STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, resident and staff interviews, the facility failed to provide incontinence care, resulting in neglect, for 1 of 1 resident (Resident #165) who was in need of personal care assistance. The findings included: Resident #165 was admitted to the facility on 01/26/16 with diagnoses including lung disease, respiratory failure, high blood pressure, and anxiety. The admission Minimum Data Set (MDS) dated 02/02/16 indicated Resident #165 was alert and oriented with mild cognitive impairment. The MDS also indicated Resident #165 required extensive assistance with bed mobility, toileting, hygiene, and dressing. The quarterly MDS dated 04/21/16 indicated the cognitive impairment was resolved and Resident #165 had no short or long term memory problems. During an observation of Resident #165 on 07/28/16 at 1:54 PM, Resident #165 stated she was awakened that morning around 2:30 AM by the Nurse (N #1) who gave her medicine. Resident #165 stated she recognized she was wet and asked if she could be changed. Resident #165 stated that N #1 said ok and left the room.	F 224	Valley Nursing Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of qualify of care of residents. The plan of correction is submitted as a written allegation of compliance. Valley Nursing Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further Valley Nursing Center reserves the right to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or administrative or legal proceedings. F224 483.13(c) Prohibit Mistreatment/Neglect/Misappropriation It is the policy of this facility to prohibit	8/19/16

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

Electronically Signed | 08/19/2016

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F 224	Continued From page 1 Resident #165 stated she fell back to sleep and was awakened by Nurse Aide (NA #1) at 7:45 AM. Resident #165 stated NA #1 had brought in her breakfast tray. Resident #165 stated she asked to be changed before breakfast as she had the sensation of having a wet brief and could also feed the dampness on the lower edges of the back of her shirt. Resident #165 stated NA #1 stated she could not be changed then because they were passing out breakfast trays and her roommate had already received hers. Resident #165 stated she was not given the option to be changed or to wait on breakfast until after she was changed, but had to eat breakfast in a wet brief. An interview with NA #1 on 07/28/16 at 2:33 PM revealed NA #1 was asked by Resident #165 to be changed before she ate her breakfast. NA #1 stated she had already given a breakfast tray to the roommate of Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 she would need to wait until trays had been passed out. NA #1 acknowledged she had been told by upper management if a tray was in the room they were not allowed to change anyone. An interview with NA #2 on 07/28/16 at 2:54 PM revealed NA #2 assisted NA #1 with incontinence care for Resident #165 after breakfast. NA #2 stated that Resident #165 told her that she had been wet for a while and had to eat breakfast in a wet brief. NA #2 stated she was told when she first started working at the facility, they were not allowed to change a resident if there were trays on the halls or trays in resident's rooms because it was unsanitary to do that. During an interview with Resident #165 on 07/29/16 at 8:32 AM, Resident #165 was asked about how felt about not being changed before	F 224	mistreatment, neglect, and abuse of resident and misappropriation of resident property. 1. Corrective Action taken for residents affected by alleged deficient practice: Resident #165 was provided incontinence care by NA#1 and NA#2 and both NA #1 and NA #2 were told by the DON that staff is expected to provide timely incontinence care to every resident as soon as possible even if meals were being served. 2.Corrective action for residents having the potential to be affected by alleged deficient practice: A) Administrative Nurses made rounds on each hall on 7/29/16 to ensure that any resident who requested or needed incontinence care received timely incontinence care. B) On 08/01/16, the Social Workers interviewed each interviewable resident, who requires incontinence care, to determine if there were other residents with similar issues of receiving timely care after requesting the care, even if it was during a meal. No other resident expressed a problem with this issue. 3. Measures put in place or systemic changes made to ensure deficient practice will not occur: In-Service training for all staff was initiated by the DON on 7/29/16 to ensure that all	

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F 224	Continued From page 2 breakfast yesterday. Resident # 165 started crying and stated that she just wasn't being taken care of as well since she had been moved off the ventilator unit. Review of completed care tasks for the morning of 07/28/16 indicated NA #2 had documented an incontinent episode at 3:49 AM for Resident #165. A second interview with NA #2 on 07/29/16 at 1:08 PM revealed NA #2 stated she didn't know what had actually happened with Resident #165 the 4 hours before she came into work. NA #2 stated NA #3 reported off to her before leaving at 3:00 AM that morning and had not expressed any concerns or tasks needed to be completed for Resident #165. NA #2 stated she signed off Resident #165 was incontinent, but did not actually provide incontinence care until after breakfast that morning. During an interview with the Director of Nursing (DON) on 07/29/16 at 1:19 PM, the DON acknowledged it was her expectation for a resident that was soiled to be changed when they asked to be changed. During a phone interview with NA #3 on 07/29/16 at 1:55 PM, NA #3 indicated she was not aware that Resident #165 was wet and needed to be changed before she left her shift at 3:00 AM. Attempts to contact N #1 were not successful.	F 224	staff are aware to provide timely incontinence care to all residents in every circumstance when they are made aware of the need for such care, including when meal trays are being served. This in-service training was completed for 100% of full-time and part-time Nurses and CNAs by the Quality Improvement / Staff Development Nurse on 8/19/16. 4. Indicate how facility plans to monitor its performance to make sure solutions are sustained and how the plan will be implemented and corrective actions evaluated for effectiveness and integrated into QA system: Beginning 08/15/16 the Quality Improvement/Staff Development Nurse will conduct audits / interviews of residents to ensure timely incontinence care is being provided to residents at all times. These audits are being conducted on 10 random residents each week X 4 weeks, then 10 residents each month X 3 months, then 10 residents each quarter for 2 consecutive quarters. The Quality Improvement/Staff Development Nurse will report the results of these audits to the Director of Nursing for review. Any issues or concerns will be addressed at the time of occurrence. Results of the monitor/audits will be reported by the Quality Improvement/Staff Development Nurse in the monthly Quality Assurance Performance Improvement	

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F 224	Continued From page 3	F 224	meetings. The results will be reviewed and discussed and the QAPI committee will assess and modify the action plan as needed to ensure continued compliance with F224.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, resident and staff interviews, the facility failed to maintain the dignity for 2 of 4 residents by allowing a resident to eat breakfast in a wet brief (Resident #165) and allowing a resident to be fed while staff was standing over them (Resident #56). The findings included: 1. Resident #165 was admitted to the facility on 01/26/16 with diagnoses including stroke, lung disease, respiratory failure, high blood pressure, and anxiety. The admission Minimum Data Set (MDS) dated 02/02/16 indicated Resident #165 was alert and oriented with mild cognitive impairment. The MDS also indicated Resident #165 required extensive assistance with bed mobility, toileting, hygiene, and dressing. The MDS further indicated she had an indwelling urinary catheter and was incontinent of bowel. The quarterly MDS dated 04/21/16 indicated the cognitive impairment was resolved and Resident #165 had no short or long term memory	F 241	F241 483.15(a) Dignity and Respect of Individuality It is the policy of this facility to care for our residents in a manner that maintains or enhances dignity and respect in full recognition of his/her individuality. 1. Corrective Action taken for residents affected by alleged deficient practice: 1.) Resident #165 was provided incontinence care by NA#1 and NA#2 immediately after she ate her breakfast. Both NA #1 and NA #2 were informed by the DON that staff is expected to provide timely incontinence care to every resident as needed, even if meals were being served. 2.) Resident #56 was fed her next meal on 7/29/16 with the CNA seated in a chair beside her. The DON reminded	8/19/16

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F 241	Continued From page 4 problems. Review of nurse's notes indicate Resident #165 was admitted to the facility with an indwelling catheter. An attempt to remove the catheter was successful in May 2016, although Resident #165 remained frequently incontinent of urine. During an observation of Resident #165 on 07/28/16 at 1:54 PM, Resident #165 stated she was awakened that morning by Nurse Aide (NA #1) at 7:45 AM. Resident #165 stated NA #1 had brought in her breakfast tray. Resident #165 stated she asked to be changed before breakfast as she had the sensation of having a wet brief and could also feed the dampness on the lower edges of the back of her shirt. Resident #165 stated NA #1 stated she could not be changed then because they were passing out breakfast trays and her roommate had already received hers. Resident #165 stated she was not given the option to be changed or to wait on breakfast until after she was changed, but had to eat breakfast in a wet brief. An interview with NA #1 on 07/28/16 at 2:33 PM revealed NA #1 was asked by Resident #165 to be changed before she ate her breakfast. NA #1 stated she had already given a breakfast tray to the roommate of Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 she would need to wait until trays had been passed out. NA #1 acknowledged she had been told by upper management if a tray was in the room they were not allowed to change anyone. An interview with NA #2 on 07/28/16 at 2:54 PM revealed NA #2 assisted NA #1 with incontinence care for Resident #165 after breakfast. NA #2 stated that Resident #165 told her that she had been wet for a while and had to eat breakfast in a wet brief. NA #2 stated she was told when she	F 241	both NA #1 and NA #2 to be seated when feeding residents in the chairs provided. 2. Corrective action for residents having the potential to be affected by alleged deficient practice: 1.) Administrative Nurses made rounds on each hall during all meals on 7/29/16 to ensure that any resident who requested or needed incontinence care prior to or during meals, received timely incontinence care. 2.) Administrative Nurses made rounds on each hall during meals on 7/29/16 to ensure that staff was seated on chairs while feeding all residents. No observations of staff standing while feeding were made. 3. Measures put in place or systemic changes made to ensure deficient practice will not occur: In-Service training for all staff was initiated by the DON on 7/29/16. The in-service topics included: 1.) Staff are required to provide timely incontinence care to all residents in every circumstance when they are made aware of the need for such care, including when meal trays are being served. 2.) Staff are to be seated beside residents when feeding in the chairs provided and to obtain a folding chair from the day room or from the break room in the event the in room chair is unavailable. This in-service was completed for 100%	

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F 241	Continued From page 5 first started working at the facility, they were not allowed to change a resident if there were trays on the halls or trays in resident's rooms because it was unsanitary to do that. During an interview with Resident #165 on 07/29/16, Resident #165 was asked about how felt about not being changed before breakfast yesterday. Resident # 165 started crying and stated that she just wasn't being taken care of as well since she had been moved off the ventilator unit. During an interview with the Director of Nursing (DON) on 07/29/16 at 1:19 PM, the DON acknowledged it was her expectation for a resident that was soiled to be changed when they asked to be changed. 2. Resident # 56 was admitted to the facility on 02/27/09 with diagnoses that included hypertension, Alzheimer's disease, anxiety, and cerebrovascular disease. Review of the most recent quarterly minimum data set (MDS) dated 07/03/16 revealed that Resident # 56 was severely cognitively impaired and required total assistance of one staff member with eating. The MDS also revealed no behaviors were present and no rejection of care was present. Observation and interview with Nursing Assistant (NA) #1 on 07/26/16 at 12:32 PM revealed NA #1 standing beside the bed feeding Resident # 56	F 241	of full-time and part-time Nurses and CNAs by the Quality Improvement/Staff Development Nurse on 8/19/16. 4. Indicate how facility plans to monitor its performance to make sure solutions are sustained and how the plan will be implemented and corrective actions evaluated for effectiveness and integrated into QA system: The Quality Improvement/Staff Development Nurse began conducting audits / interviews of randomly chosen residents on 07/29/16. These audits / interviews are to ensure: 1.) The staff is providing timely incontinence care and toileting to residents at all times to include during meals if needed. 2.) The staff is seated in a chair when feeding residents to promote a pleasant dining experience. These audits are being conducted on 10 random residents each week X 4 weeks, then 10 residents each month X 3 months, then 10 residents each quarter for 2 consecutive quarters. The Quality Improvement / Staff Development Nurse will report the results of these audits / interviews to the Director of Nursing for review. Any issues or concerns will be noted and addressed at the time of occurrence. Results of the monitor/audits will be reported by the Quality Improvement/Staff	

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F 241	Continued From page 6 with the spoon going in a downward motion to the residents mouth. NA#1 stated she worked with Resident # 56 most days and fed her meals quite frequently. There was a high back winged chair noted in the corner of the room. Observation of NA #1 on 07/27/16 at 12:51 PM standing beside the bed feeding Resident #56 with the spoon going in a downward motion to the residents mouth. There was a high back winged chair noted in the corner of the room. Observation of NA #2 on 07/28/16 at 8:14 AM standing beside the bed feeding Resident # 56 with the spoon going in a downward motion to the residents mouth. There was high back winged chair noted in the corner of the room. Interview with NA #1 on 07/28/16 at 2:51 PM revealed that she had worked at the facility for 3 years and routinely fed Resident # 56 her meals. NA #1 stated that they have been told that they were supposed to feed residents while sitting beside the resident. NA #1 stated that if there was a chair available she would slide it up to the bed or table to feed the resident, NA#1 also stated that if there was no chair available she would just stand up next to the resident to feed them. NA#1 stated that there was no chair available to sit in when she fed Resident #56. Interview with Director of Nursing (DON) on 07/29/16 at 10:06 AM revealed that she expected the staff to obtain either a high back winged chair or a folding chair to sit down in while feeding a resident to make the meal as pleasant as possible. Interview with the Assistant Administrator (AA) on 07/29/16 at 10:42 AM revealed that if the nursing staff could safely sit and feed the resident then she would expect them to do so.	F 241	Development Nurse in the monthly Quality Assurance Performance Improvement meetings. The results will be reviewed and discussed and the QAPI committee will assess and modify the action plan as needed to ensure continued compliance with F241.	
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		8/19/16

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F 318 SS=D	Continued From page 7 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: Based on observations, record reviews, resident and staff interviews the facility failed to apply a sling and hand brace to prevent worsening contractures for 1 of 3 residents sampled for range of motion. (Resident #108) The findings included: Resident #108 was admitted to the facility on 07/06/12 and readmitted to the facility on 05/06/16 with diagnoses that included cerebrovascular accident, hemiplegia, arthritis, and osteoporosis. Review of the most recent comprehensive minimum data set (MDS) dated 05/13/16 revealed that Resident #108 was cognitively intact and required extensive assistance of 2 staff members for bed mobility, transfers, dressing, and toileting. The MDS further revealed that Resident #108 required extensive assistance of one staff member for eating and had an impairment to one upper and lower extremity. The MDS also revealed that no behaviors or rejection of care was noted. Review of a physician order dated 5/6/16 read "sling to stroke affected side when out of bed, document refusal." Review of a physician order dated 07/07/16 read	F 318	F318 483.25(e)(2) Increase/Prevent Decrease in Range of Motion It is the policy of this facility to provide appropriate treatment and services to increase range of motion and/or to prevent further decline in range of motion. 1. Corrective Action taken for residents affected by alleged deficient practice: RA #1 applied sling and brace to resident #108 on 7/29/16, per the residents plan of care. 2. Corrective action for residents having the potential to be affected by alleged deficient practice: Administrative Nurses made rounds on all halls on 07/29/16 to ensure that all residents who□s plan of care included devices to prevent decline in/or improve range of motion, had them in place unless it was documented that the resident had refused such application for the day.	

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F 318	Continued From page 8 "documents skin condition to left hand shoulder due to daily brace and sling use." Review of a restorative nursing referral dated 07/07/16 read, in part, resident needed assistance with left hand brace and sling to left upper extremity. Plan of care was initiated. Review of medication administration record (MAR) dated 07/01/16 through 07/31/16 read Sling to stroke affected side when out of bed and document any refusals. It was initialed by nursing staff daily from 07/01/16 through 07/30/16 indicating that the sling had been applied. Review of MAR dated 07/01/16 through 07/31/16 read document skin condition to left hand and shoulder due to daily brace and sling use. It was initiated by nursing staff daily from 07/01/16 through 07/30/16. Review of a facility document titled "Restorative Therapy Minutes 3.0 Roster" dated 07/01/16 through 07/28/16 indicated that on 07/26/16 through 07/28/16 15 minutes each day had been provided to Resident #108 for splint or brace assistance. Observation of Resident #108 on 07/26/16 at 1:29 PM revealed she was up in geri-chair at bedside. Resident #108's left hand was contracted into a ball and she was unable to open it. There was no sling or brace to Resident #108's left upper extremity. Observation of Resident #108 on 07/27/16 at 11:48 AM revealed she was up in geri-chair in the dining room. Resident #108's left hand was contracted into a ball and she was unable to open it. There was no sling or brace to Resident #108's left upper extremity. Observation of Resident #108 on 07/28/16 at 9:26 AM revealed she was up in geri-chair at bedside. Resident #108's left hand was contracted into a ball and she was unable to open	F 318	All other residents had their devices in place. 3. Measures put in place or systemic changes made to ensure deficient practice will not occur: In-Service education provided for the Restorative Nursing Aides by the ADON on 08/01/16. This training was on ensuring proper application and documentation of orthotic devices as per the plan of care, and to report any missing or ill-fitting devices to the ADON in order to facilitate timely and proper interventions. The Therapy Director ordered additional orthotic devices to have available on hand if needed while others are being laundered. In-Service training initiated by the DON on 07/29/16 for all Nurses and CNAs on the importance of following the residents plan of care for all orthotic devices in order to increase range of motion and/or to prevent further decline in range of motion and to immediately report any missing or ill-fitting devices to the ADON for intervention. This in-service was concluded for 100% of full-time and part-time Nurses, CNAs, and Restorative CNAs, by the Quality Improvement/Staff Development Nurse on 8/19/16. 4. Indicate how facility plans to monitor its	

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F 318	Continued From page 9 it. There was no sling or brace to Resident #108's left upper extremity. Observation of Resident #108 on 07/28/16 at 12:09 PM revealed she was in geri-chair at bedside. Resident #108's left hand was contracted into a ball and she was unable to open it. There was no sling or brace to Resident #108's left upper extremity. Interview with Nursing Assistant (NA) #2 on 07/28/16 at 9:43 AM revealed that Resident #108 required total assistance all aspects of ADLs due to her stroke that affected her left side. NA#2 stated that when they dressed Resident #108 they stretched her left arm out as much as possible but other than that they did not do anything with her left arm or hand because she hollered in pain. NA#2 stated that Resident #108 was not receiving any therapy that she was aware of. Interview with the Assistant Director of Nursing (ADON) on 07/28/16 at 3:30 PM revealed that Resident #108 was on restorative caseload and was receiving a sling and hand brace to her left upper extremity while out of bed as much as tolerated. The ADON stated that if the resident refused the sling or brace it would be documented in the electronic medical record, after reviewing the documentation confirmed that Resident #108 had not refused either the sling or brace. The ADON also stated that she met with the 3 restorative aides on a regular basis and during those meeting they had never mentioned to her that Resident #108 had refused her sling or brace. Observation and Interview with Resident #108 on 07/29/16 at 9:36 AM revealed she was up in geri-chair at bedside. Resident #108's left hand was contracted into a ball and she was unable to open it. There was no sling or brace to Resident	F 318	performance to make sure solutions are sustained and how the plan will be implemented and corrective actions evaluated for effectiveness and integrated into QA system: The Quality Improvement/Staff Development Nurse began conducting audits of residents who□s plan of care includes the use of devices to Increase/Prevent Decrease in Range of Motion on 08/01/2016. These audits are to ensure that residents have devices in place, per their individualized plan of care, to increase/prevent decrease in Range of Motion. These audits are being conducted on 10 random residents each week X 4 weeks, then 10 residents each month X 3 months, then 10 residents each quarter for 2 consecutive quarters. The Quality Improvement/Staff Development Nurse will report the results of these audits to the Director of Nursing for review. Any issues or concerns will be noted and addressed at the time of occurrence. Beginning 8/5/16, the Therapy department is auditing all residents who uses orthotic devices to ensure the devices are available and in good repair. These audits will be completed weekly X 8 weeks, then every other week X 8 weeks, and then continue on a quarterly basis thereafter. The Therapy Director will	

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F 318	Continued From page 10 #108's left upper extremity. Resident #108 stated that sometimes the staff would put a sling on her left arm, she could not recall the last time they had applied the sling or brace to her left extremity. Resident #108 stated that she could not tell if the sling helped or not but stated that when the staff came to put the sling and brace on she did not refuse, she would let them put it on her left upper extremity. Resident #108 stated that when they would apply the sling she would holler in pain but as soon as they were done applying it, the pain would subside. Interview with the Director of Nursing (DON) on 07/29/16 at 10:03 AM revealed that if Resident #108 had an order for a sling and brace to her left upper extremity then she would expect it to be in place and worn as ordered. Interview with the Assistant Administrator (AA) on 07/29/16 at 10:39 AM revealed that if Resident #108 had an order for a sling and brace to her left upper extremity then she expected the order to be followed through with and applied as ordered. Interview with Restorative Aide (RA) #1 on 07/29/16 at 2:09 PM revealed that Resident #108 was on her caseload for range of motion and sling and brace to her left upper extremity. RA #1 stated that Resident #108's sling and brace had been in the laundry yesterday and that is why she had not had them on. RA #1 stated she went earlier today and got Resident #108 a new sling and brace for her left upper extremity and they were in place. RA #1 also confirmed that Resident #108 did not refuse her treatment but did scream in pain but tells them to go ahead and put it on.	F 318	address any issues identified during this audit. Results of the audits will be reported by the Quality Improvement/Staff Development Nurse in the monthly Quality Assurance Performance Improvement meetings. The results will be reviewed and discussed and the QAPI committee will assess and modify the action plan as needed to ensure continued compliance with F318.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		8/19/16

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F 329	Continued From page 11 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner interviews, the facility failed to follow the physician's order to discontinue a medication for 1 of 6 of sampled residents (#125) reviewed for unnecessary medications. This resulted in an unnecessary continued administration of an antipsychotic to Resident #125 for 1 day. The findings included: Resident #125 was admitted to the facility on 01/25/2016 with diagnoses which included Alzheimer's disease, Parkinson's disease, anxiety	F 329	F329 483.25(l) Drug regimen is Free from Unnecessary Drugs It is the policy of this facility for all residents to be free from unnecessary drugs. 1. Corrective Action taken for residents affected by alleged deficient practice: Resident # 125 was discharged from this	

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F 329	Continued From page 12 disorder, schizophrenia, and dementia. Resident #125 was discharged on 02/24/2016. The most recent Minimum Data Set (MDS) dated 02/01/16 coded Resident #125 with moderately impaired cognition and requiring extensive assistance with one to two person assist for activities of daily living. Review of the Physician's Order Sheet (POS) signed by the physician on 01/30/2016 indicated Risperdal 0.5 milligram (mg) orally disintegrated tablet (ODT), one tablet sublingually twice daily was ordered for psychosis and aggression/dementia. Review of the POS signed by the physician on 02/10/2016 revealed Risperdal 0.5 mg ODT, one tablet sublingually twice daily was ordered to be discontinued on 02/10/2016. According to the POS, the above order was transcribed by Nurse #2 on 02/11/2016 at 4:43 AM. Review of the Medication Administration Records (MAR) from 01/30/2016 to 02/29/2016 revealed Resident #125 had received Risperdal 0.5 mg ODT two times daily from 01/30/2016 to 02/10/2016. In addition, Resident #125 also received the morning dose of Risperdal 0.5 mg ODT on 02/11/2016 at 9:00 AM. Review of nurse's notes and physician orders from 01/25/2016 to 02/24/2016 did not indicate any verbal or written orders from the physician to extend the above order beyond 02/10/2016. In an interview conducted on 07/29/2016 at 3:56 PM, Nurse #3 stated that she had administered Risperdal 0.5 mg ODT to Resident #125 on 02/11/2016 at 9:00 AM. She did not know the above order was discontinued as it showed up in the computer during the morning medication administration. She added once a stop order was entered into the facility's computer system, the order would be discontinued instantly. She further	F 329	facility on 02/24/16. No further doses of the Risperdal that was discontinued on the evening of 02/10/16 was given after the one identified dose that was given on the morning of 02/11/16. 2. Corrective action for residents having the potential to be affected by alleged deficient practice: On 08/01/16, Administrative Nurses audited all Physicians Orders (green slips) that had been written to discontinue medications for the month of July to ensure that all Stop Orders had been entered timely and the medication had been stopped as ordered. There were no other issues identified by that audit. 3. Measures put in place or systemic changes made to ensure deficient practice will not occur: In-Service education provided by the DON on timely Physician□s Order entry and ensuring that timely and accurate stop date is entered when medication is discontinued. This in-service was initiated on 07/29/16 for all Nurses then the Quality Improvement/Staff Development Nurse completed the training for Medication Aides, Medical Records staff and remaining full-time and part-time Nurses. Training was completed for 100% of full-time and part-time Nurses and Medical Records staff on 08/19/16. 4. Indicate how facility plans to monitor its	

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F 329	Continued From page 13 stated that the nurse who had transcribed the above stop order might have failed to input the order into the computer system in a timely manner. After reviewing the physician's orders for Resident #125's Risperdal in MAR and POS, Nurse #3 agreed that the Risperdal should have been discontinued after 02/10/2016. An interview was conducted with the Director of Nursing (DON) on 07/29/16 at 4:00 PM. She stated that it was her expectation for all nurses to transcribe physician's orders into the computer system correctly and in a timely manner. In this case, she believed that Nurse # 2 had failed to input the above stop order into the system in a timely manner as the order still existed on 02/11/2016 at 9:00 AM. All nurses who transcribed physician's orders into the system were expected to record the exact time of transcription. According to DON, Nurse # 2 was no longer working in the facility. After reviewing the physician's orders, the DON agreed that Resident #125's antipsychotic therapy with Risperdal should have been discontinued after 02/10/2016. In an interview conducted on 07/29/2016 at 4:13 PM, the Nurse Practitioner agreed that the Risperdal dose on 02/11/2016 at 9:00 AM should not be administered. She stated that the nurse who transcribed the order failed to enter the order into the system in a timely manner. It was her expectation for all the nursing staff to execute her order correctly and in a timely manner.	F 329	performance to make sure solutions are sustained and how the plan will be implemented and corrective actions evaluated for effectiveness and integrated into QA system: The Quality Improvement/Staff Development Nurse began conducting audits of Physicians Orders to stop medication (stop orders) on 07/29/16. These audits are to ensure that timely and accurate medication stop dates are entered into the electronic medical record system and to ensure that no medication doses are given after the order to stop has been written. These audits are being conducted on 10 random residents each week X 4 weeks, then 10 residents each month X 3 months, then 10 residents each quarter for 2 consecutive quarters. The Quality Improvement/Staff Development Nurse will report the results of these audits to the Director of Nursing for review. Any issues or concerns will be noted and addressed at the time of discovery. Results of the monitor/audits will be reported by the Quality Improvement/Staff Development Nurse in the monthly Quality Assurance Performance Improvement meetings. The results will be reviewed and discussed and the QAPI committee will assess and modify the action plan as needed to ensure continued compliance with F329.	

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F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family, and staff interviews the facility failed to ensure that all fly reduction measures were effective to prevent fly activity in resident rooms for 2 of 3 residents sampled. (Resident #94 and Resident #108) The findings included: Resident #94 was admitted to the facility on 01/09/13 and readmitted to the facility on 12/23/13 with diagnoses that included anoxic brain injury, pseudobulbar affect disorder (labile affect), and mood disorder. Review of the most recent minimum data set (MDS) dated 05/02/16 revealed that Resident #94 was severely cognitively impaired and required extensive assistance of 2 staff members for bed mobility and dressing. The MDS also revealed that Resident #94 required total assistance of 2 staff members with transfers, toilet use, and personal hygiene and had impairments to one upper and lower extremity. Observation and interview on 07/26/16 at 1:26 PM with Resident #94's family member revealed 2 flies flying around Resident #94's face and mouth. Resident #94's family member was observed swatting the flies with a napkin off of his lunch tray. The family member stated "I try to keep them away from his face and mouth because he can't do that." There was a fly swatter	F 469	F469 483.70(h)(4) Maintains Effective Pest Control Program It is the policy of this facility to maintain an effective pest control program and keep the facility free of pests including flies. 1. Corrective Action taken for residents affected by alleged deficient practice: On 7/29/16 the Environmental Services Director was made aware of the fly problem on the 300 hall in the rooms of residents #94 and #108. She met with housekeeper #1 and made sure she knew to keep her fly swat on the cart and monitor for flies at all times. They then went into the rooms of resident #94 and #108 to eliminate any flies present in those rooms and disinfected the surfaces. 2. Corrective action for residents having the potential to be affected by alleged deficient practice: On 7/29/16, the Environmental Services Director made rounds on each resident hallway and checked all housekeeping carts to ensure that fly swats were	8/19/16

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F 469	Continued From page 15 laying on the dresser at the foot of Resident #94's bed. Observation and interview on 07/27/16 at 11:40 AM with Resident #94's family member revealed 2 flies flying around Resident #94's face and mouth. The family member stated "at times the flies come in here and I keep a fly swatter in here to keep them away from his face and mouth." The family member pointed to the fly swatter laying on the dresser at the foot of Resident #94's bed. Observation of Resident #94 on 07/28/16 at 9:27 AM revealed Resident #94 was up in a chair at bedside and there was a fly flying around his face and mouth. There was a fly swatter laying on the dresser at the foot of Resident #94's bed. Observation of Resident #94's room on 07/28/16 revealed that Resident #94 was not in the room, there was an open cup of thicken liquids sitting on the bedside table with a fly resting on the inside edge of the cup of thicken liquids. Interview with House Keeper #1 on 07/29/16 at 9:07 AM revealed that she was aware of the fly problem in Resident #94's room and she was given a fly swatter to use and to her knowledge that was all the facility was doing about the fly problem. House keeper #1 did not have fly swatter on her cart at that time. Interview with the House Keeping Supervisor on 07/29/16 at 9:23 AM revealed that she was not aware of any problem with flies in the facility. The House Keeping Supervisor stated that if they saw a fly they would kill it with the fly swat that all housekeepers had on their carts. The House Keeping Supervisor stated the pest control company came regularly to the facility and sprayed both inside and outside and that whatever chemical he used covered all types of flying insects including flies.	F 469	available on all carts and that the housekeepers knew to monitor for flies and if observed, to eliminate them on an acceptable surface and then disinfect the surface. There were no other concentrated areas of fly activity observed in the facility at that time. 3. Measures put in place or systemic changes made to ensure deficient practice will not occur: On 08/02/16, the Environmental Services Director provided mandatory in-service training to all Environmental Services staff members on the importance of eliminating flies, keeping swats on carts at all times, acceptable surfaces to swat flies on, and following proper disinfecting procedures afterwards. On 08/05/16 the pest control company technician came to the facility and applied additional Fly Bait treatment outside the facility and the Assistant Administrator obtained additional Fly Light Traps from the pest control company for use inside the facility. On 8/3/16, the Environmental Service Director completed audit on screens on resident room windows on and made adjustments as needed to ensure screens fit well in effort to prevent flies from entering. 4. Indicate how facility plans to monitor its performance to make sure solutions are sustained and how the plan will be	

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F 469	Continued From page 16 Interview with the Assistant Administrator (AA) on 07/29/16 at 10:22 AM revealed that she was not aware any specific problem with flies in the facility. The AA stated that the pest control company came to the facility every 2 weeks and baited the flies with a powder substances, and they have also invested in a "Fliaway" strip that they have placed on the exit doors of the facility. The AA also stated that they had the fans on the outside doors that blow air out when the door is open to keep the flies from flying into the facility. The AA also stated that on the 300 hall flies may be more prevalent because they used the door on that hall to bring in laundry, trash went in/out of that door, and supplies came in through that door. The AA also stated the door on 300 had more in/out activity, plus it was summer time and very hot and humid. The AA stated "they are combating the flies to the absolute best of their ability." 2. Resident #108 was admitted to the facility on 07/06/12 and readmitted to the facility on 05/06/16 with diagnoses that include cerebrovascular accident, hemiplegia, depression and atrial fibrillation. Review of the most recent comprehensive minimum data set (MDS) dated 05/13/16 revealed that Resident #108 was cognitively intact and required extensive assistance of 2 staff members for all activities of daily living (ADL) and had an impairment to one upper and lower extremity. Observation and interview with Resident #108 on 07/26/16 at 2:59 PM revealed Resident #108 lying in bed on her right side, 2 flies were noted on her left leg and hand. Resident #108 kept swatting at them to get the flies off her left leg and hand but the flies kept returning. Resident #108	F 469	implemented and corrective actions evaluated for effectiveness and integrated into QA system: The Environmental Services Director began conducting observation rounds on each hallway on 08/01/16 to ensure and document that housekeeping carts have fly swats available, to observe that fly activity is being addressed timely, and that the current pest control procedure is effective as evidenced by no noticeable fly activity. These rounds will be conducted weekly x 8 weeks, then every other week for 2 months. The Environmental Services Director will report the results of these audits to the Assistant Administrator. Results of the monitor/audits will be reported by the Assistant Administrator in the monthly Quality Assurance Performance Improvement meetings. The results will be reviewed and discussed and the QAPI committee will assess and modify the action plan as needed to ensure continued compliance with F469.	

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stated "they are driving me crazy, I wish they would leave me alone".
Observation and interview with Nursing Assistant (NA) #1 on 07/26/16 at 2:59 PM revealed that there was a fly swatter in Resident #108's room and she used the fly swatter to swat the flies away from Resident #108. NA #1 stated "I don't want to kill the flies on Resident #108 or on her bed." The flies remained in and around Resident #108 during the remainder of interview.
Interview with House Keeper #1 on 07/29/16 at 9:07 AM revealed that she was aware of the fly problem in Resident #108's room and she was given a fly swatter to use and to her knowledge that was all the facility was doing about the fly problem. House keeper #1 did not have fly swatter on her cart at that time.
Interview with the House Keeping Supervisor on 07/29/16 at 9:23 AM revealed that she was not aware of any problem with flies in the facility. The House Keeping Supervisor stated that if they saw a fly they would kill it with the fly swat that all housekeepers had on their carts. The House Keeping Supervisor stated the pest control company came regularly to the facility and sprayed both inside and outside and whatever chemical he used covered all types of flying insects including flies.
Interview with the Assistant Administrator (AA) on 07/29/16 at 10:22 AM revealed that she was not aware any specific problem with flies in the facility. The AA stated that the pest control company came to the facility every 2 weeks and baited the flies with a powder substances, and they have also invested in a "Fliaway" strip that they have placed on the exit doors of the facility. The AA also stated that they had the fans on the outside doors that blow air out when the door is open to keep the flies from flying into the facility.

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F 469	Continued From page 18 The AA also stated that on the 300 hall flies may be more prevalent because they used the door on that hall to bring in laundry, trash went in/out of that door, and supplies came in through that door. The AA also stated the door on 300 had more in/out activity, plus it was summer time and very hot and humid. The AA stated "they are combating the flies to the absolute best of their ability."	F 469		