STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews facility failed to provide the assistance to maintain a safe parameter of the bed during care and allowed a resident (Resident #7) to slide out of the bed for one of three sampled residents with falls. The findings included: Resident #7 was admitted to the facility on 9/4/15 with diagnoses including dementia, stroke,	F 323	F323 Facility failed to provide the assistance to maintain a safe parameter of the bed during care and allowed a resident to slide out of the bed. -Resident # 7 no longer resides in the facility. - All Certified Nursing Assistants (C.N.A.)	3/24/17

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

Electronically Signed | 03/21/2017

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F 323	Continued From page 1 diabetes, Alzheimer's, macular degeneration, and Parkinson's disease . Review of the Minimum Data Set (MDS), an Annual, dated 1/24/17 indicated Resident #7 required total assistance of two staff for bed mobility, transfer, and toileting. Resident #7 was unable to walk, was incontinent of bowel and bladder. The Annual MDS indicated Resident #7 had long and short term memory problems, moderately impaired cognition and exhibited no behaviors. Review of the Care Area Assessments (CAAs) dated 2/7/17, for Activity of Daily Living (ADL) function, revealed Resident #7 was alert with confusion, and required total of 2 person assist for bed mobility, transfers and toileting. She had limited range of motion to the left upper extremity and left lower extremity, was incontinent of bowel and bladder with incontinence care provided by staff. There were no changes noted with ADL function, she remained non-ambulatory Review of the CAAs dated 2/7/17 for Falls included the analysis of findings as an "Actual" problem/need. The nature of the problem indicated she had a history of Alzheimer's dementia and macular degenerative disease. She was alert and verbal with confusion. She required total care of "2p" (two people) with bed mobility, transfers and toileting. She had limited range of motion to the left upper extremity and left lower extremity. There were no changes noted with ADLs. She remained at risk for falls due to the above factors. The care plan team made a decision to proceed to the care plan with a goal to minimize risk of falls.	F 323	were in-serviced by Nurse Practice Educator (NPE) on checking C.N.A. assignment sheets daily to verify the number of staff needed to take care of a resident during care/repositioning. In-service will be completed by 3/24/17. - A review of the Reposition/ Lift Assessments were completed on 3/24/17 to determine how many staff are needed to safely provide care and updated for all residents by Center Nurse Executive (CNE), Assistant Director of Nursing (ADON), Nurse Scheduler. C.N.A. Assignment Sheets were updated by Scheduler and CNE to reflect current care/repositioning needs. - NPE will conduct random checks on each hall, on each shift 1 x Weekly x 4 weeks using the C.N.A. Assignment Sheet to ensure that C.N.A.'s are correctly and safely providing care/repositioning using the correct, required number of staff. -NPE will give results of the random monitoring to the CNE weekly for any additional education if needed. CNE will bring the results of the audit to the Executive Quality Assurance meeting for review to ensure compliance.	

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The care plan dated 12/21/16 included a problem of fall risk due to impaired mobility. The stated goal indicated Resident #7 would have no falls with injury during the next 90 days. The approaches to this problem included a bed alarm, low bed, assist resident getting in and out of bed, and assess for changes in medical status, pain status, mental status and report to the physician as indicated.

Review of the C. N. A. (Certified Nursing Assistant) Assignment Sheet dated 2/6/17 indicated Resident #7 was "E" "extensive assistance needed", was a total lift for transfers, and accident prevention included bed alarm, non-skid material in wheelchair, and low bed. Review of the "ADL Record" of the aides documentation of the care they provided for the dates of 2/1/17 to 2/8/17 included "Bed Mobility" for the night, day and evening shifts. The aides documented the resident performance as "D" or dependent, and the support provided as sometimes one person and sometimes two person assist. On 2/8/17 the day shift documented support as 2 person and the evening shift was blank.

Review of a fall report dated 2/8/17 at 10: 30 PM revealed Resident #7 had a fall that resulted in no immediate injury. The incident was described as "during last round C N A providing care and resident fell from bed on floor. Nurse entered room and saw resident on floor face down, head on shoes. 3p to assist with rolling resident over. No facial injuries noted. Hand grips equal. Able to move R (right) hand and R leg. No increase pain noted. L (left) arm and leg with limited ROM (range of motion). No skin tears or hematomas noted, 4p assisted resident with Hoyer (total) lift

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back to bed. Neuro checks initiated ....C N A was providing incontinent care and had to change sheets to bed, had rolled resident towards door and resident began to slid (sic) off bed. C N A was on the other side of bed providing care and couldn't keep resident from going to floor."

Review of the nurse's note on 2/9/17 at 6:30 am right knee with red area noted and sore when touched. No change in range of motion. Neuro checks continued with no abnormal findings.

Interview on 2/28/17 at 7:30 PM via phone with Aide #4 revealed she provided the care to Resident #7 on 2/8/17 on the evening shift. Aide #1 described the events surrounding the fall and explained she was changing the resident, had turned her onto her right side, and her feet came off the bed. The resident began sliding out of the bed and she could not prevent the fall. The aide was asked how many staff assist with turning and providing care. Aide #1 replied she knew the resident and had worked with her on night shift. Aide #1 explained she could provide care by herself and did not need two people assist. She did not obtain help because she had taken care of her by herself before. The resident would "hold onto the side rail" when turned to her side. The aide further explained she knew how to care for the resident by the C N A assignment sheet.

Interview with Nurse #3 at 9:53 AM on 3/1/17 revealed she was working when Resident #7 had the fall on 2/8/17. The aide came up the hall and told her the resident was in the floor. Aide #1 explained she had rolled her over, and she rolled out of bed. Nurse #1 further explained the resident was on the floor, on her right side, facing door. Aide #1 was on the left, the opposite

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F 323	Continued From page 4 side of the bed. The bed was at waist level to provide care. There were no obvious injury at that time. Nurse #1 explained the aides were to use the assignment sheet, which was printed daily to provide information about resident care. Nurse #1 would expect aides to have two people to provide care due to her requiring a mechanical lift for transfers. Interview with Aide #5 on 3/1/17 at 10:05 am revealed some staff have 2 person assist and others have one. Interview with the Director of Nursing on 3/1/17 at 11:09 AM revealed the C. N. A. Assignment Sheet had the assistance needed as Limited, Extensive or independent. For this resident it was extensive. The resident had weakness of the one arm (left), was on an air mattress and the aide was providing a complete bed linen change with incontinence care when she fell. Investigating the fall revealed these factors would require assistance of two people. Interview with the MDS nurse on 3/1/17 at 11:45 AM revealed she reviewed the aides' documentation, and factors considered in planning care to meet the ADL needs. These factors included a history of hemiparesis on one side, history of stroke and diabetes. In response as to why the care plan did not include a 2 person assist for bed mobility, the MDS nurse explained the aides know the residents well, what the resident can perform and how much help would be needed. This resident did not vary from day to day.	F 323		
F 333 SS=E	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		3/24/17

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F 333	Continued From page 5 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident reviews and observations, the facility failed to administer injections (Procrit) as ordered for 2 of 2 residents (Resident # 2 and Resident #11) reviewed for Procrit administration. Findings included: 1. Resident #2 was admitted to the facility on 4/29/2016 with diagnoses to include chronic obstructive pulmonary disease (COPD) and myelodysplastic syndrome. Medications ordered for the resident included Procrit 20,000 units subcutaneously every week on Tuesday, initially ordered on 4/29/2016. The medication administration record (MAR) for Resident #2 was reviewed for November 2016 and revealed the Procrit was ordered to be administered on November 7, 14, 21 and 29, 2016. The documentation on the MAR revealed the Procrit had been administered on November 7 and November 21, by evidence of nurse initials. No initials were noted on the MAR for November 14 or 29, 2016 administration dates. The most recent quarterly Minimum Data Set (MDS) completed on 12/12/2016 assessed the resident to be cognitively intact. The MAR was reviewed for December 2016 and revealed Procrit was administered on December	F 333	F333 Facility failed to administer injections (Procrit) as ordered by physician - Resident #2 no longer resides in the facility -On 3/1/2017 the physician for Resident #11 was notified of missed dose of Procrit on 2/24/17. No new orders were obtained due to the missing dose of Procrit was instructed to continue with the next due dose. - On 3/21/17 an audit was completed by Omnicare Pharmacy for all residents on Procrit. Results indicated that resident # 11 was the only resident on Procrit with no other residents affected. - All nurses were in-serviced on checking Electronic Medication Administration Record (EMAR) before leaving hall to check for any medications not given and instructed to correct before leaving the floor. If the resident is out of the facility the nurses were instructed to call physician to get an order to give med late. - On 3/21/17 Center Nurse Executive (CNE) updated the EMAR for the current hemoglobin to be documented before administration of the Procrit. - Medication Administration Audit Report will be ran at the beginning of each week	

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F 333	Continued From page 6 6, 13, 20 and 28, 2016 by evidence of nurse initials on those administration dates. The MAR for Resident #2 was reviewed for January 2017 which revealed the Procrit was ordered to be administered on January 3, 10, 17 and 24, 2017. The medication was documented as administered on January 10 and 24, 2017 as evidenced by the nurse initials. No nurse initials were noted on the MAR for January 3 or 17, 2017. A review of the MAR for February revealed the February 1, 2017 Procrit dose was circled, to indicate it had not been administered. The order for Procrit was changed to 40,000 units subcutaneously every week on Tuesday on 2/20/2017. A review of the nursing notes for Resident #2 revealed no documentation for the missed medication administration on November 14, 29, 2016, or January 3, 17, 2017. No documentation was noted for the circled dose on February 1, 2017. Resident #2 ' s lab results were reviewed and the results were noted for hemoglobin, 9.4 g/dL (grams per deciliter) on 10/7/2017; 8.4 g/dL on 1/10/2017; 7.8 g/dL on 2/10/2017 and 8.9 g/dL on 2/16/2017. An interview was conducted with the Medical Director (MD) on 2/27/2017 at 3:13 PM and he reported that he did not feel the missed doses of Procrit harmed Resident #2 due to her disease process, but the medication should have been administered. He further stated the hematologist managed Resident #2 ' s Procrit.	F 333	by the Center Nurse Executive (CNE) and/or Assistant Director of Nursing (ADON) to ensure that the Procrit was administered as ordered. - CNE will bring Reports to Executive Quality Assurance meeting for review.	

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An interview was conducted with Nurse #2 on 2/27/2016 at 3:20 PM and she reported that she had been assigned to Resident #2 on November 29, 2016, January 17, 2017 and February 1, 2017 and this was accurate per the nursing schedule. Nurse #2 reported she administered Resident #2 ' s medications to her. She reported that she must have forgotten to document that she administered the Procrit on November 29, 2016, and January 17, 2017. She reported that she did not recall why she circled the dose on February 1, 2017 and did not document why the medication was not administered February 1, 2017.

An interview was conducted with Nurse #5 on 2/28/2017 at 11:21 AM and she reported that she had been assigned to Resident #2 on November 14, 2016 and January 3, 2017 and this was accurate per the nursing schedule. Nurse #5 reported she administered Resident #2 ' s medications to her. She reported Procrit was stored in the refrigerator and she did not have it on the cart to administer. She further reported she had made note of the missing medication and "flagged" the medication to administer later in the day, but she forgot to administer the Procrit on November 14, 2016 and January 3, 2017.

Resident #2 was observed on 3/1/2017 at 10:03 AM. Her skin tone was pale and she stated that she did not feel very well on this date. Resident #2 was interviewed on 3/1/2017 at 10:03 AM and she reported she is unable to "keep track" of her medications or injections.
A call was placed to Resident #2 ' s hematologist on 3/1/2017 at 12:13 PM and a message was left requesting a return phone call, but the hematologist did not return the call.

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2. Resident #11 was readmitted to the facility on 10/28/2015 with diagnoses to include chronic kidney disease and anemia related to the chronic kidney disease.

The orders were reviewed for Resident #11 and revealed an order initiated on 1/18/2016 for Procrit 10,000 units subcutaneously once weekly, unless Hemoglobin was greater than 10.0, then the Procrit was not to be administered.

A review of the MAR for November 2016 revealed the Procrit was to be administered on November 4, 11, 18 and 25, 2016. The medication was administered on November 4, 2016 as evidenced by nurse initials. The doses for November 11, 18 and 25, 2016 were not administered.

Lab results for November 2016 were reviewed and Hemoglobin lab draws were completed in November with results of 9.7 g/dL on November 10, 2016, 9.9 g/dL on November 17, 2016 and 9.0 g/dL on November 25, 2016.

During a review of the lab results, a handwritten note was found on lab work from November 25, 2016 that stated a message had been left on voice mail for the lab results that date.

Nursing notes for Resident #11 for the month of November 2016 were reviewed and no notes for November 11 or 18 were found in the notes, however a note for November 25, 2016 was found documenting the message left to the physician regarding the lab results on that date.

The most recent annual MDS dated 1/10/2017 assessed the resident to be cognitively intact.

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F 333	Continued From page 9 An interview was conducted with Nurse #5 on 2/28/2017 at 11:21 AM and she reported that she had been assigned to Resident #11 on November 11, 18 and 25, 2016. Nurse #5 reported she administered Resident #11 ' s medications to her. She reported that she did not recall why the Procrit was not administered on those dates. Resident #11was interviewed on 3/1/2017 at 11:07 AM. She reported that she did notice when her injections were not given, but believed that lab results were "good" and she did not need the medication. The MD was interviewed on 3/1/2017 at 11:58 AM and he reported the Procrit for Resident #11 was managed by the Nurse Practitioner. He further reported staff communicated with him via phone calls, faxes and notes on the chart. He stated he did not feel the missed doses harmed Resident #11 due to her disease process, but the medication should have been administered. The Director of Nursing (DON) was interviewed on 2/28/2017 at 1:50 PM. She stated she was unaware of the missed medications for Resident #2 or Resident #11. She went on to state the new electronic medication administration system flagged medication omissions and prompted the nurse administering the medication for documentation. She stated it was her expectation that medications were administered as the physician ordered and labs were monitored as the physician ordered and documentation was completed regarding any communication with the physician.	F 333		