STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON HEALTH AND REHABILITATION CENTER	820 WELLINGTON AVENUE WILMINGTON, NC 28401

(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 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff, Physician and Physician Assistant interviews, and record review, the facility failed to notify the facility Physician or the	F 157	Resident #3, #4, #11, #19, #20, #33, #34, #35 and #36 attending physician were notified of non-documented/missed	10/30/16

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

Electronically Signed | 10/11/2016

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F 157	Continued From page 1 Physician Assistant that medications were not administered for 10 of 10 residents reviewed for non-documented medications (Res. #3, #4, #11, #19, #20, #30, #33, #34, #35, and #36) in a 48 hour period August 27 - 28, 2016. Findings included: 1. a. Resident #3 was admitted 6/20/2016 with diagnoses of throat cancer, tracheostomy, gastrostomy, chronic obstructive pulmonary disease and depression. A review of the August 2016 Medication Administration Record revealed on 8/28/2016 Resident #3 had one dose of the following medications scheduled at 2:00 PM that were not documented as administered on 8/28/2016: Vitamin B-12, Multivitamin capsule, Zoloft (an antidepressant) 50 milligram (mg), Tylenol 325 mg 2 tablets for pain, and Morphine Sulfate solution 2.5 milliliters (ml) for shortness of breath. A review of nurse notes revealed no notification during this time period to the physician or the physician assistant concerning Resident #3. b. Resident #4 was admitted 8/9/2016 with diagnoses of epilepsy, altered mental status, hypertension, stroke, difficulty speaking and swallowing and dementia. A review of the August 2016 Medication Administration Record revealed: On 8/28/2016 Resident #4 had one dose of the following medications that were not documented as administered: Multivitamin 1 tablet at 9:00 AM, Vitamin C at 9:00 AM, Magnesium Oxide (a supplement) at 8:00 AM, Omeprazole (reduces stomach acid) 20 milligrams (mg) at 9:00 AM, Plavix (an anticoagulant) 75 mg at 9:00 AM and Keppra (to prevent seizures) 500 mg at 8:00 AM.	F 157	medication for the period of August 27 □ 28, 2016 on September 12, 2016. No additional physician orders received. The facility Director of Nursing and/or Designee will complete an audit of facility residents to ensure that the physician was notified of any non documented medications for August 27-28, 2016. The Director of Nursing and/Designee will re- educate facility licensed nurses regarding notification to the resident and/or responsible party and physician of any medications not administered / not documented completed by October 30, 2016. Newly hired licensed nurses will receive the education during orientation. The facility will complete re- education on any licensed nurse that does not receive the reeducation prior to working next scheduled shift. Director of Nursing and/or Designee will perform random audits daily times 2 weeks, weekly times 3 weeks and monthly times 3 to ensure residents have received medications as ordered. The DON will report findings of audits to the Quality Assurance Improvement Committee. The QAPI committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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A review of the nurse notes revealed no documented physical problems or notification of the Physician or Physician Assistant regarding missed medications for this time period.

c. Resident #11 was admitted on 8/17/2016 with diagnoses which included leukemia, heart failure, atrial fibrillation and hypertension.

A review of the August 2016 Medication Administration Record revealed on 8/28/2016 Resident #11 missed one dose of the following medications, Aspirin 81 milligram (mg) chewable at 9:00 AM, Fluticasone nasal spray at 9:00 AM, Multivitamin with minerals at 9:00 AM, Potassium 10 milliequivalents (meq) at 9:30 AM for hypertension, Metoprolol 25 mg at 9:30 AM for hypertension, Amlodipine 5 mg at 9:30 AM for hypertension, Plavix 75 mg at 9:00 AM for anti-platelet clotting, Amiodarone 200 mg at 8:00 AM for heart failure, which were not documented as given.

A review of nurse notes on 8/28/2016 revealed no documentation of any problems with Resident #11 or documentation of notification to the Physician regarding missed medications.

d. Resident #19 was admitted 1/6/2016 with a diagnosis of atrial fibrillation (irregular heart rhythm).

A review of the Medication Administration Record for Res. #19 on 8/28/2016 revealed the daily 8:00 AM of Digoxin (a medication used to control heart rate) 125 micrograms daily was not documented

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as given.

A review of the nurse notes revealed no notification to the Physician or the Physician Assistant concerning the missed medication dose for Resident #19.

e. Resident #20 was admitted on 1/27/2016 with diagnoses of hypertension, diabetes mellitus and bi-Polar disorder.

A review of the August 2016 Medication Administration Record for Resident #20 indicated the following medication doses were not documented as given
Abilify 2 milligram (mg) give 1 by mouth (po) one time a day for bi-polar disorder. The 9:00 AM dose on 8/28/2016 was not documented as given.
Abilify 5 mg give 1 po one time a day with Abilify 2 mg to equal 7 mg for bi-polar disorder. The 9:00 AM dose on 8/28/2016 was not documented as given.
Insulin Detimir (long acting) inject 30 units subcutaneously at bedtime for diabetes. The 11:30 AM and 9:00 PM doses on 8/27/2016 were not documented as given.
Carvedilol 12.5 mg 1 po two times a day for hypertension. The 9:00 AM dose on 8/27/2016 was not documented as given.
Sliding scale insulin given after blood sugar measurement by finger stick before meals and at bedtime. Sliding scale doses at 11:30 AM and 9:00 PM on 8/27/2016, and at 9:00 PM on 8/28/2016 were not documented as given.

A review of the nurse progress notes revealed no documentation regarding notification to the Physician or the Physician Assistant concerning

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missing medications for Resident #20 on 8/27/2016 or 8/28/2016.

f. Resident #30 was admitted on 5/27/2016 with diagnoses of diabetes mellitus, atrial fibrillation and hypertension.

A review of the August 2016 Medication Administration Record revealed:
Bumetanide 2 milligrams (mg) 1 by mouth (po) once daily for congestive heart failure. 8:00 AM dose on 8/27/2016 was not documented as given.
Diltiazem ER (extended release) 300 mg 1 po once daily for atrial fibrillation. 8:00 AM dose on 8/27/2016 was not documented as given.
Toujeo insulin inject 32 units subcutaneously at bedtime for diabetes mellitus. 9:00 PM dose on 8/27/2016 was not documented as given.
Apixaban 5 mg 1 po two times daily for atrial fibrillation. The 8:00 AM dose on 8/27/2016 was not documented as given.
Humalog sliding scale insulin given subcutaneously before meals after blood sugar measurement by finger stick for diabetes mellitus. Insulin doses at 8:00 AM and 12:30 PM on 8/27/2016 were not documented as given.
Humalog insulin inject 6 units subcutaneously three times a day for diabetes mellitus. The 8:00 AM and 12 noon doses on 8/27/2016 and 12 noon dose on 8/28/2016 were not documented as given.

A review of nurse progress notes did not reveal a notification to the Physician or the Physician Assistant concerning Resident #30 not receiving medications.

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g. Resident #33 was admitted 11/25/2013 with diagnoses of hypoxemia, diabetes mellitus, depressive disorder, congestive heart failure and atrial fibrillation.

A review of the August 2016 Medication Administration Record revealed:
Dilacor XR 120 milligrams (mg) give 1 by mouth (po) once daily for CHF. The 9:00 AM dose on 8/27/2016 was not documented as given.
Lantus insulin inject 12 units subcutaneously at bedtime for diabetes mellitus. The 9:30 PM dose on 8/27/2016 was not documented as given.
Lasix 40 mg 1 po once daily for CHF. The 8:00 AM dose on 8/27/2016 was not documented as given.
Eliquis 2.5 mg 1 po twice daily for atrial fibrillation. The 8:30 AM dose on 8/27/2016 was not documented as given.
Humalog insulin given sliding scale after blood sugar check by finger stick was to be administered subcutaneously before meals and at bedtime for diabetes. On 8/27/2016 at 6:30 AM Resident #33 had a blood sugar of 292 (normal blood sugar level for diabetic persons is 70 - 130), and received 4 units of insulin. Insulin at the 11:30 AM, 4:30 PM and 9:00 PM scheduled times was not documented as given.
A review of progress notes revealed no notification to the Physician or Physician Assistant concerning missing medication doses for Resident #33 on 8/27/2016 or 8/28/2016.

h. Resident #34 was admitted on 7/29/2015 with diagnoses of heart failure, diabetes mellitus, hypertension and unspecified convulsions.

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A review of the August 2016 Medication Administration Record revealed:
Lasix 40 milligrams (mg) 1 by mouth (po) in the morning for hypertension. The 9:00 AM dose on 8/27 and 8/28/2016 was not documented as given.
Coreg 6.25 mg 1 po two times a day for hypertension. Obtain blood pressure and pulse reading before administering the medication. The 9:30 AM dose on 8/27 and 8/28/2016 were not documented as medication given or vital signs obtained.
Lantus insulin inject 52 units subcutaneously two times a day for diabetes. The 9:30 AM and the 9:30 PM doses on 8/27 and 8/28/2016 were not documented as given.
Humalog insulin inject 18 units subcutaneously three times a day for diabetes mellitus. The 8:00 AM and the 12:30 PM doses on 8/27 and 8/28/2016 were not documented as given.
Keppra 750 mg 1 po three times a day related to convulsions. The 9:30 AM and the 1:30 PM doses on 8/27 and 8/28/2016 were not documented as given.
Humalog insulin on a sliding scale was ordered with a blood sugar measurement by a finger stick. The insulin was to be injected subcutaneously before meals and at bedtime for diabetes mellitus. On 8/27/2016 the 9:30 PM blood sugar was not obtained and no insulin was documented as given. On 8/28/2016 the 12:30 PM insulin and the 9:30 PM insulin were not documented as given.

There was no documentation in the nurse notes of the Physician or Physician Assistant being notified concerning missing medications.

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i. Resident #35 was admitted 4/20/13 with diagnoses including stroke, diabetes mellitus and high blood pressure.

A review of the August Medication Administration Record revealed:
Amlodipine 5 milligrams (mg) 1 by mouth (po) once daily for blood pressure. The 9:00 AM dose on 8/27/2016 was not documented as given.
Hydrochlorothiazide 12.5 mg 1 po once daily for hypertension. The 9:00 AM dose on 8/27/2016 was not documented as given.
Carvedilol 25 mg 1 po two times a day for high blood pressure (BP) and hold for BP under 110. On 8/27/2016 at 9:30 AM no BP was recorded and the dose was not documented as given.
On 8/27/2016 at 5:30 PM the BP was recorded as 186/106 and the medication was not documented as administered.
Lisinopril 10 mg 1 po twice a day for hypertension. The 9:00 AM dose on 8/27/2016 was not documented as given.
Clonidine 0.3 mg 1 po every 8 hours for hypertension. The 2:00 PM doses on 8/27 and 8/28/2016 were not documented as given.
Isosorbide 20 mg 1 po every 8 hours for vessel dilation (opening up). The 2:00 PM doses on 8/27 and 8/28/2016 were not documented as given.

A review of the progress notes revealed no notification to the Physician or Physician Assistant for any missed medication doses on 8/27/2016 or 8/28/2016.

j. Resident #36 was admitted 11/19/2015 with diagnoses of stroke and essential hypertension. Resident #36 currently has a diagnosis of pneumonia

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A review of the August Medication Administration Record revealed:
Augmentin 500-125 milligrams (mg) give 1 via G-tube two times a day for pneumonia. The 9:00 AM and 5:00 PM doses on 8/27 and 8/28/2016 were not documented as given.
Clonidine 0.1 mg 1 via G-tube every 12 hours for hypertension. Hold for systolic blood pressure lower than 120. The 8:30 AM dose on 8/27 and 8/28/2016 was not documented as given.
Eliquis 2.5 mg 1 tablet via G-tube two times a day for blood clot prevention. The 9:00 AM doses on 8/27 and 8/28/2016 were not documented as given.
Labetalol 200 mg give 200 mg via G-tube every 12 hours for hypertension. Hold for systolic BP lower than 120. No BP was recorded for the 8:30 dose and medication for the 8:30 doses on 8/27 and 8/28/2016 were not documented as given.
Levitiracetam 500 mg via G-tube every 12 hours for seizures. The 8:30 AM doses on 8/27 and 8/28/2016 were not documented as given.
Jevity 1.5 calorie liquid. Give 300 ml via G-tube five times a day for feeding. The 12:30 PM feedings on 8/27 and 8/28/2016 were not documented as given.

On 9/12/2016 at 2:50 PM, in an interview, the Staff Development Coordinator (SDC) stated she worked in the facility on August 27 and 28, 2016 on the 7:00 AM to 3:00 PM shift. The SDC stated several staff members had walked out of the facility that week, so there was a shortage of staff. The SDC stated the Unit Manager was scheduled to work a 4 hour shift from 7:00 AM to 11:00 AM on August 27 also. The SDC noted she tried to cover the 300 hall as well as the 100 and 200 halls with the Unit Manager. The SDC stated

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she felt there were many meds she did not give, but she tried her best. When asked specifically about each of Residents #3, #4, #11, #19, #20, #30, #33, #34, #35 and #36 medications, the SDC stated if there was no documentation, she did not give them.

On 9/13/2016 at 3:22 PM in a telephone interview, the Unit Manager stated she was working on August 27, 2016 for a 4 hour shift from 7:00 AM until 11:00 AM. The Unit Manager stated when it was discovered there was no nurse for the 300 hall, the SDC went to try and cover the 300 hall and also work on the 100 and 200 hall. When a list of Residents #3, #4, #11, #19, #20, #30, #33, #34, #35 and #36 ' s medications that were not documented as given was read to the Unit Manager she stated if she gave a medication, she documented it. If it was not documented she could not say she gave it. The Unit Manager stated there were a lot of missed medications on the 7 AM - 3 PM shift on 8/27/2016. The Unit Manager also stated she gave medications on the 100 and the 200 hall.

In an interview on 9/15/2016 at 11:30 AM, the facility physician stated she had worked here since May, and was usually at the facility two to three times weekly, sometimes more. The Physician stated the Physician Assistants (PA) take call from 5:00 PM until morning but the PA could always reach me at any time. The Physician stated she did not know about missed medications until 9/13/2016. The PA stated she did not know about missed medications until 9/13/2016, and the PA stated she did not receive any calls in regard to residents not receiving their meds. The Physician stated she would have

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F 157	Continued From page 10 wanted residents who had missed insulin to have had their blood sugar checked immediately and then a Basic Metabolic Panel lab drawn or perhaps blood gases to make sure the resident was not in any danger of Diabetic Ketoacidosis (a complication of diabetes when there is not enough insulin in the body). The Physician stated she would have done that for any resident that missed a scheduled insulin dose. The Physician stated she was very concerned about these medications not being given. . In regard to the anti-seizure medication, the Physician stated she would have ordered a Keppra level and initiated seizure precautions to make sure a resident who missed the medication was watched closely. The Physician indicated Resident #35 ' s blood pressure was too high not to have notified me. The Physician stated his missed doses affected Resident #35 ' s blood pressure. The Physician stated Resident #35 probably should have had an extra dose and had his blood pressure monitored after his next dose and checked every two hours or until it was stable and normal. The Physician stated the blood pressure was significant. On 9/15/2016 at 12:32 PM, in an interview, the Director of Nursing stated her expectation was the medications would be documented as they were given, and that the medications would be given.	F 157		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices	F 242		10/30/16

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F 242	Continued From page 11 about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to honor bathing preferences for 2 of 3 residents reviewed (Resident #34 and Resident # 40). Findings included: 1. Record review revealed Resident #34 was admitted to the facility on 7/29/15 with cumulative diagnoses which included Diabetes and Hypertension. A review of the annual MDS (Minimum Data Set) assessment of 8/4/16 indicated Resident #34 was cognitively intact and able to communicate effectively. The MDS indicated the resident required 2 person assist for transfers and bathing. The MDS revealed the resident felt it was important (but can't do or no choice) to choose between a tub bath, shower, bed bath or sponge bath. A review of the medical record revealed Resident #34's showers were scheduled on the 7 AM-3 PM shift for Monday, Wednesday and Friday. A review of the nursing assistant records revealed from 8/6/2016 to 9/16/16 (7 weeks), there were 7 days which documented Resident #34 received a bath. The documentation did not indicate showers were given. During an interview on 9/13/16 at 9:10 AM, Resident #34 stated she did not receive showers on her scheduled shower days of Mondays, Wednesdays and Fridays. Resident #34 stated she did not receive any showers the previous week. Resident #34 reported she asked for a shower on each scheduled shower day of the previous week and was told by the nurse and the	F 242	Resident #34 and #40 were interviewed by the Director Nursing/Designee to determine bathing'/showering preferences. Unit Managers will conduct interviews with residents identified as inter-viewable to determine residents bathing preferences. The Director of Nursing and/or Designee will re- educate direct care staff on resident preferences to include honoring bathing/shower preferences completed on October 30, 2016. Newly hired licensed nurses will receive the education during orientation. The facility will complete re-education on any licensed nurse that does not receive the reeducation prior to working next scheduled shift. Director of Nursing and/or Designee will perform random audits on each unit weekly times 4weeks and monthly times 3 to ensure residents preferences/showers are met. The DON will report findings of audits to the Quality Assurance Improve Committee. The QAPI committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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nursing assistants there was not enough staff available in the facility to complete her shower. Resident #34 said she felt if the staff was able to take the time to give her a bed bath, they could give her a shower. Resident # 34 stated she reported her preference for a shower to the staff on her scheduled shower days but she could not recall the last time she received showers on each of her scheduled days. Resident # 34 also reported there were many weeks she did not receive a shower at all.
During an interview on 9/13/16 at 10:15 AM the 7AM-3PM nursing assistant (NA#15) assigned to Resident #34 stated the resident was scheduled for a shower on Monday, Wednesday and Friday on the day shift. NA#15 stated on the days there were only 2 nursing assistants on the hall it was too difficult to complete Resident #34 ' s shower because it required 2 people to get her in the lift and to the shower. NA #15 stated Resident #34 requested a shower each scheduled day, but there was not enough nursing assistants on most days and there was just no way to get everything done. NA #15 reported they had been short staffed in the last few months and there were many days Resident #34 did not receive her scheduled shower.
During an interview on 9/16/2016 at 9:18 AM, the Director of Nursing stated the expectation was the residents ' care to be provided according to individual preferences and choices.

2. Record review revealed Resident #40 was admitted to the facility on 8/26/2016 with cumulative diagnoses which included Hypertension and Anemia. A review of the most recent comprehensive Minimum Data Set (MDS) dated 9/7/2016 indicated Resident #40 was cognitively intact and able to communicate

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effectively. The MDS indicated the resident required 2 person assist for transfers and bathing. The MDS revealed the resident felt it was very important to choose between a tub bath, shower, bed bath or sponge bath.
A review of the medical record revealed Resident #40's showers were scheduled on the 3 PM-11 PM shift for Tuesday and Thursday. A review of the nursing assistant records revealed numerous blanks on the bathing record. There were no entries for completed showers.
An interview was conducted with Resident #40 on 9/15/16 at 5:00 PM. The resident stated he was supposed to receive a shower on Tuesdays and Thursdays on the 3 PM-11 PM shift. Resident #40 reported the shower schedule was posted in his room. Observation revealed the shower schedule was posted in the resident ' s room and indicated Resident #40 ' s scheduled shower days were Tuesday and Thursday on 3 PM-11 PM shift. Resident #40 stated he did not consistently get his scheduled showers because there was not enough staff to assist with showers. Resident #40 stated the Nursing Assistants (NA) would tell him at the beginning of the shift if there were enough NAs for him to get his shower. Resident #40 stated he preferred a shower but he knew most days there wasn't enough staff to give showers.
An interview was conducted with NA#5 on 9/15/16 at 5:20 PM. NA# 5 indicated she was the NA who cared for Resident #40 on the 3 PM-11 PM shift. NA#5 reported she had worked at the facility for a year and a half. NA#5 stated most evenings she was not able to give Resident #40 his scheduled shower because there was not enough staff to assist her. NA# 5 reported there was no way to get everything done in a shift and there was care that was not completed. NA#5 stated when there were 2 NAs on the hall,

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F 242	Continued From page 14 showers were not completed. NA#5 stated she felt bad for the residents because they would not get the care needed. NA#5 stated the nurses were short staffed too and were unable to assist the NAs like they used to. NA#5 reported it had been worse over the last few months and she hoped the facility would get more staff so the residents ' needs would be met. During an interview on 9/16/2016 at 9:18 AM, the Director of Nursing stated the expectation was the residents' care to be provided according to individual preferences and choices.	F 242		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident and physician interviews and record review, the facility failed to administer medications as ordered for 2 of 10 residents reviewed (Resident #3 and Resident #11) , and failed to complete post dialysis assessments by not obtaining vital signs per the Physicians order and care plan for 1 of 1 residents reviewed for dialysis (Resident #20). Findings included: 1. Resident #3 was admitted 6/20/2016 with diagnoses of throat cancer, tracheostomy,	F 309	Resident #3, and #11, attending physician were notified of non-documented/administered medication for the period of August 27 □ 28, 2016 on September 12, 2016. No additional physician orders received. Resident #20 has been discharged from the facility. The facility Director of Nursing and/or Designee will complete an audit of facility residents to ensure that the physician was notified of any non documented/administered medications for	10/30/16

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F 309	Continued From page 15 gastrostomy, COPD (Chronic Obstructive Pulmonary Disease), dysphagia (difficulty swallowing), and depression. The Admission Minimum Data Set (MDS) dated 6/27/2016 noted the resident to be cognitively intact and needed limited to total assistance for all Activities of Daily Living with the physical assistance of one person. The care plan dated 7/6/2016 noted a focus area of- · Resident #3 has pain related to cancer. Intervention was- Administer pain medication prior to treatments and therapy, if indicated. A review of the August 2016 signed physician orders revealed: Vitamin B-12 Active Tablet Chewable. Give 1000 micrograms (mcg) via percutaneous endoscopic gastrostomy (PEG) Tube one time a day for supplement. On 8/28/2016 the 2:00 PM scheduled dose was not documented as given in the Medication Administration Record (MAR). Multivitamin Capsule .Give 1 tablet via PEG-Tube one time a day for supplement. On 8/28/2016 the 2:00 PM dose was not documented as given in the MAR. Zoloft Tablet 50 milligram (mg) Give 1 tablet via G-Tube in the morning for depression. The 2:00 PM dose on 8/28/2016 was not documented as given in the MAR. Tylenol Tablet 325mg Give 2 tablets via PEG Tube every 8 hours for pain. On 8/28/2016 the 2:00 PM dose was not documented as given in the MAR. On 9/12/2016 at 2:50 PM, in an interview, the Staff Development Coordinator (SDC) stated she worked in the facility on August 27 and 28, 2016 on the 7:00 AM to 3:00 PM shift. The SDC stated several staff members had walked out of the	F 309	August 27-28, 2016. Will complete an audit of residents receiving dialysis to ensure that each have physician orders for assessment of vital signs and shunt site post dialysis . The Director of Nursing and/or Designee will re- educate facility licensed nurses regarding notification to the resident and/or responsible party and physician of any medications not administered / not documented; re-education regarding assessment of resident post dialysis to include obtaining post dialysis vital signs and shunt site assessment completed by October 30, 2016. Newly hired licensed nurses will receive the education during orientation. The facility will complete re-education on any licensed nurse that does not receive the reeducation prior to working next scheduled shift. The Director of Nursing and/or Designee will perform random audits daily times 2 weeks, weekly times 3 weeks and monthly times 3 to ensure residents have received medications as ordered; will review 2 dialysis residents three times a week to ensure assessment of resident post dialysis; to include obtaining post dialysis vital signs and shunt site assessment. Weekly times four and monthly times three. The DON will report findings of audits to the Quality Assurance Improve Committee. The QAPI committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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facility that week, so there was a shortage of staff. The SDC stated she felt there were many meds she did not give, but she tried her best. When asked specifically about each of Resident #3 ' s meds she stated if there was no documentation, she did not give them. The SDC stated it was not humanly possible to do everything.

2. Resident #11 was admitted on 8/17/2016 with diagnoses of coronary artery disease, Urinary Tract Infection (UTI), leukemia, heart failure, atrial fibrillation and hypertension.
The Admission MDS dated 8/24/2016 noted Resident #11 to be severely impaired for cognition and needed limited to extensive assistance for all ADLs with the physical assistance of one to two persons.

A review of the August 2016 signed physician orders revealed:
Aspirin 81 mg chewable tablet. Take 81 mg by mouth daily. On 8/28/2016 at 9:00 AM the dose was not documented as given in the MAR.
Flonase 50 microgram (mcg) nasal spray. 1 spray by nasal route daily. Spray in each nostril for allergic rhinitis. On 8/28/2016 the 9:00 AM dose was not documented as given in the MAR.
Multivitamin with minerals tablet. Take 1 tablet by mouth daily for supplement. On 8/28/2016 the 9:00 AM dose was not documented as given in the MAR.

A review of nurse notes on 8/28/2016 revealed no significant documentation of any problems with Resident #11.

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On 9/12/2016 at 2:50 PM, in an interview, the Staff Development Coordinator (SDC) stated she worked in the facility on August 27 and 28, 2016 on the 7:00 AM to 3:00 PM shift. The SDC stated several staff members had walked out of the facility that week, so there was a shortage of staff. The SDC noted she tried to cover the 300 hall as well as the 100 and 200 halls with the Unit Manager. The SDC stated she felt there were many meds she did not give, but she tried her best. When asked specifically about each of Resident 11 ' s meds she stated if there was no documentation, she did not give them. The SDC stated it was not humanly possible to do everything.

3. Resident #20 was admitted to the facility on 1/27/2016 with diagnoses which included End Stage Renal Disease (ESRD) with Hemodialysis 3 times a week, Anemia and Diabetes.
The most recent comprehensive Minimum Data Set (MDS) dated 8/16/2016 indicated Resident #20 was cognitively intact and required hemodialysis for End Stage Renal Disease (ESRD). A Care Area Assessment associated with the MDS indicated nursing would proceed with a Care Plan related to dialysis.
A review of the Care Plan dated 8/30/2016 indicated Resident #20 required dialysis due to renal failure. The goal was Resident #20 would have no signs or symptoms of complications from dialysis. Interventions included vital signs to be checked post dialysis, every shift for 24 hours post dialysis and to notify Physician of significant abnormalities.
A review of signed monthly Physician's orders dated August 1 through August 31 and

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September 1 through September 30 2016 revealed an order to obtain vital signs every Monday, Wednesday and Friday post dialysis and every shift for 24 hours post dialysis. Further record review revealed no documented vital signs from August 31, 2016 to September 14, 2016.
An interview was conducted with nurse #1 on 9/14/2016 at 10:30 AM. Nurse #1 reported she was the primary nurse for Resident #20. Nurse #1 was Resident #20's primary nurse on 9/14/2016 and reported the resident left the facility for dialysis around 9:00 AM that morning. Nurse #1 stated when the resident returned from dialysis an assessment was supposed to be completed which included a dialysis site check and vital signs. Nurse #1 looked in the medical record to view Resident #20 ' s vital signs and was not able to locate any documented vital signs in the medical record since August 6, 2016. Nurse #1 stated she was unsure if she obtained Resident #20 ' s vital signs post dialysis but she remembered the resident was sick post dialysis on 9/12/2016, so she did not bother her to obtain the vital signs. Nurse #1 reported she did not document anything on Resident #20's condition on 9/12/2016. Nurse #1 reported she attended a recent facility in-service on post dialysis assessments, but Monday was a " terrible day " and the post dialysis assessment on Resident #20 was not completed.
An interview was conducted on 9/14/2016 at 4:15 PM with Resident #20. Resident #20 was observed sitting in a motorized wheelchair outside the facility at the front entrance sitting area. Resident #20 was alert, oriented and pleasant during the interview. The resident stated when she returned from dialysis today at 1:00 pm, Nurse #1 checked her blood pressure and pulse. The resident stated it was the first time she

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F 309	Continued From page 19 recalled anyone checking her vital signs post dialysis. Resident #20 reported she asked Nurse #1 why she obtained them and Nurse #1 told her she was " supposed to. " Resident #20 stated she did not remember any nurse ever checking her blood pressure when she returned from dialysis and that was the reason she questioned Nurse #1. An interview was conducted with the facility Interim Director of Nursing (DON) on 9/14/2016 at 4:45 PM. The DON indicated her expectation was for nursing staff to obtain dialysis resident's vital signs post dialysis to assess the resident for complications from the dialysis treatment. The DON reported all nursing staff attended a recent in-service on post dialysis assessments for the facility Recertification Plan of Correction (POC). The completion date for the POC was 8/31/2016.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to maintain a nutritional/	F 325	A nutritional assessment was completed on resident # 36.	10/30/16

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F 325	Continued From page 20 therapeutic diet for 1 of 5 residents (Resident #36) reviewed for feeding tube, resulting in an unintended weight loss of 9.2% over a seven month period. Findings included: Resident #36 was admitted 11/19/2015 with diagnoses of dysphagia and placement of a gastrostomy tube (G tube). The quarterly Minimum Data Set (MDS) dated 8/12/2016 noted Resident #36 was moderately impaired for cognition and needed limited to extensive assistance for all Activities of Daily Living (ADL)s with the physical assistance of one person. MDS noted a feeding tube was present. The MDS noted the resident received more than 51% of his total calories from tube feeding. On 2/26/2016 Resident #36 had a recorded weight of 163 pounds. The tube feeding was originally ordered on 3/18/2016 and was written: Enteral Feed Order five times a day Enteral 1-Feeding: Administer Jevity 1.5 per Percutaneous Endoscopic Gastrostomy (PEG) via Bolus (a method of using gravity to allow liquid to flow into a feeding tube). Rate: 300 milliliter (ml.) per feeding. 5 times per day, to provide 2,250 Calories per 24 hours. A review of the August 2016 signed physician orders revealed: Administer Jevity 1.5 per PEG via Bolus Rate: 300 ml. per feeding. 5 times per day, to provide 2,250 Calories per 24 hours. The scheduled feeding times were 12:30 AM, 6:00 AM, 12:30 PM, 4:30 PM and 8:30 PM. Jevity	F 325	The facility Director of Nursing and/or Designee will complete an audit of tube fed residents to ensure residents have not had significant weight loss and orders for tube fed residents are in place and accurate. The Director of Nursing and/or Designee will re- educate facility licensed nurses regarding tube fed residents to ensure weights are obtained weekly and orders for tube fed residents are in place and accurate October 30, 2016. Newly hired licensed nurses will receive the education during orientation. The facility will complete re- education on any licensed nurse that does not receive the reeducation prior to working next scheduled shift. The Director of Nursing and/or Designee will perform random audits on tube fed residents weekly times 4 then monthly times 3 to ensure weights are obtained weekly and orders for tube fed residents are in place and accurate. The DON will report findings of audits to the Quality Assurance Improve Committee. The QAPI committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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1.5 provides 1.5 Calories per ml. One feeding for Resident #36 at 300 ml. would provide 450 Calories.

On 9/11/2016 Resident #36 had a recorded weight of 148 pounds.

On 9/12/2016 at 2:50 PM, in an interview, the Staff Development Coordinator (SDC) stated she worked in the facility on August 27 and 28, 2016 on the 7:00 AM to 3:00 PM shift. The SDC stated several staff members had walked out of the facility that week, so there was a shortage of staff. The SDC stated she felt there were many meds she did not give, but she tried her best. When asked specifically about Resident #35 ' s bolus feedings she stated if there was no documentation, she did not give them. The SDC stated staffing had gotten worse in the past few weeks. The SDC was not noted on the schedule for any other time in August.

On 9/13/2016 at 3:22 PM in a telephone interview, the Unit Manager stated she was working on August 27, 2016 for a 4 hour shift from 7:00 AM until 11:00 AM. When asked if Resident #35 ' s bolus feeding was administered, the Unit Manager stated, if she gave a medication, she documented it. If it was not documented she could not say she gave it. The Unit Manager stated she did not remember giving the bolus feeds.

On 9/14/2016 at 9:00 AM, in an interview, the Registered Dietician (RD) stated Resident #36 was taken off continuous feeding and changed to bolus feeds because he liked to move about in the facility in his wheel chair. The RD stated she was aware of Resident #36 ' s unintended weight

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F 325	Continued From page 22 loss when she completed his monthly assessment. The RD stated she was not aware Resident #36 had missed any feedings and stated missing a feeding was " essentially missing a meal. " The RD noted no staff had mentioned any missed feeding. The RD indicated Resident #36 ' s tube feedings are calculated according to his caloric needs, and he should not have weight loss, if he receives the ordered tube feeds. On 9/15/2016 at 11:30 AM in an interview with the facility Physician and the Physician Assistant (PA), the Physician stated she was not aware of the tube feedings that were not documented as given for Resident #36. The Physician stated she was concerned in regard to Resident #36 and his unintended weight loss. On 9/15/2016 at 12:32 PM, in an interview, the Director of Nursing stated her expectation was the tube feedings would be documented as they were given.	F 325		
F 333 SS=E	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 resident and staff interviews and record review, the facility failed to administer significant medications ordered for 8 of 25 residents reviewed (Res. #11, #19, #20, #30, #33, #34, #35, and #36). Findings included:	F 333	Resident #3, #4, #11, #19, #20, #33, #34, #35 and #36 attending physician were notified of non-documented medication for the period of August 27 □ 28, 2016 on September 12, 2016 no additional physician orders received.	10/30/16

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F 333	Continued From page 23 1. Resident #11 was admitted on 8/17/2016 with diagnoses of coronary artery disease, Urinary Tract Infection (UTI), leukemia, heart failure, atrial fibrillation and hypertension. The Admission MDS dated 8/24/2016 noted Resident #11 to be severely impaired for cognition and needed limited to extensive assistance for all ADLs with the physical assistance of one to two persons. A review of the August 2016 signed physician orders revealed: Amiodarone 200 milligram (mg) tablet .Take 1 tablet by mouth daily with breakfast for atrial fibrillation. On 8/28/2016 the 8:00 AM dose was not documented as given in the Medication Administration Record (MAR). Plavix 75mg tablet. Take 75mg by mouth daily for coronary artery disease. On 8/28/2016 the dose at 9:00 AM was not documented as given in the MAR. Amlodipine 5 mg tablet. Take 1 tablet by mouth 2 times daily for hypertension. On 8/28/2016 the 9:30 AM dose was not documented as given in the MAR. Metoprolol 25 mg 24 hour tablet. Take 1 tablet by mouth 2 times daily at 0600 and 1800 for hypertension and atrial fibrillation. On 8/28/2016 the scheduled dose at 9:30 AM was not documented as given on the MAR. Potassium Chloride 10 milliequivalents (meq) CR tablet. Take 2 tablets by mouth 2 times daily for hypokalemia (low potassium). On 8/28/2016 the 9:30 AM dose was not documented as given in the MAR. 2. Resident #19 was admitted 1/6/2016 with	F 333	The facility Director of Nursing and/or Designee will complete an audit of facility residents to ensure that the physician was notified of any non documented medications for August 27-28, 2016. The Director of Nursing and/Designee of Nursing will re- educate facility licensed nurses regarding notification to the resident and/or responsible party and physician of any medications not administered / not documented medications completed by October 30, 2016. Newly hired licensed nurses will receive the education during orientation. The facility will complete re- education on any licensed nurse that does not receive the reeducation prior to working next scheduled shift. Director of Nursing and/or Designee will perform random audits daily times 2 weeks, weekly times 3 weeks and monthly times 3 to ensure residents have received medications as ordered. The DON will report findings of audits to the Quality Assurance Improvement Committee. The QAPI committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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diagnoses of atrial fibrillation (irregular heart rhythm) and diabetes mellitus.
The admission Minimum Data Set (MDS) dated 1/25/2016 noted Resident #19 to be impaired for cognition and needed extensive assistance for all Activities of Daily Living (ADLs) with the physical assistance of one person.

A review of the signed physician orders for August, 2016 revealed:
Digoxin 125 micrograms (mcg) via G tube (gastrostomy tube) daily. The 8:00 AM dose on 8/28/2016 was not documented as given in a review of the August Medication Administration Record.

On 9/12/2016 at 2:50 PM, in an interview, the Staff Development Coordinator (SDC) stated she worked in the facility on August 27 and 28, 2016 on the 7:00 AM to 3:00 PM shift. The SDC stated several staff members had walked out of the facility that week, so there was a shortage of staff. The SDC stated the Unit Manager was scheduled to work a 4 hour shift from 7:00 AM to 11:00 AM on August 27 also. The SDC noted she tried to cover the 300 hall as well as the 100 and 200 halls with the Unit Manager. The SDC stated she felt there were many meds she did not give, but she tried her best. When asked specifically about Resident #19 ' s medication, she stated if there was no documentation, she did not give it.

On 9/13/2016 at 3:22 PM in a telephone interview, the Unit Manager stated she was working on August 27, 2016 for a 4 hour shift from 7:00 AM until 11:00 AM. The Unit Manager stated when it was discovered there was no nurse for the 300 hall, the SDC went to try and cover the 300 hall and also work on the 100 and

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200 hall. When Resident #19 ' s medication that was not documented as given was read to the Unit Manager, she stated if she gave a medication, she documented it. If it was not documented she could not say she gave it. The Unit Manager stated there were a lot of missed medications on the 7AM - 3 PM shift on 8/27/2016. The Unit Manager also stated she gave medications on the 100 and the 200 hall.

At 11:30 AM on 9/15/2016, in an interview with the Facility Physician and the Physician Assistant (PA), the Physician indicated she was not aware of the medication that was not documented as given for Resident #19. The Physician stated for missing Digoxin doses the Physician would do a thorough assessment and obtain vital signs every 2 hours. If the Digoxin was dosed based on levels, the Physician stated she would have a digoxin level drawn immediately.

3. Resident #20 was admitted on 1/27/2016 with diagnoses of End Stage Renal Disease (ESRD), Diabetes Mellitus and Bi-Polar disorder.
The Admission MDS noted Resident #20 to be cognitively intact and needed limited to extensive assistance for all ADLs with the physical assistance of one person. The CAA noted a focus in the area of psychotropic drug use and this area went to care plan.
The care plan dated 2/9/2016 noted a focus of Resident #20 receives anti-psychotic medications and a goal of Resident #20 will remain free of drug related complications. Interventions included: Administer antipsychotic medications as ordered by physician, observe for side effects and effectiveness every shift. Consult with pharmacy,

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Medical Director (MD) to consider dosage reduction when clinically appropriate at least quarterly.
Discuss with MD, family about ongoing need for use of medication. Observe /document / report any adverse reactions of psychotropic medications. Observe/record occurrence of for target behavior symptoms and document per facility protocol.

A review of the signed physician orders for August 2016 for Resident #20 indicated the following:
Abilify 2 milligram (mg) give 1 by mouth (po) one time a day for bi-polar disorder. Take with 5 mg to equal 7 mg daily. The 9:00 AM dose on 8/28/2016 was not documented as given in the Medication Administration Record (MAR).
Abilify 5mg give 1 po one time a day with Abilify 2 mg to equal 7mg for bi-polar disorder. The 9:00 AM dose on 8/28/2016 was not documented as given in the MAR.
Insulin Detimir (long acting) inject 30 units subcutaneously at bedtime for diabetes. The 9:00 PM dose on 8/27/2016 and 8/28/2016 were not documented as given in the MAR.
Carvedilol 12.5 mg 1 po two times a day for hypertension. The 9:00 AM dose on 8/27/2016 was not documented as given in the MAR.
Lispro sliding scale insulin given subcutaneously before meals and at bedtime. The 11:30 AM and 9:00 PM doses on 8/27/2016, and the 9:00 PM dose on 8/28/2016 were not documented as given in the MAR.

On 9/12/2016 at 2:50 PM, in an interview, the Staff Development Coordinator (SDC) stated she worked in the facility on August 27 and 28, 2016 on the 7:00 AM to 3:00 PM shift. The SDC stated several staff members had walked out of the

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facility that week, so there was a shortage of staff. The SDC stated she felt there were many meds she did not give, but she tried her best. When asked specifically about each of Resident #20 ' s meds she stated if there was no documentation, she did not give them.

On 9/13/2016 at 3:22 PM in a telephone interview, the Unit Manager stated she was working on August 27, 2016 for a 4 hour shift from 7:00 AM until 11:00 AM. When a list of Resident #20 ' s medications that were not documented as given was read to the Unit Manager, she stated if she gave a medication, she documented it. If it was not documented she could not say she gave it. The Unit Manager stated there were a lot of missed medications on the 7AM - 3 PM shift on 8/27/2016.

At 11:30 AM on 9/15/2016, in an interview with the Facility Physician and the Physician Assistant (PA), the Physician was not aware of the medications that were not documented as given for Resident #20.The Physician stated she would have wanted Resident #20 ' s blood sugar checked immediately and then a Basic Metabolic Panel lab drawn or perhaps blood gases to make sure the resident was not in any danger of Diabetic Ketoacidosis (a complication of diabetes when there is not enough insulin in the body). The Physician stated she would have done that for any resident that missed a scheduled insulin dose.

4. Resident #30 was admitted on 5/27/2016 with diagnoses of diabetes mellitus, atrial fibrillation (irregular heart rhythm) and hypertension.

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The Admission MDS dated 6/3/2016 noted Resident #30 to be cognitively intact and needed supervision to extensive assistance for all ADLs with supervision or 1 person assist.
The care plan dated 8/2/2016 noted a focus for diabetes and is at risk for complications secondary to the disease. Also a focus of diuretic therapy related to high blood pressure, and a focus of anti-coagulant therapy related to atrial fibrillation. The interventions included: Administer diabetes, diuretic and anti-coagulant medications as ordered by the physician and observe for side effects and effectiveness every shift.

A review of the August 2016 signed physician orders revealed:
Bumetanide 2 milligrams (mg) 1 by mouth (po) once daily for congestive heart failure. The 8:00 AM dose on 8/27/2016 was not documented as given in the Medication Administration Record (MAR).
Diltiazem ER (extended release) 300 mg 1 po once daily for atrial fibrillation. The 8:00 AM dose on 8/27/2016 was not documented as given in the MAR.
Toujeo insulin inject 32 units subcutaneously at bedtime for diabetes mellitus. The 9:00 PM dose on 8/27/2016 was not documented as given in the MAR.
Apixaban 5 mg 1 po two times daily for atrial fibrillation. The 8:00 AM dose on 8/27/2016 was not documented as given in the MAR.
Humalog sliding scale insulin given subcutaneously before meals for diabetes mellitus. The insulin doses at 8:00 AM and 12:30 PM on 8/27/2016 and the 12:30 PM dose on 8/28/2016 were not documented as given in the MAR.
Humalog insulin inject 6 units subcutaneously

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three times a day for diabetes mellitus. The 8:00 AM and 12 noon doses on 8/27/2016 and 12 noon dose on 8/28/2016 were not documented as given in the MAR.

On 9/12/2016 at 2:50 PM, in an interview, the Staff Development Coordinator (SDC) stated she worked in the facility on August 27 and 28, 2016 on the 7:00 AM to 3:00 PM shift. The SDC stated several staff members had walked out of the facility that week, so there was a shortage of staff. The SDC stated she felt there were many meds she did not give, but she tried her best. When asked specifically about each of Resident #30 ' s meds she stated if there was no documentation, she did not give them.

On 9/13/2016 at 3:22 PM in a telephone interview, the Unit Manager stated she was working on August 27, 2016 for a 4 hour shift from 7:00 AM until 11:00 AM. When a list of Resident #30 ' s medications that were not documented as given was read to the Unit Manager, she stated if she gave a medication, she documented it. If it was not documented she could not say she gave it. The Unit Manager stated there were a lot of missed medications on the 7AM - 3 PM shift on 8/27/2016.

At 11:30 AM on 9/15/2016, in an interview with the Facility Physician and the Physician Assistant (PA), the Physician was not aware of the medications that were not documented as given for Resident #30.The Physician stated she would have wanted Resident #30 ' s blood sugar checked immediately and then a Basic Metabolic Panel lab drawn or perhaps blood gases to make sure the resident was not in any danger of

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F 333	Continued From page 30 Diabetic Ketoacidosis (a complication of diabetes when there is not enough insulin in the body). The Physician stated she would have done that for any resident that missed a scheduled insulin dose. The Physician stated she was very concerned about these medications not being given. 5. Resident #33 was admitted 11/25/2013 with diagnoses of diabetes mellitus, congestive heart failure (CHF) and atrial fibrillation. The quarterly MDS dated 6/28/2016 noted Resident #33 to be moderately impaired for cognition and needed limited to extensive assistance for all ADLs with the physical assistance of one person. The care plan dated 6/30/2016 noted a focus of Resident #33 had acute and chronic congestive heart failure (CHF) and a goal of clear lung sounds and heart rate and rhythm within normal limits through the next review. There was also a focus of Resident #33 had diabetes mellitus and a goal of no complications related to diabetes mellitus. Interventions for both CHF and diabetes included: give cardiac meds as ordered and diabetes medication as ordered. Another focus was Resident #33 received anticoagulant therapy related to atrial fibrillation with a goal of no adverse reactions related to anticoagulant use through next review. The interventions included: administer anticoagulant medications as ordered by physician. Observe for side effects and effectiveness. Teaching included take/give the medication at the same time each day. The care plan also had a focus of Resident #33 receives diuretic therapy related to heart	F 333		

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failure and included interventions of administer diuretic medications as ordered by the physician and observe for side effects and effectiveness every shift.

A review of the August 2016 signed physicians orders revealed:
Dilacor XR 120 milligrams (mg) give 1 by mouth (po) once daily for CHF. The 9:00 AM dose on 8/27/2016 was not documented as given in the Medication Administration Record (MAR).
Lantus insulin inject 12 units subcutaneously at bedtime for diabetes mellitus. The 9:30 PM dose on 8/27/2016 was not documented as given in the MAR.
Lasix 40mg 1 po once daily for CHF. The 8:00 AM dose on 8/27/2016 was not documented as given in the MAR.
Eliquis 2.5mg 1 po twice daily for atrial fibrillation. The 8:30 AM dose on 8/27/2016 was not documented as given in the MAR.
Humalog insulin inject per sliding scale subcutaneously before meals and at bedtime for diabetes. On 8/27/2016 at 6:30 AM Resident #33 had a blood sugar of 292 (normal blood sugar level for diabetic persons is 70 - 130), and received 4 units of insulin. Resident #33 ' s MAR had no documentation of insulin administration at the 11:30 AM, 4:30 PM and 9:00 PM scheduled times on 8/27/2016. Resident #33 had a blood sugar level of 374 at 6:30 AM on 8/28/2016 and received 8 units of insulin as ordered.

On 9/12/2016 at 2:50 PM, in an interview, the Staff Development Coordinator (SDC) stated she worked in the facility on August 27 and 28, 2016 on the 7:00 AM to 3:00 PM shift. The SDC stated several staff members had walked out of the facility that week, so there was a shortage of

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staff. The SDC stated she felt there were many meds she did not give, but she tried her best. When asked specifically about each of Resident #33 ' s meds she stated if there was no documentation, she did not give them.

On 9/13/2016 at 3:22 PM in a telephone interview, the Unit Manager stated she was working on August 27, 2016 for a 4 hour shift from 7:00 AM until 11:00 AM. When a list of Resident #33 ' s medications that were not documented as given was read to the Unit Manager, she stated if she gave a medication, she documented it. If it was not documented she could not say she gave it. The Unit Manager stated there were a lot of missed medications on the 7AM - 3 PM shift on 8/27/2016.

At 11:30 AM on 9/15/2016, in an interview with the Facility Physician and the Physician Assistant (PA), the Physician was not aware of the medications that were not documented as given for Resident #33.The Physician stated she would have wanted Resident #33 ' s blood sugar checked immediately and then a Basic Metabolic Panel lab drawn or perhaps blood gases to make sure the resident was not in any danger of Diabetic Ketoacidosis (a complication of diabetes when there is not enough insulin in the body). The Physician stated she would have done that for any resident that missed a scheduled insulin dose. The Physician stated she was very concerned about these medications not being given. The Physician noted missing a diuretic would require a thorough assessment, including a pulse oximetry (to measure oxygen in the blood), an edema assessment and a BNP (test to determine developing or worsening heart failure) to check for the possibility of some congestive

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heart failure " brewing " . The Physician stated depending on the negative findings from the interventions, she would have ordered a chest x-ray.

6. Resident #34 was admitted on 7/29/2015 with diagnoses of diabetes mellitus, hypertension, and unspecified convulsions.
The annual MDS dated 8/4/2016 noted Resident #34 to be cognitively intact and needed extensive to total assistance with all ADLs . The CAA noted a focus of medications and this went to care plan.
The care plan dated 9/7/2016 noted a focus of risk of hypotensive episodes and the intervention included give antihypertensive medications as ordered and observe for side effects and effectiveness.
The care plan also focused on fluid volume deficits related to the use of diuretics with an intervention of administer medications as ordered and observe for side effects and effectiveness.
Diabetes mellitus was a focus with an intervention of diabetic medication as ordered and observe for side effects and effectiveness. Also fasting blood sugar as ordered. There was a focus of Resident #34 has a seizure disorder and the intervention was to give anti-seizure medication as ordered and observe for side effects and effectiveness.

A review of the August 2016 signed physician orders revealed:
Lasix 40 milligrams (mg) 1 by mouth (po) in the morning for hypertension. The 9:00 AM doses on 8/27 and 8/28/2016 were not documented as given in the Medication Administration Record (MAR).
Coreg 6.25 mg 1 po two times a day for

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hypertension. The BP check, the pulse reading and the 9:30 AM dose were not documented as taken and given on 8/27 and 8/28/2016 in the MAR.
Lantus insulin inject 52 units subcutaneously two times a day for diabetes. The 9:30 AM and the 9:30 PM doses were not documented as given on 8/27 and 8/28/2016 in the MAR.
Humalog insulin inject 18 units subcutaneously three times a day for diabetes mellitus. The 8:00 AM and the 12:30 PM doses were not documented as given on 8/27 and 8/28/2016 in the MAR.
Keppra 750 mg 1 po three times a day related to convulsions. The 9:30 AM and the 1:30 PM doses on 8/27 and 8/28/2016 were not documented as given in the MAR.
Humalog insulin inject per sliding scale subcutaneously before meals and at bedtime for diabetes mellitus. There was no documentation in the MAR, of insulin given at 12:30 PM on 8/27/2016. The
9:30 PM insulin was not documented as given on the MAR. On 8/28/2016 at 6:30 AM Resident #34 had a blood sugar level of 243, and received 2 units of insulin. The 12:30 PM insulin was not documented as given in the MAR. The blood sugar level checked at 5:30 PM was 314 and Resident #34 received 6 units of insulin and it was noted Resident #34 had nausea and vomiting. There was no documentation insulin was given for a 9:30 PM dose on 8/28/2016 in the MAR.

On 9/12/2016 at 2:50 PM, in an interview, the Staff Development Coordinator (SDC) stated she worked in the facility on August 27 and 28, 2016 on the 7:00 AM to 3:00 PM shift. The SDC stated several staff members had walked out of the

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facility that week, so there was a shortage of staff. The SDC noted she tried to cover the 300 hall as well as the 100 and 200 halls with the Unit Manager. The SDC stated she felt there were many meds she did not give, but she tried her best. When asked specifically about each of Resident #34 ' s meds she stated if there was no documentation, she did not give them.

On 9/13/2016 at 3:22 PM in a telephone interview, the Unit Manager stated she was working on August 27, 2016 for a 4 hour shift from 7:00 AM until 11:00 AM. When a list of Resident #34 ' s medications that were not documented as given was read to the Unit Manager she stated if she gave a medication, she documented it. If it was not documented she could not say she gave it. The Unit Manager stated there were a lot of missed medications on the 7AM - 3 PM shift on 8/27/2016.

At 11:30 AM on 9/15/2016, in an interview with the Facility Physician and the Physician Assistant (PA), the Physician was not aware of the medications that were not documented as given for Resident #34.The Physician stated she would have wanted Resident #34 ' s blood sugar checked immediately and then a Basic Metabolic Panel lab drawn or perhaps blood gases to make sure the resident was not in any danger of Diabetic Ketoacidosis (a complication of diabetes when there is not enough insulin in the body). The Physician stated she would have done that for any resident that missed a scheduled insulin dose. The Physician stated she was very concerned about these medications not being given. In regard to the anti-seizure medication, the Physician stated she would have ordered a Keppra level and initiated seizure precautions to

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F 333	Continued From page 36 make sure Resident #34 was watched closely. 7. Resident #35 was admitted 4/20/13 with diagnoses of stroke, diabetes mellitus, and high blood pressure. The quarterly MDS dated 8/3/2016 noted Resident #35 to be cognitively intact and only needed 2 person assistance for transfers. The care plan dated 2/24/2015 noted a focus of Resident #35 has high blood pressure and the goal was Resident #35 would remain free from signs or symptoms of hypertension through next review. Interventions included: avoid taking the blood pressure reading after physical activity or emotional distress. Observe abnormal urine output. Report significant changes to the physician. Obtain blood pressure readings weekly and as needed. A review of the August signed physician orders revealed: Amlodipine 5 milligrams (mg) 1 by mouth (po) once daily for blood pressure. The 9:00 AM dose on 8/27/2016 was not documented as given in the Medication Administration Record (MAR). Hydrochlorothiazide 12.5 mg 1 po once daily for hypertension. The 9:00 AM dose on 8/27/2016 was not documented as given in the MAR. Carvedilol 25 mg 1 po two times a day for arteriosclerotic heart disease and hold for blood pressure (BP) under 110. The BP recorded for 8/26/2016 at 5:30 PM was 142/78 and the medication was documented as administered. On 8/27/2016 at 9:30 AM no BP was recorded and the dose was not documented as given in the MAR. On 8/27/2016 at 5:30 PM the BP was	F 333		

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recorded as 186/106 and the medication was documented as administered.
Lisinopril 10 mg 1 po twice a day for hypertension. The 9:00 AM dose on 8/27/2016 was not documented as given in the MAR.

Clonidine 0.3 mg 1 po every 8 hours for hypertension. The 2:00 PM dose on 8/27 and 8/28/2016 was not documented as given in the MAR.
Isosorbide 20 mg 1 po every 8 hours for arteriosclerotic heart disease. The 2:00 PM dose on 8/27 and 8/28/2016 was not documented as given in the MAR.

On 9/12/2016 at 2:50 PM, in an interview, the Staff Development Coordinator (SDC) stated she worked in the facility on August 27 and 28, 2016 on the 7:00 AM to 3:00 PM shift. The SDC stated several staff members had walked out of the facility that week, so there was a shortage of staff. The SDC noted she tried to cover the 300 hall as well as the 100 and 200 halls with the Unit Manager. The SDC stated she felt there were many meds she did not give, but she tried her best. When asked specifically about each of Resident #35 ' s meds she stated if there was no documentation, she did not give them.

On 9/13/2016 at 3:22 PM in a telephone interview, the Unit Manager stated she was working on August 27, 2016 for a 4 hour shift from 7:00 AM until 11:00 AM. When a list of Resident #35 ' s medications that were not documented as given was read to the Unit Manager she stated if she gave a medication, she documented it. If it was not documented she could not say she gave it. The Unit Manager

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stated there were a lot of missed medications on the 7AM - 3 PM shift on 8/27/2016.

At 11:30 AM on 9/15/2016, in an interview with the Facility Physician and the Physician Assistant (PA), the Physician was not aware of the medications that were not documented as given for Resident #35. The Physician indicated Resident #35 ' s blood pressure was too high not to have notified her. The Physician stated his missed doses affected Resident #35 ' s blood pressure. The Physician stated Resident #35 should have had an extra dose of his medication and had his blood pressure monitored after his next dose and checked every two hours or until it was stable and normal. The Physician stated the blood pressure was significant.

8. Resident #36 was admitted 11/19/2015 with cumulative diagnoses of stroke, essential hypertension, seizures, and acute respiratory failure with tracheostomy and gastrostomy tube (G tube).
The quarterly MDS dated 8/12/2016 noted Resident #36 was moderately impaired for cognition and needed limited to extensive assistance for all ADLs with the physical assistance of one person. MDS noted feeding tube present.

A review of the August signed physician orders revealed:
Augmentin 500-125 milligrams (mg) give 1 via (gastro-intestinal tube) G-tube two times a day for pneumonia. The 9:00 AM and 5:00 PM doses on 8/27 and 8/28/2016 were not documented as

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given in the Medication Administration Record (MAR).
Clonidine 0.1 mg 1 via G-tube every 12 hours for hypertension. Hold for systolic blood pressure (BP) lower than 120. The 8:30 AM dose on 8/27 and 8/28/2016 was not documented as given in the MAR.
Eliquis 2.5mg 1 tablet via G-tube two times a day for blood clot prevention. The 9:00 AM dose on 8/27 and 8/28/2016 was not documented as given in the MAR.
Labetalol 200 mg give 200 mg via G-tube every 12 hours for hypertension. Hold for systolic BP lower than 120. The 8:30 dose on 8/27 and 8/28/2016 was not documented as given in the MAR.
Levitiracetam 500mg via G-tube every 12 hours for seizures. The 8:30 AM dose on 8/27 and 8/28/2016 was not documented as given in the MAR.

On 9/12/2016 at 2:50 PM, in an interview, the Staff Development Coordinator (SDC) stated she worked in the facility on August 27 and 28, 2016 on the 7:00 AM to 3:00 PM shift. The SDC stated several staff members had walked out of the facility that week, so there was a shortage of staff. The SDC stated she felt there were many meds she did not give, but she tried her best. When asked specifically about each of Resident #36 ' s meds she stated if there was no documentation, she did not give them.

On 9/13/2016 at 3:22 PM in a telephone interview, the Unit Manager stated she was working on August 27, 2016 for a 4 hour shift from 7:00 AM until 11:00 AM. When a list of Resident #36 ' s medications that were not documented as given was read to the Unit

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Manager she stated if she gave a medication, she documented it. If it was not documented she could not say she gave it. The Unit Manager stated there were a lot of missed medications on the 7AM - 3 PM shift on 8/27/2016.

At 11:30 AM on 9/15/2016, in an interview with the facility Physician and the Physician Assistant (PA), the Physician was not aware of the medications that were not documented as given for Resident #36. The Physician stated the Physician Assistants (PA) take call from 5:00 PM until morning but the PA could always reach me at any time. The PA stated she had not been called in regard to missed medication doses.
The Physician stated for residents that missed anti-seizure medications she would have ordered an anti-seizure medication level and initiated seizure precautions to make sure the resident was watched closely. For any resident that was on a seizure medication, the Physician stated she would have used the same interventions. The Physician indicated for missed doses of anti-hypertensives, Resident #36 should have had his blood pressure monitored after his next dose and checked every two hours or until it was stable and normal. The Physician stated she thought the medications that were described to her were significant, but were for a particular time. The Physician stated she would have ordered labs, vital signs and more frequent assessments, seizure precautions for residents that missed anti-seizure medications, closer observations of residents, and extended the missed doses of antibiotics.

On 9/15/2016 at 12:32 PM, in an interview, the Director of Nursing stated her expectation was

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F 333	Continued From page 41 the medications would be documented as they were given, and that the medications would be given.	F 333		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to provide sufficient staffing to ensure residents received medications as ordered for 9 of 25 residents reviewed for missing medications (Residents #3, #11, #19, #20, #30, #33, #34, #35, #36), nutritional maintenance by way of tube	F 353	Resident #3, #4, #11, #19, #20, #33, #34, #35 and #36 attending physician were notified of non-documented medication for the period of August 27 □ 28, 2016 on September 12, 2016 no additional physician orders received. Resident #34 and #40 were interviewed by the Director	10/30/16

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F 353	Continued From page 42 feedings for 1 of 5 residents reviewed (Res.#36) and Activities of Daily Living (ADL) care for showers as scheduled for 2 of 3 residents reviewed (Res. #34 and Res. #40). Findings included: 1. This citation is cross referenced to F333. Based on resident and staff interviews and record review, the facility failed to administer significant medications ordered for 8 of 25 residents reviewed (Res. #11, #19, #20, #30, #33, #34, #35, and #36). 2. This citation is cross referenced to F309. Based on observation, staff, resident and physician interviews and record review, the facility failed to administer medications as ordered for 2 of 10 residents reviewed (Resident #3 and Resident #11) , and failed to complete post dialysis assessments by not obtaining vital signs per the Physicians order and care plan for 1 of 1 residents reviewed for dialysis (Resident #20). 3. This citation is cross referenced to F325. Based on observation, staff interview and record review, the facility failed to maintain a nutritional/ therapeutic diet for 1 of 5 residents (Resident #36) reviewed for feeding tubes, resulting in an unintended weight loss of 9.2% over a seven month period. 4. This citation is cross referenced to F242. Based on observations, record review, resident and staff interviews, the facility failed to honor bathing preferences for 2 of 3 residents reviewed (Resident #34 and Resident # 40). On 9/13/2016 at 9:10 AM, in an interview, Res. #34 stated she was bothered by the lack of help	F 353	Nursing/Designee to determine bathing/showering preferences. A nutritional assessment was completed on resident # 36. Resident #20 has been discharged from the facility. The facility Director of Nursing and/or Designee will complete an audit of facility residents to ensure that the physician was notified of any non documented medications for August 27-28, 2016; Will complete an audit of residents receiving dialysis to ensure that each have physician orders for assessment of vital signs and shunt site post dialysis. Unit Managers will conduct interviews with residents identified as inter-viewable to determine residents bathing/shower preferences. Will complete an audit of tube fed residents to ensure no unintended weight loss has occurred and orders for tube fed residents are in place and accurate. The Director of Nursing and/or Designee will re- educate facility licensed nurses regarding notification to the resident and/or responsible party and physician of any medications not administered/not documented medications, resident preferences to include honoring bathing/shower,regarding assessment of resident post dialysis to include obtaining post dialysis vital signs and shunt site assessment and tube feed residents to ensure weights are obtained weekly and orders for tube fed residents are in place and accurate completed by October 30, 2016. Newly hired licensed nurses will receive the education during orientation. The facility will complete re- education on	

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F 353	Continued From page 43 in the facility. Res #34 stated some nights on the 11:00 PM to 7:00 AM shift, there is only one nurse and one Nursing Assistant (NA) in the entire building. Res. #34 stated " if there was only one nurse in the building on the eleven to seven shift, and there was a fire, how would they get us out? I worry about that sometimes. " In an interview on 9/13/2016 at 10:10 AM, NA #2 stated she worked the 300 hall on 8/27 - 8/28/2016 on the 7AM - 3 PM shift. NA #2 stated when the Unit Manager left the 100 hall, the SDC tried to cover that hall as well as the 300 hall. NA #2 stated there is not enough nursing or NA help at the facility. On 9/13/2016 at 10:49 AM, in an interview, the Scheduler who was also a Medication Aide (MA) and an NA stated the Unit Manager left part way through the shift on 8/27/2016. The Scheduler stated she was on call for scheduling and she began to look for someone to come in to work, but she was physically unable to come in. The Scheduler noted the Director of Nursing (DON) was on vacation, and the Minimum Data Set (MDS) nurses cannot work on the medication carts. The Scheduler stated there had been a few times when there was only one nurse and a MA for the entire building. The Scheduler also noted the agency nurses would sometimes stay over their assigned shifts and she would come in early. The Scheduler also indicated there were nights with 2 or 3 NAs for the entire building. On 9/13/2016 at 3:22 PM, in a telephone interview, the Unit Manager stated on Friday Aug. 26, she was asked to work on Sat. Aug.27 and Sun. Aug. 28 for 4 hours from 7:00 AM until 11:00 AM. The Unit Manager stated staffing had been	F 353	any licensed nurse that does not receive the reeducation prior to working next scheduled shift. Director of Nursing and/or Designee will perform random audits daily times 2 weeks, weekly times 3 weeks and monthly times 3 to ensure residents have received medications as ordered. Director of Nursing and/or Designee will perform random audits on each unit weekly times 4 weeks and monthly times 3 to ensure residents preferences/showers are met. The Director of Nursing/Designee will review 2 dialysis residents three times a week to ensure assessment of resident post dialysis; to include obtaining post dialysis vital signs and shunt site assessment. Weekly times four and monthly times three. The Director of Nursing and/or Designee will perform random audits on tube fed residents weekly times 4 then monthly times 3. The DON will review the daily staffing patterns to ensure adequate staffing daily times 2 weeks, weekly times 3 weeks and monthly x 3 months. The DON will report findings of audits to the Quality Assurance Improvement Committee. The QAPI committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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short, and so, four hours seemed like nothing. The Unit Manager stated she met the SDC in the facility and they counted narcotics on both carts for the 100/200 halls. At 7:30 AM the Unit Manager stated she discovered no nurse had been seen on the 300 hall since 3:30 AM, so the SDC nurse went to try and cover the 300 hall, as well as help the Unit Manager on the 100/200 hall. The Unit Manager noted she had counted the cart, so it was up to her to be there. " I stayed, I emailed the Administrator and the Assistant Director of Nursing and begged for help. " The Unit Manager stated at that point she was just giving water. The Unit Manager noted she texted the Administrator and asked him to come help. The Unit Manager indicated the Administrator texted her back and thanked her for being a team player. The Unit Manager stated when the agency nurse arrived, she counted the cart with him and left. The Unit Manager stated she called the Assistant Director of Nursing (ADON), who called the corporate nurse who stated she was out of town and told the ADON she would have to handle it. The Unit Manager stated she texted the DON and told her it was not safe and she refused to put her license on the line. The Unit Manager stated there were lots of medications not given on the 7:00AM- 3:00 PM shift that day (8/27).

In an interview on 9/15/2016 at 3:00 PM, Nursing Assistant (NA) #4 stated August and September of 2016 had been awful, and there was not enough staffing. NA #4 stated she could not get everything done, and sometimes there were 2 NAs with 20 residents each, so you just had to do everything together. NA #4 indicated some residents required total care and if you had to use the lift, 2 staff were needed to assist.

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F 353	Continued From page 45 On 9/15/2016 at 3:20 PM, in an interview, NA #8 stated she did not feel there was enough staff, and that the lack of staff had been bad in the last 2 months and had been even worse for the past 3 weeks. NA #8 stated she could not provide quality care to the residents when the staffing was short. NA #8 indicated she had told the ADON, the scheduler and the SDC nurse about the fact the facility needed more staff. On 9/15/2016 at 3:30 PM, in an interview, NA #6 stated there were not enough NAs on the 3-11 shift. NA #6 stated when she started working at the facility there was not a problem with staffing, but it had changed, and was much worse in the last month. NA #6 indicated there were times if the NAs worked short, the residents did not receive their scheduled showers, but the staff tried to make sure the residents got good bed baths. NA #6 stated there was no way to care for 17 residents effectively and ensure the resident ' s needs were met. NA #6 reported some evenings there were only 3 NAs and with the extensive and total care residents, complete care was impossible. In an interview on 9/15/2016 at 4:00 PM, NA #7 stated there was not enough staff. NA #7 indicated the staffing shortage had gotten worse in the last couple of months. NA #7 reported call lights did not get answered timely on some evenings due to lack of staff. In an interview on 9/15/2016 at 11:11 PM. NA #13 stated the lack of staffing had gotten worse in the last 2 months. NA #13 stated the previous night	F 353		

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WILMINGTON HEALTH AND REHABILITATION CENTER	820 WELLINGTON AVENUE WILMINGTON, NC 28401

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F 353	Continued From page 46 (9/14/2016) on the 11:00 PM to 7:00 AM shift, she had worked alone with 37 residents. NA #13 reported if she needed help with turning or changing a resident, she would call to another hall and an NA would come over to help her. On 9/16/2016 at 12 noon, in an interview, the Administrator stated when he was informed of the shortage of staff on 8/27/2016, he came to the building and worked as an NA. The Administrator stated there were 7 vacancies for nursing, and there were 3 new nurses hired that were to be oriented. Also stated another was hired the day before our interview. The Administrator stated there were arrangements made for 5 travel nurses and a wound nurse who would be employed as long as needed, and the facility continues to search for staff. The Administrator stated he had gotten permission from corporate to contract with another agency staffing group in town, but the contract had not been completed until after the weekend of August 27 - 28th.	F 353		