications at bedside. Therefore, Resident Ambassador will interview and educate residents and or Responsible Parties on self-administering of medication and the need for facility to complete an assessment to deem it appropriate and that physician order is required. Any resident who prefers to self-administer medications will have self-administration assessment performed | 1/1/16 |

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

Electronically Signed | 12/28/2015

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| F 176 | Continued From page 1<br>her bedside table. When asked about the container, Resident #20 stated it was a medication one of her family members brought in for her that she took for her stomach.<br><br>An interview was conducted with Nurse Aide (NA) #4 on 12/02/15 at 2:04 PM. NA #4 indicated that Resident #20 "pretty much does for herself." NA #4 stated he was her NA and did not recall seeing a medication on the bedside table on this day or any other day NA #4 has cared for her.<br><br>An interview was conducted with Certified Medication Aide (CMA) #2 on 12/02/15 at 2:08 PM. CMA #2 indicated that she was not aware that the medication was at the bedside table and knew Resident #20 was not supposed to have it there. CMA #2 reviewed the Medication Administration Record (MAR) which indicated Resident #20 had 2 different daily scheduled antacids and an as needed antacid. CMA #2 verified all the antacids listed on the MAR were pills taken by mouth and there were no liquid antacids taken by mouth.<br><br>An interview was conducted with Nurse (RN) #4 on 12/02/15 at 2:10 PM. RN #4 was present in the room when Resident #20 was asked about the contents of the bottle. Resident #20 stated a family member brought it in and it had been sitting on her bedside table for 4 or 5 days. RN #4 picked up the Vitamin D container with pink substance in the bottom, opened it, looked inside, and smelled the contents. RN #4 indicated she thought it may be some type of liquid antacid. RN #4 told Resident #20 that medication could not stay in the room but a request would be made for the physician to write an order to administer the medication as needed. RN #4 proceeded to | F 176 | by nursing and DON will obtained physician order as indicated.<br><br>3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Area Staff Development RN/ DON will provide in-service/re-education for all nursing staff regarding on-going observations of resident rooms for medications at bedside and nursing assessments for residents to safely self- administer medications. Medications cannot be at bedside if resident does not meet guideline for self-administering medications. Additionally, The DON will conduct 5 weekly audits of the residents who self administer medications for 2 months and 5 monthly audits for 3 months for residents who self- administer medications.<br><br>4. The DON will bring the results of the audits to the monthly QAPI meeting for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.<br><br>Complete by 01/01/2016 | |

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| F 176 | Continued From page 2<br>remove the medication from the room.<br><br>An interview was conducted with Nurse Supervisor (NS) #2 on 12/03/15 at 3:27 PM. NS #2 stated there had never been an evaluation for Resident #20 to self-administer medications. NS #2 checked the chart and validated there was not an assessment to self-administer medications or a physician's order for Resident #20 to self-administer medications.<br><br>An interview was conducted with the Director of Nursing (DON) on 12/04/15 at 10:12 AM. The DON stated families bring in medications without the facility's knowledge and some residents leave from the facility and get medications themselves. If medications were found they were removed and the families were contacted and asked to come and pick up the medication. The DON acknowledged medication should not be at the bedside table unless an order from the physician to self-administer, along with an assessment evaluating a resident's ability to self-administer, was present on the chart. | F 176 | | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews, the facility failed to serve the dinner meal at the same time to the residents sitting at | F 241 | F241<br><br>1. Corrective action has been | 1/1/16 |

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| F 241 | Continued From page 3<br>the same table for 1 of 1 resident observed during the dining observation (Resident #83).<br><br>The findings included:<br><br>A medical record review for Resident #83 indicated she was admitted to the facility on 12/11/14. Upon review of her quarterly Minimum Data Set (MDS) dated 09/04/15, documentation was present that noted Resident #83 to be cognitively intact and independent with eating. Resident #83 had diagnoses of hypertension, anxiety, depression, manic depression, and chronic lung disease among others.<br><br>A continuous observation of the dinner meal on 12/02/15 from 5:08 PM to 5:26 PM noted Nurse Aide (NA) #5 in the dining room with no other staff. NA #5 distributed dinner meal trays to 11 residents which included residents sitting at 4 tables of 2 residents per table and 3 tables of 1 resident per table. NA #5 was observed to deliver each resident's dinner tray, including resident #83's tray, in random order to residents being served in the dining room. Residents seated together were not observed receiving all dinner trays at their table before NA #5 continued to the next table to deliver the next dinner tray.<br><br>An interview with NA #5 on 12/02/15 at 5:26 PM indicated that NA #5 verified there was usually more than one NA giving out trays at meal times, but the other NA showed up late after she delivered all the dinner trays. NA #5 stated that she usually tried to give out all trays to one table at a time but sometimes she wasn't able to. NA #5 stated she worried the resident's food may be cold if she took the time to put the trays together in order on the cart before giving them out. | F 241 | accomplished for resident #83 by re-educating the Resident Care Specialist on proper meal service and to ensure all residents are passed at the same table, in a timely manner, by DON.<br><br>2. Facility residents have the potential to be affected by the same alleged deficient practice. Therefore, the Dietary Manager and DON will develop and implement a dining room seating chart. So trays will be delivered in a more orderly manner.<br>3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Area Staff Development RN/ DON will provide in-service/re-education for all nursing staff regarding correct and proper meal delivery. Additionally, the Dietary Manager will conduct dining room meal audits 3 times weekly for four weeks and then 1 time weekly for 2 months.<br><br>4. The Dietary Manager will review the data and report patterns/trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.<br><br>Complete by 01/01/2016 | |

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| F 241 | Continued From page 4<br><br>An interview was conducted with Resident #83, who had been sitting at one of the dining room tables with 2 residents, on 12/02/15 at 5:32 PM. Resident #83 indicated that often at the lunch and dinner meals, the residents don't always get their food served at the table together. Resident #83 indicated that tonight she got her tray about 15 minutes before the other resident sitting at her table received a dinner tray. Resident #83 stated that she was uncomfortable because she had to ask the other resident's if they wanted her to wait until everyone received their food before she started to eat. Resident #83 stated "this bothers me and I feel bad eating before they do."<br><br>An attempt was made to interview the resident seated with Resident #83 on 12/02/15 at 5:39 PM. This resident was unable to be interviewed due to cognitive impairment.<br><br>An interview with the Dietary Manager (DM) on 12/04/15 at 9:26 AM revealed the tray cards were listed on the carts according to room number. The DM acknowledged the meal trays should be served to all residents seated together at the same table before moving to the next table to serve trays.<br><br>An interview with the Director of Nursing (DON) on 12/04/15 at 10:24 AM, revealed the DON expected all residents at the same table to be served at the same time so all residents could eat together before the Nurse Aide served the next table. | F 241 | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES | F 253 | | 1/1/16 |

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| F 253 | Continued From page 5<br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and record review the facility failed to maintain in good repair, walls, doors, tile, bathroom light fixtures, and mirrors for 2 of 2 halls (South and North).<br><br>The findings included:<br><br>On 11/30/15 at 11:00 AM during initial tour of the facility, and on 12/01/15 at 10:30 AM during Stage 1 of the survey the following observations were made:<br>1. Room 26 bathroom- tattered blue vinyl tape observed around outer edges of mirror.<br>2. Room 27 bathroom- tattered blue vinyl tape observed around outer edges of mirror.<br>3. Room 28/30 bathroom- tattered blue vinyl tape observed around outer edges of mirror.<br>4. Room 30 bathroom- quarter sized hole on bottom inside of bathroom door, and 1 inch x 2 inch piece missing baseboard tile to left of shower.<br>5. Room 33/34 bathroom- tattered blue vinyl plastic around outer edges of mirror.<br>6. Room 35/36 bathroom- sink had broken, jagged edge on front of vanity; tattered blue vinyl tape on edge of mirror.<br>7. Room 36- hole on wall above bed where call light cover does not fit hole cut in wall.<br>8. Room 39/40- part of toilet seat connecting seat to bowl is rusted, dirty, and paint is peeling; light cover over sink is cracked with piece broken away; piece of tile where vanity connects with | F 253 | F253<br>1. The facility removed the blue vinyl “tape” from around the bathroom mirrors in rooms 26, 27, 28/30, 33/34, 35/36, 39/40, 41, 43, 46, 48.<br>Bathroom doors were repaired for rooms 30, 43, 48.<br>Tile was repaired in rooms 30, 43.<br>Walls were repaired and painted for rooms 39/40, 43, 48.<br>Call stations refitted 36, & 43.<br>Light covers in bath room replaced rooms 39/40, 43<br>Sink vanities replaced rooms 35/36,<br>Toilet seat part removed room 39/40.<br>2. Facility residents have the potential to be affected by this alleged deficient practice. The Maintenance Director and the Housekeeping Director will conduct an audit of resident’s rooms, bathrooms and hallways to ensure the master repair list is complete and up-to-date.<br>3. Measures put into place to ensure the alleged deficient practice does not reoccur include: The Maintenance Director, Administrator will conduct re-education for staff regarding observations of furnishings, walls, cleanliness of rooms, bathrooms, and appropriate process for reporting needed repairs. The facility’s Ambassadors (team members who visit with residents routinely to identify | |

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| F 253 | Continued From page 6<br>floor is broken and missing; and tattered blue vinyl tape around outer edges of mirror.<br>9. Room 41 bathroom- tattered blue vinyl tape around outer edges of mirror.<br>10. Room 43 bathroom- pieces of tile behind toilet at floor level broken and missing; bathroom door scratched, scuffed, and has quarter sized hole 18 inches from bottom of door; blue vinyl plastic around outer edges of mirror.<br>11. Room 43- hole on wall above bed where call light cover does not fit hole cut in wall.<br>12. Room 46 bathroom - tattered blue vinyl tape around outer edges of mirror<br>13. Room 48 bathroom- hole on outside of bathroom door; scratched, scuffed, and missing paint on bathroom wall; tattered blue vinyl tape around outer edges of mirror.<br><br>A review of maintenance logs for the past 30 days revealed no requests were logged for repair of identified areas of need.<br><br>On 12/4/15 at 8:30 AM a tour of the facility was conducted with the Maintenance Director (MD) and the Administrator. The following areas were identified:<br>1. Room 26 bathroom- tattered blue vinyl tape observed around outer edges of mirror.<br>2. Room 27 bathroom- tattered blue vinyl tape observed around outer edges of mirror.<br>3. Room 28/30 bathroom- tattered blue vinyl tape observed around outer edges of mirror.<br>4. Room 30 bathroom- quarter sized hole on bottom inside of bathroom door, and 1 inch x 2 inch piece missing baseboard tile to left of shower.<br>5. Room 33/34 bathroom- tattered blue vinyl plastic around outer edges of mirror.<br>6. Room 35/36 bathroom- sink had broken, | F 253 | concerns/needs) will observe and inspect 10 residents' rooms weekly for 4 weeks and then 10 resident's rooms monthly for 3 months to include observation of walls, cleanliness of bathroom/rooms, and observation of condition of furnishings. Additionally, The Maintenance Director and the Housekeeping Director will establish a timeline of completion of items on the master list. The facility Ambassadors (team members who visit with residents routinely to identify concerns/needs) will observe and inspect 10 rooms weekly for 4 weeks and then 10 rooms every other week for two months including observation of walls, odors and cleanliness.<br><br>4. The Administrator, Maintenance Director and Housekeeping Manager will review data obtained during facility audits and analyze data and report any trends to the QAPI meeting monthly for 3 months. The committee will evaluate the effectiveness of the plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance.<br><br>To be completed by 01/01/2016 | |

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| F 253 | Continued From page 7 | F 253 | | |

jagged edge on front of vanity; tattered blue vinyl tape on edge of mirror.
7. Room 36- hole on wall above bed where call light cover does not fit hole cut in wall.
8. Room 39/40- part of toilet seat connecting seat to bowl is rusted, dirty, and paint is peeling; light cover over sink is cracked with piece broken away; piece of tile where vanity connects with floor is broken and missing; and tattered blue vinyl tape around outer edges of mirror.
9. Room 41 bathroom- tattered blue vinyl tape around outer edges of mirror.
10. Room 43 bathroom- pieces of tile behind toilet at floor level broken and missing; bathroom door scratched, scuffed, and has quarter sized hole 18 inches from bottom of door; blue vinyl plastic around outer edges of mirror.
11. Room 43- hole on wall above bed where call light cover does not fit hole cut in wall.
12. Room 46 bathroom - tattered blue vinyl tape around outer edges of mirror
13. Room 48 bathroom- hole on outside of bathroom door, scratches and missing paint on bathroom wall, tattered blue vinyl tape around outer edges of mirror.

On 12/04/15 at 8:45 AM an interview was conducted with the Administrator. He stated both he and the MD toured the facility weekly and noted issues that needed repair. He stated the facility was working to correct issues, but things took time. The Administrator stated the facility had problems and had a list of issues that needed correction, but all of the issues were not identified.

On 12/04/15 at 9:00 AM an interview was conducted with the MD. He stated he was doing all he could do to keep up with day to day issues

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| F 253 | Continued From page 8<br>at the facility; and try to provide a safe, comfortable place for the residents to live. He stated there was a maintenance log on each wing for staff to document needed repairs. The MD indicated the log was checked daily and requested repairs were made. He revealed many of the issues reviewed were not reported by staff or residents. He stated the facility had repair issues and they were doing as much as they could to fix them. He stated for example, the tape on the edges of the mirrors should have been removed when the mirrors were installed, but that was not done.<br><br>On 12/04/15 at 12:55 PM an interview was conducted with the Administrator. He stated he knew there were repair issues in the building, but they were trying to address them with the hiring of a part-time maintenance person. The Administrator revealed they had identified a number of repair issues that needed to be corrected; and he realized there were issues they had not identified. | F 253 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are | F 279 | | 1/1/16 |

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| F 279 | Continued From page 9<br>to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to develop a comprehensive care plan addressing wandering behavior for 1 of 21 residents whose care plans were reviewed. (Resident # 18).<br><br>The findings included;<br><br>Resident # 18 was admitted to the facility on 08/22/15 with diagnoses including traumatic brain injury with subdural hematoma and chronic mental retardation. An admission Minimum Data Set (MDS) assessment dated 09/03/15 indicated Resident #18 had daily wandering that placed the resident at risk of wandering to a potentially dangerous place and significantly intruded on the privacy of others. A Care Area Assessment Summary completed in conjunction with the MDS indicated Resident #18 wandered around the facility and into other residents' rooms and could not be redirected. The summary indicated a decision to proceed to care plan. Review of the comprehensive care plan did not reveal a care plan that addressed the wandering behavior or any interventions to manage the resident's wandering. | F 279 | F279<br><br>Criteria 1- Resident #18 is no longer at the facility..<br><br>Criteria 2- Facility residents, who exhibit behaviors have the potential to be affected by the same alleged deficient practice. Therefore, the MDS Coordinator will assess all residents with behaviors to ensure care plans are in place.<br><br>Criteria 3- MDS nurses will be educated by Director of Nursing/ Area Staff Development Nurse on ensuring care plans address wandering type behaviors. Director of Nursing/Unit Managers will audit 4 care plans weekly for 4 weeks and then 4 care plans monthly for 3 months to ensure wandering type behaviors are reflected in care plans.<br><br>Criteria 4- The DON will analyze the data obtained during the audits and report finds monthly to the QAPI Committee for 3 months for review and additions recommendations as needed. | |

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| F 279 | Continued From page 10<br>Further review of Resident #18's medical record revealed a progress note by the physician's assistant dated 09/22/15 which indicated Resident #18 was constantly entering other residents' rooms, drinking their drinks and taking their food and scaring the elderly ladies as he entered their rooms.<br><br>A review of daily nurses' notes and weekly/monthly summaries also indicated Resident #18 entered other residents' rooms and drank their liquids which placed him at risk because he was on thickened liquids.<br><br>An interview on 12/03/15 at 9:59 AM with the Social Worker revealed Resident #18 was admitted to the facility on a short term basis while awaiting placement at a neuromedical treatment facility. The Social Worker stated Resident #18 was discharged on 10/06/15 to a neuromedical treatment facility that could provide the specialized care required to address his needs.<br><br>An interview on 12/04/15 at 10:30 AM with the MDS nurse about the MDS completed on 08/22/15 that indicated he had daily wandering which placed him at risk revealed the resident wandered into other residents' rooms and drank their beverages which placed him at risk because he was on thickened liquids. When asked about the wandering behavior not being addressed on the care plan, the MDS nurse stated the Social Worker wrote those care plans and they should be included with the other care plans in the medical record. The MDS nurse looked through Resident #18's medical record and was unable to locate a care plan that addressed the wandering behavior. | F 279 | Completed by 01/01/2016 | |

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| F 281 | Continued From page 11 | F 281 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, nurse practitioner, physician, and staff interviews the facility failed to implement a lab order for 2 of 6 sampled residents (Resident #59 and Resident #98), reviewed for unnecessary medication.<br><br>Findings included:<br><br>1. Quarterly Minimum Data Set (MDS) dated 09/11/15 indicated Resident #59 was admitted to the facility on 07/02/15 and was cognitively intact. Resident #59 diagnoses were coded as diabetes mellitus, coagulation defect, hyperlipidemia, anxiety disorder, and depression. Resident #59 required extensive assistance with toileting and personal hygiene and supervision for bed mobility, transfers and dressing.<br><br>Current care plan indicated Resident #59 had the following problems:<br><br>· Potential for medication toxicity, thyroid hormone replacement, seizure medication, and proton pump inhibitor. Interventions for Resident #59 included: Administer medications as ordered, monitor labs as ordered, observe signs and symptoms of potential toxicities, notify physician timely with signs and symptoms of potential toxicity.<br>· Bleeding risk related to coumadin and aspirin | F 281 | F 281<br>1. Lab orders were clarified, and obtained for residents #59 & #98.<br><br>2. Facility residents, who have labs ordered, have the potential to be affected by the same alleged deficient practice, therefore, Unit Managers will audits the past 30 days of lab ordered to ensure they have been obtained and are in the medical record.<br><br>3. Measures put into place to ensure that the alleged deficient practice does not reoccur include: The DON/RCMD(Resident Care Management Director)/ MDS Coordinator will conduct in-service education for all licensed nurses regarding professional standards of practice, specifically, following physicians' orders related to labs. The DON/Unit Managers will review daily labs due in clinical morning meeting. Unit Managers will be responsible for ensuring lab reconciliation process is completed. This process will be on-going Monday-Friday. Weekend labs ordered will be reviewed next business day for timely lab draw and reconciliation. | 1/1/16 |

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| F 281 | Continued From page 12<br>use. Interventions for Resident #59 included: Administer medications as ordered, monitor labs as ordered, notify physician of abnormal labs for further direction and treatment determination, and observe for bleeding or increased bruising frequently.<br><br>Laboratory results for Resident #59 dated 11/18/15 indicated a hemoglobin of 10.2 (normal range 12.0-16.5) and hematocrit of 33.5 (normal range 34.0-50.0).<br><br>Nurse practitioner order for Resident #59 dated 11/19/15 stated the following:<br><br>1. Check Resident #59's stool for occult (not visible) blood x 3.<br>2. Administer Nu Iron 150 milligrams (mg) by mouth daily with vitamin C (already ordered). Begin Nu Iron after first stool collected.<br><br>On 12/03/15 at 3:56 PM an interview was conducted with Unit Coordinator #1 who revealed Resident #59 did not have occult stool results on the medical record for 11/19/15 and 11/20/15 and the Medication Administration Record (MAR) indicated Nu Iron had been administered to Resident #59 on 11/20/15. The Unit Coordinator #1 reviewed Resident #59's medical record and MAR and verified the record did not contain a lab result for a stool sample for occult blood. Unit Coordinator #1 reviewed the MAR and verified the medication aide had administered the Nu Iron to Resident #59 on 11/20/15 per documentation without a stool sample obtained as per nurse practitioner orders. The Unit Coordinator #1 called 2 lab companies that the facility used to process labs and was informed they had no stool specimen or results for Resident #59. Unit | F 281 | 4. The DON, RCMD, or MDS Coordinator will review data obtained during lab audits, to verify labs ordered were obtained and reconciled timely. Data will be reviewed for patterns/trends and reported to the QA&A monthly for 3 months and the committee will make recommendations as needed.<br><br>Completed by 01/01/2016 | |

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Coordinator #1 reviewed the nurses notes which she stated did not indicate a stool specimen had been obtained for Resident #59 on 11/19/15 and 11/20/15. Unit Coordinator #1 stated she believed the medication aide had administered the Nu Iron medication without questioning that a stool specimen was to be obtained first.

On 12/03/15 at 4:36 PM a telephone interview was conducted with the Medication Aide who stated he had administered Nu Iron to Resident #59 on 11/20/15. The medication aide stated he saw on the MAR that a stool specimen needed to be collected prior to beginning the Nu Iron medication for Resident #59. The Medication Aide stated he remembered asking the nurse if he should start the Nu Iron medication and stated the nurse told him to administer the Nu Iron if it was listed on the MAR. The Medication Aide stated he did not remember the nurse who instructed him to administer the medication. The Medication Aide stated he was not responsible for collecting a stool specimen for Resident #59 because he was a medication aide and not a nurse.

An interview was conducted with Nurse #1 on 12/03/15 at 4:00 PM who stated he worked on 11/20/15 during the 7:00 AM to 3:00 PM shift. Nurse #1 stated he had not collected a stool specimen for Resident #59 prior to the administration of Nu Iron medication as per nurse practitioner order.

On 12/03/15 at 4:01 PM an interview was conducted with Nurse #2 who worked on 11/19/15. Nurse #2 stated she had not collected a stool specimen for Resident #59.

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On 12/03/15 at 5:17 PM a telephone interview was conducted with the Nurse Practitioner who stated she wrote the order for staff to obtain a stool specimen for occult blood prior to starting the Nu Iron medication because Resident #59 had a low hemoglobin and was anemic. The Nurse Practitioner stated Resident #59 may have been experiencing rectal bleeding as the cause of the low hemoglobin and anemia. The Nurse Practitioner stated when Nu Iron was administered prior to obtaining a stool sample, the medication could cause a false positive stool test for occult blood. The Nurse Practitioner stated her expectations were that staff would have followed her order and obtained the stool specimen prior to starting the Nu Iron medication for Resident #59 because she wanted to determine if there was blood in the stool. The Nurse Practitioner stated that now she did not know if Resident #59 had experienced rectal bleeding as the cause of low hemoglobin and anemia.

On 12/04/15 at 7:49 AM an interview was conducted with Nurse #3 who worked the 11:00 PM to 7:00 AM shift on 11/19/15. Nurse #3 stated she had not collected a stool sample for Resident #59 on 11/19/15 or 11/20/15.

On 12/04/15 at 7:49 AM an interview was conducted with the Director of Nursing (DON) who stated her expectations were that staff would have followed the nurse practitioner's orders and obtained a stool sample for Resident #59 prior to administering Nu Iron medication. The DON stated no staff member asked the DON how to obtain a stool specimen prior to administering medication to Resident #59. The DON stated she was unaware that the stool sample had not been

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obtained for Resident #59 prior to administering medication as per order. The DON stated the 24 hour report sheet that she received did not indicate that Resident #59 required a stool sample prior to the administration of Nu Iron medication. The DON stated the stool sample got missed for Resident #59 prior to administering Nu Iron medication as per order.

On 12/04/15 at 8:50 AM an interview was conducted with the Administrator who stated he was aware that a stool sample had not been obtained for Resident #59 prior to administering medication as per nurse practitioner orders. The Administrator shared that the facility had a system problem with obtaining labs per physician's order and further revealed the facility lab process would be addressed and corrected.

2. Quarterly MDS dated 11/06/15 indicated Resident #98 was admitted to the facility on 07/24/15 and was cognitively intact. Resident #98 diagnoses were coded as seizure disorder, dementia (non-Alzheimer's), diabetes mellitus, anxiety disorder, and depression. Resident #98 was coded as requiring extensive assistance with bed mobility, transfers, dressing, personal hygiene, and toileting.

Care plan for Resident #98 dated 07/09/15 and updated on 8/26/15 revealed the following problems:

· Potential for medication toxicity related to digoxin therapy and proton pump inhibitor. Interventions included: staff were to administer medications as ordered, monitor labs as ordered, observe signs and symptoms of toxicities, notify physician timely with signs of potential toxicity,

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and request physician and pharmacy review of medications.

· At risk for fluid deficit related to infection, medications, and tube feeding nutrition. Interventions included: staff were to monitor vital signs as indicated, place fluids on bedside table within reach, and monitor lab values.

On 12/02/15 a review of physician order for Resident #98 dated 08/28/15 stated add digoxin level, magnesium level, and calcium level to labs every 6 months beginning September 2015 and draw in September and March for diagnoses of orthostatic hypotension and syncope. A further review of the medical record for Resident #98 indicated lab results on 09/23/15 and 09/28/15 had an absence of digoxin, magnesium, and calcium levels.

On 12/02/15 at 5:30 PM an interview was conducted with the DON who stated the labs of digoxin, magnesium, and calcium were not completed for Resident #98 in September 2015 as recommended by the pharmacist and ordered by the physician on 8/28/15. The DON stated she called the lab and no results were available for digoxin, magnesium and calcium in September 2015 for Resident #98. The DON stated she was changing lab agencies that night 12/02/15 and the labs of digoxin, magnesium, and calcium would be drawn stat (immediately) for Resident #98.

On 12/03/15 at 8:21 AM an interview was conducted with the DON who revealed the facility had a new nursing unit coordinator who had changed the facility lab process and the labs of digoxin, magnesium, and calcium for Resident #98 were missed in September 2015 and were not completed as ordered by the physician. The

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DON stated the facility had lost 2 nursing unit coordinators and the lab system broke down. The DON stated she had the labs of digoxin, magnesium, and calcium for Resident #98 drawn on 12/02/15 due to the labs were missed in September 2015 as ordered by the physician.

12/03/15 at 9:22 AM an interview was conducted with the pharmacist who stated he had not seen a response in the medical record from the physician since August 2015 regarding his request for obtaining digoxin, magnesium, and calcium level for Resident #98. The pharmacist stated he resubmitted his request to the physician on 11/03/15 that requested labs be obtained for digoxin, magnesium, and calcium for Resident #98. The pharmacist stated he had brought to nursing staff's attention that labs for digoxin, magnesium, and calcium had not been obtained for Resident #98. The pharmacist stated he had not seen the physician's order on the medical record dated 8/28/15 that stated add digoxin, magnesium and calcium level to labs every 6 months September and March.

On 12/03/15 at 9:41 AM a telephone interview was conducted with the physician who stated her expectations were that staff would have obtained digoxin, magnesium, and calcium levels on Resident #98 as ordered by the physician.

On 12/03/15 at 10:39 AM an interview was conducted with the DON who stated her expectations were that staff would have obtained labs of digoxin, magnesium, and calcium level in September 2015 as ordered by the physician for Resident #98.

On 12/04/15 at 8:48 AM an interview was

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| F 281 | Continued From page 18<br>conducted with the Administrator who stated his expectations were that staff would have followed physician's orders and obtained lab test as ordered for Resident #98. The Administrator shared that the facility had a system problem with obtaining labs per physician's order and further revealed the facility lab process would be addressed and corrected. | F 281 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews the facility failed to assist 1 resident with dressing and getting out of bed (Resident #12) and failed to remove facial hair from 1 resident (Resident #26) for 2 of 3 cognitively impaired, dependent residents reviewed for providing assistance with activities of daily living. (Residents #12 and #26).<br><br>The findings included:<br><br>1. Resident #12 was admitted to the facility on 01/14/14 with diagnoses including diabetes mellitus, osteoporosis and schizophrenia. A quarterly Minimum Data Set (MDS) assessment dated 10/23/15 indicated Resident #12 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADL) | F 312 | F312<br>1.Resident #12 will be out of bed daily and dressed as tolerated.<br>Resident #26 was shaved.<br><br>2.All residents have the potential to be affected by the same alleged deficient practice; therefore, The Director of Nursing/<br>Assistant Director of Nursing/<br>Unit Manager will complete a 100% audit of all current residents to include being shaved, dressed and out of bed as tolerated.<br><br>3.Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing/ | 1/1/16 |

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| F 312 | Continued From page 19<br>including dressing and transfers. A care plan dated 08/03/15 and updated 10/30/15 addressed resident's dependence on staff for her ADL needs. Interventions included that staff would assist her with all ADL while allowing resident to assist if able.<br><br>Review of the Nurse Aide (NA) Care Guide indicated resident required total assistance and a lift was to be used for transfers. Listed in bold print on the Care Guide was the following: "7 - 8:30 AM UP!"<br><br>Observations of Resident #12 were as follows:<br>11/30/15 at 12:10 PM Resident #12 was sitting in bed dressed in a gown watching television.<br>12/01/15 at 12:33 PM Resident #12 was lying in bed dressed in a gown and appeared to be asleep as she didn't respond to knock on her door.<br>12/02/15 at 11:25 AM Resident #12 was lying in bed dressed in a gown and appeared to be asleep as she didn't respond to knock on her door.<br>12/02/15 at 2:00 PM Resident #12 was sitting in bed with head of bed up at 90 degree angle and was dressed in a gown; her eyes were closed and she appeared to be asleep as she didn't awaken to knock on her door.<br>12/03/15 at 9:36 AM Resident #12 was lying in bed dressed in a gown and appeared to be asleep as she didn't respond to knock on her door.<br>12/03/15 at 11:32 AM Resident #12 was lying in bed dressed in a gown and appeared to be asleep as she didn't respond to knock on her door.<br>12/03/15 at 6:10 PM Resident #12 was sitting in bed eating dinner and was dressed in a gown. | F 312 | Assistant Director of Nursing completed an In-service/ re-education for all Nursing staff to including residents being shaved, dressed and out of bed as tolerated. Additionally,<br>the DON/RN unit managers will audit at least 5<br>residents weekly for 4weeks, Then 5 residents<br>monthly x three months to ensure they are shaved, dressed and out of bed as tolerated per their personal preference sheets.<br><br>4.Director of Nursing will<br>review data obtained from audits, analyze the data and report patterns/ trends to the QAPI committee every month for 3 months. The committee will make recommendations as indicated.<br><br>Completed by 01/01/2016 | |

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12/04/15 at 9:35 AM Resident #12 was sitting in bed drinking water and was dressed in a gown. 12/04/15 at 10:24 AM Resident #12 was sitting in wheelchair at nurse's station wearing a dress. She was awake and alert and observing the activity occurring in the hall around her. She didn't appear lethargic and didn't appear to be having any difficulty maintaining proper body alignment. 12/04/15 12:20 PM Resident #12 was sitting in the main dining room, was awake and alert and wearing a dress. She didn't appear lethargic and didn't appear to be having any difficulty maintaining proper body alignment.

An interview on 12/04/15 at 9:44 AM with Unit Coordinator (UC) #2 revealed she had worked with Resident #12 for about a year. UC #2 stated the resident was usually dressed and gotten out of bed every day and enjoyed sitting in her recliner. UC #2 stated Resident #12's family provided really nice clothes for her and wanted her to be out of bed and dressed so she would look good if she had visitors. When asked if there was a reason Resident #12 had been in bed and dressed in a gown on all observations from 11/30/15 through 12/04/15, UC #2 stated she had been busy and hadn't noticed Resident #12 was left in bed and in a gown. UC #2 stated ordinarily she reminded the nurse aides to get her out of bed and dressed.

An interview on 12/04/15 at 9:55 AM with Nurse Aide (NA) #2 revealed she had worked with Resident #12 for about 5 months. NA #2 stated she had noticed Resident #12 was sleeping more than she did in the past and had trouble sitting upright in the chair. NA #2 offered no other explanation for not getting resident dressed and out of bed.

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An interview on 12/04/15 at 12:30 PM with the Director of Nursing (DON) about her expectation for residents being dressed and out of bed revealed she expected residents to be dressed and out of bed every day unless the resident or family requested otherwise.

2. Resident #26 was admitted to the facility on 11/27/12 with diagnoses including diabetes mellitus type 2, hypertension, chronic kidney disease stage 3 and senile dementia. A quarterly Minimum Data Set (MDS) assessment dated 10/03/15 indicated Resident #26 had moderate cognitive impairment, had no rejection of care and required extensive assistance with personal hygiene and was dependent on staff for bathing. A care plan last updated 10/10/15 addressed the resident's need for assistance with activities of daily living (ADL) including personal hygiene and bathing. Interventions included that staff would assist her with all ADL while allowing resident to assist if able.

A review of the Nurse Aide (NA) Care guides revealed Resident #26 was scheduled to receive a shower every Tuesday and Friday on the 3:00 PM - 11:00 PM shift. The care guide also included the following instructions: "shave chin qd (every day)."

Observations of Resident #26 were made on 11/30/15 at 11:58 AM, 12/01/15 at 11:35 AM; 12/02/15 at 1:57 PM, 12/03/15 at 6:05 PM and 12/04/15 at 8:45 AM. During each of those observations Resident #26 was observed to have several long hairs approximately 1/4 inch in length on both sides of her chin.

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| F 312 | Continued From page 22<br>An interview on 12/03/15 at 5:58 PM with NA #3, who was assigned to provide care to Resident #26 on 12/01/15 on the 3:00 PM - 11:00 PM shift revealed she had worked with Resident #26 for about a year and was familiar with her care needs. NA #3 stated she didn't give Resident #26 a shower on 12/01/15 because the resident was expecting her family to visit and didn't want to take a shower. When asked what she did when a resident didn't want their shower, NA #3 stated sometimes she would just wait till the next shower day and sometimes she would ask the nurse to try to get the resident to take a shower, if she felt the resident really needed a shower. When asked what care was provided as part of a shower, NA #3 stated the resident was shaved if they needed and wanted shaved and their nails were trimmed if they didn't have diabetes. When asked if she had noticed the facial hair on Resident #26, NA #3 stated she had noticed it but didn't know if the resident or her family wanted it removed. NA #3 stated she had not been instructed to shave Resident #26.<br><br>An interview on 12/04/15 with Unit Coordinator (UC) #2 about her expectation for removal of facial hair on female residents revealed she felt it was a standard of care to remove facial hair of female residents as part of their routine personal hygiene. UC #2 stated she had not noticed the long facial hair on Resident #26's chin.<br><br>An interview with the Director of Nursing on 12/04/15 at 12:30 PM revealed she expected facial hair to be removed from female residents unless the resident refused. | F 312 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES | F 323 | | 1/1/16 |

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| F 323 | Continued From page 23<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to securely lock the biohazard waste disposal units on 2 of 6 medication carts (medication cart #1 and medication cart #2).<br><br>The findings included:<br><br>An interview was conducted with Unit Coordinator #2 on 12/04/15 at 8:32 AM. This interview was to gather information describing the disposal of sharps containers on the medication carts. The Unit Coordinator verified that the contents in the sharps containers were removed from the medication carts once they were full and disposed of in a biohazard room. A request was made that Unit Coordinator #2 check the metal door to the sharps container to verify that it was locked. Unit Coordinator put her hand on the edge of the door and easily opened the door, thus indicating it was unlocked. Medication cart #1 had a sharps container that was more than 25% full, but less than half full.<br><br>A verbal request was then made for Certified Medication Aide (CMA) #4 to check the metal door covering the sharps containers on medication cart #2 to verify it was locked. When | F 323 | F323<br><br>Criteria #1-<br><br>The two unlocked biohazard waste disposal units were immediately locked, and all other units were checked and found to be secure.<br><br>Criteria #2-<br>As facility residents have the potential to be affected by the alleged deficient practice. The Medication nurse/aide will check the biohazard waste disposal units on all carts daily. The DON/ RN Unit Managers will check all biohazard waste disposal units to ensure that they are securely locked every Friday.<br><br>Criteria #3-<br><br>The Director of Nursing/Unit Manager will conduct re-education for all nursing staff on the importance keeping the biohazard disposal units securely locked. The DON/Unit Manager will conduct weekly audits for 4 weeks and then monthly for 3 | |

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| F 323 | Continued From page 24<br>CMA #4 checked medication cart #2, it was also noted to have the metal door covering the sharps container unlocked. Medication cart #2 had a sharps container that was just under 25% full.<br><br>With assistance by the Area Staff Development Manager, all other medication carts were checked and no other medication cart was noted to have the external sharps container door unlocked. An observation of the medication carts revealed there was a metal container with exterior lock noted on each side of all 6 carts. When opened, each metal container contained an interior plastic red container with clear detachable lid that was visibly noted to have potentially hazardous medical waste including needles and lancets when the top of the plastic container was opened.<br><br>An interview with the Area Staff Development Manager on 12/04/15 at 8:49 AM validated that the metal side doors to the sharps containers could be opened easily when unlocked if someone attempted to open one. The Area Staff Development Manager further noted that the sharps container could be easily removed but it would take some work to get the top off but the container could easily have the contents dumped out or someone's fingers could be put in the opening. Her expectation was that the nurses should be checking the medication cart when they came on shift to ensure the door was locked. She also stated this was to be done for the safety of the residents.<br><br>During an interview with CMA #4 on 12/04/15 at 9:07 AM the CMA indicated that she does not check the metal containers on the side of the medication cart when she comes in to work. | F 323 | months to ensure biohazard disposal units are locked.<br><br>Criteria #4-<br><br>Any concerns will be addressed immediately by auditor. The results of the audits will be reported monthly for 3 months during the QAPI meeting and the plan will be amended as appropriate. The committee will evaluate and make further recommendations as needed.<br><br>Completed by 01/01/2016 | |

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| F 323 | Continued From page 25<br>CMA #4 remembers being told when she was in training to become a CMA that the sharps containers are supposed to be locked at all times. She acknowledged that she did not check the lock box on either medication cart that she had been using this morning and didn't know when they had been unlocked.<br><br>An interview with the Director of Nursing (DON) on 12/04/15 at 10:19 45AM indicated her expectation was for the medication sharps external locked boxes to always be locked and not be overfull. The DON acknowledged that a resident could sustain an injury if the door was left unlocked with medical waste in the sharps container and a resident was able to access it. | F 323 | | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, and resident and staff interviews the facility failed to provide podiatry treatment for 1 of 1 residents reviewed for podiatry care (Resident #105). | F 328 | F328<br>1.Resident #105 was taken on 12/04/2015 for podiatry care. | 1/1/16 |

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| F 328 | Continued From page 26<br><br>The findings included:<br><br>Resident #105 was admitted to the facility on 06/03/15 with diagnoses that included kidney disease, dialysis, and nutritional deficiencies among others. Review of the quarterly Minimum Data Set (MDS) dated 11/30/15 indicated he had mild cognitive impairment, but he was able to answer screening questions for resident interviews and was interviewable. The MDS revealed Resident #105 required extensive assistance for some activities of daily living including personal hygiene.<br><br>Review of the medical record indicated Resident #105 was transported from the facility three times weekly for dialysis treatment. On 11/03/15 Resident #105 was seen for dialysis, and a Dialysis Communication Record from that appointment was returned to the facility with a follow-up recommendation for him to have his toenails trimmed and feet were to be kept moisturized.<br><br>On 11/30/15 at 4:02 PM during an initial observation of Resident #105, he acknowledged his toenails were very long. He pulled back a blanket on his bed to expose his sock covered feet. His toenails were observed to be long and pressing against the ends of his socks.<br><br>On 12/02/15 at 8:45 AM an interview was conducted with Resident #105. He acknowledged at that time that his toenails were long. He stated he did not want to remove his socks at that time.<br><br>On12/02/15 at 2:15 PM an interview was conducted with Nurse Aide #1. She stated nail | F 328 | 2. All residents have the potential to be affected by the same alleged deficient practice; therefore,<br>The Director of Nursing/RN Unit Managers<br>will complete audits on all current residents and will obtain a Podiatrist consult as needed.<br><br>3.Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing/Area Staff Development Nurse will complete<br>an in-service/re-education to all nursing staff on podiatry care. Staff are to assess toenails during ADL care, including shower days and skin assessment days. If nail care is needed, the DON/Unit Manager will be notified in order to determine proper nail care/podiatry referral. Additionally, the DON Unit Manager will check 10 residents weekly for podiatry needs x 4 weeks, then monthly x 3 months. Podiatry consult will be obtained as needed.<br><br>4.Director of Nursing, will review data obtained during facility audits and rounds; analyze the data and report patterns/trends to the QAPI committee every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan.<br><br>Complete by 01/01/2016 | |

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| F 328 | Continued From page 27 | F 328 | | |

care was provided to residents every day and as needed. She revealed podiatry services were scheduled every 3 months and more often if needed for specific issues.

On 12/03/15 at 7:40 AM an interview was conducted with the facility appointment scheduler (FS). She stated she was responsible for scheduling podiatry appointments. The FS revealed the podiatrist came to the facility quarterly, and was scheduled to be at the facility on 12/10/15. She acknowledged Resident #105 was not on the list to be seen by the podiatrist. The FS stated if Resident #105 was requested by the dialysis center to have his toe nails trimmed, it would be placed on the dialysis communication record and the nurse who reviewed the sheet when he came back to the facility would notify her to place him on the podiatry list. The FS revealed that this was not done in Resident #105's case.

On 12/03/15 at 8:00 AM an interview was conducted with Unit Coordinator #2 (UC #2). She acknowledged that when Resident #105 came back from dialysis, the request from dialysis for him to have his toe nails trimmed should have been placed on the in-house communication sheet and sent to the podiatry scheduler. She stated the nurse signed off on the dialysis communication sheet, but did not communicate that Resident #105 need to be scheduled for podiatry. The UC #2 indicated the recommendation was missed.

On 12/03/15 at 8:45 AM an interview was conducted with the Director of Nursing (DON). She stated the request for Resident #105's toe nail trimming came in on a dialysis communication sheet and should have been

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| F 328 | Continued From page 28<br>placed on an in-house communication sheet and scheduled. The DON revealed the nurse missed it, and it should have been done.<br><br>On 12/03/15 at 3:00 PM, Resident #105 was observed in his room visiting with family. He stated he would like to have his toe nails cut. He allowed his toe nails to be observed. The toe nails on both feet were jagged, yellowed, thick, and ¼ to ½ inch beyond the end of each toe.<br><br>On 12/04/15 at 7:50 AM an interview was conducted with Nurse #2. She stated when Resident #105 came back from the dialysis center on 11/03/15, she reviewed the communication record and signed off on the request. She indicated she did not complete an in-house communication sheet or refer Resident #105 to podiatry.<br><br>On 12/04/15 at 12:00 Noon an interview was conducted with the DON. She stated Resident #105 was taken to the podiatrist that morning to have his toenails trimmed. She acknowledged the nails were so thick, there was no way they could have been cut by the facility.<br><br>On 12/04/15 at 12:35 PM Resident #105 was observed in his room. He stated he had returned from the podiatrist and his feet felt much better after getting his toe nails cut. He revealed he was happy the foot care was provided. | F 328 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all | F 431 | | 1/1/16 |

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| F 431 | Continued From page 29<br>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews the facility failed to remove expired stock medications from 1 of 2 medication storage rooms.<br><br>The findings included: | F 431 | F-431<br><br>1. During the survey the containers of expired Banophen, Geriatin liquid, Multi-Delyn Vitamins, and Gericare liquid acetaminophen were disposed of per | |

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| F 431 | Continued From page 30<br>On 12/04/15 at 11:45 AM an observation of the medication storage room on the South Wing revealed:<br>1. One bottle of Banophen (diphenhydramine) oral solution containing 473mililiters (ml) had an expiration date of 10/2015.<br>2. One bottle of Geriaton Liquid Vitamins (18% alcohol) containing 473ml had an expiration date of 10/2015.<br>3. One bottle of Multi-Delyn Liquid multivitamin containing 473ml had an expiration date of 05/2015.<br>4. Two bottles of Gericare liquid pain relief (acetaminophen) containing 473ml had expiration dates of 01/2015 and 09/2015 respectively.<br><br>On 12/04/15 at 11:50 AM an interview was conducted with the Supply Clerk. She stated she was responsible for ordering, stacking, rotating, and removing expired medications from the medication storage rooms. She indicated she checked and rotated medication stock on a weekly basis. The Supply Clerk revealed she checked for out of date medications during her weekly checks and removed them from resident supply areas. She acknowledged the bottles of medication were out of date, and should have been removed. The Supply Clerk stated she just missed them.<br><br>On 12/04/15 at 11:55 AM an interview was conducted with the Director of Nursing. She stated the Supply Clerk was responsible for the medication storage rooms, which included keeping them supplied and out of date medications removed. She indicated it was her expectation that the Supply Clerk checked the medication storage rooms on a weekly basis, and removed and disposed of any out of date | F 431 | policy..<br><br>2. Residents in the facility have the potential to be affected by the same alleged deficient practice. Therefore, an audit was conducted by the DON and central supply clerk of all the medication storage areas to ensure no out of date medications were found.<br><br>3. Measures put in place to ensure that the alleged deficient practice does not reoccur: The Director of Nursing conducted an in-service/reeducation for all nursing staff and central supply clerk and will be completed by 01/01/2016 regarding medication storage and inspecting medications for expiration dates. The Medication Nurses will observe and inspect their medications carts every Sunday and provide documentation to DON that inspection was completed. The central supply clerk will inspect all other medication storage areas weekly. The Unit Managers/Unit Coordinators will audit random medication storages areas medications weekly for discontinued, expired, and soon to expire medications for four weeks then twice monthly for three months.<br><br>4. The Director of Nursing will review the data obtained during facility audits; analyze the data and report patterns/trends to the QAPI committee every other month for 3 months. The QAPI Committee will evaluate the effectiveness of the above plan and will | |

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| F 431 | Continued From page 31<br>medications properly. | F 431 | add additional interventions based on identified trends/outcomes to ensure continued compliance.<br><br>Complete by 01/01/2015 | |
| F 504 SS=D | 483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN<br><br>The facility must provide or obtain laboratory services only when ordered by the attending physician.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, physician, and staff interviews the facility failed to obtain a physician's order prior to obtaining a lab test for 1 of 6 sampled residents (Resident #98), reviewed for unnecessary medications.<br><br>Findings included:<br><br>Quarterly Minimum Data Set dated 11/06/15 revealed Resident #98 was admitted to the facility on 07/24/15 and was cognitively intact. He was coded with diagnoses of seizure disorder, dementia (non-Alzheimer), anxiety disorder, depression, and diabetes mellitus. Resident #98 required extensive assistance with bed mobility, transfers, dressing and toileting.<br><br>Resident #98's care plan dated 07/09/15 and updated on 08/26/15 revealed a problem of potential for medication toxicity. Interventions included medications were to be administered as ordered, labs were to be monitored as ordered, and physician was to be notified of any signs of | F 504 | F504<br><br>1. Corrective action has been accomplished for the alleged deficient practice for Resident #98 by obtaining a physicians order for labs.<br><br>2. Facility residents, who have labs ordered, have the potential to be affected by the same alleged deficient practice. Therefore, DON/Unit Managers will assess all labs ordered for the past 30 days to ensure that all labs have orders, and any medications that require labs prior to administering have been completed.<br><br>3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Area Staff Development nurse will provide in-service/re-education for all licensed nurses including the DON regarding | 1/1/16 |

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| F 504 | Continued From page 32<br>potential toxicity.<br><br>A record review of a lab requisition form dated 12/03/15 for Resident #98 revealed a blood specimen had been obtained for a lab test on 12/03/15. A review of Resident #98's medical record revealed an absence of a physician's order to obtain the lab test.<br><br>An interview was conducted with the Director of Nursing (DON) on 12/03/15 at 8:21 AM. The DON revealed she had made a mistake on 12/02/15 and ordered a lab for a medication level for Resident #98 without obtaining a physician's order. The DON stated she misinterpreted the pharmacist recommendation dated 08/03/15 that requested the physician to review the use of a particular medication for Resident #98 due to the side effects of the continued use of the medication. The DON stated she thought the pharmacist had recommended a lab test to determine the medication level for Resident #98 and she ordered a lab test for the medication level for Resident #98 without obtaining a physician's order. The DON instructed Unit Coordinator #1 to call the physician and obtain a physician's order for the lab test that had already been obtained on 12/03/15 for Resident #98.<br><br>On 12/03/15 at 10:27 AM a telephone interview was conducted with the physician who stated her expectations were that the DON would have called her first for an order prior to obtaining a lab test for Resident #98. The physician further stated she should have been notified by the DON prior to the lab test being performed because there was no standing order or physician's order to obtain the lab test for Resident #98. | F 504 | correctly obtaining physician orders prior to collecting labs. Additionally, the DON/ Unit Managers will audit lab orders in 10 charts weekly for 4 weeks then 10 charts monthly for 3 months to ensure they have been obtained and are in the medical record.<br><br>4. The DON will analyze the data obtained, and report patterns/trends to the QAPI committee every other monthly for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.<br><br>Complete by 01/01/2016 | |

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| F 504 | Continued From page 33<br>An interview was conducted on 12/03/15 at 10:39 AM with the DON who stated the facility had a new Medical Director that started at the facility during the past 2 weeks. The DON stated she was not familiar with the new Medical Director and ordered a lab in error without calling the physician for an order. The DON stated the physician was called on 12/03/15 for a telephone order after the lab test specimen had been obtained from Resident #98. The DON stated her expectation for staff who obtained a lab or performed a treatment or administered a medication without a physician's order was to receive disciplinary action.<br><br>On 12/04/15 at 8:50 AM an interview was conducted with the Administrator who stated he was aware that the DON had ordered a lab test without acquiring a physician's order for Resident #98. The administrator stated he was aware that the lab test had been obtained from Resident #98 without a physician's order. The administrator stated his expectation was that the DON should have acquired a physician's order prior to the lab test being obtained from Resident #98. | F 504 | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>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.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and | F 514 | | 1/1/16 |

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| F 514 | Continued From page 34<br>services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to ensure that medication orders were complete and accurate for 1 of 6 residents reviewed for unnecessary medications. (Resident #26).<br><br>The findings included:<br><br>Resident #26 was admitted to the facility on 11/27/12 with diagnoses that included diabetes mellitus type 2, hypertension, chronic kidney disease stage 3, deep vein thrombosis and senile dementia. A quarterly Minimum Data Set (MDS) assessment dated 10/03/15 indicated the resident received anticoagulant medication for 7 days of the observation period. A care plan updated on 10/10/15 addressed Resident #26's need for anticoagulant medication and the associated risk of abnormal bleeding or bruising. The interventions were appropriate to address the resident's needs and included to monitor for abnormal bleeding or bruising.<br><br>Review of Resident #26's medical record revealed a monthly recapitulation of physician's orders dated 12/01/15 which included the following entries:<br>Coumadin 7.5 milligrams (mg) every day (qd); Coumadin 5 mg every day.<br>Review of the monthly recapitulation of physician's orders for September - November 2015 included the Coumadin listed the same as | F 514 | F514<br>1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident #26 by clarifying, and documenting the clarification of the Coumadin order during the survey.<br>2. Facility residents, who have orders for Coumadin, have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing and Unit Coordinators have completed an audit of current Coumadin orders and Medication Administration Records to determine accuracy of transcription. Any discrepancies were corrected upon identification.<br>3. Measures put in place to ensure the alleged deficient practice does not recur include:<br>The Director of Nursing/ Area Staff Development Manager will conduct in-service re-education for Licensed Nurses, Certified Medication Aides, and Health Information Manager regarding accuracy of the clinical record to include accuracy of transcription of physician's orders using the Five Rights of Medication Administration; specifically, a review of the facility's practice of monthly recapitulation of orders and how to transcribe a physician's order. Licensed Nurses are to | |

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| F 514 | Continued From page 35<br>noted above.<br><br>Review of Resident #26's December 2015 Medication Administration Record (MAR) revealed an entry which read Coumadin 5 mg 1 tablet by mouth every day at 4:00 PM. The time for administration of the medication was listed as 4:00 PM. All days for the month were blocked out except for Saturdays. Another entry on the December 2015 MAR read Coumadin 7.5 mg by mouth every day at 4:00 PM. The time for administration of the medication was listed as 4:00 PM. Every Saturday of the month was blocked out. The medication was initialed as given on 12/01/15 and 12/02/15.<br><br>Review of Resident #26's November MAR revealed an entry which read Coumadin 5 mg 1 tablet by mouth every day at 4:00 PM. The time for administration of the medication was listed as 4:00 PM. All days for the month were blocked out except for Saturdays. The Coumadin 5 mg was initialed as given every Saturday. Another entry on the November 2015 MAR read Coumadin 7.5 mg by mouth every day at 4:00 PM. The time for administration of the medication was listed as 4:00 PM. Every Saturday of the month was blocked out. The medication was initialed as given every day in November except 11/07/15, 11/14/15, 11/21/15 and 11/28/15, which were Saturdays.<br><br>Review of Resident #26's October MAR revealed an entry which read Coumadin 5 mg 1 tablet by mouth every day at 4:00 PM. The time for administration of the medication was listed as 4:00 PM. All days for the month were blocked out except for Saturdays. The Coumadin 5 mg was initialed as given every Saturday. Another entry | F 514 | transcribe physician's orders accurately, physician's orders are to be validated by the licensed nurse to contain all necessary components of a medication order, and Licensed Nurses are to validate the accuracy of the information provided on the Medication Administration Record (MAR). Certified Medication Aides are to bring to the nurse's attention any discrepancies identified during medication administration passes so that the Five Rights of Medication Administration are followed. The Health Information Manager is to enter physician's orders accurately and timely to facilitate licensed nurse review of medication recapitulations on a monthly basis.<br>The Director of Nursing or Unit Coordinator will review Coumadin orders daily, Monday through Friday, during the morning clinical meeting and validate that the order has been correctly transcribed to the MAR for 4 weeks and then 2 times a week for 2 months. On a monthly basis, the Director of Nursing, Unit Coordinators, and assigned Licensed Nurses will review the monthly recapitulation of Coumadin orders to validate accuracy of transcription for 3 months. Discrepancies will be corrected at the time of discovery. Newly admitted residents' Coumadin orders will be reviewed by the Director of Nursing or Unit Coordinator during the morning clinical meeting to validate accuracy of transcription for 3 months.<br>4. The Director of Nursing or Administrator will review the results of audits and monthly recapitulations, | |

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| F 514 | Continued From page 36<br>on the October 2015 MAR read Coumadin 7.5 mg by mouth every day at 4:00 PM. The time for administration of the medication was listed as 4:00 PM. Every Saturday of the month was blocked out. The medication was initialed as given every day in October except 10/03/15, 10/10/15, 10/17/15, 10/24/15 and 10/31/15, which were Saturdays.<br><br>Review of Resident #26's September MAR revealed an entry which read Coumadin 5 mg 1 tablet by mouth every day at 4:00 PM. The time for administration of the medication was listed as 4:00 PM. All days for the month were blocked out except for Saturdays. The Coumadin 5 mg was initialed as given every Saturday. Another entry on the September 2015 MAR read Coumadin 7.5 mg by mouth every day at 4:00 PM. The time for administration of the medication was listed as 4:00 PM. Every Saturday of the month was blocked out. The medication was initialed as given every day in September except 09/05/15, 09/12/15, 09/19/15 and 09/26/15, which were Saturdays.<br><br>Further review of Resident #26's medical record revealed an undated telephone order which read: "Continue 5 mg Q (every) Saturday and 7.5 mg Monday, Tuesday, Wednesday, Thursday, Friday and Sunday. Recheck INR in 2 weeks - 10/29/15." The order was signed as noted by Nurse #2 on 10/15/15 at 5:41 PM. A telephone order dated 10/11/15 at 3:00 PM read: "INR Results 1.2 - continue same and recheck in 2 weeks (Oct 15th)." The order was signed as noted by Nurse #1 on 10/01/15 at 11:00 PM.<br><br>An interview with Nurse #1 on 12/03/15 at approximately 3:00 PM revealed he notified | F 514 | analyze the data to identify patterns/trends monthly for 3 months and report findings to the QAPI committee. The QAPI committee will evaluate the effectiveness of the plan and may amend the plan based on identified outcomes to ensure continued compliance.<br>Complete by 01/01/2016 | |

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| F 514 | Continued From page 37 | F 514 | | |

Resident #26's physician on 10/11/15 of the resident's INR (a blood test which indicates the clotting time of the blood and is used to adjust the dosage of anticoagulant medication). Nurse #1 read the order he had written and stated the physician wanted the same dose of Coumadin continued. Nurse #1 acknowledged that he failed to include the name of the medication and the dosage in the order and that he had been trained to always include the name of the information and dosage in a physician's order.

An interview with Nurse #2 on 12/02/15 at approximately 3:10 PM revealed she notified the Resident #26's physician on 10/15/15 of the resident's INR results. Nurse #2 read the order she had written and stated she ordinarily included the date and time she received an order but must have overlooked it when she wrote this order. Nurse #2 also stated she should have included the name of the medication in the order and that she had been trained to always include the name of the medication in a physician's order.

An interview with the pharmacy consultant on 12/03/15 at 5:25 PM revealed he had noticed the discrepancy in the Coumadin orders on Resident #26's December 2015 recapitulation of physician's orders when he did the drug regimen review on 12/03/15 and had asked the nurse to get a clarification order from the physician. When asked who generated the monthly recapitulation of physician's orders and the MAR, the pharmacy consultant stated the facility did.

An interview with the Medical Records Coordinator (MRC) on 12/04/15 at 12:05 PM revealed she had primary responsibility for entering medication orders into the computer

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| F 514 | Continued From page 38<br>program and for printing the monthly recapitulation of physician orders and the MAR. She stated the Unit Coordinators also assisted with putting orders in the computer. The MRC looked at the monthly recapitulation of orders for Resident #26 and stated she should have written in the full instructions for administration of the Coumadin including the specific days that each dose of Coumadin was to be administered.<br><br>An interview with the Director of Nursing (DON) on 12/04/15 at 12:30 PM about the Coumadin being listed incorrectly on the monthly recapitulation of orders and on the MARs revealed she expected the data to be entered correctly in the computer program so the order printed correctly. When asked to review the telephone orders received on 10/11/15 and 10/15/15 for Resident #26, the DON stated the orders should have included the name of the medication and the dosage. | F 514 | | |
| F 520 SS=E | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>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.<br><br>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. | F 520 | | 1/1/16 |

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| F 520 | Continued From page 39<br><br>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.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews the facility's Quality Assessment and Assurance (QA and A) Committee failed to maintain implemented procedures and monitor the interventions that the committee put in place in February 2015. This was for 3 deficiencies that were cited in February 2015 on a recertification survey. These deficiencies were re-cited on the current recertification survey. The deficiencies were in the areas of Housekeeping and Maintenance Services, Activities of Daily Living and Clinical Records. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program.<br><br>The findings included:<br><br>This tag is cross referred to:<br><br>1. a. F 253: Housekeeping and Maintenance Services: Based on observation, staff interviews and record review the facility failed to maintain in good repair, walls, doors, tile, bathroom light | F 520 | F520<br>1. The District Director of Clinical Services conducted re-education for the Administrator on the facility's Quality Assurance and Performance Improvement Program including scheduling, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity.<br>2. All facility residents have the potential to be affected by this alleged deficient practice. Continued areas of opportunity include:<br>• F-253 failure to maintain in good repair walls, doors, tile, bath room light fixtures, and mirrors for two of two halls. See attached PoC.<br>• F-312 facility failed to assist one resident with dressing and getting out of bed, and one resident with removal of facial hair. Facility failed to provide ADL assistance for two cognitively impaired dependent residents. See attached PoC.<br>• F-514 facility failed to ensure | |

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| F 520 | Continued From page 40<br>fixtures, and mirrors for 2 of 2 halls (South and North).<br><br>During the recertification survey of February 2015, the facility was cited for F 253 for failure to repair furniture in a resident's room. On the current survey the facility was cited for failing to: remove blue vinyl edging around bathroom mirrors, patch holes in walls and doors, missing baseboard, broken edge on bathroom vanity, peeling paint on commode seat, broken and missing tile and scuffed or missing paint.<br><br>b. F 312: Activities of Daily Living: Based on observations, record review and staff interviews the facility failed to assist 1 resident with dressing and getting out of bed (Resident #12) and failed to remove facial hair from 1 resident (Resident #26) for 2 of 3 cognitively impaired, dependent residents reviewed for providing assistance with activities of daily living. (Residents #12 and #26).<br><br>During the recertification survey of February 2015, the facility was cited for F 312 for failure to provide nail care to dependent residents. On the current survey the facility was cited for failing to assist residents with dressing, transfers and shaving.<br><br>c. F 514: Clinical Records: Based on record review and staff interview the facility failed to ensure that medication orders were complete and accurate for 1 of 6 residents reviewed for unnecessary medications. (Resident #26).<br><br>During the recertification survey of February 2015, the facility was cited for F 514 for failure to obtain physician's orders for capillary blood glucose checks and administration of sliding | F 520 | medications orders were complete and accurate for one six residents. See Attached PoC.<br>3. The Administrator and the Quality Assurance Committee were retrained on the Quality Assurance & Performance Improvement Program by The District Clinical Director. The Quality Assurance committee consists of:<br>• Administrator<br>• Director of Nursing<br>• Dietary Manager<br>• Rehabilitation Manager<br>• Maintenance or Environmental Representative<br>• Activities Director<br>• Social Services Director<br>• Human Resource Designee<br>• Business Office Director<br>• Resident Care Management Director<br>• Medical Director<br><br>4. The District Team will review the minutes of the facility's QAPI meetings for three months to monitor for trending of outcomes and implementation of plans for opportunities identified.<br><br>F253<br>1. The facility removed the blue vinyl "tape" from around the bathroom mirrors in rooms 26, 27, 28/30, 33/34, 35/36, 39/40, 41, 43, 46, 48.<br>Bathroom doors were repaired for rooms 30, 43, 48.<br>Tile was repaired in rooms 30, 43.<br>Walls were repaired and painted for rooms 39/40, 43, 48.<br>Call stations refitted 36, & 43. | |

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| F 520 | Continued From page 41<br>scale insulin, obtain a complete order for eye drops that indicated which eye, failed to list orders for as needed pain medication on the Medication Administration Record (MAR) and listed a medication on the MAR as once a day dosing that was ordered to be given twice a day. On the current survey the facility was cited for failing to ensure physician's orders on the monthly recapitulation of physician's orders were complete and that telephone orders included the date and time the order was received, the name and dosage of the medication.<br><br>During an interview on 12/04/15 at 3:05 PM with the Administrator, he was asked what he thought caused the continued failure in environmental concerns. The Administrator stated he thought they had changed their focus from patching small areas of concern to doing complete room renovations. The Administrator stated he intended to do an environmental inspection monthly but he missed doing the inspection in October. The Administrator was asked what he thought caused continued failure in providing assistance with activities of daily living to dependent, cognitively impaired residents. The Administrator stated he thought the recent staff turnover in Unit Coordinators caused a decrease in the oversight provided of direct care staff. The Administrator was asked what he thought caused continued failure in maintaining complete and accurate medical records. The Administrator stated he thought the recent turnover in Unit Coordinators contributed to the problem because it resulted in only the Director of Nursing and the Medical Records Coordinator checking physician's orders and Medication Administration Records for accuracy. | F 520 | Light covers in bath room replaced rooms 39/40, 43<br>Sink vanities replaced rooms 35/36,<br>Toilet seat part removed room 39/40.<br>2. Facility residents have the potential to be affected by this alleged deficient practice. The Maintenance Director and the Housekeeping Director will conduct an audit of resident's rooms, bathrooms and hallways to ensure the master repair list is complete and up-to-date.<br>3. Measures put into place to ensure the alleged deficient practice does not reoccur include: The Maintenance Director, Administrator will conduct re-education for staff regarding observations of furnishings, walls, cleanliness of rooms, bathrooms, and appropriate process for reporting needed repairs. The facility's Ambassadors (team members who visit with residents routinely to identify concerns/needs) will observe and inspect 10 residents' rooms weekly for 4 weeks and then 10 resident's rooms monthly for 3 months to include observation of walls, cleanliness of bathroom/rooms, and observation of condition of furnishings. Additionally, The Maintenance Director and the Housekeeping Director will establish a timeline of completion of items on the master list. The facility Ambassadors (team members who visit with residents routinely to identify concerns/needs) will observe and inspect 10 rooms weekly for 4 weeks and then 10 rooms every other week for two months including observation of walls, odors and cleanliness. | |

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| F 520 | Continued From page 42 | F 520 | 4. The Administrator, Maintenance Director and Housekeeping Manager will review data obtained during facility audits and analyze data and report any trends to the QAPI meeting monthly for 3 months. The committee will evaluate the effectiveness of the plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance.<br><br>To be completed by 01/01/2016<br><br>F312<br>1.Resident #12 will be out of bed daily and dressed as tolerated.<br>Resident #26 was shaved.<br><br>2.All residents have the potential to be affected by the same alleged deficient practice; therefore, The Director of Nursing/<br>Assistant Director of Nursing/<br>Unit Manager will complete a 100% audit of all current residents to include being shaved, dressed and out of bed as tolerated.<br><br>3.Measures put into place to ensure that the alleged deficient practice does not reoccur include: The Director of Nursing/<br>Assistant Director of Nursing completed an In-service/ re-education for all Nursing staff to including residents being shaved, dressed and out of bed as tolerated.<br>Additionally,<br>the DON/RN unit managers will audit at least 5<br>residents weekly for 4weeks, Then 5 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345411 | A. BUILDING _____ B. WING _____ | C 12/04/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE | 516 WALL STREET WAYNESVILLE, NC 28786 |

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|---|---|---|---|---|
| F 520 | Continued From page 43 | F 520 | residents monthly x three months to ensure they are shaved, dressed and out of bed as tolerated per their personal preference sheets.<br><br>4.Director of Nursing will review data obtained from audits, analyze the data and report patterns/ trends to the QAPI committee every month for 3 months. The committee will make recommendations as indicated.<br><br>Completed by 01/01/2016<br><br>F514<br>1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident #26 by clarifying, and documenting the clarification of the Coumadin order during the survey.<br>2. Facility residents, who have orders for Coumadin, have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing and Unit Coordinators have completed an audit of current Coumadin orders and Medication Administration Records to determine accuracy of transcription. Any discrepancies were corrected upon identification.<br>3. Measures put in place to ensure the alleged deficient practice does not recur include:<br>The Director of Nursing/ Area Staff Development Manager will conduct | |

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|---|---|---|---|---|
| F 520 | Continued From page 44 | F 520 | in-service re-education for Licensed Nurses, Certified Medication Aides, and Health Information Manager regarding accuracy of the clinical record to include accuracy of transcription of physician's orders using the Five Rights of Medication Administration; specifically, a review of the facility's practice of monthly recapitulation of orders and how to transcribe a physician's order. Licensed Nurses are to transcribe physician's orders accurately, physician's orders are to be validated by the licensed nurse to contain all necessary components of a medication order, and Licensed Nurses are to validate the accuracy of the information provided on the Medication Administration Record (MAR). Certified Medication Aides are to bring to the nurse's attention any discrepancies identified during medication administration passes so that the Five Rights of Medication Administration are followed. The Health Information Manager is to enter physician's orders accurately and timely to facilitate licensed nurse review of medication recapitulations on a monthly basis.<br>The Director of Nursing or Unit Coordinator will review Coumadin orders daily, Monday through Friday, during the morning clinical meeting and validate that the order has been correctly transcribed to the MAR for 4 weeks and then 2 times a week for 2 months. On a monthly basis, the Director of Nursing, Unit Coordinators, and assigned Licensed Nurses will review the monthly recapitulation of Coumadin orders to validate accuracy of transcription for 3 | |

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| F 520 | Continued From page 45 | F 520 | months. Discrepancies will be corrected at the time of discovery. Newly admitted residents' Coumadin orders will be reviewed by the Director of Nursing or Unit Coordinator during the morning clinical meeting to validate accuracy of transcription for 3 months.<br>4. The Director of Nursing or Administrator will review the results of audits and monthly recapitulations, analyze the data to identify patterns/trends monthly for 3 months and report findings to the QAPI committee. The QAPI committee will evaluate the effectiveness of the plan and may amend the plan based on identified outcomes to ensure continued compliance.<br>Complete by 01/01/2016<br><br>Complete by 01/01/2016 | |