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BRIAN CENTER SOUTHPOINT	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

(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 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and	F 272		7/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/28/2017

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F 272	Continued From page 1 non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record review, the facility failed to assess for less restrictive intervention or approach for a resident with a lap belt for 1 of 1 sampled resident with a restraint (Resident #37). The findings included: Resident #37 was admitted on 7/21/15. The diagnoses included dementia and seizure disorder. The most recent Minimum Data Set (MDS) dated 4/16/17, indicated Resident #37 had cognition impairment and required total assistance with activities of daily living. The MDS was coded as a trunk restraint was used in the chair. Review of the initial physical restraint reduction assessment dated 2/7/16 and the current assessment form dated 2/13/17, documented the same assessment that Resident #37 had a soft lap belt with cushion for positioning with an alarm. The medical justification was poor safety awareness, impulsivity and dementia. There was no mention of seizure activity in the assessment. Review of physician notes dated 12/15/16, 1/3/17, 2/9/17 and 3/13/17, there was no indication that restraint usage or continuation and/or behaviors	F 272	Resident #37 Physician's order for restraint was clarified to include medical symptoms on 6/8/17. Resident #37 was reassessed for physical restraint reduction utilizing the "Physical Restraint Reduction Assessment" form on 6/23/17 by Director of Nursing. Resident #37 on Occupational Therapy Caseload 6/15-6/26/17 for skilled services focused on transfers for ADLs and safety in w/c with least restrictive device. No other residents in facility have restraints. Any resident with the potential for restraint will be assessed utilizing the "Physical Restraint Reduction Assessment" Form, physician orders written for restraints to include medical symptoms that justify the restraint. Director of Nursing and Staff Development Coordinator provided re-education to Nursing Staff and Therapy on resident's with restraints for documentation of behaviors and medical symptoms to support medical necessity. Director of Nursing/Staff Development	

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F 272	Continued From page 2 were being address. Review of the most recent physician order dated 2/13/17, revealed resident to have soft lap belt at all times in wheelchair due to dementia with muscle weakness, poor short and long term memory, impulsivity, poor safety awareness with continued falls. Review of psychological evaluation dated 3/15/17, there was not documentation of mood or behavior issues. Review of MDS note dated 4/20/16 and 6/28/16, indicated therapy was to change the self- release belt to soft lap belt 4/20/2016. Review of the falls risk assessment dated 3/30/17, revealed Resident #37 had no falls in the past 3 months. Review of the care plan dated 4/1/17 identified the problem as resident required a soft lap belt secondary to poor safety awareness with continued falls and all attempts to use lesser device. The goal included dignity would be maintained and no occurrence of injury. The interventions included evaluate and reevaluate for restraint use quarterly. Monitor for proper positioning and circulatory concerns, explain reason and risk of restraint using terms resident/responsible party could understand. Apply and release per order during meals and activities of daily living as needed. The restraint care area assessment (CAA) dated 4/16/17, revealed Resident #37 had dementia with behaviors. She had a lap belt while in wheelchair. She required two person assistance	F 272	Coordinator/Unit Coordinator will audit documentation of resident for any behaviors/supporting documentation utilizing the "Restraint Documentation/Behavior Audit" Form. Audits will be conducted daily x 2 weeks, 3 x week x 4 weeks, 2 x week x 4 weeks, 1 x week x 2 weeks for 3 months. Director of Nursing will report findings of audits to QAPI Committee monthly x 3 months for review and recommendations.	

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with bed mobility, transfers, extensive assistance with toileting and eating. She had a pressure relieving mattress to bed, pad to chair in place effective as evidence y no pressure areas reported. Will proceed to care plan. Resident required lap belt in wheelchair to prevent unassisted attempts to transfer, poor cognitive status, prevents resident from being able to self-identify risks for safety concerns with self-transfer. Attempts to reduce were not successful.

During an observation on 6/7/17 at 9:20AM to 11:20AM, Resident #37 was seated in a wheelchair with a cushion in place and lap belt around her waist. She was in the hall outside of the dining room staring into space and talking to herself. She was not taken into the activity. Resident #37 was unaware of her surroundings and unable to remove the lap belt herself. She was seated in an upright positon without any repetitive movements in any direction. She was not taken into the activity. Resident sat in the same location outside of the dining room until meal time.

During an interview on 6/7/17 at 9:30 AM, Nurse #9 stated resident comes to dining room and activities with lap belt in place for safety awareness and to prevent falls.

During an observation on 6/7/17 at 12:00 PM, Resident #37 was seated at the dining room table without the restraint in place. Staff was assisting other residents with meal set up. Resident #37 say quietly without any repetitive movements in any direction or attempts to stand. After the completion of the meal the resident was removed

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from the dining area at 12:15 PM and place outside of the dining room without the lap belt. The lap belt was located on the back of the resident's wheelchair. The resident sat in the hall area without lap belt from 12:00 PM to 12:35 PM when staff returned resident to the room. She just sat quietly in her chair without leaning in any direction. Several staff were talking at the nursing station as the resident sat in the wheelchair with her hands folded across her lap as she rambled in conversation with the resident next to her. Nurse#8 escorted the resident to her room without the lap belt in place at 12:30 PM.

During an interview on 6/7/17 at 12:36 PM, Nurse #8 stated Resident #37 had the lap belt for safety awareness and to prevent the resident from fall and seizure disorder. Nurse #8 reported Resident #37 ' s last seizure was in December 2016. Nurse#8 reported the resident was unable to remove the lap belt due to cognition. The only time the belt was removed was during meals and when resident was placed in bed.

During an observation on 6/7/17 at 1:00 PM, Resident #37 was seated in wheelchair in her room alone staring into space talking to herself. There was no other stimulation in the room. She sat in an upright position without any unusual movements or attempts to stand unassisted. There was no behaviors present.

During an interview on 6/7/17 at 1:05 PM, Nurse #10 stated Resident #37 had lap belt in place due to poor safety awareness and to prevent falls. Nurse #10 stated Resident#37 ' s last fall was 3/16/17 from the bed. The nurse reported the lap belt was removed during meals and when the

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resident was placed in bed.

During an interview on 6/7/17 at 1:15PM, Nursing Assistant (NA) #4 indicated that she had worked with Resident #37 for the past four months and she had not seen the resident attempt to stand or get up unassisted. She reported she was told the soft waist lap belt was for poor safety awareness and to prevent falls. She added that the resident was able to stand for short periods of time with staff assistance and to pivot while trying to dress or clean the resident up. She reported she had not seen the resident impulsively tried to stand or get up. The resident generally sat where she was placed.

During an interview on 6//7/17 at 1:20 PM, NA#5 stated she had worked with Resident #37 for the past two years. The resident had been in and out of the facility and the family had requested the use of the lap belt. The belt was use to prevent the resident from falling, poor cognition and safety awareness. The resident on occasion would lean to the side on the armrest or turn slightly, but she would not just jump up out of the chair. She had several falls in the past but nothing recent that she was aware of.

During an interview on 6/7/17 on 1:45PM, the Director of Nursing (DON) indicated the lap belt was in place due to resident poor cognition, poor safety awareness, dementia and family request. She indicated that there was no medical justification for the use and/or continuance of the restraint. She stated that the restraint reduction process included having the resident sit with her a few minutes to observe any change of behaviors. The DON reviewed the physician and psychological notes and confirmed restraints nor

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behaviors were being addressed. There were also no documented notes of restraint reduction attempts or alternative to least restrictive device attempts.

During an observation on 6/7/17 at 4:00 PM, Resident #37 was in the room in wheelchair with soft lap belt in place. She was very calm quiet and smiling to self.

During an interview on 6/7/17 4:30 PM, Family member #1 stated Resident #37 should have the lap belt in place due to history of falls and for Resident #37 ' s safety. Family #1 stated that if Resident #37 fell again she could get seriously injured or death.

During an observation on 6/8/17 at 9:00 AM, Family Member #2 was in Resident #37 ' s room feeding her without lap belt in place. Resident #37 was seated quietly with her arms folded across her lap. The lap belt was removed from a bag located at the side of the bed by Family member #2. Family member #2 exited the room at 9:01AM to speak with the DON. Resident #37 was left alone in the room without lap belt in place until 9:11AM, when family member #2 returned and put the lap belt back on Resident #37.

During an interview on 6/8/17 at 9:01AM, Family Member #2 stated due to resident's previous history of falls and delusions of wanted to stand and do things, as soon as the lap belt would be removed within a week or so she would get a call in the middle of the night that the resident had fallen and the injury would be worst. Family member #2 also reported that previous medical assessments and neurological history it was determined a restraint should be worn at all times

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F 272	Continued From page 7 due to the severity of Resident #37 ' s previous history. During an follow-up interview on 6/8/17 at 1:38 PM, the DON in the presence of the Director of Clinical Review presented a hospital document dated 1/13/16, that Resident #37 be restrained in a skilled nursing facility. The DON stated the last documented seizure was December 2016. The DON reported the family had signed consents and verbally requested the use of restraint because previous falls. There was no documentation in psych notes or physician note of behaviors that were described by family and facility. The DON was unable to present any written information about the resident behaviors or the efforts made for restraint reductions or types of least restrictive devices used in reduction process. The CAA did not address the identified behaviors or restraint reduction or the least restrictive device types or attempts.	F 272		

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Signature and Title:
Tammy Sheppard , MDS Coordinator RN [ESOF]

Cognitive impairment/behavioral symptoms that may lead to restraint use (also see Cognitive Loss and Behavior CAAs)

Inattention, easily distracted (C1310B)

Disorganized thinking (C1310C)

Fidgety, restless

Agitation behavior (E0200) -describe the specific verbal or motor activity- e.g. screaming, babbling,

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F 272	Continued From page 10 cursing, repetitive questions, pacing, kicking, scratching, etc. Confusion (C0100, C0600) Psychosis (E0100A-E0100B) Physical symptoms directed toward others (E0200A) Verbal behavioral symptoms directed toward others (E0200B) Rejection of care (E0800) Wandering (E0900) Delirium (C1310), including side effects of medications (clinical record) Alzheimer's disease (I4200) or other dementia (I4800) Traumatic brain injury (I5500) Psychiatric disorder (I5700-I6100) Care plan dated:	F 272		

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F 272	Continued From page 11 SEIZURES: Ms. Wilcox has a seizure disorder r/t epilepsy. + H . Ms. Wilcox will remain free from injury related to seizure activity through review date. + H . Give seizure medication as ordered by doctor. Observe/document side effects and effectiveness. [NSG] + H . Observe labs and report any sub therapeutic or toxic results to MD. + H . Obtain and observe lab/diagnostic work as ordered. Report results to MD and follow up as indicated. [NSG] + H . POST SEIZURE TREATMENT: Turn on side with head back, hyper-extended to prevent aspiration, Keep airway open, After seizure take vital signs and neuro check, Observe for aphasia, headache, altered LOC, paralysis, weakness, pupillary changes. [NSG] + H . SEIZURE DOCUMENTATION: location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or	F 272		

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F 272	Continued From page 12 dazed post-ictal state, after seizure activity. [NSG] + H . SEIZURE PRECAUTIONS: Do not leave resident alone during a seizure. Protect from injury. If resident is out of bed, help to the floor to prevent injury. Remove or loosen tight clothing. Don't attempt to restrain resident during a seizure as this could make the convulsions more severe. Protect from onlookers, draw curtain, etc. FALLS: Ms. Wilcox is High risk for falls r/t recurrent of falls (fall with injury), psychotropic meds, seizure d/o, and severely impaired cognitive status. + H . Ms. Wilcox will not sustain serious injury through the review date. + H . Ms Wilcox will be free of falls through the review date. + H . Anticipate and meet the resident's needs. [NSG,ACTD,SW,NUTR] + H . Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. [NSG,ACTD,SW] + H	F 272		

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F 272	Continued From page 13 . continue with current plan of care social worker to speak with family about placement at another facility and/or sitter [OT,NSG,PT] + H . continue with current POC keep resident up as long as possible [PT,OT,NSG] + H . continue with POC [NSG,PT,OT] + H . Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. [NSG] + H . FALL 3/16/17 THERAPY REFERRAL, MATS ON THE SIDES OF LOW BED [NSG] + H . falls anticipated due to diagnosis. staff will continue POC and minimize injuries [NSG,PT,SW] + H . Follow facility fall protocol. [NSG,ACTD,SW,NUTR] + H . IDT to eval for most appropriate interventions [DON,NSG,PT,RCS] + H . Make sure bed is lowest position at all times [PT,DON,NSG,RCS] + H . mats on floor Will discuss with family about alternate placement [NSG,PT] + H .	F 272		

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F 272	Continued From page 14 Neuro checks after each fall that resident hits head [NSG] + H . PT evaluate and treat as ordered or PRN. [PT,NSG] + H . resident to sit in geri-chair when she is tired and nodding off [DON,PT,NSG,RCS] + H . Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/ IDT as to causes. [NSG,SW,ACTD,NUTR] + H . Send to ER as necessary [NSG] + H . The resident uses chair electronic alarm. Ensure the device is in place as needed. [NSG] + H . Therapy to change self release belt to soft lap belt, staff to check and change position at least q2-3 hours while belt is on. Monitor ongoing safety needs to determine most appropriate safety devices. [NSG,PT,OT] + H . treatment as ordered to forehead r/t laceration [NSG] + H . will discuss with DON and IDT re: appropriate interventions, OT rec 24 hour supervision vs restraint vs different setting better equipped [DON,NSG,ACTD,RCS] + H	F 272		

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F 272	Continued From page 15 . xray of right hip for possible fracture. transferred to ER Therapy to change self release belt to soft lap belt, staff to check and change position at least q2-3 hours while belt is on. Monitor ongoing safety needs to determine most appropriate safety devices. 6/28/2016 . Therapy to change self release belt to soft lap belt 4/20/2016 Theresa Brooks . During an observation on 6/7/17 at 12:00 PM, resident was seated at the table without the restraint. The resident did not demeonstrate any reptitive movements, attempts to stand or move in any direction. After the completion of the meal the resident was removed from the dining area at 12:15PM and place outside of the dining room without the restraint. The lap belt was located on the back of the resident's wheelchair. Several staff were talking at the nursing station as the resident sat in the wheelchair with her hands folded across her lap as she rambled in conversation with the resident next to her. Staff excorted the resident to her room without the resident at 12:30PM. The resident sat in the hall area without lap belt from 12:00PM to 12:35PM when staff returned resident to the room. She just sat quietly in her chair without leaning in any direction. During an interview on 6/7/17 at 12:36PM, Cheryl Olive, LPN stated that resident had the lap belt for safety awareness and to prevent the resident from fall and seizure disorder. Nurse reported last seizure was in december.. Nurse reported resident was unable to remove the lap belt due to	F 272		

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cognition. The only time the belt is removed is during meals and when resident is placed in bed.

During an interview on 6/7/17 at 1:00PM, Teresa Brooks, LPN, resident had lap belt due to poor safety awareness and to prevent falls. nurse stated last fall was 3/16/17 Note indicated: was in room at 5:00PM. Resident was noted sitting on the floor next to her bed. Resident unable to state how incident happen. No injury. Nurse stated restraint was removed during meals and when resident is placed in bed.

Seroquel 25mg qhrs and ativan 0.5mg q12/prn(anxiety/depression.

MD order dated 2/3/17. soft lap belt at all times in wheelchair due to demenita with muscle weakness, poor ST/LT memory, impulsivity poor safety safety awareness with coninuted falls attempts at using using lesser device relase and exerisce.

Psych evaluation dated 3/15/17. report indicated there were no mood or behaviors.

During an interview on 1:15PM, tiffany Harris, NA indicated that she had worked with the resident for the past four months and she had not seen the resident attempt to stand or get up unassisted. She reported she was told the soft waist lap belt was for poor safety awareness and to prevent falls. She added that the resident was able to stand for short periods of time with staff assistance and to piviot while trying to dress or clean the resident up. She reported she had not seen the resident impulsively tried to stand or get up. the resident generally sat wheere she was placed.

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During an interview on 6//7/17 at 1:20PM, Adriene Guy, NA stated that the resident had the resident on for the past two or more years. The resident had been in /out of the facility and the family had requested the use of the lap belt.. nThe belt was use to prevent the resident from fall and her poor cognition and safety awareness. The resident on occassion would lean to the side on the armrest or turn slightly but she would not just jump up out of the cahir. She had several falls in the past but nothing recent that she was aware of.

During an interview on 6/71/17 on 1:45PM, Vickie O Quinn, DON, indicated that the lap belt was in place due to resident poor cognition, poor safety awareness , dementia and family request. She indicated that there was no medical jusitfication for the use and./or continuance of the restraint. She stated that the restraint reduction process included having the resident sit with her a few minutes to observe the change of behaviors and having physical therapy evaluate for services. DON reviewed the phsyciain's note and pscyh notes and confirmed that reestraints nor behaviors were being addressed.

Review of the PT report dated5/9/17 ST Goal:improve posture in wheelchair, feet dragging the floor. Resident would improve sitting position, propel.

MDS dated 4/16/17 coded trunk rstraint in chair. No pain noted. CAA for restraint..

Last falls risk assessment dated 3/30/17 no falls in 3month.

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Review of the physiciab's progress notes dated 3/13/17 was seen for swelling of right lower extremeities. There was no evidence of swelling of her legs. Suggest arthritis of knees. There was no documentation or note that the restraint or behaviors were being addressed.. On 2/17/17 residen seen for cough and congestion. there was no evidence of respiratory distress or suspect of viral infection. There was no evidence or documentation of the restraint or behavior concerns or the continuance of the lap belt.. 2/9/17 resident seen for routine visit. there was no indication or evidencee the restraint was addressed or behavioral concerns to continue use of the lap belt. Resident was seen on 1/3/17 and12/15/16.

Review of the physcial restraint reduction assessmeent dated 2/3/17: continue with soft lapbelt in wheelchair with psoture works cushion for positioning upright due to continued falls with self relasing. Stable and alarm.. medical symptons or targeted behavior: poor safety awareness, impulsivity, relase per protocol. 11/16/16:continues to have soft lap belt on wheelchair with posture works cushion for positining upright due to continuous falls with self relasing seat belt with alarm.Medical justificiation or targeted behavior: poor safety awareness, impulsivity, dementia. 8/10/16, 5/11/16, 2/17/16.

During an interview on 6/7/17 4:30PM, Raymond ESon n law feels like his mother n law should have the restraint due to history of falls. He feels that if mother falls again she may get seriously injuried and die. Son n law stated resident doesnt walk and may feel therapy could do no more for

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F 272	Continued From page 19 her. Family wants restraint for resident safety. During an interview on 6/8/17 at 9:01AM, Carroll Enterkins, Daughter in room feeding mom without restraint in place. Resident sitting quietly in wheelchair with arms fold. Daughter exited the room at 9:01AM to speak with DON with lap belt in hand and resident seated in room alone. NA Sarah enters the room to remove the tray from room. Resident remained calm. during the interaction. Daughter feels that due to resident's previous history of falls and delusions of wanted to stand and do things. Daughter feels as soom as the lap belt would be removed within a week or so she would get a call in the middle of the night that the resident had fallen and the injury would be worst.(daughter renters the room at 9:11AM). During an interview on 6/8/17 at 9:06AM, Sarah Devane, NA/RCS stated she had not seen the resident to attempt to stand or do anything. She just sits. During a follow-up 6/8/17 at9:25AM, Carroll Enterkin, daughter stated that she put the restraint back on her mother . Physician note dated 6/7/17 : 82-YO F LTC resident of SNF with comorbid Alzheimer's Dementia, legal blindness, Seizures seen to eval use of lap belt. She was originally admitted 2015 and began use of lap belt 5/11/16 after mult fallls	F 272		

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including injuries requiring ER visit for laceration repair. At the last ER visit for repair of R brow laceration 1/3/16, the ER attending recommended use of some form of restraint while seated, to prevent serious injury. She had multidisciplinary involvement in fall safety prevention and training, and subsequently with family approval she was given a soft lap belt. She cont to self propel WC throughout facility, requires max assist with transfer, toileting and hygiene care. Family is supportive and visits frequently

PAST MEDICAL HISTORY: seizures, Alzheimer's dementia, GERD, Anxiety and depressive disorder, Fracture of Humerus 2y to fall, Recurrent falls, peripheral neuropathy, OA, Recurrent UTI

PAST SURGICAL HISTORY: Benign brain tumor excision, hysterectomy, laminectomy, cataract.

MEDICATIONS:
Ativan Solution 2 MG\/ML Inject 1 ml intramuscularly every 5 minutes as needed for seizures give 2mg\/ml q 5 minutes times 3 doses at onset of seizures and check BP in between. Call MD after first dose
Ativan Tablet 0.5 MG Give 1 tablet by mouth every 12 hours as needed for Anxiety;Behavior
Calcium Carbonate-Vit D-Min Tablet 600-400 MG-UNIT Give 1 tablet by mouth one time a day for Health Supplement
Carboxymethylcellulose Sodium Solution 0.5 % Instill 1 drop in both eyes every 8 hours as needed
LamoTRIgine Tablet 150 MG Give 0.5 tablet by mouth every 12 hours related to EPILEPTIC SEIZURES RELATED TO EXTERNAL CAUSES, NOT INTRACTABLE, WITH STATUS

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F 272	Continued From page 21 EPILEPTICUS (G40.501) LevETIRAcetam Tablet 250 MG Give 1 tablet by mouth one time a day related to EPILEPTIC SEIZURES RELATED TO EXTERNAL CAUSES, NOT INTRACTABLE, WITH STATUS EPILEPTICUS (G40.501) LevETIRAcetam Tablet 500 MG Give 1 tablet by mouth at bedtime related to EPILEPTIC SEIZURES RELATED TO EXTERNAL CAUSES, NOT INTRACTABLE, WITH STATUS EPILEPTICUS (G40.501) Melatonin Tablet Give 3 mg by mouth at bedtime for insomina Omeprazole Capsule Delayed Release 20 MG Give 1 capsule by mouth in the morning related to GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS (K21.9) Tylenol Extra Strength Tablet 500 MG Give 2 tablet by mouth three times a day for pain Valproic Acid Syrup 250 MG\5ML Give 5 ml by mouth two times a day related to EPILEPTIC SEIZURES RELATED TO EXTERNAL CAUSES, NOT INTRACTABLE, WITH STATUS EPILEPTICUS (G40.501) Zinc Oxide Ointment 20 % Apply to groin and buttocks topically every shift for incontinence with each incontinent care ALLERGIES: Augmentin Objective VITAL SIGNS: 118/70 93 18 97.4 degF 155.0# 65" General: Alert, oriented x 1, in no acute distress, elderly female. HEENT: PERRLA, EOMI, EACs clear. No scleral	F 272		

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icterus or conjunctival erythema. Oral mucosa moist.

Neck: Supple, no masses, no thyromegaly, no bruits.

Chest: no rales, rhonchi or wheezes.

Heart: RR, no murmurs, no rubs, no gallops.

Abdomen: soft, no tenderness, no masses, BS normal.

Extremities: Stigmata of severe degenerative joint disease. No clubbing, cyanosis or edema. Pedal pulse 1+ bilaterally.

Neuro: No focal neuro defecit.

Skin: Warm, dry no exanthem, no suspicious lesions noted. Mult limb ecchymosis.

Psych: No depressed mood noted.

Assessment
83-YO F LTC resident with comorbid seizures, Alzheimer's dementia, GERD, Anxiety and depressive disorder, Recurrent falls, peripheral neuropathy, OA, Recurrent UTI, legal blindness, being seen to eval use of lap belt.

Plan
*Alzheimer's Dementia with delusions, paranoia, poor fall safety with recurrent falls - cont supportive care, fall precautions, staff and family collaboration with redirection. Avoid deliriogenic agents. She has been weaned from prior

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antipsychotics for psychosis. Will cont Psychiatry involvement. Current use of lap belt has been effective in preventing injury. Facility continues to eval risk vs benefits of its use with multi-disciplinary team, and discussion with family.

*Seizure disorder - no recent breakthrough episode. Cont AEDs, monitor symptoms, f/u Neurology.

*Anxiety and depressive disorder - monitor mood, emotional support on psychotropic regimen. Psychiatry involvement.

*Osteoporosis with Hx of Fx- cont Calcium, Vit D. Fall precautions.

*OA, peripheral neuropathy - cont oral and topical analgesics, prn PT/OT pain mgmt modalities.

*Legal blindness - cont supportive care, fall precautions.

3/3/2017 15:03 MDS Note Note Text: 81 YEAR OLD FEMALE ADMITTED TO BCS TO LTC WITH DIAGNOSIS THAT INCLUDES ALZHEIMERS DEMENTIA, ANXIETY, SYMBOLIC DYSFUNCTION, GERD, CONVULSION, AND MAJOR DEPRESSION. DENIES PAIN IN THE LAST 5 DAYS. SCORED 3/15 ON BIMS. SHE WEARS A LAP BELT WHEN UP IN W/C. SHE REQUIRES EXTENSIVE ASSIST X 2 FOR BED MOBILITY, TRANSFERS, TOILETING, AND EXTENSIVE ASSIST OF 1 WITH EATING. SHE IS INCONTIENT OF BOWEL AND BLADDER, VISION HEARING AND SPEECH ARE WNL.

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SHE WEARS GLASSES. SHE UTILIZES PRESSURE RELEIVING MATTRESS TO BED, AND PAD TO CHAIR EFFECTIVE,NO PRESSURE AREAS REPORTED

3/30/2017 10:34 MDS Note Note Text: RESIDENT SCORED 2/15 ON BIMS. DENIES PAIN IN LAST FIVE DAYS. SHE HAS DEMENTIA WITH BEHAVIOR. SHE HAS A LAP BELT WHILE IN WHEEL CHAIR. SHE REQUIRES TWO PERSON EXTENSIVE ASSIST WITH BED MOBILITY, TRANSFERS, EXTENSIVE ASSIST WITH TOILETING AND EATING. SHE HAS PRESSURE RELIEIVING MATTRESS TO BED, PAD TO CHAIR IN PLACE EFFECTIVE AEB NO PRESSURE AREAS REPORTED.

1/9/2017 10:30 Nursing Note Note Text: Late entry from 01/08/17. Resident was found sitting on the floor next to her bed. Bilateral floor mats were in place and residents bed was in the lowest position. Resident assessed and found to have no injuries, moves all extremities wnl, no redness bruising, skin tears, or s/s of pain noted. Call placed to residents daughter and a message was left for her to call the facility.

12/15/2016 18:00 Physician Note Note Text: Physician Routine visit note

A elderly female with h/o Alzheimer's dementia,brain injury as a child/developed SZ, Brain tumor/surgery 10 years ago (benign), recurrent UTI is a long term care resident here. Has been stable, fair po, nl BMS, sleeping, no SZ episodes.

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PAST MEDICAL HISTORY: Alzheimer's dementia,brain injury as a child/developed SZ, Brain tumor/surgery 10 years ago (benign),recurrent UTI GERD, Anxiety and depressive disorder, Recurrent falls, peripheral neuropathy from neurontin, OA, Hysterectomy, Back surgery

ALLERGIES: Augmentin

SOCIAL HISTORY: Lives at SNF. No ETOH, Tob or illicit drug use.

FHx, HTN/DM-M/Daughter, Dementia-father, sister

ROS, unable to perform due to dementia

PE, vs WNL
Alert, NAD. PERRLa. Neck is supple without significant lympadenopathy or thyromegaly. Chest CTA with normal I:E. no rales or wheezing. Heart is RRR, nL S1 and S2 without murmers, thrills, or rubs. Abdomen soft & non-tender. No HSM or masses appreciated, normal bowel sounds. Extremities show no cyanosis, clubbing, or edema. o x 1

A/P

Alzheimer's dementia with behavior problems (intermittent yelling, hallucination), stable, f/u with pscyh

Brain injury as a child/developed SZ, pt has been on three meds, lamictal 75mg bid, depakote 250mg bid, keppra 250mg AM, 500mg hs, both lamictal and depakote are subtherapeutic dosages for SZ, depakote level was 47 to 44. I called pt daughter in the past and had very long

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discussion with her and learned that pt had SZ since childhood due to head injury. She was on phenobarbital and dilantin before. Pt developed P. neuropathy from dilantin per daughter. Daughter said pt had been f/u with Duke neurologist Dr. Rodley Radtkes for 25 years. Then I paged and talked to Dr. Radtkes. According to Dr. Radtkes, pt's SZ was not well controlled with dilantin and phenobarbital. Pt had a lot falls/head injuries due to SZ episodes. He said finally pt's SZ were well controlled with current three meds/dosages. He said even though her depakote was subtherapeutic, but clinically pt had been stable, no need to change her current meds dosage. He recommended check all of them level q 6months. Pt f/u with him q year.

Brain tumor/surgery 10 years ago (benign),stable

Recurrent UTI stable

GERD, stable, PPI

Anxiety and depressive disorder, stable, lamictal and seroquel might help

Recurrent falls,stable

Peripheral neuropathy from neurontin, stable

OA,stable

Code, DNR, still aggressive medical management per POA

Addendum
Reviewed the chart, labs, meds, PMHs, SHX and

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FHx.
Discussed the case with Staffs and discussed the diagnosis and treatment plans with staffs,

admitted DX: SZ, dementia, anxietyy, depression, Gerd
spoke with Cindy Deporter on 6/8/17 at 9:31AM, informed her of the family concerns regarding regulation for restraints.

During an interiveiw on 6/8/17 at 1:38PM, Vickie OQuinn, DON and Gloria Whitley, Director of clinical review of the record revealed that the resident seizure have been controlled on two different medications. Last seizure was December 2016. The DON presented a Last neurological in patient summary from duke hospital report dated 1/13/16 that recommended that the resident be restrained in SNF(grand mal sz and brief myoclonic jerks seizures). The family have signed consents for restraint and verbally requested the use of restraint because previous falls and their fear if the next fall may result in resident death.. There was no documentation in psych notes or physician note of behaviors that are described by family and facility. DON was unable to present any information or written about the resident behaviors or the efforts or types of restraint reduction efforts that were done.

During an interview on 6/8/17 at 2:05PM, Anita Gonzalez, NA stated that today in the dining room when the resident was in the dining room got agitated and attempted to stand up. the resident was removed from the dining area and the restraint replaced. Gloria Whitley present during interview. When asked were the behaviors documented and Gloria stated all staff would be insierviced on restraints and document what the

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F 272	Continued From page 28 resident behavior. 4/4/2017 12:58 Social Services Note Note Text: ANN: Resident is a LTC patient residing on the 400 hall, and she has no mood issues per section D staff interview. There are no issues with room mate She attends many OOR activities and socializes in the halls often. A care plan meeting is scheduled for 3/15/17 and a letter has been mailed to the family. Code status is remaining the same and we will continue to follow the patient as needed.	F 272		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		7/6/17

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	345408	A. BUILDING _____ B. WING _____	06/08/2017

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F 431	Continued From page 29 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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 observation and staff interviews, the facility failed to store medications in labeled packaging to identify the medication name, strength and expiration date and failed to remove expired medication from potential distribution in six of seven medication carts inspected. Findings included:	F 431	All medication rooms, carts were inspected and expired, loose medications were removed immediately. Director of Nursing and Staff Development Coordinator provided re-education to Licensed Nursing Staff beginning 6/8/17 through 6/30/17. Re-education included to check for	

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F 431	Continued From page 30 1. During an inspection of Station 2 Medication Cart D on 06/08/17 at 9:15 a.m., a whole blister card of ferrous glucomate 324 mg tablets were found in the top drawer of the right-hand side of the cart. The expiration date of "10/2016" was found on the crimp of the card. In the third drawer on the right-hand side, the opened box of ferrous glucomate 324 mg was discovered with five whole blister cards and two partial cards. The expiration date listed on the box was "10/2016." In the second drawer on the right-hand side, one loose white tablet and four loose blue tablets were found. In the bottom drawer on the right-hand side, one loose blue tablet and one loose white partial tablet were found. Nurse # 11 could not identify the unpackaged medications and she wasted them. She acknowledged they were not labeled or stored correctly. She indicated that she would return the expired blister pack and box of ferrous glucomate to Central Supply for wasting and reordering. 2. During an inspection of Station 2 Medication Cart B on 06/08/17 at 11:45 a.m., one loose white tablet was found in the second drawer on the right-hand side of the cart. One loose red and one loose white partial tablets were found in the second drawer on the left-hand side, A single Tylenol suppository was found in the back of the top drawer on the left-hand side with an expiration date of "Jan 2017" printed on the crimp. Nurse #12 wasted the medications and indicated she checked the stock for expired medication but had overlooked the suppository. 3. During an inspection of Station 1 Medication Cart A on 06/08/17 at 10:35 a.m., the following	F 431	expiration date on all medications before administration, on removal of expired medications from Medication rooms/carts immediately, medication storage and discard any open or loose medications. Director of Nursing/Staff Development Coordinator/Unit Coordinators will randomly audit medication rooms and carts for any expired or loose medications and removal. Audits will be documented utilizing the "Medication Storage Audit Sheet". Audits will be conducted weekly x 4, biweekly x 2, monthly x 1 for 3 months. Director of Nursing will report findings of audits to QAPI Committee monthly x 3 months for review and recommendations.	

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F 431	Continued From page 31	F 431		

loose medications were found in the second drawer on the left-hand side of the cart: one brown tablet, two white tablets, one white partial tablet and one white capsule. Nurse #13 wasted the medications retrieved from the cart.

4. During an inspection of Station 1 Medication Cart C on 06/07/17 at 4:36 p.m., one loose blue tablet was found in the second drawer on the right-hand side. Nurse #14 wasted the medications. She indicated that the medications might have come from one of the blister packs delivered by pharmacy.

5. During an inspection of Station 2 Medication Cart A on 06/08/17 at 11:00 a.m., the following loose medications were found in the second drawer on the left-hand side of the cart: one white tablet, three white partial tablets, one yellow tablet, and one white capsule. Nurse #15 wasted the medications retrieved from the cart. She indicated that if the pills are pushed too hard or quickly from the blister packs they may land in the drawer and it ' s hard to find out where they went. When asked, she stated that it was the nurse ' s responsibility to inspect the mobile cart and remove any expired medications.

6. During an inspection of Station 2 Medication Cart C on 06/07/17 at 3:42 p.m., one loose brown tablet and three loose white tablets were found in the second drawer on the right-hand side of the cart. Nurse #2 wasted the medications.

In an interview with the Manager of Central Supply on 06/08/2017 at 10:05 a.m., he stated that he ordered the over-the-counter and bulk supply medications to stock the medication rooms. He checked the medication rooms weekly

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F 431	Continued From page 32 and removed and wasted any expired medications. He indicated that he did not inspect the mobile medication carts. In an interview with the Director of Nursing on 06/08/17 at 5:55 p.m., she stated that pharmacy technicians did a quality assurance check on the mobile carts for expired medications every four to six weeks but it was primarily the responsibility of the nurses giving medications to inspect the carts and ensure the medications given have not expired as part of the "five rights" of giving medications. She stated that she considered the pharmacy technicians a secondary check. She shared her expectation that all medications were labeled and stored correctly and that expired medications were removed from the cart to prevent distribution.	F 431		