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PRUITTHEALTH-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint survey of 01/11/17. Event# IF1D11. The extended exit date of the recertification and complaint survey was due to four days of inclement weather.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to complete a significant change Minimum Data Set (MDS) for 1 of 1 sampled residents (Resident #60) reviewed for hospice services. Findings included: Resident #60 was admitted to the facility 01/19/15. Her diagnoses included pneumonia, non-Alzheimer ' s dementia, anxiety, depression,	F 274	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. Immediate corrective action taken for this alleged deficient practice includes:	2/8/17

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

Electronically Signed | 01/31/2017

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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F 274	Continued From page 1 psychotic disorder, schizophrenia, and lung cancer with inoperable metastases. The most recent MDS, an annual assessment dated 10/21/16, showed that the resident required limited activities of daily living (ADL) assistance except for dressing, toileting and personal hygiene for which she required extensive assistance. She had a Brief Interview for Mental Status (BIMS) score of 05 which indicated cognitive impairment. The resident was not receiving hospice care at the time the MDS was completed. A physician ' s order to admit Resident #60 to Hospice care was dated 12/13/16. Orders were present for pain management. Resident #60 has been assessed by Hospice at least weekly beginning 12/14/16 and RN progress notes relating to the care are present in the record. The care plan signed and reviewed on 01/03/17 included five issues " secondary to inoperable lung cancer with mets " : impaired communication, pain related to tumor on chin/neck, risk for weight loss, an advanced directive and admission to hospice program. Palliative care measures were listed. Resident #60 was observed on 01/05/16 at 11:55 a.m. resting quietly in bed with her eyes closed. During an interview with the MDS Coordinator on 01/05/17 at 1:45 p.m., she provided the MDS dated 10/21/16 as the most recent MDS document. When asked, she indicated that a new MDS was in progress due to the resident now receiving palliative care. She acknowledged that the MDS was not finished within 14 days (by	F 274	1.Resident # 60 MDS was transmitted on 1/5/2017. Resident with potential to be affected. 1.All residents have the potential to be affected. Measures put into place to assure that the alleged deficient practice does not recur include: 1.During the daily clinical meetings, the Case Mix Director identifies potential significant changes that includes a non-self- limiting event. 2.Interdisciplinary team discusses the non-self-limiting event to determine if significant change is warranted. 3.The Assessment reference date is set and minimum data set is transmitted within the confines of the guidelines of the Resident Assessment Instrument. 4.The Case Mix Director completes the significant change is status review which contains the date the significant change is identified, the assessment reference date, the date MDS is completed and the date the MDS is transmitted. Monitoring put in place to assure the alleged deficient practice does not recur includes: 1.Findings and interventions put in place	

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F 274	Continued From page 2 12/27/16) of hospice care being initiated for the resident. On the morning of 01/06/17, the MDS Coordinator provided a written copy of the MDS documenting the significant change for Resident #60. In an interview on 01/11/17 at 1:40 p.m., she indicated that the completed MDS was transmitted on 01/05/17. In an interview with the Director of Nursing on 01/11/17 at 1:45 p.m., he indicated his awareness of the failure to complete the MDS within 14 days of the initiation of palliative care for this resident. He shared his expectation that MDS assessments are done within the required timeframe.	F 274	for Significant changes will be reported in Quality Assurance Performance Improvement Committee Meetings for review of any additional needs monthly until three months of consecutive compliance has been established.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		2/8/17

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F 279	Continued From page 3 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to develop a comprehensive care plan for 1 of 5 sampled residents (Resident #2) reviewed for nutrition. Findings included: Resident #2 was originally admitted to the facility on 9/18/10 and re-admitted on 7/28/16 with diagnoses which included: Wilson's disease, right sided hemiplegia following cerebrovascular accident, multiple contractures, feeding difficulties, aphasia, ataxia, and muscle weakness. Review of the Nutrition Assessment dated 8/5/16 revealed Resident #2's weight was 225.8 pounds which was above the ideal body weight range of 131-209 pounds. The resident received a diet of regular consistency with thin liquids; and was able to make his needs known through the use of a message board. Review of the Physician's Order dated 8/19/16 revealed an OT (occupational therapy) clarification for Resident #2 to have the use of a flexible long handled spoon and a raised lip plate for all meals. Review of the Admission MDS (minimum data set) dated 8/8/16 and the quarterly MDS dated 10/17/16 indicated Resident #2 was cognitively	F 279	Immediate corrective action taken for this alleged deficient practice includes: 1.Resident #2 had a comprehensive care plan developed for adaptive equipment. Resident with potential to be affected. 1.Residents utilizing adaptive equipment have the potential to be affected. Measures put into place to assure that the alleged deficient practice does not recur include: 1.A master list of adaptive equipment has been compiled and validated with the resident□s comprehensive care plan to ensure the adaptive equipment is identified on the care plan. 2.The Interdisciplinary team (Director of Health Services, Care Mix Director, Clinical Competency Coordinator, Social Worker, Certified Dietary Manager, Activity Director, Nurse Manager) will review new physician orders to validate the care plans have been updated for new adaptive equipment orders during clinical rounds daily. 3.The Director of Health Services / Nurse	

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F 279	Continued From page 4 intact, required extensive assistance with eating; and no weight loss or weight gain. The review of the Resident #2's clinical record revealed Nutrition was not included in the Care Plan. During an interview on 1/6/17 at 11:27am, NA#2 (nursing assistant) revealed Resident #2 was able to feed himself with an adaptive spoon that had a handle which could be wrapped around his forearm. NA#2 indicated the resident ate his meals in the dining room with staff supervision. During an observation on 1/6/17 at 1:15pm, Resident #2 was observed in a high-back wheelchair feeding himself a meal of regular consistency, using a flexible long handled spoon and a raised lip plate. The resident was consuming the meal without any problems. During an interview on 1/6/17 at 3:26pm, the DON (Director of Nursing) stated that his expectation is for the Care Plan to provide an accurate picture of the resident, including nutrition with the use of adaptive feeding equipment. After reviewing the clinical records and facility records, the DON acknowledged there was no nutrition care plan completed for Resident#2 and should have been.	F 279	Managers will complete a review of the Care Plan validation daily which include, new orders for adaptive equipment and validation that the adaptive equipment was placed on the comprehensive care plan. 4.The Clinical Competency Coordinator / Director of Nursing / Case Mix Director and/or Nurse Managers will educate the Licensed Nurses on updating residents care plan as resident condition changes. Monitoring put in place to assure the alleged deficient practice does not recur includes: 1.The Director of Health Services will present their findings of the Adaptive equipment/Care Plan review, to the Quality Assurance Performance Improvement Committee Meetings for review of any additional needs. This will be completed monthly until three months of consecutive compliance has been established	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		2/8/17

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F 280	Continued From page 5 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to update and revise the care plan for 5 out of 17 residents sampled. (Resident #29, #55, #38, #89 and #95). Findings included: 1. Resident #89 was admitted on 10/28/15. Diagnoses included a stroke due to a bleed with left sided weakness. A review of an order written by the Physical Therapist (PT) on 10/25/16 revealed an order for a right knee splint and position the resident into neutral rotation X8 hours at night. The minimum data set (MDS) quarterly assessment dated 11/24/16 revealed the resident was cognitively intact, required total dependence	F 280	Immediate corrective action taken for this alleged deficient practice includes: 1.Resident # 89. #95, #38, #55, and #29 care plan was updated and/or revised. Resident with potential to be affected. 1.All Residents have the potential to be affected. Measures put into place to assure that the alleged deficient practice does not recur include: 1.The Interdisciplinary team (Director of Health Services, Care Mix Director, Clinical Competency Coordinator, Social Worker, Certified Dietary Manager, Activity Director, Nurse Manager) will review new physician orders and resident changes during clinical rounds. to validate	

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F 280	Continued From page 6 to extensive assist with all activities of daily living, and was impaired to one side and used a wheelchair. The MDS noted the resident had a splint for passive range of motion (PROM). A review of the care plan revealed the resident had a plan of care for a left hand splint updated on 11/29/16 which included restorative nursing for splinting to left hand for contracture management. The intervention was to apply the left hand splint in the morning and allow resident to wear for 6-8 hours and remove in evening, perform hand hygiene, passive range of motion (PROM) and monitor skin for breakdown. There was no care plan noted for nursing to apply a right knee splint. An interview with the physical therapist #1 (PT) on 1/6/17 at 9:41 am revealed the resident had an order for nursing to apply the splint to his right knee on the night shift. The PT stated that it was a nursing measure verses a restorative measure since it was being applied at night and there was no restorative team at night. An interview with the MDS nurse on 1/11/17 at 1:30 pm revealed the care plan should have been updated to include the right knee splint as a nursing measure. An interview with the resident on 1/11/17 at 11:19 am revealed the resident reported the night shift applied the splint to his right knee every night. The knee splint was noted to be on the resident's bed. An interview with the Director of Nursing (DON) on 1/11/17 at 4:15 pm revealed his expectation was that the care plan was the care plan should have been updated when the order for the knee	F 280	that the care plans have been updated for resident□s changes. 2.The Clinical Competency Coordinator / Director of Nursing / Case Mix Director and/or Nurse Managers will educate the Licensed Nurses on updating residents care plan as resident condition changes. 3.The Director of Health Services / Nurse Managers will complete a review of the Care Plan validation daily which include, new orders and resident changes and validation that the changes have been placed on the comprehensive care plan. Monitoring put in place to assure the alleged deficient practice does not recur includes: 1.The Director of Health Services will present their findings of the Care Plan review, to the Quality Assurance Performance Improvement Committee Meetings for review of any additional needs. This will be completed monthly until three months of consecutive compliance has been established.	

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splint was put in place.

2. Resident #95 was admitted on 9/1/16. Diagnoses included Alzheimer ' s disease, anxiety, depression, psychosis and convulsions.

The minimum data set (MDS) quarterly assessment dated 12/5/16 revealed the resident was severely cognitively impaired.

A review of the initial care plan written on 9/1/16 and updated on 12/13/16 revealed a plan of care for impaired decision making related to Alzheimer ' s, a plan of care for adverse reactions to psychotropic, antianxiety, and antidepressants medications. There was no care plan noted for convulsions.

A record review of the nurse ' s notes revealed Resident #95 had seizure like symptoms on 10/9/16 and was sent to the emergency room (ER) for evaluation. He was returned to the facility with no new orders.

A record review of the nurse ' s notes revealed Resident #95 was observed having seizure like activity on 12/11/16. The note indicated the resident was not sent to the ER, but the physician was made aware.

An interview with Nurse #4 on 1/6/17 at 10:00 am was conducted. Nurse #4 reported the resident was sent to the hospital in October for seizure like activity and confirmed the resident had further seizure activity on 12/11/16. The nurse confirmed there was no care plan in place for convulsions. The nurse stated there should have been an updated care plan to reflect this diagnosis.

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An interview with the physician via phone on 1/11/17 at 4:30 pm revealed he reviewed the chart and was aware of the seizure activity for this resident. The physician reported the resident was currently being treated with Neurontin for the seizures and the physician was going to continue to monitor the resident for further seizures.

An interview with the Director of Nursing (DON) on 1/11/17 at 4:15 pm revealed his expectation was for care plans to be updated.
3. Resident #38 was admitted to the facility 06/21/16. His diagnoses included morbid obesity, Alzheimer ' s disease, non-Alzheimer ' s dementia, age-related osteoporosis, major depressive disorder, anxiety disorder and psychotic disorder.

The most recent Minimum Data Set (MDS) dated 12/01/16 for Resident #38 indicated the presence of one Stage 3 pressure ulcer compared to the previous MDS (09/01/16) which stated no Stage 1 or higher ulcer was present. Measurements of the Stage 3 ulcer were listed as 2.0, 1.4, and 0.2 depth. The MDS recorded a Brief Mental Status Score (BIMS) score of 3 indicating a marked degree of cognitive impairment.

The facility care plan was signed as reviewed on 12/06/16. One skin-related problem was present on the care plan with an Onset Date of 06/28/16: the resident was " at risk for impaired skin integrity related to incontinence and impaired mobility. " Nursing interventions were listed. One page of the care plan listing a problem of " unstageable pressure ulcer to right trochanter " was lined through. The page was initialed and dated 10/10/16 with a notation of " healed."

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A physician ' s order dated 11/07/16 listed wound care instructions for an " unstageable pressure ulcer to right buttock. " Wound Assessment and Observation Forms and Treatment Administration Records were present in the medical record beginning 11/07/16.

Resident #38 was referred to Quality Surgical Management (QSM) on 12/02/16 for an assessment of the skin impairment to his right buttock.
The QSM evaluation listed impediments to wound healing as "obesity, dementia, urinary incontinence, and muscle weakness."

The wound dressing change for Resident #38 ' s pressure ulcer on the right buttock was observed 01/05/17 at 3:11 p.m.

Resident #38 was later observed 01/05/17 at 4:52 p.m. sitting in the group room in his wheelchair with a pressure-relieving cushion in place.

During an interview with the Wound Treatment nurse on 01/05/17 at 5:31 p.m., she indicated that the wound clinician visits the facility every Monday and does physical assessments with the Wound Treatment Nurse of all residents with wounds. When asked about the pressure ulcer problem discontinued on the care plan, the treatment nurse indicated that the pressure ulcer on the right trochanter was healed and that the current Stage 3 ulcer on the right buttock was new.

On 01/06/17 the Wound Treatment Nurse provided a Care Plan sheet (page 1 of 1) for " pressure ulcer to right buttock related to poor

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mobility. " The Onset Date is listed as 11/07/16. She indicated that she had placed this care plan update in the medical record.

During an interview with the Director of Nursing (DON) on 01/11/17 at 1:45 p.m., he shared his expectation that the presence of a pressure ulcer should be reflected on the care plan.

4. Resident #55 was originally admitted to the facility on 7/2/15 and re-admitted on 1/5/16 with diagnoses which included: end-stage renal disease, dependence of renal dialysis, and renal osteodystrophy.

The Quarterly MDS (minimum data set) dated 12/9/16 indicated Resident #55 was moderately, cognitively impaired and received dialysis treatments.

Review of the Care Plan approved 12/13/16, revealed Resident #55 was at risk for complications from hemodialysis due to ESRD (end-stage renal disease). The goal was to ensure the resident ' s AV (arteriovenous) access will remain patent, as evidenced by palpable thrill, bruit on auscultation and adequate color and temperature in extremity through next review. Approaches included: monitor fistula site for signs and symptoms for infection; and no blood pressure taken or venipuncture on affected side.

There was no documentation in the clinical records indicating Resident #55 had a fistula placed as an access site for hemodialysis.

Review of the Medication Administration Record for December 2016 and January 2017 indicated Resident #55 had a perma-catheter which was

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monitored by nursing staff, daily.

There were no goals or approaches in the resident's Care Plan indicating the resident had a perma-catheter placed for hemodialysis access.

During an observation and interview on 1/4/17 at 3:31pm, Resident #55 was lying in bed, partially covered with bed linen. The resident revealed she received dialysis treatments on Mondays, Tuesdays, sometimes on Wednesdays, and on Fridays.

During an interview on 1/5/17 at 11:04am, N#3 stated that Resident #55 had a perma-catheter placed her left chest area for hemodialysis which she receives on Mondays, Wednesdays, and Fridays from 5:30am to 11:30am and on Tuesdays from 10:30am to 4:00pm. N#3 revealed the resident's perma-catheter had been in place for over a year.

During an interview on 1/5/17 at 11:42am, NA#3 revealed she had worked with Resident #55 since the resident's admission. NA#3 also revealed that the resident's dialysis access site was located on the resident's upper left chest and covered by a clear bandage. She indicated that the site area was observed for swelling, redness, drainage, pain and the covering bandage was to remain clean and dry.

During an interview on 1/5/17 at 3:23pm, the MDS Coordinator acknowledged the dialysis care plan incorrectly indicated Resident #55 had a fistula when she actually had a perma-catheter. She stated that the incorrect documentation was due to human error.

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5. Resident #29 was admitted to the facility on 10/8/08 with diagnoses which included: myoclonus, hemiplegia, contractures, muscle spasms, dysphagia, and dysarthria.

The annual MDS (minimum data set) dated 11/8/16 indicated Resident #29 was moderately, cognitively impaired and had range of motion impairments on one side of his body of the upper/lower extremities.

Review of the Restorative Therapy Referral dated 11/22/16 indicated Resident #29 was to receive PROM (passive range of motion) of his left hand; and donning/doffing of a palm protector to the resident's left hand.

The Care Plan dated 11/22/16 indicated Resident #29 was to receive restorative nursing of PROM to his left hand prior to donning and after doffing palm protector daily. Approaches included: PROM through all fields to the resident's left hand as tolerated.

The Care Plan dated 11/22/16 indicated Resident #29 was to receive Restorative nursing for the application of the palm protector to his left hand 4-6 hours a day. Approaches included: inspect skin before donning and doffing palm protector; donn palm protector to the resident's left hand, daily.

During an observation on 1/03/17 at 5:06pm, Resident #29 was lying in his bed. The resident was alert and responsive through movement, but his speech very difficult to understand. The two fingers on the end of the resident's right hand were noted to be folded towards the palm of his

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right hand. The resident was not wearing a splinting device.

During an interview on 1/11/17 at 1:07pm, the OT (occupational therapist) revealed Resident #29 was discharged from therapy on 11/23/16 to the Restorative Program to receive PROM of bilateral hands and continued application of a palm protector to his right hand. After review of the referral form, the OT stated that the Rehabilitative Manager incorrectly recorded the "left hand" on the referral sheet. The OT revealed the Restorative Program falls under the nursing department and the restorative nursing assistant was correctly trained by OT to place the palm protector on the resident's right hand.

During an interview on 1/11/17 at 1:30pm, RNA#2 (restorative nursing assistant) revealed Resident #29 received PROM and palm protector application to his right hand as tolerated for six days per week. The RNA#2 indicated the resident would wear the palm protector to his right hand for 4-6 hours as tolerated and was checked every two hours to ensure no problems. There was no scheduled time of day for the palm protector to be worn.

During an interview on 1/11/17 at 1:35pm, the MDS Coordinator revealed that she was the nurse in charge of the Restorative Program at the facility. She acknowledged the Care Plan incorrectly indicated Resident #29 was to receive range of motion and palm protector application to his left hand.

During an observation on 1/11/17 at 1:40pm, Resident #29 was sitting in a broad-chair (specialized positioning chair) in the facility's

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F 280	Continued From page 14 common area. The resident was noted wearing a right handed palm protector with no signs of discomfort or pain.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow physician ' s orders on 1 of 5 residents reviewed for unnecessary medications. (Resident #75) Findings included: Resident #75 was admitted on 3/4/16. Diagnosis included fracture to left tibia and fibula, rheumatoid arthritis, diabetes, chronic anticoagulation, and coronary artery disease with multiple stents. The minimum data set (MDS) dated 8/16/16 quarterly assessment revealed the resident was cognitively aware. The resident required extensive assist with two staff assist with bed mobility and transfers, extensive assist with one staff assist with dressing, toileting and personal hygiene. She had no impairment and used a wheel chair. She was always incontinent of bowel and bladder. The MDS reported she had 7 doses of an anticoagulant during the 7 day assessment period. A review of the care plan initiated on 3/4/16 and	F 281	Immediate corrective action taken for this alleged deficient practice includes: 1.Resident # 75 no longer resides in the facility. Resident with potential to be affected. 1.All residents with physician orders have the potential to be affected. 2.Resident Medication Administration records have been reviewed to ensure physician orders have been followed by the Licensed Nurses. Measures put into place to assure that the alleged deficient practice does not recur include: 1.The Clinical Competency Coordinator / Director of Health Services / Nurse Manager began educational in-services on Order Transcription and following physician orders with emphasis on hemocult orders.	2/8/17

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F 281	Continued From page 15 updated on 12/27/16 included a plan of care for anticoagulant use. The interventions included to monitor for signs or symptoms of bleeding, bruising, petechia, nosebleeds, tarry stools, or blood in urine, and to keep physician informed of lab results and medications as ordered for anticoagulant use. A review of the physician ' s order written on 8/19/16 revealed the resident was prescribed a blood thinner, Xeralto 20 milligrams daily. A review of the monthly consultant pharmacy drug regimen record revealed on 12/12/16, the pharmacist acknowledged the resident was on Xeralto and recommended to hemocult 3 stools (a smear test of stool to determine if there is any bleeding). A review of the physician ' s orders revealed an order was written on 12/19/16 to hemocult 3 stools due to risk of bleeding related to Xeralto. A review of the Medication Administration Record (MAR) revealed the order was transcribed to the MAR to read hemocult stool X 3 due to risk of bleeding with Xeralto. Each shift, 7 AM to 3 PM, 3PM to 11 PM, and 11PM to 7 AM was allotted space on the MAR to place initials to indicate if a stool specimen had been obtained and tested, but there was no documentation to support the stool was obtained. On 12/22/16 the nurse circled his initials in the 11 PM to 7 AM space which indicated the resident did not have a bowel movement. On 12/23/16, the nurse circled her initials in the 7AM to 3 PM space which indicated the resident did not have a bowel movement. It was noted on the MAR only	F 281	2.The Licensed Nursing off going / on coming each shift will review the Medication Administration Record to ensure Physician orders have been followed through. 3.The Director of Nursing / Nurse Managers will review new Physician Orders for transcription and follow through of orders daily for two weeks, then weekly for three weeks then monthly for three months Monitoring put in place to assure the alleged deficient practice does not recur includes: 1.The Director of Health Services will present their findings of the Transcription review to the Quality Assurance Performance Improvement Committee Meetings for review of any additional needs. This will be completed monthly until three months of consecutive compliance has been established.	

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3 attempts were made to obtain the stool and test it as ordered.

An interview with the Medical Director (MD) on 1/10/17 via phone at 10:30 AM revealed he had just started with the facility on 12/1/16. The MD did not recall the order for the hemocult stools X 3, however he stated " I'm sure I ordered it. " He stated his expectation would be for the nurses to obtain and hemocult the stool 3 times. The MD stated he would expect the order to be active until all the stools were obtained. The MD stated if the nurse's did not obtain the stools he would have expected them to let him know. The MD reported he did not recall any of the nurses getting back to him regarding the hem occult. He reported the reason we ask for 3 stools was because sometimes it could be difficult to obtain the stool and it could read a negative result.

On 1/11/17 at 12:51 PM an interview with Nurse #5 on the 7 -3 shift was conducted. Nurse #5 reviewed the order for the hemocult stools X3 on 12/19/16. Nurse #5 stated she understood the order to read to obtain 3 stools, not try 3 times. Nurse #5 replied her signature was the one on the 7-3 shift on 12/23/16. Nurse #5 stated she circled her initials because she did not obtain any stools this shift because the resident did not have a bowel movement. Nurse #5 stated she did not continue to try and obtain stools and replied " I guess I must have missed it. " Nurse #5 reported she did not obtain any stool to hemocult. She reported she did not tell the aids she needed to hemocult the stool, but she did tell the resident. Nurse #5 stated she did not know why the order did not get followed as prescribed. Nurse #5 stated if she had obtained a stool she would have tested it and would have documented and

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F 281	Continued From page 17 reported the results to the MD. An interview with Nurse #2 on the 3-11 shift on 1/11/17 at 4:30 PM reviewed the order as it was written on the MAR on 12/19/16. Nurse #2 stated he understood the order to read obtain 3 stools. Nurse #2 also stated the order should have continued until all 3 stools were obtained. Nurse #2 revealed the order did not get carried out as it was ordered and he realized when Resident #75 was sent out to the emergency room the importance of carrying out this order. Nurse #2 stated if he had obtained any stools he would have signed the MAR and written on the back that stool was obtained. The nurse reported he believed he told the aids he needed a stool, but he could not remember. The nurse on the 11-7 shift was unable to be reached for an interview. An interview with the Director of Nursing (DON) on 1/11/17 at 4:45 PM revealed that his expectation of the nursing staff was to follow the order as prescribed. The DON reported he would have expected his nursing staff to obtain 3 stools before stopping the order.	F 281		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		2/8/17

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F 329	Continued From page 18 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to obtain an Abnormal Involuntary Movement Scale (AIMS) assessment as ordered by the physician for 1 of 5 residents (Resident #95). Findings included: A review of the facility ' s policy dated 11/21/16 for monitoring antipsychotic medications specified was provided. Number 4 of the policy stated " Upon initiation of antipsychotic medication therapy (or upon admission for new residents receiving antipsychotics) and twice per year thereafter, the DISCUS (Dyskinesia Identification System Condensed User Scale) or similar test AIMS (Abnormal Involuntary Movement Scale was what the facility used) was performed on the resident and the information was recorded in the	F 329	Immediate corrective action taken for this alleged deficient practice includes: 1.Resident #95 AIMS test was completed on 1-11-2017. Resident with potential to be affected. 1.Residents with antipsychotic drug therapy have the potential to be affected. 2.A review of Residents on antipsychotic therapy has been completed to validate the Abnormal Involuntary Movement scale is up to date. Measures put into place to assure that the alleged deficient practice does not recur include:	

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F 329	Continued From page 19 residents ' medical record. " Resident #95 was admitted on 9/1/16. Diagnoses included Alzheimer ' s disease, anxiety, depression, and psychosis. The minimum data set (MDS) quarterly assessment dated 12/5/16 revealed the resident was severely cognitively impaired. He was noted to have received 7 doses of antipsychotic, antidepressant and anti-anxiety medications and 1 dose of an antibiotic during the 7 day assessment period. A review of the initial care plan written on 9/1/16 and updated care plans on 12/13/16 revealed a plan of care for impaired decision making related to Alzheimer ' s, a plan of care for adverse reactions to psychotropic, antianxiety, and antidepressants medications. The interventions included AIMS testing per physician order, monitor mood and behaviors, administer medications as ordered and notify physician of any adverse reaction to medication or non-compliance. A review of the physician ' s orders revealed the resident was prescribed Zyprexa (anti-psychotic) 5 milligrams by mouth daily at bed time for behavioral disturbances on 9/1/16. A review of the physician ' s orders written on 9/1/16 revealed an AIMS test to be completed every 6 months in September and March. A review of the medical record revealed there was no AIMS test completed upon admission on 9/1/16.	F 329	1.Licensed Nurses will complete the Abnormal Involuntary Movement scale for resident admitted / readmitted on antipsychotic therapy to the facility within 24 hours. 2.Admitted / Readmitted residents chart will be reviewed for the AIMS (abnormal involuntary movement scale) within 24 hours of admission to the facility. This will be completed by the Director of Health Services, Clinical Competency Coordinator and/or Nurse Managers daily for seven days, weekly for 3 weeks then monthly for 3 months. 3.The Clinical Competency Coordinator / Nurse Managers has started education with the Licensed Nurses on when a AIMS test is to be completed. Monitoring put in place to assure the alleged deficient practice does not recur includes: 4.The Director of Nursing will present the AIMS review to the Quality Assurance Performance Improvement Committee Meetings for review of any additional needs. This will be completed monthly until three months of consecutive compliance has been established.	

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F 329	Continued From page 20 An interview with Nurse #4 on 1/6/17 at 10:00 am was conducted. Nurse #4 confirmed that an AIMS test should have been completed for Resident #95 upon admission since he was on the Zyprexa. Nurse #4 added that any resident on an antipsychotic should be assessed by the nurse for adverse reactions to the antipsychotic upon admission and every six months using the AIMS scale. An interview with the Director of Nursing (DON) on 1/11/16 at 3:15 pm revealed his expectations of the nurses would be to follow the policy for monitoring antipsychotics.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		2/8/17

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F 431	Continued From page 21 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure one of four medication carts located on the (100/200 hall). Findings included: On 1/5/17 at 1:15 pm the medication cart on the 100/200 hall was observed to be unlocked. The medication cart was facing a dining room full. There were approximately 20 residents in the dining room and several residents in the common area adjacent to the dining room. An interview with the Unit Manager (UM), who was standing nearby, was conducted on 1/15/17 at 1:15 pm. The UM identified the 100/200 cart as being unlocked and locked the cart at this time. The UM revealed Nurse #1 was managing the cart for the 100/200 hall. The UM reported she would locate Nurse #1. The UM reported her expectation of the nursing staff was to keep the medication carts locked at all times when unsupervised.	F 431	Immediate corrective action taken for this alleged deficient practice includes: 1.The medication cart was locked at the time identified by the unit manager. Resident with potential to be affected. 1.All Residents have the potential to be affected. 2.Nurse Management will complete random observations of medication carts to ensure the carts are locked. Measures put into place to assure that the alleged deficient practice does not recur include: 1.The Clinical Competency Coordinator has begun Educating Licensed Nurses on the storage of medications in a locked compartment when the medication cart is not in visual sight.	

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F 431	Continued From page 22 An interview was conducted with Nurse #1 at 1:20 pm. Nurse #1 confirmed that she did leave the cart unlocked and unsupervised. Nurse #1 reported that she thought it was locked before she walked away from it.	F 431	2.The Nurse Management team and Department Managers are randomly auditing the medication carts daily to validate the security. These daily random auditing will occur daily for 7 days, then weekly for 3 weeks, then monthly for 3 months. Monitoring put in place to assure the alleged deficient practice does not recur includes: 1.The Director of Nursing will present the findings of the daily medication cart security review to the Quality Assurance Performance Improvement Committee Meetings for review of any additional needs. This will be completed monthly until three months of consecutive compliance has been established.	