STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. BUILDING ______ B. WING ______	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE RIVERS HEALTH AND REHAB	**1403 CONNER DRIVE** **WINDSOR, NC 27983**

(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 273 SS=E	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete comprehensive assessments within 14 days after admission for 4 of 6 sampled residents (Residents 27, 136, 153 and 155) whose admission assessments were reviewed. Findings included: 1. Resident #27 was admitted to the facility on 10/14/16 with diagnoses that included acute kidney failure, sacral pressure ulcer, atrial fibrillation, congestive heart failure, diabetes and a degenerative disease of the nervous system. The admission comprehensive assessment had an assessment reference date of 10/21/16. The completion date was documented as 11/4/16 which was after the resident's death. During an interview with the Minimum Data Set (MDS) nurse and the corporate MDS nurse on 12/21/16 at 10:00 AM, they confirmed the resident's comprehensive assessment had not been completed within the specified 14 days.	F 273	F273 • Corrective action accomplished for those residents affected by cited deficient practice; Comprehensive MDS Assessments had been previously completed and submitted late for Residents # 27 and #136 – no further action available to correct. Comprehensive MDS Assessments on Residents #153 and #155 were completed and submitted late following the survey – no further action available to correct. • Facility identification of other residents potentially affected by cited deficient practice; All scheduled MDS were reviewed for timely completion following the survey. Corporate MDS Consultant, facility Administrator and facility MDS Coordinator combined efforts and completed all comprehensive MDS assessments and submitted to QIES database. As of the date of 1/16/2017 all comprehensive MDS assessments on	1/25/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/19/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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The MDS nurse stated she had been running behind in completing comprehensive assessments, but had not notified the corporate MDS nurse. The corporate MDS nurse stated when she became aware the MDS nurse was behind in completing assessments, she tried to help her catch up. The MDS nurse and the corporate MDS nurse stated when the former Director of Nursing (DON) left, the MDS nurse had assumed more duties and determined resident care was more important than completing the comprehensive assessments.

The DON was interviewed on 12/21/16 at 2:17 PM. She stated while she was not familiar with the MDS she was aware the MDS nurse was behind on completing assessments. She stated the problem had been discussed in morning meeting since May or June 2016. The DON added when the former DON left, the MDS nurse had been pulled to assist with other tasks.

During an interview with the MDS nurse on 12/22/16 at 10:50 AM, she stated she first realized she was getting behind on completing assessments in October 2016.

2. Resident #136 was admitted to the facility on 10/6/16 with diagnoses that included hypertension and diabetes.

Review of the admission comprehensive assessment indicated an assessment reference date of 10/13/16. Documentation provided on the assessment indicated the assessment had not been completed until 11/2/16, which exceeded the 14 day time limit.

During an interview with the Minimum Data Set

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both active and discharged residents had been completed and submitted to the QIES database.

• Measures implemented or systemic changes made to ensure cited deficient practice will not recur;

All members of the Interdisciplinary Care Plan Team who complete sections or portions of the comprehensive MDS Assessments received training by corporate MDS Consultant on proper scheduling and timely completion of Comprehensive / Admission MDS Assessments on 1/16/2017.

Daily Monday through Friday the Nurse Management team (Director of Nursing, MDS Coordinator, LPN Support Nurse or designee(s)) will review all new admissions - excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave).

The Nurse Management Team or Designee(s) will ensure the Comprehensive MDS Assessment for each admission has been opened in Point Click Care during the next Daily Clinical Meeting following the admission with an ARD at or prior to day 14 of stay.

Weekly during the Daily Quality Assurance Meeting, which includes all department managers, the Administrator or Designee will review with the Quality Assurance Committee all opened comprehensive MDS Assessments to

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(MDS) nurse and the corporate MDS nurse on 12/21/16 at 10:00 AM, they confirmed the resident's comprehensive assessment had not been completed in the specified 14 days. The MDS nurse stated she had been running behind in completing comprehensive assessments, but had not notified the corporate MDS nurse. The corporate MDS nurse stated when she became aware the MDS nurse was behind in completing assessments, she tried to help her catch up. The MDS nurse and the corporate MDS nurse stated when the former Director of Nursing (DON) left, the MDS nurse had assumed more duties and determined resident care was more important than completing the comprehensive assessments.

The DON was interviewed on 12/21/16 at 2:17 PM. She stated while she was not familiar with the MDS she was aware the MDS nurse was behind on completing assessments. She stated the problem had been discussed in morning meeting since May or June 2016. The DON added when the former DON left, the MDS nurse had been pulled to assist with other tasks.

During an interview with the MDS nurse on 12/22/16 at 10:50 AM, she stated she first realized she was getting behind on completing assessments in October 2016.

3. Resident #153 was admitted to the facility on 12/2/16 with diagnoses that included right hip fracture with repair, seizures and transient ischemic attacks.

Review of the resident's comprehensive assessment indicated an assessment reference date of 12/9/16. The assessment had not been

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assure they have been completed within the required 14 day time period.

• Monitoring performance to ensure solutions are implemented, achieved and sustained with demonstration of integration into the quality assurance system;

The QA MDS Assessment Tool will be utilized by the Administrator or Designee to review 5 Admissions weekly for comprehensive MDS Assessment completion for a total of 4 weeks and then will review 5 randomly selected Admissions monthly for comprehensive MDS Assessment completion for a total of 6 months afterward.
The QA MDS Assessment Tool reviews the Date of Admission, the ARD of the comprehensive MDS Assessment, the date of the MDS completion at Z0500A and verification of submission to the QIES database.
Findings will be reviewed during the Monthly Quality Assurance Meeting which includes all department managers. Any concerns will be addressed immediately during audits with resolution discussed with Quality Assurance Committee during Monthly QA Meeting.

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completed when reviewed on 12/21/16.

During an interview with the Minimum Data Set (MDS) nurse and the corporate MDS nurse on 12/21/16 at 10:00 AM, they confirmed the resident's comprehensive assessment had not been completed in the specified 14 days. The MDS nurse stated she had been running behind in completing comprehensive assessments, but had not notified the corporate MDS nurse. The corporate MDS nurse stated when she became aware the MDS nurse was behind in completing assessments, she tried to help her catch up. The MDS nurse and the corporate MDS nurse stated when the former Director of Nursing (DON) left, the MDS nurse had assumed more duties and determined resident care was more important than completing the comprehensive assessments.

The DON was interviewed on 12/21/16 at 2:17 PM. She stated while she was not familiar with the MDS she was aware the MDS nurse was behind on completing assessments. She stated the problem had been discussed in morning meeting since May or June 2016. The DON added when the former DON left, the MDS nurse had been pulled to assist with other tasks.

During an interview with the MDS nurse on 12/22/16 at 10:50 AM, she stated she first realized she was getting behind on completing assessments in October 2016.

Review of the comprehensive assessment on 12/22/16 revealed the assessment had not been completed.

4. Resident #155 was admitted to the facility on

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F 273	Continued From page 4 12/5/16 with diagnoses that included end stage renal disease requiring dialysis and cancer. Review of the resident's comprehensive assessment with an assessment reference date of 12/5/16 revealed as of 12/21/16, the assessment had not been completed. This exceeded the specified 14 days completion time line. During an interview with the Minimum Data Set (MDS) nurse and the corporate MDS nurse on 12/21/16 at 10:00 AM, they confirmed the resident's comprehensive assessment had not been completed in the specified 14 days. The MDS nurse stated she had been running behind in completing comprehensive assessments, but had not notified the corporate MDS nurse. The corporate MDS nurse stated when she became aware the MDS nurse was behind in completing assessments, she tried to help her catch up. The MDS nurse and the corporate MDS nurse stated when the former Director of Nursing (DON) left, the MDS nurse had assumed more duties and determined resident care was more important than completing the comprehensive assessments. The DON was interviewed on 12/21/16 at 2:17 PM. She stated while she was not familiar with the MDS she was aware the MDS nurse was behind on completing assessments. She stated the problem had been discussed in morning meeting since May or June 2016. The DON added when the former DON left, the MDS nurse had been pulled to assist with other tasks. During an interview with the MDS nurse on 12/22/16 at 10:50 AM, she stated she first	F 273		

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F 273	Continued From page 5 realized she was getting behind on completing assessments in October 2016. Review of the comprehensive assessment on 12/22/16 revealed the assessment had not been completed.	F 273		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to maintain a medication administration error rate of less than 5% as evidenced by 2 medication errors out of 29 opportunities resulting in a medication administration error rate of 6.9% for 2 of 7 residents (Resident #53 and Resident #84) observed during medication pass. Findings included: 1.) Review of the manufacturers' instructions, revised 2009, for the NovoLog FlexPen used by the facility revealed the insulin pen should always be primed with 2 units of insulin before each injection (Priming an insulin pen is performed by, after attaching the needle to the pen, ejecting a small amount of insulin out of the needle.) Review of Resident #84's currently active physician orders for December 2016 revealed Resident #84 was ordered NovoLOG FlexPen Solution 100 UNIT/ Milliliter to be injected per sliding scale subcutaneously before meals for diabetes. (Based on the sliding scale, the resident	F 332	F332 • Corrective action accomplished for those residents affected by cited deficient practice; Physicians for Resident #84 and #53 were notified of Medication Errors. Both received orders to monitor patients for Adverse Side Effects resulting from medication errors. Neither patient demonstrated any Adverse Side Effects related to the medication errors. • Facility identification of other residents potentially affected by cited deficient practice; Reviewed all patients receiving insulin by pen on 12/20/2017 by nurse #1 and verified insulin pen was properly primed during administration of daily dose. Reviewed Calcium Carbonate orders and verified ordered dosage was available. If	1/25/17

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F 332	Continued From page 6 needed 2 units of insulin during medication pass.) During medication pass observation on 12/20/16 at 11:14 AM, Nurse #1 was observed administering a 2 unit NovoLog injection to Resident #84 via a NovoLog FlexPen. Nurse #1 did not prime the insulin pen with 2 units before giving the resident his 2 unit injection. During an interview on 12/20/2016 at 12:59 PM Nurse #1 stated that she realized she did not prime the insulin pen to prepare the injection. She stated she had called the resident's physician to let him know about the medication error and that the physician stated to continue to monitor the resident for signs and symptoms related to blood sugar levels. She stated she understood that it was a medication error and that an insulin pen needed to be primed prior to administering the insulin to be sure that the correct dose of insulin was given. During an interview on 12/20/2016 at 4:39 PM the Director of Nursing stated it was her expectation the nurses followed the manufacturers' recommendations for insulin pens for medication administration. 2.) Review of Resident #53's currently active physician orders for December 2016 revealed Resident #53 was ordered 1000 milligrams of Calcium Carbonate to be taken by mouth one time a day for supplement. During medication pass observation on 12/21/16 at 8:33 AM, Nurse #2 was observed giving 1125 milligrams of Calcium Carbonate to Resident #53. During an interview on 12/21/16 at 8:35 AM, Nurse #2 stated that she administered the incorrect dose of Calcium Carbonate to the resident. She stated the resident received more than the 1000 milligrams ordered by the physician. She further stated that this was a medication error.	F 332	not available for specific order, Calcium Carbonate in the correct dosage was purchased locally on 12/21/2017 and provided to nursing staff. Director of Nursing reviewed with all licensed nurses the need to closely compare label of over the counter medications for both generic drug composition as well as dosage. Also verified over the counter medications and dosages available as compared to current active orders and verified available in facility. Provided 1:1 training to nurse #1 and nurse #2 on manufacturer's recommendations for insulin administration using the insulin pen and standards of practice of medication administration including verification of drug on hand and dosage compared to order prior to administration on both 12/20/2017 and 12/21/2017. • Measures implemented or systemic changes made to ensure cited deficient practice will not recur; All licensed nurses and medication aides on staff received training on standards of care in regard to proper medication administration practices beginning on 12/21/2017 and completed by 12/28/2017. The same training will be provided to all newly employed licensed nurses and medication aides ongoing. • Monitoring performance to ensure solutions are implemented, achieved and sustained with demonstration of integration into the quality assurance system;	

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F 332	Continued From page 7 During an interview on 12/21/16 at 9:07 AM, the Director of Nursing stated her expectation was that any nurse who did not have the correct dosage of a medication available would call the physician and receive an order covering the different dosage of that medication. She further stated the dosage of Calcium Carbonate received by Resident #53 was a medication error.	F 332	A member of the nurse management team will complete a medication pass audit utilizing the CMS-20056 Form observing 5 licensed nurses and/or medication aides on staff each month for the next 3 months. A total of 10 medication opportunities observing multiple routes of administration will be monitored for each licensed nurse or medication aide. Additionally, a member of the nurse management team will complete a medication pass audit utilizing the CMS-20056 on each newly hired licensed nurse and medication aide as part of their orientation process ongoing. All completed medication pass audits utilizing the CMS-20056 will be reviewed by the Quality Assurance Committee during the Monthly Quality Assurance Meeting each month. Any concerns or trends will be addressed with re-training as indicated and further auditing if need is determined by the Quality Assurance Committee.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520		1/25/17

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F 520	Continued From page 8 issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assurance (QA) Committee failed to maintain implemented procedures and effective monitoring practices to address the medication error rate to ensure compliance was sustained. The facility had a pattern of a recited deficiency which was originally cited on 1/14/16 during a recertification survey and on the current survey for medication error rate greater than 5%. The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag was cross referenced to: F332 - Based on observations, record review and staff interviews the facility failed to maintain a medication administration error rate of less than 5% as evidenced by 2 medication errors out of 29 opportunities resulting in a medication administration error rate of 6.9% for 2 of 7 residents (Resident #53 & Resident #84)	F 520	F520 Corrective Action: Physicians for Resident #84 and #53 were notified of Medication Errors. Both received orders to monitor patients for Adverse Side Effects resulting from medication errors. Neither patient demonstrated any Adverse Side Effects related to the medication errors. (Cross reference Tag F 332) Identification of other residents who may be involved with this practice: Reviewed all patients receiving insulin by pen on 12/20/2017 by nurse #1 and verified insulin pen was properly primed during administration of daily dose. Reviewed Calcium Carbonate orders and verified ordered dosage was available. If	

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F 520	Continued From page 9 observed during medication pass. During the recertification survey of 1/14/16 the facility was cited for failing to maintain a medication error rate of less than 5%. During an interview with the Administrator on 12/22/16 at 9:30 AM she stated the Quality Assurance Committee staff members met daily during the morning meeting to discuss current QA topics and monitoring processes. She added that the full QA team attended the quarterly meeting. She reported that the facility had hired new nurses since the last recertification survey and now also had a newly appointed Director of Nursing.	F 520	not available for specific order, Calcium Carbonate in the correct dosage was purchased locally on 12/21/2017 and provided to nursing staff. Director of Nursing reviewed with all licensed nurses the need to closely compare label of over the counter medications for both generic drug composition as well as dosage. Also verified over the counter medications and dosages available as compared to current active orders and verified available in facility. Provided 1:1 training to nurse #1 and nurse #2 on manufacturer's recommendations for insulin administration using the insulin pen and standards of practice of medication administration including verification of drug on hand and dosage compared to order prior to administration on both 12/20/2017 and 12/21/2017. (Cross reference Tag F 332) Systemic Changes: All licensed nurses and medication aides on staff received training on standards of care in regard to proper medication administration practices beginning on 12/21/2017 and completed by 12/28/2017. The same training will be provided to all newly employed licensed nurses and medication aides ongoing. (Cross reference Tag F 3332) Monitoring: To ensure compliance, Administrator or Director of Nursing will monitor this issue using the QA survey tool. Facility will monitor compliance of monitoring the	

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F 520	Continued From page 10	F 520	completion of the med pass audits. This will be done on a monthly basis for 3 months by the Administrator, DON, or designee. Reports will be presented to the QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Quarterly Quality of Life Meeting. QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.	