STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/CH	5939 REDDMAN ROAD CHARLOTTE, NC 28212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review, the facility failed to accurately code the Minimum Data Set regarding bowel continence (Resident #95) for 1 of 22 sampled residents. The findings included:	F 278	F278 D This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or	7/28/16

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

Electronically Signed | 07/22/2016

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F 278	Continued From page 1 Resident #95 was admitted to the facility on 09/30/14 with diagnoses that included anemia, adult failure to thrive, dysphagia, and weakness. Review of the most recent quarterly minimum data set (MDS) dated 05/10/16 revealed that Resident #95 was moderately impaired for daily decision making and required extensive assistance of one staff member for toileting. The MDS also revealed that Resident #95 was occasionally incontinent of urine and bowel continence was coded as "not rated." Observation on 06/27/16 at 4:22 PM of Resident #95 toileting herself revealed that Resident #95 did not have a colostomy. Interview with Nursing Assistant (NA) #1 on 06/30/16 at 1:52 PM revealed that she was taking care of Resident #95. NA#1 stated that Resident #95 was very independent and was able to clean and wash herself. NA#1 stated I just have to make sure she has the supplies that she needs. NA#1 stated Resident #95 was continent of bowel and bladder and stated Resident #95 did not have a colostomy. Interview with MDS nurse on 06/30/16 explained that she was a "floater" for the company so she traveled to multiple buildings to help out. The MDS nurse explained that "not rated" would be coded on a MDS for bowel continence when the resident had a colostomy. The MDS nurse further explained that the MDS auto populated from the NA documentation in the electronic medical record and they were responsible for checking it for accuracy. The MDS nurse was not familiar with Resident #95 and could not answer specific questions about the resident. Interview with the MDS Coordinator on 06/30/16 at 2:30 PM revealed that Resident #95 toileted herself and did not have a colostomy. The MDS	F 278	agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility policy is to submit correctly completed MDS Assessments. 1. Corrective action was accomplished for the alleged deficient practice for Resident #95 MDS with ARD 5/10/16 to accurately reflect bowel continence. The MDS Coordinator completed this modification on 6/30/2016. 2. All residents who are coded on the MDS have the potential to be affected by this alleged deficient practice. An audit of MDSs for the preceding quarter is being completed between 7/1/2016 and 7/28/2016 by the MDS Coordinator to ensure there are no MDS with inaccurate coding. Any MDS found to be coded inaccurately will be corrected. 3. The Director of Nursing re-educated the MDS Coordinator on accurate MDS coding related to bowel function on 7/19/2016. The MDS Coordinator will be alert for the not Rated code that may flow into the MDS from the CNA charting in the Point of Care program. The MDS Coordinator will randomly audit 10 completed MDSs weekly for twelve weeks to ensure accurate coding in all section. 4. Measures to ensure that corrections	

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F 278	Continued From page 2 nurse stated that "not rated" auto populated to the MDS from the NA documentation and that she could have went into the MDS and changed it but did not. The MDS nurse stated that coding the most accurate information would have been to code "always continent." The MDS nurse also stated that when she completed the MDS she went to Resident #95's room and verified with the resident and her family that she had had a bowel movement during the look back window. Interview with the Director of Nursing on 06/30/16 at 3:55 PM revealed that she expected all MDS's to be coded accurately to reflect the patient and if the MDS was auto populated from the NA electronic documentation she expected the MDS coordinator to review it for accuracy and make changes as required.	F 278	are achieved and sustained include: The MDS Coordinator will present the results of the audits monthly for three months at the facility QAPI meeting. The committee will evaluate the effectiveness and amend as needed. 5. Date of compliance is 7/28/16.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to provide nail care to 3 of 3 sampled residents (Residents #60, #99 and #36) . Findings included: 1. Resident #60 was admitted 06/23/15 with diagnosis that include cerebrovascular accident with right hemiplegia, dementia, diabetes, anxiety and depression. The Minimum Data Set (MDS)	F 312	F312 E This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of	7/28/16

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F 312	Continued From page 3 dated 04/16/2016 Resident #60 needed assistance with his activities of daily living related to CVA with hemiplegia. He was cognitively impaired to make daily clinical care decisions. Observation 06/28/2016 8:22 AM revealed Resident #60 had brown debris under fingernails. Observation 06/30/2016 9:00 AM revealed Resident #60 had uneven fingernails with brown substance under the nails. Interview 6/29/2016 9:00 AM Nurse Aide (NA) #3 stated he gets a shower Mondays and Fridays. He is assisted with his showers. He needed assistance with incontinence care and transfers. He eats in his room after his tray is set up. Interview 06/29/2016 4:00 PM NA #4 stated she worked evening shift. She stated Resident #60 was " total care " . He fed himself. She stated she changed him and put a gown on him for bedtime. She stated she changed him every two hours and sometimes in between. Interview 06/29/2016 11:41 AM the RN Unit Manager (UM) revealed that nail care was done when residents go to activities can have their nails filed. The nurse aides are expected look at nails and if they are long they are expected to let the nurse know. Interview 06/29/2016 12:03 PM the Director of Nursing revealed her expectation was that the NAs would have cleaned nails and if they are unable to cut them they should let the nurse know so they could be trimmed. The UM goes around and checks against the shower list and sees it's done. Interview 06/29/2016 4:00 PM NA #4 stated she worked evening shift. She stated the resident was	F 312	correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is our facility policy that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming. 1. Corrective action was accomplished for the alleged deficient practice for resident #36 by the unit nurse, ensuring nail care was provided for resident #36 on the morning of 6/30/2016. Resident #36 had been resistive to care the two days prior and was now calm enough to have her nails cleaned and trimmed. Corrective action was accomplished for the alleged deficient practice for residents #60 and #99 by the Unit Manager on July 1, 2016 during their regularly scheduled shower time. 2. All residents requiring assistance with nail care have the potential to be affected by this alleged deficient practice. The Director of Nursing, the Assistant Director of Nursing and/or the Unit Managers completed an audit of residents requiring assistance with nail care to ensure nail care was completed as required according to the resident□s preferences. The audit was completed by 7/20/2016. 3. The Nursing staff was re-educated by the DON, ADON and Unit Managers regarding the completion of nail care according to resident preference. The education was completed by 7/22/2016.	

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F 312	Continued From page 4 " total care " . He fed himself. She stated she changed him and put a gown on him for bedtime. She stated she changed him every two hours and sometimes in between. Interview 06/30/2016 9:54 AM with NA #5 revealed she bathes Resident #60, does range of motion with him uses the Hoyer lift for transfers. She stated she changes him and sets him up for breakfast. 2. Resident #99 was admitted 12/23/2015 with diagnosis that included dementia. The MDS dated 05/23/2016 indicated that he was severely cognitively impaired for daily decision making. He needed assistance with personal hygiene, toileting and eating. Reviewed of Resident #99's care plan documented goals and interventions needed to meet the resident ' s need for assistance his activities of daily living. Observation 06/28/2016 08:10 AM Resident #99's fingernails were long and had brown debris under the nails on both hands. Observation 06/29/201612:00 PM Resident #99's fingernails on both hands were long, uneven and had brown debris underneath the nails. Observation 06/30/2016 08:30 AM Resident #99's fingernails were long and had brown debris underneath the nails. Interview 6/30/2016 09:54 AM NA #5 revealed she bathed Resident #99 and shaved him. She assisted him with getting dressed and kept a	F 312	The DON, ADON or Unit Managers will randomly observe five residents requiring nail care weekly for twelve weeks to validate that nail care is provided according to the resident preferences. Opportunities will be corrected as identified and staff will be appropriately counseled if needed. 4. Measures to ensure that corrections are achieved and sustained include: Results of observations will be submitted to QAPI committee by DON for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. 5. Date of compliance: 7/28/16.	

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close " eye on him " since he was busy. He fed himself after having his tray set up. She stated sometimes he was incontinent and sometimes she took him to the bathroom.

Interview 06/29/2016 11:41 AM the RN Unit Manager (UM) revealed that nail care was done when residents go to activities can have their nails filed. The nurse aides are expected look at nails and if they are long they are expected to let the nurse know.

Interview 06/29/2016 12:03 PM the Director of Nursing revealed her expectation was that the NAs would have cleaned nails and if they are unable to cut them they should let the nurse know so they could be trimmed. The UM goes around and checks against the shower list and sees it's done.

Interview 06/29/2016 4:00 PM NA #4 stated she worked evening shift. She stated the resident was " total care ". He fed himself. She stated she changed him and put a gown on him for bedtime. She stated she changed him every two hours and sometimes in between.

3. Resident #36 was admitted to the facility on 05/25/12 with diagnoses that included anemia, hypertension, non-Alzheimer's dementia, depression, and stiffness of hand. Review of the most recent quarterly Minimum Data Set (MDS) dated 06/06/16 revealed that Resident #36 was severely cognitively impaired for daily decision making. Physical behaviors symptoms directed towards others occurred 1 to 3 days during the look back period and verbal behavior symptoms not directed towards other occurred 1 to 3 days during the look back period. Rejection of care occurred 1 to 3 days during the look back period.

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The MDS also revealed that Resident #36 required extensive assistance of one staff member with bed mobility, dressing, eating, toileting use, and personal hygiene.
Review of a care plan dated 11/11/15 stated that Resident #36 required assistance with activities of daily living related to dementia. The goal of the care plan was Resident #36 would have grooming and hygiene needs met with staff assistance. The interventions of the care plan included staff was to provide assistance as required for completion of all activities of daily living tasks.
Review of the medical record from 5/29/16 through 6/29/16 revealed no refusal of nail care or evidence that nail care was offered or provided.
Observation on 06/28/16 at 9:06 AM revealed Resident #36's fingernails were ¼ inch long with brown substance under them.
Observation on 06/28/16 at 1:59 PM revealed Resident #36's fingernails were ¼ inch long with brown substance under them.
Observation on 06/29/16 at 9:52 AM revealed Resident #36's fingernails were ¼ inch long with brown substance under them.
Interview with the Unit Coordinator on 06/29/16 at 11:41 AM revealed that the activity department paints and files resident nails. The nursing assistants (NA) are supposed to look at nails and if they are long they are expected to let the nurse know. The unit coordinator stated that they NA's could file nails but they were not allowed to trim them. The unit coordinator further stated that she performed random weekly audits on fingernails. The unit coordinator stated that the NA's should have alerted the nurse or herself so that Resident #36's nails could have been trimmed.
Interview with the Director of Nursing on 06/29/16

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F 312	Continued From page 7 at 12:03 PM revealed that she expected that the NA's would have cleaned Resident #36's nails and if they were unable to cut them they should have alerted the nurse so that they could have been trimmed. The DON stated that the NA s are able to trim resident nails as long as they are not diabetic. The DON also stated that the unit coordinator completed random audits for nail care and cleanliness. Interview on 06/29/16 at 2:36 PM with NA #2 revealed that she worked part time at the facility and was taking care of Resident #36 today. NA#2 stated that they are able to trim fingernails but not toenails, NA#2 also stated that as part of daily care they are supposed to check residents nails and make sure they are clean and trim. NA#2 stated that she worked yesterday and she was supposed to provide nail care to whomever needed it, but she got pulled to the rehab unit and was unable to get them all done. NA#2 also stated that she had noticed yesterday that Resident #36's nails were long and dirty but she was unable to get to them yesterday because she got pulled to a unit.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318		7/28/16

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F 318	Continued From page 8 Based on observations, record reviews, and staff interviews the facility failed to apply a palm guard to prevent worsening contracture for 1 of 3 residents reviewed for range of motion. (Resident #36) The Findings included: Resident #36 was admitted to the facility on 05/25/12 with diagnoses that included contracture and stiffness of hand. Review of the most recent quarterly Minimum Data Set (MDS) dated 06/06/16 revealed that Resident #36 was severely cognitively impaired for daily decision making. Rejection of care occurred 1 to 3 days during the look back period. The MDS also revealed that Resident #36 required extensive assistance of one staff member with bed mobility, dressing, eating, toileting use, and personal hygiene. The MDS also revealed that Resident #36 received 7 days of restorative nursing program for splint or brace assistance. Review of a care plan dated 11/11/15 read in part that Resident #36 required assistance with activities of daily living (ADLs) related to dementia. The goal of stated care plan was resident will have grooming and hygiene needs met with staff assistance. The interventions of the care plan included resident was discharged from restorative on 05/18/16. Nursing to continue to apply palm protector daily. Review of physician order dated 06/17/16 read palm guard for right hand to be placed by restorative aid in bed to decrease risk of contracture. Review of medication administration record (MAR) dated 06/01/16 through 06/30/16 revealed the following: Apply left palm guard protection daily to left hand in the morning. It had been initialed by staff the entire month indicating that it had been applied, except for 06/30/16 it was	F 318	F318 D This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is our facility policy that a resident who has limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. 1. Corrective action was accomplished by 7/5/16 for the alleged deficient practice by the Unit Manager providing one on one education to the CNAs who apply the palm guard to resident #36. 2. All residents with devices to prevent contractures have the potential to be affected by the alleged deficient practice, The Unit Managers completed an audit of all residents who have devices to ensure that if the device is ordered that it is placed properly per order. This audit is being completed 7/28/2016. 3. The CNAs were re-educated by the ADON and Unit Manager regarding application of Resident #36 palm guard daily. They were instructed that if the	

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F 318	Continued From page 9 documented that Resident #36 refused the palm guard. Review of facility document titled "100 hall Resident care specialist assignment sheet" dated 06/29/16 contained the following information for Resident #36 palm guard to left hand. Observation of Resident #36 on 06/28/16 at 1:59 PM up in day room, there was no palm guard noted to right or left hand. Observation of Resident #36 on 06/29/16 at 8:31 AM in bed laying on her right side. No palm guard noted to right or left hand. There was a palm guard noted to be laying on nightstand next to bed. Observation of Resident #36 on 06/29/16 at 9:52 AM resting in bed with eyes closed no palm guard was noted to right or left hand. There was a palm guard noted to be laying on nightstand next to bed. Observation of Resident #36 on 06/29/16 at 10:57 AM up in day room with no palm guard noted to right or left hand. Interview with the Director of Nursing (DON) on 06/29/16 at 12:03 PM revealed that the Nursing Assistants (NA) or the restorative aides were responsible for applying the palm guard to Resident #36. The DON stated that if it is on the "100 hall Resident care specialist assignment sheet" then the NA's are expected to apply it as ordered, if the resident refused the NA's are expected to document this in the electronic medical record and alert the nurse. Interview with NA #2 on 06/29/16 at 2:36 PM revealed that she worked part time at the facility and was taking care of Resident #36 today. NA #2 stated that she did not pick up her assignment sheet today when she came to work but stated Resident #36 does have a palm guard and she applied it this am before lunch but when she went	F 318	resident is resistive to care, as she sometimes is, they are to report the resistance to the nurse. Documentation of refusal to wear the palm guard is to be completed when it occurs. Education was completed by 7/5/2016. The unit manager will randomly observe 5 residents with devices to prevent contractures at least once weekly for twelve weeks on random days to ensure proper application of devices. Unit manager will monitor documentation of refusal to wear palm guard 4. Measures to ensure that corrections are achieved and sustained include: The results of these observations will be submitted to the QAPI committee by the DON for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. 5. Date of compliance is 7/28/16.	

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F 318	Continued From page 10 to the dining room Resident #36 had removed it, NA #2 stated she had not documented this anywhere and had not reported this to the nurse.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews and record review, the facility failed to monitor a serum drug level for 1 of 5 sampled residents who received medications which required	F 329	F329 D This plan of correction is the centers credible allegation of compliance.	7/28/16

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F 329	Continued From page 11 monitoring (Resident #93). The findings included: Resident #93 was admitted to the facility on 11/05/13 with diagnoses which included seizures. Review of Resident #93's August 2015 monthly physician ' s orders revealed direction to administer Levetiracetam 500 milligrams (mg.) twice daily to treat convulsions obtain a Levetiracetam level every 3 months. Review of Resident #93's subsequent monthly physician's orders from September 2015 to June 2016 revealed direction to obtain a Levetiracetam serum level every 3 months. The order specified the level to be drawn in August, November, February and May. (A serum level is used to measure the amount of Levetiracetam in the blood to determine whether the drug level is within therapeutic range.) Review of Resident #93's clinical record revealed a Levetiracetam serum level dated 08/08/15 of 32.7 micrograms/milliliter. Further review revealed there was no documentation of Levetiracetam levels since the 08/08/15 result. Interview with the unit coordinator of the A wing on 06/29/16 at 9:29 AM revealed Resident #93 did not receive a Levetiracetam serum blood test since 08/08/15 because the laboratory electronic logs listed the order as single test obtained on 08/08/15. The A wing unit coordinator was not able to provide a reason for the entry error. Interview with the Director of Nursing on 06/29/16 at 11:27 AM revealed she expected physician's	F 329	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is our facility policy that physician orders be followed as written. 1. Corrective action was accomplished for the alleged deficient practice for resident #93 by the Unit Manager, who followed the new physician order on 6/29/16 to obtain a serum Levetiracetam level once per year. The unit manager entered a lab order for the level to be drawn in August, 2016, one year from the last recorded draw. 2. All residents requiring labs have the potential to be affected by the alleged deficient practice. The Unit Managers completed an audit of resident□s lab orders to ensure labs are entered in the lab computer as ordered by the physician. The audit was completed by 7/22/2016. 3. The Nurses were re-educated by the DON, ADON, and Unit Managers regarding the process for entering lab orders into the lab computer. This education was completed by 7/22/2016. 10 Resident□s lab orders will be validated for accurate entry into the lab computer weekly for 12 weeks by the Unit Manager or ADON . If there are any errors in entry,	

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F 329	Continued From page 12 orders to be implemented and Resident #93's Levetiracetam level should have been done. Interview with Resident #93's physician on 06/29/16 at 2:51 PM revealed she expected physician's orders to be implemented. The physician reported the Levetiracetam level did not need to be done quarterly and would change the order to be done on an annual basis.	F 329	the Unit Manager will correct and re-educate the nurse. 4. Measures to ensure that corrections are achieved and sustained include: Results of the monitoring of lab entry into the lab computer will be submitted to the QAPI committee by the DON for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. 5. Date of compliance is 7/28/16.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to be free of a medication error rate of 5% or greater as evidenced by 3 medication errors out of 30 opportunities resulting in a medication error rate of 10% for 2 of 6 residents observed during medication pass. (Resident #109 and Resident #45) The findings included: Resident #109 was admitted to the facility on 08/22/14 with diagnoses that included hypertension. Review of the most recent quarterly minimum data set (MDS) dated 05/24/16 revealed that Resident #109 was cognitively intact. The MDS further indicated that Resident	F 332	F332 D This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is our facility policy that medications are to be administered as ordered.	7/28/16

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F 332	Continued From page 13 #109 required supervision of one staff member with most aspects of activities of daily living. 1a. Review of a physician order dated 08/22/14 read Clonidine 0.1 milligram (MG) 24 hour patch. Apply one patch transdermally one time a day every Wednesday related to essential hypertension. Observation on 06/29/16 at 9:30 AM revealed Medication Aide (MA) #1 removed a Clonidine transdermal patch from Resident #109's left arm. The patch contained Clonidine and a foam covering to keep the medicated patch in place. The MA then placed the Clonidine patch and covering in the trash can. The MA proceeded to check Resident #109's blood pressure which was 176/77. On 06/29/16 at 9:40 AM MA #1 was observed preparing medications for Resident #109. MA #1 pulled out of the top drawer of the medication cart a packet from a box of medication that was labeled with Resident #109's name, room number, and directions for administration. On the front of the packet it stated, "This contains no active medication." This was the foam dressing that was used to cover the Clonidine transdermal patch. MA #1 opened the packet that stated, "This contains no active medication" removed the patch and wrote her initials and the date on the foam dressing. On 06/29/16 at 9:43 AM MA #1 entered Resident #109's room and applied the foam dressing to Resident #109's left chest area and exited the room. MA #1 did not apply the Clonidine medicated patch. Interview on 06/29/16 at 11:28 AM with the Unit Coordinator for A wing revealed that if the MAs have any questions about medications or how to administer them they are to immediately go to the nurse or herself. The MAs are expected to	F 332	1. Corrective action was accomplished on 6/29/16 for the alleged deficient practice by the Certified Medication Aide for residents #109 and #45 by the unit manager reporting the alleged omissions to the physician . The Clonidine patch was ordered stat from the pharmacy, delivered and placed on the resident under the supervision of the Unit Manager. The second 5 mg amlopidine tablet was administered under the supervision of the Unit Manager. The physician reviewed resident #109 medications and made changes in resident #109 orders. Those orders were entered in the computer and carried out. The vitamin D for resident #45 was located on another medication cart and administered to the resident under supervision of the Unit Manager. Vitamin D is an over the counter medication which is administered from non-resident specific bottles. Medication Variances were completed for the above listed errors by the DON on 6/29/16. 2. All residents who receive medication have the potential to be affected by the alleged deficient practice. The Unit Managers, ADON and DON observed one med pass completed by each Certified Medication Aide to validate correct medication administration techniques. The SDC will do med pass observations once per month with random Certified Medication Aides and licensed nurses. The Certified Medication Aide who was observed committing the alleged deficient	

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F 332	Continued From page 14 administer medications as prescribed and give the correct dose of medication. Interview on 06/29/16 at 12:01 PM with the Director of Nursing (DON) revealed that she expected the staff to administer medications exactly as prescribed and if the MAs had any questions they were to immediately go the nurse or to the unit coordinator. On 06/30/16 at 10:46 AM, MA #1 stated that she thought that when she was preparing the Clonidine patch that it was already there with the foam covering. Medication Aide #1 stated that she was aware that there were 2 patches with the Clonidine, one that contained medication and one that was used to hold the medicated patch in place. MA #1 stated, "I just got mixed up." 1b. Review of a physician order dated 08/22/14 read Amlodipine (medication to control blood pressure) 5 mg give 2 tablets by mouth one time a day. On 06/29/16 at 9:30 AM MA #1 was noted to check Resident #109's blood pressure which was 176/77. On 06/29/16 at 9:40 AM MA #1 was observed preparing medications for Resident #109. MA #1 pulled out a card of medication that was labeled with Resident #109's name, room number and directions for administration. The directions read, Amlodipine 5 mg by mouth, give 2 tablets one time daily. The MA took the card and punched one Amlodipine 5 mg tablet into a medication cup and returned the card to the appropriate drawer on the medication cart and then locked the medication cart. On 06/29/16 at 9:43 AM, MA #1 entered resident #109's room to administer the Amlodipine 5 mg by mouth one tablet. Resident #109 took the medication cup and swallowed the one tablet of Amlodipine.	F 332	practice was re-educated by the SDC on 7/6/2016. 3. The Certified Medication Aide who was observed committing the alleged deficient practice was given a re-education course which included competency pre and post tests, review of medication management for Medication aides, and medication pass evaluation. This education was completed on 7/6/2016. The SDC will do med pass observations once per month with random Certified Medication Aides and licensed nurses. 4. Measures to ensure that corrections are achieved and sustained include: The results of these observations will be submitted to the QAPI committee by the DON for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. 5. Date of compliance is 7/28/16.	

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Interview on 06/29/16 at 11:28 AM with the Unit Coordinator for A wing revealed that if the MAs have any questions about medications or how to administer them they are to immediately go to the nurse or herself. The MAs are expected to administer medications as prescribed and give the correct dose of medication.
Interview on 06/29/16 at 12:01 PM with the Director of Nursing (DON) revealed that she expected the staff to administer medications exactly as prescribed and if the MAs had any questions they were to immediately go the nurse or to the unit coordinator.
On 06/30/16 at 10:46 AM, MA #1 stated that she knew Resident #109 received 2 Amlodipine tablets and that she had always given her 2, but yesterday "I got mixed up." MA #1 then stated that the MD had changed some of Resident #109's medications and the Amlodipine had been stopped.
2. Resident #45 was readmitted to the facility on 11/13/15 with diagnosis that included Vitamin D deficiency. A review of the most recent quarterly MDS dated 05/25/16 revealed that Resident #45 was cognitively intact and required extensive assist of one staff member for bed mobility, transfers, dressing, toileting, and personal hygiene.
Review of June Medication Administration Record (MAR) contained the following order: Vitamin D3 2000 units by mouth bid.
On 06/29/16 at 9:05 AM MA #1 was observed preparing medications for Resident #45, MA #1 was observed to pull all ordered medications except Vitamin D3 2000 units by mouth. MA#1 stated that the Vitamin D3 comes from central supply and "they are out of it" and she would "documents that" in the electronic medical record.

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F 332	Continued From page 16 On 06/29/15 at 9:15 AM MA #1 was observed to enter Resident #45's room and administer her morning medication but omitted the Vitamin D3 2000 units by mouth because they were out of it. Interview on 06/29/16 at 11:28 AM with the Unit Coordinator for A wing revealed that if the MAs have any questions about medications they are to immediately go to the nurse or herself. The MAs are expected to administer medications as prescribed and give the correct dose of medication. Interview on 06/29/16 at 12:01 PM with the Director of Nursing (DON) revealed that she expected the staff to administer medications exactly as prescribed and if the MAs had any questions they were to immediately go the nurse or to the unit coordinator. Interview with MA #1 on 06/30/16 at 10:46 AM revealed that if she had any questions about medications she was to immediately go to the nurse or to the unit coordinator. MA #1 stated that she should have went to central supply to see if the medication had come in and "it was just a mistake."	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, and medical doctor interview, the facility failed to administer antihypertensive medications as ordered for 1 of 6 residents	F 333	F333 D This plan of correction is the centers credible allegation of compliance.	7/28/16

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F 333	Continued From page 17 observed during medication pass (Resident #109). The findings included: Resident #109 was admitted to the facility on 08/22/14 with diagnoses that included hypertension. Review of the most recent quarterly minimum data set (MDS) dated 05/24/16 revealed that Resident #109 was cognitively intact. The MDS further indicated that Resident #109 required supervision of one staff member with most aspects of activities of daily living. 1a. Review of a physician order dated 08/22/14 read Clonidine 0.1 milligram (MG) 24 hour patch. Apply one patch transdermally one time a day every Wednesday related to essential hypertension. Observation on 06/29/16 at 9:30 AM revealed Medication Aide (MA) #1 removed a Clonidine transdermal patch from Resident #109's left arm. The patch contained Clonidine and a foam covering to keep the medicated patch in place. The MA then placed the Clonidine patch and covering in the trash can. The MA proceeded to check Resident #109's blood pressure which was 176/77. On 06/29/16 at 9:40 AM MA #1 was observed preparing medications for Resident #109. MA #1 pulled out of the top drawer of the medication cart a packet from a box of medication that was labeled with Resident #109's name, room number, and directions for administration. On the front of the packet it stated, "This contains no active medication." This was the foam dressing that was used to cover the Clonidine transdermal patch. MA #1 opened the packet that stated, "This contains no active medication" removed the patch and wrote her initials and the date on the foam dressing. On 06/29/16 at 9:43 AM MA #1 entered Resident	F 333	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is our facility policy that medications are to be administered as ordered. 1. Corrective action was accomplished on 6/29/16 for the alleged deficient practice by the Certified Medication Aide for residents #109 by reporting the alleged omissions to the physician. The Clonidine patch was ordered stat from the pharmacy, delivered and placed on the resident under the supervision of the Unit Manager. The second 5 mg amlopidine tablet was administered under the supervision of the Unit Manager. The physician reviewed resident #109 medications and made changes in resident #109 orders. Those orders were entered in the computer and carried out. 2. All residents who receive medications have the potential to be affected by the alleged deficient practice. The Unit Managers, ADON and DON are observing one med pass by each Certified Medication Aide and licensed nurses to ensure correct medication administration. The SDC will do med pass observations once per month with random Certified Medication Aides and licensed nurses. The Certified Medication Aide or nurse	

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F 333	Continued From page 18 #109's room and applied the foam dressing to Resident #109's left chest area and exited the room. Interview on 06/29/16 at 11:28 AM with the Unit Coordinator for A wing revealed that if the MAs have any questions about medications they are to immediately go to the nurse or herself. The MAs are expected to administer medications as prescribed and give the correct dose of medication. Interview on 06/29/16 at 12:01 PM with the Director of Nursing (DON) revealed that she expected the staff to administer medications exactly as prescribed and if the MAs had any questions they were to immediately go the nurse or to the unit coordinator. Interview on 06/29/16 at 12:26 PM with Medical Doctor (MD) #1 revealed that with Clonidine you cannot stop it suddenly. After reviewing the blood pressures for Resident #109, she stated that her blood pressures have been running high and she would use this error to reevaluate Resident #109's medications. The MD #1 stated that the MAs have no knowledge of the action of the medications and that this error with the Clonidine was serious and she expected the staff to follow the physician orders exactly as written. MD #1 stated, "Thank you for letting me know about this. Without you, I would not know what was really going on. " On 06/30/16 at 10:46 AM, MA #1 stated that she thought that when she was preparing the Clonidine patch that it was already there with the foam covering. Medication Aide #1 stated that she was aware that there were 2 patches with the Clonidine, one that contained medication and one that was used to hold the medicated patch in place. MA #1 stated, " I just got mixed up. " 1b. Review of a physician order dated 08/22/14	F 333	who was observed committing the alleged deficient practice was re-educated by the SDC on 7/6/2016. 3. The Certified Medication Aide who was observed committing the alleged deficient practice was given a re-education course which included competency pre and post tests, review of medication management for Medication aides, and medication pass evaluation. This education was completed on 7/6/2016. The SDC will do med pass observations once per month with random Certified Medication Aides and licensed nurses. Education will be provided as needed. 4. Measures to ensure that corrections are achieved and sustained include: The results of these observations will be submitted to the QAPI committee by the DON for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. 5. Date of compliance is 7/28/2016.	

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read Amlodipine (medication to control blood pressure) 5 mg give 2 tablets by mouth one time a day.
On 06/29/16 at 9:30 AM MA #1 was noted to check Resident #109's blood pressure which was 176/77.
On 06/29/16 at 9:40 AM MA #1 was observed preparing medications for Resident #109. MA #1 pulled out a card of medication that was labeled with Resident #109's name, room number and directions for administration. The directions read, Amlodipine 5 mg by mouth, give 2 tablets one time daily. The MA took the card and punched one Amlodipine 5 mg tablet into a medication cup and returned the card to the appropriate drawer on the medication cart and then locked the medication cart.
On 06/29/16 at 9:43 AM, MA #1 entered resident #109's room to administer the Amlodipine 5 mg by mouth one tablet. Resident #109 took the medication cup and swallowed the one tablet of Amlodipine.
Interview on 06/29/16 at 11:28 AM with the Unit Coordinator for A wing revealed that if the MAs have any questions about medications they are to immediately go to the nurse or herself. The MAs are expected to administer medications as prescribed and give the correct dose of medication.
Interview on 06/29/16 at 12:01 PM with the Director of Nursing (DON) revealed that she expected the staff to administer medications exactly as prescribed and if the MAs had any questions they were to immediately go the nurse or to the unit coordinator.
Interview on 06/29/16 at 12:26 PM with Medical Doctor (MD) #1 revealed that Resident #109 ' s blood pressure had been running high. The MD stated she would reevaluate Resident #109's

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F 333	Continued From page 20 medication and that maybe she would use this error with the Amlodipine to possibly change the medicine. MD #1 stated she expected the staff to administer the medications exactly as prescribed. MD #1 stated "Thank you for letting me know about this. Without you, I would not know what was really going on." On 06/30/16 at 10:46 AM, MA #1 stated that she knew Resident #109 received 2 Amlodipine tablets and that she had always given her 2, but yesterday "I got mixed up." MA #1 then stated that the MD had changed some of Resident #109's medications and the Amlodipine had been stopped.	F 333		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		7/28/16

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F 431	Continued From page 21 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, policy review, and staff interviews the facility failed to remove expired medications from 1 of 3 medication carts (100 hall Medication Aide cart), 1 of 2 medication room (A wing Medication Room), and 1 of 1 central supply closet. The findings included: 1a. An observation on 06/30/16 at 11:15 AM of the 100 Hall Medication Aide Cart revealed one box of Duoneb (inhaled medication) that expired 05/16 and a card of Ibuprofen 600 milligrams (mg) that contained 15 tablets that expired 04/30/16. Interview with Medication Aide #1 on 06/30/16 at 11:15 AM stated that she would make sure the expired medication was returned to the pharmacy. b. An observation of A Wing Medication Room on 06/30/16 at 11:00 AM revealed a bottle of liquid pain relief that expired 05/16 and 3 opened undated vials of Tuberculin Serum. Interview with the Unit Coordinator on 06/30/16 at 11:00 AM revealed that the Tuberculin Serum	F 431	F431 D This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is our facility policy that drugs and biological be stored properly. 1. Corrective action was accomplished for the alleged deficient practice by the Unit Manager discarding all identified expired drugs on 6/30/2016 from the 100 hall Medication Aide cart and the A Wing Medication Room. The Central supply clerk discarded all identified expired drugs from the central supply store room on	

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	345243	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 22 vials are good for 30 days after opening but was unaware of when they were opened. The Unit Coordinator stated that the vials should have been dated when opened and they would be discarded. c. An observation of Central Supply Closet on 06/30/16 at 12:00 PM revealed the following: · 3 bottles of Enteric Coated Baby Aspirin that expired 3/16. · 1 bottle of Enteric Coated Baby Aspirin that expired 1/16. · 3 bottles of Coenzyme Q 10 50 milligrams (MG) that expired 3/16. · 6 bottles of Vitamin B complex that expired 3/16. · 2 bottles of Niacin 250 mg that expired 3/16. Interview with Central Supply Clerk on 06/30/16 at 12:00 PM revealed that when she puts up the stock she rotates the oldest to the front to be used first and puts the newest at that back of the cabinet. The Central Supply Clerk also stated that on the last day of the month she goes through the cabinets and checked expiration dates and rotated the stock, she further stated that she had gone through the cabinets in the middle of June 2016. The Central Supply Clerk stated that she was also responsible for staffing of the nursing department and they had a lot of turn over and this had been "a rough month" for her. Interview with the Director of Nursing (DON) on 06/30/16 at 3:49 PM revealed that the medication carts and rooms are basically checked once a week by the nursing staff at the facility. The DON also stated that the pharmacy came in once a month to check the medication carts and medication rooms. The DON stated she expected that all expired medication to be removed from the medication carts and rooms and returned to the pharmacy.	F 431	6/30/16. 2. All residents have the potential to be affected by this alleged deficient practice. An audit of all medication storage rooms, refrigerators and medication carts was conducted by the ADON and Unit Managers and completed on 6/30/2016. All expired and unlabeled items were discarded immediately. 3. The DON re-educated the supply clerk on 6/30/2016 regarding storage of medications. The DON, ADON, and Unit Managers educated the licensed nurses regarding storage and labeling of medications including insulins and PPD solution and discarding any resident specific items that are expired. This education was completed by 7/22/2016. The DON, ADON, SDC or Unit Managers will audit medication storage rooms, refrigerators and medication carts three times per week for twelve weeks to verify medication storage per policy. Opportunities will be corrected as identified. 4. Measures to ensure that corrections are achieved and sustained include: The results of the audits will be presented to the QAPI committee monthly for three months by the DON. The QAPI committee will evaluate the effectiveness and amend as needed. 5. Date of compliance is 7/28/2016.	

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F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in June, 2015. This was for a recited deficiencies which was originally cited during the facility's current recertification survey completed on 05/22/15. The deficiencies were in the areas of	F 520	F520 E This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of	7/28/16

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F 520	Continued From page 24 Minimum Data Set (MDS) accuracy and the provision of assistance with activities of daily living. The facility also failed to maintain implemented procedures and monitor these interventions the committee put into place in October, 2015. This was for a recited deficiency cited on a complaint investigation survey completed on 09/29/15. The deficiencies were in the area of MDS accuracy and ineffectiveness of the facility's Quality Assurance Program. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 278: Based on staff interviews, and record review, the facility failed to accurately code the Minimum Data Set regarding bowel continence (Resident #95) for 1 of 22 sampled residents. F 312: Based on observations, interviews and record review, the facility failed to provide nail care to 3 of 3 sampled residents (Residents #60, #99 and #36). The facility was recited for F 278 regarding failure to accurately code the MDS regarding bowel continence. F 278 was originally cited during a survey completed on 05/22/15 for inaccuracy regarding hospice care services. The facility was recited during a survey completed on 09/29/15 for inaccurate coding of pressure relieving devices. The facility was recited for F 312 regarding failure to provide nail care. F 312 was originally cited	F 520	correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This facility□s goal is to have an effective QAPI committee. 1. Corrective action was accomplished by the Administrator for the alleged deficient practice at the monthly QAPI meeting on 7/21/16 where the outcomes of the 6/30/16 survey were discussed, and the failure to sustain an effective Quality Assurance program in the areas of MDS coding and nail care was also discussed. The IDT reviewed the previous citations, the current citations, and the proposed plan of correction for the survey ending 6/30/16 2. All residents whose bowel function is coded on the MDS have the potential to be affected by this alleged deficient practice. An audit of MDSs for the preceding quarter is being completed between 7/1/2016 and 7/28/2016 by the MDS Coordinator to ensure there are no MDS with not rated in the bowel section. Any MDS found to be coded in this section inaccurately will be corrected. All residents requiring assistance with nail care have the potential to be affected by this alleged deficient practice. The Director of Nursing, the Assistant Director of Nursing and/or the Unit Managers completed an audit of residents requiring assistance with nail care to ensure nail care was completed as required according to the resident□s preferences.	

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F 520	Continued From page 25 during a survey completed on 05/22/15 for failure to provide nail care. The facility was recited for F 520 regarding the facility's Quality Assessment and Assurance Committee's failure to maintain implemented procedures and monitor the interventions regarding MDS accuracy. The facility was originally cited during a survey completed on 09/29/15 for failure to sustain an effective Quality Assurance Program. Interview with the Administrator on 06/30/16 at 4:12 PM revealed the facility's Quality Assessment and Assurance Committee monitored the MDS for accuracy. The Administrator reported resident care, which included provision of assistance with activities of daily living, received monitoring with problems addressed when identified.	F 520	The audit was completed by 7/20/2016. 3. . The District Director of Clinical Services is conducting a re-education for the Administrator and Director of Nursing on the facility□s Quality Assurance and Performance Improvement programs including identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity. All members of the QAPI committee submit data related to each department and participate in the identification of areas in need of improvement. To be completed by 7/28/16. 4. Measures to ensure that corrections are reviewed and sustained include: Weekly audits of the MDS for correct coding of bowel function, weekly audits of nail care, review of the audits at the weekly Risk committee meeting, and submission of the audits to the QAPI committee for review. The QAPI committee will evaluate effectiveness and amend as needed. 5. Date of compliance is 7/28/16.	