STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING _____ B. WING _____	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

(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 242 SS=D	SELF-DETERMINATION - RIGHT TO MAKE CHOICES CFR(s): 483.10(f)(1)-(3) (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review, the facility failed to provide showers as scheduled to 1 of 1 residents (Resident #116) reviewed for choices. The findings included: Resident #116 was admitted to the facility on 8/25/17 with multiple diagnoses that included unsteadiness on feet, repeated falls, osteoporosis, and muscle weakness. The admission Minimum Data Set (MDS) assessment dated 9/1/17 indicated Resident #116 ' s cognition was intact. She was assessed with no rejection of care and no behaviors. Resident #116 required extensive assistance of 1 staff member with bed mobility, transfers, locomotion on/off unit, dressing, toileting, and personal hygiene. She was assessed as	F 242	Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. F 242 Resident #116 was provided a shower 10/26/17 on the 3pm to 11pm shift. The resident was discharged to her home on 10/27/17. The monitoring of care had not been provided by the charge nurse to assure that showers are being done.	11/17/17

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

Electronically Signed | 11/17/2017

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F 242	Continued From page 1 dependent on 1 staff member for bathing. Resident #116 was coded as unsteady on her feet and unable to stabilize without staff assistance. She had one fall in the month prior to her admission to the facility. The plan of care for Resident #116, initiated on 9/7/17, indicated she required assistance with Activities of Daily Living (ADL) tasks. The interventions included physical help with bathing for Resident #116. The shower schedule for Resident #116 indicated she was scheduled for showers on Mondays and Thursdays on the second shift (3:00 PM to 11:00 PM). A review of the shower documentation from Resident #116 ' s admission on 8/25/17 through 10/23/17 revealed Resident #116 received 1 shower (on 10/16/17) in 60 days. An interview was conducted with Resident #116 on 10/23/17 at 3:55 PM. Resident #116 reported she enjoyed showers and she required the assistance of staff with showers. She indicated she recalled only receiving a couple of showers since her admission to the facility (8/25/17). She stated she had not known what days her showers were supposed to be provided on. Resident #116 reported she had not complained about not receiving showers as she assumed this was the way it was supposed to be as she had not ever been in a facility before. She indicated she had received assistance with bed baths and personal hygiene as needed. An interview was conducted with Nurse #2 on 10/25/17 at 9:40 AM. She stated she was familiar with Resident #116 and she was unaware of her rejecting care from staff.	F 242	A 100% audit was initiated by the Social Worker on 10/27/17 of all residents to determine bathing preference. On 11/1/17, the Social Worker interviewed 100% of alert and oriented residents to determine that they are receiving their bath or shower as scheduled. As a result, two residents reported they were not receiving showers; however, documentation indicated one of the residents received frequent showers and the other resident had refused showers. The Unit Manager visually inspected all non-interviewable residents to determine cleanliness and well-kept appearance. No negative findings were found upon physical assessment by the Unit Manager. As of 11/1/17, moving forward, The Minimum Data Set Nurse will have updated resident care plans and care guides by 11/13/17 for bathing preferences. A 100% in-service was initiated on 11/1/17 by the Director of Nursing and Unit Manager for all nursing staff regarding bathing preferences and shower schedule. This in-service will be completed by 11/17/17. No clinical staff member will be allowed to work until they receive this in-service. All newly hired nursing staff will receive the training during orientation. Utilizing the shower schedule, the Unit Manager will review the daily shower scheduled and verify residents on the	

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F 242	Continued From page 2 An interview was conducted with Nursing Assistant (NA) #1 on 10/25/17 at 3:50 PM. She stated she had worked at the facility since March of 2017 and she normally worked on the second shift (3:00 PM to 11:00 PM). She indicated she was familiar with Resident #116. She reported Resident #116 required assistance with ADLs including bathing and showers when she was first admitted to the facility. She stated since her admission, Resident #116 had been receiving rehabilitation services and she had not required as much assistance with ADLs. NA #1 indicated Resident #116 had not refused care. She was unable to explain why Resident #116 had not received her showers as scheduled. An interview was conducted with NA #2 on 10/25/17 at 4:10 PM. She stated she had worked at the facility since May of 2017 and she normally worked on the second shift (3:00 PM to 11:00 PM). She indicated she was familiar with Resident #116. She reported Resident #116 required some assistance with ADLs due to unsteady balance. NA #2 indicated Resident #116 had not refused care. She was unable to explain why Resident #116 had not received her showers as scheduled. An interview was conducted with the Director of Nursing (DON) on 10/25/17 at 4:15 PM. She stated she expected the preferences of residents to be honored and for showers to be provided as scheduled.	F 242	schedule for a shower actually received a shower. From 11/1/17 moving forward, the floor nurse has been responsible for asking the residents being monitored if they received a shower or not. Monitoring will include 3 random residents to occur Monday through Friday x 2 weeks, then 3 random residents twice weekly x 2 weeks, then 3 random residents weekly x 1 month, then 3 random residents monthly x 1 month to ensure showers were given as scheduled. If a shower was not given, then the reason is documented in the resident chart. The results of the shower audits will be reviewed by the Director of Nursing weekly x 4 weeks, then every 2 weeks x 2, the monthly x 1 month by the Director of Nursing for trends or concerns. The Director of Nursing will present the results of the monitoring at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for 3 months for review and recommendations for any modification of the monitoring process.	
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment	F 278		11/17/17

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F 278	Continued From page 3 must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Resident #64 for the diagnosis of depression on her admission Minimum Data Set (MDS) for 1 of 14 MDS assessments reviewed. The findings included:	F 278	F 278 The last Minimum Data Set (MDS) assessment completed for resident #64 was reviewed by MDS Coordinator on	

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F 278	Continued From page 4 Resident #64 was admitted on 8/11/17 with cumulative diagnoses of depression, chronic pain and congestive heart failure. The admission MDS dated 8/18/17 indicated Resident #64 received an antidepressant medication 7 of 7 days for the look back period. The diagnosis of depression was not coded. The Care Assessment Area dated 8/18/17 triggered for psychotropic medications and indicated she was taking an antidepressant and it would be care planned. Resident #64 was care planned on 8/24/17 for antidepressant medication use. In an interview on 10/25/17 at 12:40 PM, MDS Nurse stated she neglected to code the admission MDS for depression and would complete a modification MDS. In an interview on 10/25/17 at 4:20 PM the Director of Nursing stated she was responsible to sign off on all MDS assessments completed by the MDS Nurse and it was her expectation the MDS be accurate. In an interview on 10/27/17 at 11:30 AM, the Administrator stated it was his expectation that Resident #64 ' s MDS would have been coded for depression.	F 278	10/25/17 and Section I was modified to include the diagnosis of Depression to accurately reflect the residents current condition. A 100% audit of the last completed MDS assessment for all residents, to include resident # 64, will be conducted by Regional Reimbursement Managers (RRMs) to be completed by 11/17/17 to ensure coding of the minimum data set accurately reflects the residents. No errors were found in the diagnosis coding in section I of the MDS by 11/17/17. For all areas of concern identified, a modification or significant correction of prior assessment (Quarterly/Comprehensive) will be completed by the facility MDS Nurse by 11/17/17. The MDS Nurse, Dietary Manager (DM), and Activities Director (AD) will be re-in-serviced on proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual by the RRM to be completed by 11/17/17. When coding the MDS assessment the MDS Nurses and Care Plan Team will follow the instructions for proper coding found in the Resident Assessment Instrument (RAI) Manual and ensure that the assessment accurately reflects the resident□s current condition. An audit of 25% of completed Minimum Data Set (MDS) assessments will be conducted weekly x 4 weeks, then bi-weekly for 4 weeks, then 10% monthly x 1 month by	

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F 278	Continued From page 5	F 278	RRM to ensure compliance and accuracy utilizing a MDS audit Tool. All identified areas of concern will be addressed immediately by the RRM by retraining appropriate staff responsible for the coding error and by the MDS Nurse with modification or significant correction of the MDS. The Administrator will review and initial the MDS Audit Tool weekly x 4 weeks, then bi-weekly x 4 weeks then monthly x 1 month. The results of the MDS Audit Tool will be compiled by the Administrator and presented to the Quality Improvement Committee monthly x 3 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights	F 279		11/17/17

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F 279	Continued From page 6	F 279		

set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) 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 §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(iv)In consultation with the resident and the resident’s representative (s)-

(A) The resident’s goals for admission and desired outcomes.

(B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

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F 279	Continued From page 7 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop an individualized and accurate plan of care related to Activities of Daily Living (ADLs) for 1 of 1 residents (Resident #116) reviewed for choices. The findings included: Resident #116 was admitted to the facility on 8/25/17 with multiple diagnoses that included unsteadiness on feet, repeated falls, osteoporosis, and muscle weakness. The admission Minimum Data Set (MDS) assessment dated 9/1/17 indicated Resident #116 ' s cognition was intact. Resident #116 required the extensive assistance of 1 staff member with bed mobility, transfers, locomotion on/off unit, dressing, toileting, and personal hygiene. The plan of care for Resident #116 was reviewed in the Electronic Medical Record (EMR) on 10/24/17 at 12:29 PM. Portions of this care plan for Resident #116 appeared to be generic, requiring the reader to fill in the blank. The care plan read, in part, "(Specify name) needs assistance with ADL tasks daily including the management of incontinence secondary to (specify diagnosis or reason)". The goal for this problem area read, "(Specify name) will actively participate in ADLs as is able to tolerate and perform through next review". The interventions included transfers utilizing a mechanical lift with two persons assistance.	F 279	F 279 The care plan for resident #116 was reviewed and update by the MDS Coordinator on 10/25/17 to accurately reflect the assistance the resident requires for activities of daily living, including bed mobility, transfers, locomotion on/off unit, dressing, toileting, and personal hygiene, and related diagnosis. In addition the care plan was updated to remove the intervention of Mechanical Lift which was not currently being utilized to transfer the resident. A 100 % audit of all residents care plans will be conducted by Regional Reimbursement Manager (RRM) by 11/17/17, including the care plan for resident #116 to ensure comprehensive care plans have been developed per the comprehensive assessment. The care plans were updated for any identified areas of concern by utilizing CAA s from last comprehensive assessment, progress notes, medication administration records, and treatment records to ensure the care plans address the resident□s current medical, nursing, mental, and psychosocial needs as indicated, to include assistance needed with activities of daily living, by RRM on	

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F 279	Continued From page 8 On 10/24/17 at 12:40 PM a hard copy of Resident #116 ' s plan of care was requested from the MDS Nurse. On 10/24/17 at 2:10 PM the MDS Nurse provided a hard copy of Resident #116 ' s plan of care. The plan of care related to ADLs for Resident #116 was reviewed with the MDS Nurse. This plan of care had been revised to include Resident #116 ' s name, her related diagnoses, and to remove the intervention of a mechanical lift with 2 persons assistance for transfers. The MDS Nurse revealed she had revised the plan of care for Resident #116 on this date, 10/24/17, after a hard copy was requested for review. She stated the revisions included the addition of Resident #116 ' s name, her related diagnoses, and the removal of the intervention for the mechanical lift with 2 persons assistance for transfers. The MDS Nurse indicated she was not sure why Resident #116 ' s name and related diagnoses had not been specified on her plan of care prior to this date, 10/24/17. She revealed this was an error. The MDS Nurse additionally indicated the intervention of a mechanical lift with the 2 persons assistance for transfers was an error. She revealed Resident #116 had never required a mechanical lift for transfers since her admission to the facility on 8/25/17. An interview was conducted with the Director of Nursing on 10/25/17 at 11:05 AM. She indicated her expectation was for plans of care to be individualized and an accurate representation of the resident.	F 279	11/17/17. No negative findings were noted during the care plan audit. The MDS Coordinator, Dietary Manager, and Activity Director were educated on care planning requirements, per instructions provided in the RAI Manual by RRM and on 11/16/17. The in-service was completed on 11/16/17. RRM will review all resident care plans to include resident #116, in comparison to triggered Care Area Assessments on all subsequent comprehensive assessments, 24 hour reports, shift change notes, progress notes, current interventions, and physician telephone orders 5 x per week x 4 weeks, then an audit of 10% of care plans weekly x 3 months to ensure that care plans reflect the residents current medical, nursing, mental, and psychosocial needs utilizing a care plan audit tool. The MDS Nurse will immediately update the care plan for all identified areas of concerns and the Administrator or RRM will provide retraining with the identified staff member. The results of the care plan audit tool will be compiled by the Administrator and presented to the Quality Improvement Committee monthly x 3 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring. Completion Date: 11/17/17	

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F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to date the dressing after the dressing change and failed to transcribe the treatment order correctly to the electronic Physician's order and electronic Treatment Administration Record (TAR) for 1 of 1 sampled resident reviewed for pressure ulcer (Resident #71). Findings included: 1a. Resident #71 was admitted to the facility on 11/5/12 with multiple diagnoses including stage 4 sacral pressure ulcer. The quarterly Minimum Data Set (MDS) assessment dated 9/7/17 indicated that Resident #71's cognition was intact and she had a stage 4 pressure ulcer. Resident #71's electronic physician' orders for October 2017 were reviewed. There was an order dated 10/16/17 to "cleanse stage 4 pressure ulcer to sacrum with wound cleanser, apply Promogran AG foam (a wound dressing that helps with healing and protect from infection) and to cover with dry dressing daily and as needed." On 10/25/17 at 8:41 AM, Resident #71 was observed during the dressing change. Nurse #6	F 281	F281 The dressing for Resident #71 continued to be changed as ordered. The dressing had not been dated until 11/2/17 after nurse re-training. It was the facility practice not to date dressings, as the signature date on the electronic Treatment Administration Record signified which nurse completed the dressing change on the ordered dressing and on what date it was changed. Dressings have been dated when changed beginning 11/2/17 under the direction of the Director of Nursing. The Director of Nursing initiated an in-service on 11/7/17 to the Treatment Nurse and all licensed nurses that they are required to date all dressings when applied. All newly hired treatment nurses and licensed nurses will receive the education. The education was completed on 11/17/17 and no nurses will work until they have been educated. Beginning 11/13/17 Utilizing a Dressing QI	11/17/17

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F 281	Continued From page 10 (Treatment Nurse) was observed to clean the sacral pressure ulcer with wound cleanser, Promogran AG foam was applied and covered with dry dressing. Nurse #6 was not observed to date the dressing. On 10/25/17 at 8:50 AM, Nurse #6 was interviewed. She stated that in the past, she was dating the dressing after the dressing change but months ago she was informed by the corporate office not to date the dressing anymore. On 10/25/17 at 2:28 PM, the Director of Nursing (DON) was interviewed. The DON stated that she had received a memo from the corporate office not to date dressing after dressing change. b. Resident #71 was admitted to the facility on 11/5/12 with multiple diagnoses including stage 4 sacral pressure ulcer. The quarterly Minimum Data Set (MDS) assessment dated 9/7/17 indicated that Resident #71's cognition was intact and she had a stage 4 pressure ulcer. Resident #71's electronic physician's orders for October 2017 were reviewed. There was an order dated 10/16/17 to "cleanse stage 4 pressure ulcer to sacrum with wound cleanser, apply Promogran AG foam and to cover with dry dressing daily and as needed." The electronic Treatment Administration Record (eTAR) for October 2017 was reviewed. The eTAR indicated to "cleanse stage 4 pressure ulcer to sacrum with wound cleanse, apply Promogran AG foam and cover with dry dressing daily and as needed."	F 281	Audit Tool, the Unit Manager will complete a visual audit of 5 random wound dressings Monday through Friday x 2 weeks, then twice weekly to include weekends x 6 weeks, then twice monthly to include weekends x 1 month to assure dressings are dated appropriately. The Director of Nursing will review and initial the audit tool weekly x 8, then monthly x 1 for trends and concerns. The Dressing QI Audit Tools are turned in to the Director of Nursing for review to ensure facility is compliant with current Plan of Correction. Problems identified during the audits will be corrected by the Director of Nursing and the Plan of Correction will be revised as deemed necessary to maintain Regulatory Compliance. The treatment order for Resident #71 was clarified by the Unit Manager on 10/25/17 and transcribed to the electronic Treatment Administration Record by the Unit Manager. The error in transcription occurred due to human error and the lack of no verification by another nurse that the order was transcribed correctly. On 10/30/17 a 100% audit of all the treatment orders was initiated by the Unit Manager to ensure all orders were transcribed correctly. Thirteen orders were identified that included a PRN frequency. All thirteen orders were clarified and rewritten in the Electronic Health Record with separate PRN orders. This was completed by the Unit Manger	

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	345051	A. BUILDING _____ B. WING _____	10/26/2017

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F 281	Continued From page 11 The eTAR for October 2017 revealed that treatment to Resident #71's sacral pressure ulcer was provided on October 19, 22 and 25. On 10/25/17 at 8:41 AM, Resident #71 was observed during the dressing change. Nurse #6 was observed to clean the sacral pressure ulcer with wound cleanser, Promogran AG foam was applied and covered with dry dressing. On 10/25/17 at 10:52 AM, Nurse #6 was interviewed. She stated that she was the one who wrote the treatment order for Resident #71 dated 10/16/17. Nurse #6 indicated that the treatment order was to change the dressing 3 times a week but she transcribed the order to the electronic physician's order and electronic TAR incorrectly. She acknowledged that she transcribed the treatment order to be changed daily instead of 3 times a week. On 10/25/17 at 10:55 AM, a copy of the treatment order dated 10/16/17, signed by the doctor, was provided by Nurse #6. The treatment order read "cleanse stage 4 pressure ulcer to sacrum with wound cleanser, apply Promogran AG foam and cover with dry dressing 3 times a week and PRN." On 10/25/17 at 2:28 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to transcribe doctor's orders to the electronic physician's orders and to the electronic TAR correctly and to read the TAR before performing the dressing change.	F 281	on 10/31/2017. There was not a negative outcome for any of the thirteen residents. An in-service for 100% licensed nurses was initiated 11/1/17 by the Director of Nursing on accurately transcribing physician orders. An additional in-service was initiated by the Director of Nursing on 11/7/17 to all licensed nurses requiring a second signature for each physician□s order to assure transcription accuracy from the written telephone order into the electronic health record AHT. Both in-services were completed by 11/17/17. Nursing staff will be in-serviced prior to working on the floor. All newly hired licensed nurses will receive the education during orientation. Beginning 11/13/17 Utilizing a Treatment Orders Review QI audit tool, the Unit Manager will review each new treatment order Monday through Friday x 2 weeks, then twice weekly to include weekends x 6 weeks, then monthly to include weekends x 1 month to ensure accuracy of transcription and verification of the order by a second nurse. The Treatment Orders QI Audit Tools are turned in to the Director of Nursing for review to ensure the facility practice is compliant with current Plan of Correction. The Plan of Correction will be revised as deemed necessary to maintain Regulatory Compliance. Any concerns will be corrected at the time of discovery and the staff involved will be re-educated. The Director of Nursing will review and initial	

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F 281	Continued From page 12	F 281	the audit tools weekly x 8, then monthly x 1 for trends and concerns. The Director of Nursing will present the results of the monitoring Treatment Orders Audit Tool and the Dressing Audit Tool to the monthly QI meeting x 3 months to identify trends and continued need for monitoring and recommendations for any modification of the process.	
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, physician interview, and record review the facility failed to follow the plan of care interventions related to seizure medication for 1 of 5 residents (Resident #85) reviewed for unnecessary medications and related to Preadmission Screening and Resident Review (PASRR) Level II for 1 of 1 residents (Resident #86) reviewed for PASRR. The findings included: 1. Resident #85 was admitted to the facility on 3/11/16 with multiple diagnoses that included epilepsy.	F 282	F 282 1)The lab results for a Keppra level of 9/14/17 for Resident # 85 was reviewed by the physician on 10/25/17 with no new orders. The lab results were inadvertently filed in the resident□s record before being reviewed by the physician and with no follow up for assuring labs have been drawn, received, reviewed, and any new orders carried out. A 100% audit of all ordered labs for 10/10/17 through 11/10/17 were reviewed	11/17/17

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F 282	Continued From page 13 A review of the physician ' s orders for Resident #85 indicated an order dated 5/9/17 for Keppra (anticonvulsant) 500 milligrams (mg) in the morning and 1000 mg in the evening. The quarterly Minimum Data Set (MDS) assessment dated 8/19/17 indicated Resident #85 ' s cognition was intact. His active diagnoses included epilepsy. A physician ' s order dated 9/13/17 indicated a laboratory test for Resident #85 ' s Keppra level. A review of Resident #85 ' s medical record revealed no laboratory results related to the 9/13/17 physician ' s order for a Keppra level. The plan of care for Resident #85 was reviewed on 10/24/17. The plan of care included the problem/need of monitoring Resident #85 ' s safety related to a diagnosis of seizures. The interventions included, in part, obtaining laboratory tests as ordered to monitor for therapeutic drug levels of seizure medication and notification of the physician of laboratory results. This plan of care was first initiated on 3/22/16 and no revision dates were noted. An interview was conducted with Unit Manager (UM) #1 on 10/24/17 at 4:30 PM. Resident #85 ' s medical record that contained no laboratory results related to the 9/13/17 physician ' s order for a Keppra level was reviewed with UM #1. She verified these laboratory results were not in Resident #85 ' s medical record. A follow up interview was conducted with UM #1 on 10/24/17 at 4:40 PM. She provided a copy of laboratory results dated 9/14/17 for a Keppra	F 282	by the Director of Nursing (DON) to assure all lab results were obtained as ordered, received in the facility timely, reviewed by the physician timely and all new orders were carried out by the licensed nurse. The lab audit was completed on 11/10/17. There were 22 identified concerns with the initial audit completed by the Director of Nursing. All concerns were addressed/corrected by the Director of Nursing and the Unit Manger by 11/10/17. A new lab log was created by the Regional Clinical Consultant on 11/17/17 include: Date Patient Name" Room # Test Ordered Date Specimen Obtained Tech/Nurse Initial Date Report Received Check If Abnormal Date MD Notified MD Response: New Order or No New Order Nurse Note: Family Notified An In-service was initiated by the Director of Nursing on 11/8/17 to 100% of all licensed nurses related to the process they will follow once they receive an order for a lab to be obtained. Nurses will not work until they have received the in-service and this in-service will be included in new nurse orientation. The Unit Manager will review the lab log Monday through Friday x 2 weeks, then twice weekly to include weekends x 6 weeks, then monthly x 1 to include	

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F 282	Continued From page 14 level for Resident #85. These laboratory results showed no indication the physician or Nurse Practitioner had reviewed them. UM #1 revealed she was not sure why these laboratory results were not in Resident #85 ' s medical record. An interview was conducted with the physician on 10/25/17 at 10:26 AM. The physician ' s order dated 9/13/17 for a Keppra level for Resident #85 was reviewed. The laboratory results dated 9/14/17 for Resident #85 ' s Keppra level was reviewed with the physician. The physician reviewed his records and revealed he and/or the Nurse Practitioner (NP) had not received the results of this Keppra level dated 9/14/17 for Resident #85. He stated his expectation was for himself and/or the NP to receive the results of all ordered laboratory tests. The physician reviewed these laboratory results dated 9/14/17 and reported no concerns with the Keppra level for Resident #85. An interview was conducted with the Director of Nursing (DON) on 10/26/17 at 8:27 AM. She indicated she expected plans of care to be followed and for the physician to be notified of laboratory results. 2. Resident #86 was admitted to the facility on 11/28/16 with multiple diagnoses that included schizophrenia. A review of the medical record revealed Resident #86 was determined to have a Level II Preadmission Screening Resident Review (PASRR), dated 5/25/17. Further record review revealed a significant	F 282	weekends to assure all lab results have been received, the physician has been notified of the results, and any new orders were carried out. The Lab Diagnostic Log will be turned in to the Director of Nursing for review weekly x 8, then monthly x 1 for trends and concerns to ensure the facility practice is compliant with current Plan of Correction. Any concerns will be corrected at the time of discovery and the staff will be re-educated. The Plan of Correction will be revised as deemed necessary to maintain Regulatory Compliance. The Director of Nursing will review and initial the results of the Lab monitoring tool x 8 weeks,then monthly x 1 for trends and/or concerns. The Director of Nursing will report the results of the Lab monitoring tool to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process. 2) A PASRR screening was submitted to NC Must with the appropriate paperwork for Resident # 86 by the Social Worker on 10/30/17 due to his Significant Change in Condition as indicated in the care plan. A response was received on 10/30/17 from NC Must to retain the resident□s existing PASRR number. The Social Worker was re-educated related to Level 11 PASRR for Significant Change in Condition by the Regional	

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F 282	Continued From page 15 change Minimum Data Set (MDS) assessment dated 8/10/17 for Resident #86. This assessment indicated Resident #86 had a Level II PASRR related to serious mental illness. The plan of care for Resident #86 was reviewed on 10/25/17. Resident #86 had a plan of care, initiated on 11/28/16, related to his Level II PASRR. The interventions included, in part, "Notify PASRR if change in condition." The Social Worker (SW) was indicated as the responsible staff member for this intervention. An interview was conducted with the SW on 10/25/17 at 4:30 PM. She indicated she was responsible for the responsibilities related to Level II PASRRs. She confirmed Resident #86 had a Level II PASRR. She revealed she was unaware of the requirement for a referral for re-evaluation to the PASRR Authority for a resident with a Level II status following a significant change in condition. She stated the PASRR Authority was not notified of Resident #86 ' s significant change in condition related to his 8/10/17 MDS. An interview was conducted with the MDS Nurse on 10/25/17 at 4:30 PM. She indicated her awareness of the requirement for a referral for re-evaluation to the PASRR Authority for a resident with a Level II status following a significant change in condition. The MDS Nurse indicated the SW was responsible for making a referral to the PASRR Authority when a resident with Level II status had a significant change in condition. An interview was conducted with the Director of Nursing on 10/26/17 at 8:27 AM. She stated it	F 282	Clinical Manager on 11/1/17. This information will be included in the Social Worker orientation packet for new Social Work hires. A 100% audit of all residents with a PASRR Level II was completed on 10/31/17 by the Regional Clinical Manager for the past 6 months to assure no significant change of condition had occurred without notification to NC Must as the care plans indicates. No other resident with a Level II PASRR were noted to have had a significant change in condition. The Regional Clinical Manager provided an in-service to the Social Worker and MDS Nurse on 11/1/17 on reporting a significant change in condition for any PASRR Level II resident to NC Must at the time of the discovery of the significant change per the resident care plan. As the Social Worker has resigned at the facility, the new Social Worker will be educated on the process during orientation and prior to working the floor. The MDS nurse will update the care plans and submit a Level II PASRR request to NC Must in the event a resident has a significant change in condition until the new Social Worker starts on 12/12/17 and is educated on the requirements of a Level II PASRR by the Director of Nursing upon hire. Utilizing a Significant Change of Condition PASRR Level II QI Audit Tool, the DON	

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F 282	Continued From page 16 was her expectation that plan of care interventions were followed as well as the regulations related to PASRR.	F 282	will review the MDS schedule of completed assessments weekly x 8 weeks, and then monthly x 1 to ensure that any significant change of condition assessment that was completed for a PASRR Level II resident, that the MDS Nurse or Social Worker has notified NC Must of the significant change as indicated on the resident care plan. The Director of Nursing will review and initial the QI Audit tool weekly x 8, then monthly x 1 month for trends or concerns. The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process.	
F 285 SS=D	PASRR REQUIREMENTS FOR MI & MR CFR(s): 483.20(e)(k)(1)-(4) (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related	F 285		11/17/17

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F 285	Continued From page 17	F 285		

condition for level II resident review upon a significant change in status assessment.

(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:

(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires

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F 285	Continued From page 18 specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3)	F 285		

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F 285	Continued From page 19 or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to make a referral for re-evaluation after a significant change in condition, for 1 of 1 sampled residents (Resident #86) reviewed for Preadmission Screening Resident Review Level II status. The findings included: Resident #86 was admitted to the facility on 11/28/16 with multiple diagnoses that included schizophrenia. A review of the medical record revealed Resident #86 was determined to have a Level II Preadmission Screening Resident Review (PASRR), dated 5/25/17. Further record review revealed a significant change Minimum Data Set (MDS) assessment dated 8/10/17 for Resident #86. This assessment indicated Resident #86 had a Level II PASRR related to serious mental illness. The plan of care for Resident #86 was reviewed on 10/25/17. Resident #86 had a plan of care, initiated on 11/28/16, related to his Level II PASRR. The interventions included, in part, "Notify PASRR if change in condition." The	F 285	F 285 A PASRR screening was submitted to NC Must with the appropriate paperwork for Resident # 86 by the Social Worker on 10/30/17 due to his Significant Change in Condition as indicated in the care plan. A response was received on 10/30/17 from NC Must to retain the resident□s existing PASRR number. The Social Worker was re-educated related to Level 11 PASRR for Significant Change in Condition by the Regional Clinical Manager on 11/1/17. This information will be included in the Social Worker orientation packet for new Social Work hires. A 100% audit of all residents with a PASRR Level II was completed on 10/31/17 by the Regional Clinical Manager for the past 6 months to assure no significant change of condition had occurred without notification to NC Must as the care plans indicates. No other resident with a Level II PASRR were noted to have had a significant change in	

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F 285	Continued From page 20 Social Worker (SW) was indicated as the responsible staff member for this intervention. An interview was conducted with the SW on 10/25/17 at 4:30 PM. She indicated she was responsible for the responsibilities related to Level II PASRRs. She confirmed Resident #86 had a Level II PASRR. The SW revealed she was unaware of the requirement for a referral for re-evaluation to the PASRR Authority for a resident with a Level II status following a significant change in condition. She stated the PASRR Authority was not notified of Resident #86 ' s significant change in condition related to his 8/10/17 MDS. An interview was conducted with the MDS Nurse on 10/25/17 at 4:30 PM. She indicated her awareness of the requirement for a referral for re-evaluation to the PASRR Authority for a resident with a Level II status following a significant change in condition. The MDS Nurse reported the SW was responsible for making a referral to the PASRR Authority when a resident with Level II status had a significant change in condition. An interview was conducted with the Director of Nursing on 10/26/17 at 8:27 AM. She stated it was her expectation that the regulations related to PASRR were followed. She indicated it was the responsibility of the SW to make a referral for re-evaluation to the PASRR Authority for a resident with a Level II status following a significant change in condition.	F 285	condition. The Regional Clinical Manager provided an in-service to the Social Worker and MDS Nurse on 11/1/17 on reporting a significant change in condition for any PASRR Level II resident to NC Must at the time of the discovery of the significant change per the resident care plan. As the Social Worker has resigned at the facility, the new Social Worker will be educated on the process during orientation and prior to working the floor. The MDS nurse will update the care plans and submit a Level II PASRR request to NC Must in the event a resident has a significant change in condition until the new Social Worker starts on 12/12/17 and is educated on the requirements of a Level II PASRR by the Director of Nursing upon hire. Utilizing a Significant Change of Condition PASRR Level II QI Audit Tool, the DON will review the MDS schedule of completed assessments weekly x 8 weeks, and then monthly x 1 to ensure that any significant change of condition assessment that was completed for a PASRR Level II resident, that the MDS Nurse or Social Worker has notified NC Must of the significant change as indicated on the resident care plan. The Director of Nursing will review and initial the QI Audit tool weekly x 8, then monthly x 1 month for trends or concerns. The Director of Nursing will report the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

(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 285	Continued From page 21	F 285	results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process.	
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 315		11/17/17

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F 315	Continued From page 22 (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, responsible party (RP), staff and physician interviews, the facility failed to follow through with a scheduled urology appointment on 9/08/17 for 1 of 3 residents (Resident #51) who had a history of urinary tract infections. This resulted in a missed opportunity for urology care and the resident was re-hospitalized seven days later with diagnoses of sepsis and a urinary tract infection. The findings included: Resident #51 was admitted 4/03/17 with cumulative diagnoses of benign prostate hypertrophy (BPH) and urinary retention. He was care planned on 4/16/17 for the potential for UTIs secondary to urinary retention. A nursing note dated 8/25/17 at 1:12 PM read that Resident #51 was transported to the hospital due to blood clots from his urethra and altered mental status. A review of the hospital discharge summary dated 8/30/17 read Resident #51 had a history of UTIs and presented with urinary retention. The nursing home was unable to place a urinary catheter despite multiple attempts due to presumed BPH. Urology was consulted and an indwelling urinary catheter was placed. The discharge summary read that Resident #51 was to have a follow up appointment with the Urologist on 9/08/17 at	F 315	F315 The admitting nurse did not use the discharge packet from the hospital that arrived with the resident to do the resident□s readmission orders. She used the referral discharge summary prior to the resident□s readmission to complete the resident□s admission orders. The discharge packet had been updated with the Urology Consult information, but the referral discharge summary did not have the Urology Consult Information included, causing the urology appointment information to be missed on readmission on 8/30/17. A second check of the orders was not completed on the admission orders. Resident #51 was seen by the Urologist on 10/27/17 new orders were received and carried out. A 100% audit of residents admitted or re-admitted residents in the past 30 days to assure all recommended follow up appointments/consults were ordered and scheduled was completed by the Regional Clinical Managers x 2. There were a total of 5	

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F 315	Continued From page 23 10:00 AM. A review of Resident #51's re-admission orders on 8/30/17 included antibiotic therapy of Cefdinir 300 milligrams (mg) by mouth every twelve hours with no stop date for a UTI. Resident #51 was care planned for his urinary catheter on 8/30/17 secondary to obstructive uropathy. Interventions included ongoing assessment of the color, clarity and character of his urine along with monitoring for symptoms of a UTI and for urinary catheter change per the facility protocol or as ordered by the physician. A review of the September 2017 transportation schedule did not include Resident #51's scheduled Urology appointment for 9/08/17. A nursing note dated 9/13/17 at 6:50 PM read the RP stated Resident #51 was "hot" and had not voided. The nurse assessed Resident #51. His temperature was 99.6 degrees Fahrenheit and his urinary catheter was noted to have a small amount of dark urine in the tubing. The facility physician was notified and orders were obtained for Intravenous fluids (IV), continue his ongoing antibiotic therapy and to get a chest -x-ray. A nursing note dated 9/14/17 at 2:40 PM read Resident #51 was lethargic, his urinary catheter was patent draining cloudy yellow urine. IV antibiotics were started for a left lung infiltrate. A nursing note dated 9/15/17 at 10:13 AM read Resident #51 was sent to the ER due to unresponsiveness. A review of the hospital discharge summary dated	F 315	admissions/readmissions reviewed. There was one noted issue related to omitted orders during the audit. The missed order was addressed during the audit by the Regional Clinical Manager. The Director of Nursing initiated an in-service to 100% of licensed nurses on 11/9/17 to use the final Discharge Summary for writing admission orders with special attention to recommend follow up appointments/consults. A second nurse must review orders with the final Discharge Summary and verify that the orders were transcribed correctly with special attention to recommend follow up appointments/consults. All newly hired nurses will receive the education during orientation prior to working the floor. The in-service was completed on 11/17/17. Utilizing a Consult QI Audit Tool, the Unit Manager will review all admission/re-admission final Discharge Summaries to assure recommended follow up appointments/consults were ordered and scheduled. Monitoring will occur within three days of the admission date to ensure recommended follow up appointments/consults were scheduled. All admissions x 3 months will be audited using the consult QI Audit Tool. The Director of Nursing will review and initial the audits tools weekly x 3 months.	

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F 315	Continued From page 24 9/19/17 indicated Resident #51 was admitted with sepsis, encephalopathy (abnormal brain function) acute kidney injury, BPH, urinary retention and a UTI associated with catheterization of the urinary tract. He was to follow up with his primary care physician within 4-6 days. Resident #51 was observed and interviewed on 10/24/17 at 4:25 PM. He was sitting up in his wheelchair with his RP present in his room. His urinary catheter tubing contained cloudy yellow urine. Resident #51 voiced no discomfort and indicated he was made aware of an appointment to see the Urologist on 10/27/17. Resident #51 declined an observation of his urinary catheter care. In an interview on 10/25/17 at 12:10 PM, the Social Worker (SW) stated it was the readmitting nurses' responsibility to set up transportation for any post hospitalization appointments. She stated she called the Urologist and they noted that Resident #51 did not show up for his appointment scheduled on 9/8/17. He had another appointment scheduled on 10/27/17. In an interview on 10/25/17 at 12:20 PM, Unit Manager (UM) #1 stated Nurse #4 completed Resident #51's re-admission from the hospital on 8/30/17. She stated Nurse #4 should have made a copy of the urology appointment card and left it for the transport person to set up transportation the next day. UM #1 stated when a resident was readmitted during office hours, the admitting nurse makes a copy of any follow up appointments and the copies are left for the transporter. Additional copies were given to the medical records person and the receptionist since the transporter person was often out taking residents to appointments. The UM #1 stated in	F 315	The Director of Nursing will report the results of the monitoring at monthly Quality Assurance Quality Improvement (QAPI) Committee meeting X 3 months for trends and recommendations for any modification of the process.	

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F 315	Continued From page 25 this instance since Resident #51 was readmitted late on a Wednesday night, a copy would only have been left for the transport person. In an interview on 10/25/17 at 1:43 PM, the Director of Nursing (DON) stated it was her expectation that Resident #51 would have attended his scheduled follow up urology appointment on 9/8/17 because he was having problems with his catheter in the days leading up to his intended appointment and ended up being readmitted to the hospital on 9/15/17. In a telephone interview on 10/26/17 at 8:51 AM, the physician stated he would have expected Resident #51 to have been seen by the Urologist on 9/8/17 as scheduled and if the appointment was missed, he would have expected the facility to have rescheduled the appointment for the earliest date the Urologist could have seen him. The physician stated he would be following up with the DON regarding his missed appointment in September and recent re-hospitalization.	F 315		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		11/17/17

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F 329	Continued From page 26 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic 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 Nurse Practitioner and staff interview, the facility failed to ensure resident was free from duplicate antibiotic therapy (Resident #71) and failed to attempt a gradual dose reduction (GDR) for an antidepressant medication (Resident # 85) for 2 of 5 sampled residents reviewed for unnecessary medications. Findings included: 1. Resident #71 was admitted to the facility on	F 329	F329 1) The Physician was notified of the duplicate antibiotic therapy for Resident #71 on 10/24/17 by the Unit Manager and orders were received to discontinue Augmentin at that time. The resident completed the course of Doxycycline on 10/29/17 as ordered. The duplication of orders was due to failure of the staff to notify the physician of the previously	

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F 329	Continued From page 27 11/5/12 with multiple diagnoses including stage 4 sacral pressure ulcer. The quarterly Minimum Data Set (MDS) assessment dated 9/7/17 indicated that Resident #71's cognition was intact and she had a stage 4 pressure ulcer. On 10/9/17, Resident #71 had a doctor's order to culture the sacral pressure ulcer. The culture report dated 10/11/17 revealed "Gram negative bacilli and light growth of Group B streptococcus." Resident #71's wound care-specialist evaluation form dated 10/16/17 was reviewed. The form revealed a surface culture of stage 4 pressure ulcer on the sacrum demonstrated a positive result with light growth of Group B streptococcus. The form indicated a recommendation for Augmentin (an antibiotic used to treat bacterial infection) 825-125 mgs 1 tablet by mouth twice a day for 7 days. On 10/16/17, Resident #71 had a doctor's order for Augmentin 875-125 milligrams (mgs) 1 tablet by mouth every 12 hours for 7 days for wound infection. On 10/18/17, Resident #71 had a doctor's order for Doxycycline (antibiotic used to treat bacterial infection) 100 mgs 1 tablet by mouth every 12 hours for 10 days for sacral wound. The Medication Administration Records (MARs) for October 2017 were reviewed. The MARs revealed that Resident #71 had received Augmentin on October 17, 18, 19, 20, 21 and 22 and Doxycycline on October 19, 20, 21, 22, 23 and 24.	F 329	ordered antibiotic. The Regional Clinical Manager provided an in-service to the Unit Manager and Director of Nursing on duplicate medication therapy on 11/01/17. A 100% in-service of the nursing staff was initiated 11/01/17 by the Director of Nursing on documenting in the order the indication for medications ordered by the physician and also reviewing to see if multiple antibiotics are being used, and reporting antibiotic duplication orders to the Physician. The in-service was completed on 11/17/17. Licensed nursing staff will not work the floor until they have signed the in-service. Newly hired licensed nurses will receive the education during orientation. On 10/30/17, the Unit Manager initiated a 100% audit of the Medication Administration Records for unnecessary duplication of antibiotic medications ordered in the past 30 days. The in-service was completed on 11/17/17. No instances of duplicate therapy were found. All newly hired licensed nurses will receive the education during orientation. Licensed nursing staff will not work the floor until they have signed the in-service. A Duplicate Antibiotic Monitoring QI audit tool will be completed by the Unit Manager Monday through Friday x 2 weeks, then twice weekly x 6 weeks to include weekends, then twice monthly to include the weekend x1 month. Identified concerns will be corrected by the Unit	

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F 329	Continued From page 28 On 10/24/17 at 3:50 PM, the Family Nurse Practitioner (FNP) was interviewed. She stated that she ordered the Doxycycline for the sacral wound due to Gram negative bacilli culture report. The FNP added that she was not aware that Resident #71 was already on Augmentin for the same purpose (sacral wound infection). She stated that she would discontinue the Augmentin as this was a duplicate antibiotic therapy. On 10/25/17 at 2:28 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to clarify with the Nurse Practitioner if there was a duplicate antibiotic ordered. She also indicated that she expected the NP to see if the resident was already on an antibiotic before writing another order for an antibiotic therapy. 2. Resident #85 was admitted to the facility on 3/11/16 with diagnoses that included major depressive disorder. A review of Resident #85 ' s medical record revealed an order dated 9/16/16 for Lexapro (antidepressant) 20 milligrams (mg) once daily. The quarterly Minimum Data Set (MDS) assessment dated 8/19/17 indicated Resident #85 ' s cognition was intact. He had no mood issues, no behavior issues, and no rejection of care. Resident #85 received antidepressant medication on 7 of 7 days during the MDS review period.	F 329	Manger as they are discovered. The Director of Nursing will review and initial the weekly audits x 8 weeks, then monthly x 1 for trends and concerns and adjust the plan of correction as needed to ensure regulatory compliance. The Director of Nursing will present the results of the monitoring at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for 3 months for review and recommendations for any modification of the monitoring process. 2)Resident #85 s pharmacy recommendation of 8/23/17 for a gradual dose reduction of Lexapro was reviewed by the Psychiatric Nurse Practitioner on 10/26/17. The Nurse Practitioner has scheduled the resident for a full review on her next visit on 11/9/17 for dose reduction. The error was due to the lack of oversight to assure recommendations were reviewed timely by the physician and Psychiatric Nurse Practitioner. The Director of Nursing reviewed all pharmacy consults for the months of August 2017 and September 2017. The audit was completed on 10/31/17. Multiple recommendations were not completed prior to the next pharmacy review. All pharmacy recommendations that were found not completed in the audit were followed up on by the Director of Nursing by 10/31/17. On 10/24/17, the Regional Clinical	

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F 329	Continued From page 29 A Consultant Pharmacist Communication to Physician form dated 4/28/17 indicated a recommendation for a Gradual Dose Reduction (GDR) of Lexapro (antidepressant) 20 milligrams (mg) once daily for Resident #85 in an effort to use the lowest effective dose. There was no response from the physician on the form. A Consultant Pharmacist Communication to Physician form dated 8/23/17 indicated a repeat recommendation for a GDR of Lexapro 20 mg once daily for Resident #85 in an effort to use the lowest effective dose. There was no response from the physician on the form. A review of Resident #85 ' s physician ' s orders and electronic Medication Administration Record (eMAR) from April 2017 through October 2017 revealed he received Lexapro 20mg once daily. An interview was conducted with the Director of Nursing (DON) on 10/24/17 at 3:03 PM. She stated that the recommendations made by the Pharmacy Consultant were given to the unit manager and to the Physician to be acted upon. The DON added that today (10/24/17) she had reviewed the pharmacy recommendations since November 2016 and realized that the recommendations had not been consistently followed through. She acknowledged that the facility had no system in place to make sure the recommendations made by the pharmacy consultant were responded by the Physician or by Nursing. The DON indicated that there was no evidence that the Physician had acted upon the recommendations dated 4/28/17 or 8/23/17 made by the Pharmacy Consultant for Resident #85. A phone interview was conducted with the	F 329	Manager completed an in-service with the Director of Nursing and Unit Manager on pharmacy recommendation completion and follow up process. The attending Physician received an in-service by the Regional Clinical Manager on 10/31/17 on timely responses to pharmacy recommendations, and the Psychiatric Nurse Practitioner received the in-service by the Director of Nursing on 11/2/17. Utilizing a Pharmacy Recommendation QI Audit Tool, the Unit Manager will review the pharmacy report monthly to ensure that all recommendations have been returned completed appropriately by the physician and Psychiatric Nurse Practitioner prior to the next pharmacy review. The Director of Nursing will review and initial the QI Audit Tool monthly x 3 for trends and concerns. The Director of Nursing will report the results of the monitoring at monthly Quality Assurance Quality Improvement (QAPI) Committee meeting X 3 months for review and recommendations for any modification of the process.	

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F 329	Continued From page 30 Pharmacy Consultant on 10/25/17 at 1:55 PM. She stated she started coming to facility in September 2017. She indicated she had copies of the monthly drug regimen review notes from the previous Pharmacy Consultant. She assumed the recommendations dated 4/28/17 and 8/23/17 to attempt a GRD of Lexapro for Resident #85 had been rejected by the Physician because there was no change in the Lexapro order. The Pharmacy Consultant added that in the future, she would make sure the response from the Physician, including the rationale if the recommendation was rejected, was documented on the form. A follow up interview was conducted with the DON on 10/26/17 at 8:27 AM. She confirmed Resident #85 had been on Lexapro 20mg for over a year with no attempted GDR and no documented clinical rationale for contraindication of a GDR. She stated her expectation was for GDRs to be completed as per the regulations.	F 329		
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1) (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations and staff, physician and pharmacist interviews and record review, the facility failed to maintain a medication error of 5% or less as evidenced by 3 medication errors out of 29 opportunities resulting in medication error rate	F 332	F 332 1)Medication that was crushed for Resident # 82 by Nurse # 3 on 10/25/17 was discarded and re-poured as a whole	11/17/17

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F 332	Continued From page 31 of 10.3 % for 2 (Resident #82 and Resident #89) of 7 residents observed during a medication pass. The findings included: A review of the manufacturer instructions read Do not crush Isosorbide Extended Release since it may result in hypotension (low blood pressure). 1. On 10/25/17 at 8:54 AM, Nurse #3 was observed preparing medications for administration to Resident #82. Nurse #3 stated Resident #82 took all her medications crushed. Nurse #3 pulled all the medications scheduled to be administered at 8:00 AM including Isosorbide Extended Release tablet 30 milligrams. Isosorbide Extended Release is an antihypertensive with a time released mechanism. A review of the electronic medication administration record (MAR) and a review of the individual punch card of the Isosorbide both included directions that read: DO NOT CRUSH. Nurse #3 placed all the medications including the Isosorbide into a plastic sleeve and proceeded to crush all the medications and mixed in applesauce to aid Resident #82 in swallowing her medications. Once Nurse #3 finished mixing all the medications into the applesauce and began to enter Resident #82 ' s room, this surveyor stopped Nurse #3 from administering the crushed medications. Nurse #3 stated she did not see the special instructions printed on the electronic MAR or the punch card and re-prepared all Resident #82 ' s 8:00 AM medications and separated out the Isosorbide without crushing. She placed the whole tablet in with the other medications into the applesauce and Resident #82 swallowed the medications without difficulty. Nurse #3 stated she was not aware of what could happen to a resident who received an extended release	F 332	tablet before administering the medication to the resident during the medication pass observation. The nurse failed to read the physician order completely or the bullet package of the medication where orders were written to do not crush were documented and did not follow the five rights of medication pass. On 11/1/17, the Director of Nursing (DON) initiated an in-service with all Nurses on Medication that is labeled do not crush shall not be crushed. A copy of non-crushable meds was included with the in-service and posted in front of the Narcotic book for each medication cart. The in-service was completed on 11/17/17. All current nurses will be in serviced prior to working the hall. All newly hired nurses and Med Aides will receive the education during orientation. Beginning 11/13/17, the Unit Manager, Pharmacy Consultant, Director of Nursing, or Regional Clinical Manager will complete a medication pass audit on all licensed nursing staff over all shifts to include weekends by 12/1/17. Beginning 11/29/17 no nurse will take a cart before passing a medication pass audit at a rate of 5% or less. Any concerns will be addressed at the time of the medication pass observation and the nurse will be reeducated. Medication pass audits will include Nurse #3 and #2. Any concerns will be addressed at the time of the observation and re-education provided. The Director	

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ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

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F 332	Continued From page 32 medication crushed verses whole. In an interview on 10/25/17 at 10:25 AM, the physician stated it was his expectation the Resident #82 ' s Isosorbide Extended Release be administered whole and not crushed. In a telephone interview on 10/25/17 at 2:05 PM, the consultant pharmacist stated Isosorbide Extended Release should be administered crushed because it can result in a sudden drop in Resident #82 ' s blood pressure. 2. On 10/25/17 at 10:55 AM, Nurse #3 was observed preparing medications for administration to Resident #89. Carafate (treat and prevent duodenal ulcers) one gram tablet four times daily was due at 7:30 AM and at 11:30 AM. The electronic MAR indicated the 7:30 AM dosage had not yet been administered and it was time for the 11:30 AM dose. Nurse #3 also prepared and administered Duoneb 0.5 mg in 3 milliliters using Resident #89 ' s in-room nebulizer. A review of the electronic MAR indicated the breathing treatments were to be administered four times daily and was due at 8:00 AM and again at 12:00 noon and that the 8:00 AM dose had not been administered as of 10:55 AM. Nurse #3 stated she was late with her medication pass. Nurse #3 confirmed she did not report to the unit manager or the Director of Nursing (DON) that she was late passing her morning medications. In an interview on 10/25/17 at 1:43 PM, the DON stated the facility operated with three nurses passing medications daily and that she was not aware that Nurse #3 was late in passing her morning medications. She stated it was her expectation that Resident #89 receive her medications within one hour before or one hour	F 332	of Nursing will review and initial the Medication Pass Audits as they occur and QI for trends and concerns. The Director of Nursing will present the results of the monitoring at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for 3 months for review and recommendations for any modification of the monitoring process. 2)Resident #89 was provided Carafate and Duoneb nebulizer treatment by Nurse #3 Medications were administered more than 1 hour after the ordered administration time due to the failure of the nurse to notify the Unit Manager or Director of Nursing that she was becoming late in her med pass. On 11/8/17 the DON initiated an in-service with all nurses on timely medication administration in having 1 hour before and 1 hour after to administer medications and to notify DON or Unit Manger if the nurse is running behind on medication pass. The in-service was completed on 11/17/17. Staff will not work until they have received the in-service. New staff will be in serviced regarding timely medication administration prior to working the floor. Beginning 11/13/17, the Unit Manager, Pharmacy Consultant, Director of Nursing, or Regional Clinical Manager will complete a medication pass audit on all	

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F 332	Continued From page 33 after accepted window.	F 332	licensed nursing staff over all shifts to include weekends by 12/1/17. Beginning 11/29/17 no nurse will take a cart before passing a medication pass audit at a rate of 5% or less. Any concerns will be addressed at the time of the medication pass observation and the nurse will be reeducated. Medication pass audits will include Nurse #3 and #2. Any concerns will be addressed at the time of the observation and re-education provided. The Director of Nursing will review and initial the Medication Pass Audits as they occur and QI for trends and concerns. The Director of Nursing will present the results of the monitoring at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for 3 months for review and recommendations for any modification of the monitoring process.	
F 371 SS=D	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 371		11/17/17

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F 371	Continued From page 34 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard expired nourishment and dairy product from 1 of 3 nourishment refrigerators observed (Sunflower hall). Finding included: On 10/25/17 at 3:35 PM, the Sunflower nourishment room was observed. The temperature log posted in front of the nourishment refrigerator was reviewed. The log revealed that the refrigerator was checked on 10/25/17. The following were observed inside the nourishment refrigerator: A full pack of swish cheese - deli style slices with an expiration date of 9/30/17 A bottle of Glucerna shake - rich chocolate with a used by date 10/1/17. On 10/25/17 at 3:50 PM, the Dietary Manager (DM) was interviewed. The DM stated that she was responsible for checking the nourishment rooms including the nourishment refrigerators for	F 371	F 371 On 10/25/17, the Certified Dietary Manager removed a can of Glucerna and a package of cheese from the refrigerator on the Sunflower unit. The Regional Clinical Manger checked the other nourishment refrigerators for undated or expired foods with no negative findings. The facility failed to remove expired foods from the refrigerator due the failure of the dietary staff to monitor the refrigerator daily for expired foods. On 10/27/17, the Regional Clinical Manager re-educated the Dietary Manager on the Food Receiving and Storage Policy. The Dietary Manager initiated 100 % re-education with Dietary staff. The in-service will be completed by 11/3/17. The Dietary will educate new staff during orientation on the Food Receiving and Storage Policy. Any staff not	

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F 371	Continued From page 35 temperature and for expired food. She indicated that she had checked the nourishment rooms this morning (10/25/17) and she might have missed to check the expiration dates. On 10/25/17 at 4:18 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the dietary staff to check for expiration dates of the nourishment and dairy products that were kept in the nourishment refrigerators.	F 371	in-service will not be allowed to work until in-service has been completed. All newly hired dietary staff will receive the education by the Certified Dietary Manger during orientation. Utilizing a Refrigerated Storage Audit QI Tool, the Scheduler or the Manager on Duty will complete a nourishment refrigerator audit Monday through Friday x 2 weeks, then twice weekly to include weekends x 6 weeks, then monthly 1 month. Any negative findings will be corrected immediately by the Scheduler or Manager on Duty. The Administrator will review and initial the QI Audit tool weekly x 8 weeks, then monthly x 1 month for trends and concerns. The Administrator will present the results of the monitoring at the monthly QI committee meeting x 3 months for trends or concerns, the need for continued monitoring, and review and recommendation for any modification of the monitoring process.	
F 428 SS=E	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes	F 428		11/17/17

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and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she

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F 428	Continued From page 37 identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and Physician, Pharmacist, Psychiatrist, Nurse Practitioners and staff interviews, the facility failed to act upon multiple recommendations made by the Pharmacy Consultant for 2 of 5 sampled residents reviewed for unnecessary medications (Residents #71 & #85). Findings included: 1 a. Resident #71 was admitted to the facility on 11/5/12 with multiple diagnoses including insomnia. The quarterly Minimum Data Set (MDS) assessment dated 9/7/17 indicated that Resident #71's cognition was intact and she had received an antidepressant medication during the last 7 days. Resident #71's current physician's orders were reviewed. The orders revealed that Resident #71 had an order for Remeron (an antidepressant and appetite stimulant) 15 milligrams (mgs) by mouth at bedtime for sleep/appetite. Resident #71's drug regimen reviews (DRR) were reviewed. The DRR dated 5/24/17 had recommended for a gradual dose reduction (GDR) for the Remeron. Resident #71's electronic Medication Administration Records (eMARs) from May through October 2017 revealed that she had received Remeron 15 mgs at bedtime.	F 428	F 428 Resident #71 and 85 pharmacy recommendations were reviewed with the attending physician on 10/27/17 and the Psychiatric Nurse Practitioner on 10/26/17 respectively. New orders received were carried out. The pharmacy recommendations were not reviewed timely due to lack of oversight to assure all recommendations were reviewed and returned for processing in a timely manner. The Director of Nursing reviewed all pharmacy consults for the months of August 2017 and September 2017. The audit was completed on 10/31/17. Multiple recommendations were not completed prior to the next pharmacy review. All pharmacy recommendations that were found not completed in the audit were followed up on by the Director of Nursing by 10/31/17. On 10/24/17, the Regional Clinical Manager completed an in-service with the Director of Nursing and Unit Manager on pharmacy recommendation completion and follow up process. The attending Physician received an in-service by the Regional Clinical Manager on 10/31/17 on timely responses to pharmacy recommendations, and the Psychiatric Nurse Practitioner received the in-service	

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F 428	Continued From page 38 On 10/24/17 at 3:03 PM, the Director of Nursing (DON) was interviewed. She stated that the recommendations made by the Pharmacy Consultant were given to the unit manager and to the Physician to be acted upon. The DON added that today (10/24/17) she had reviewed the pharmacy recommendations since November 2016 and realized that the recommendations had not been consistently followed through. She acknowledged that the facility had no system in place to make sure the recommendations made by the pharmacy consultant were responded by the Physician or by Nursing. The DON indicated that as of today (10/24/17) per their new Quality Assurance (QA) plan, she would be responsible for monitoring the responses to the pharmacy recommendations. The DON indicated that there was no evidence that the Physician had acted upon the recommendation dated 5/24/17 made by the Pharmacy Consultant for Resident #71. 10/24/17 at 3:04 PM, the facility's Nurse Consultant was interviewed. She stated that she expected the recommendations made by the Pharmacy Consultant to be acted upon by Nursing and by the Physician and to document their response on the Consultant Pharmacist Communication form. On 10/25/17 at 10:26 AM, Resident #71's Physician was interviewed. He stated that he had not seen the recommendation dated 5/24/17 made by the Pharmacy Consultant for Resident #71. He added that if the recommendation was regarding a psychotropic medication, the psychiatric team was responsible to respond to the recommendation.	F 428	by the Director of Nursing on 11/2/17. Utilizing a Pharmacy Recommendation QI Audit Tool, the Director of Nursing will review the pharmacy report monthly to ensure that all recommendations have been completed appropriately by the physician and Psychiatric Nurse Practitioner prior to the next pharmacy review. The Director of Nursing will review and initial the QI Audit Tool monthly x 3 for trends and concerns. The Director of Nursing will report the results of the monitoring at monthly Quality Assurance Quality Improvement (QAPI) Committee meeting X 3 months for review and recommendations for any modification of the process.	

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On 10/25/17 at 1:55 PM, the Pharmacy Consultant was interviewed. She stated that she started coming to facility in September 2017. She indicated that she had copies of the monthly drug regimen review notes from the previous Pharmacist and she assumed that the recommendation dated 5/24/17 to attempt a GRD on Remeron was rejected by the Physician because there was no change in the Remeron order. The Pharmacist added that in the future, she would make sure that the response from the Physician was documented including the rationale if the recommendation was rejected.

On 10/25/17 at 3:16 PM, the Psychiatrist was interviewed. She stated that she started coming to facility 6 months ago. She indicated that she had not seen the recommendation dated 5/24/17 made by the Pharmacy Consultant for Resident #71.

On 10/25/17 at 3:50 PM, the Family Nurse Practitioner (FNP) was interviewed. She stated that she had not seen the recommendation dated 5/24/17 made by the Pharmacy Consultant for Resident #71.

On 10/2517 at 5:05 PM, the Mental Health Nurse Practitioner was interviewed. She stated that she had not seen the recommendation made by the Pharmacy Consultant dated 5/24/17 for Resident #71.

b. Resident #71 was admitted to the facility on 11/5/12 with multiple diagnoses including insomnia. The quarterly Minimum Data Set

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(MDS) assessment dated 9/7/17 indicated that Resident #71's cognition was intact and she had received an antidepressant medication during the last 7 days.

Resident #71's current physician's orders were reviewed. The orders revealed that Resident #71 had an order for Remeron (an antidepressant and appetite stimulant) 15 milligrams (mgs) by mouth at bedtime for sleep/appetite.

Resident #71's weights were reviewed. Her weight was 123 pounds (lbs.) on 7/19/17 and was 137 lbs. on 3/2/17, a 14 lbs. weight loss over 4 months.

Resident #71's drug regimen reviews (DRR) were reviewed. The Consultant Pharmacist Communication to Physician form dated 7/25/17 revealed that the resident had a significant weight loss of 18 lbs. over 5 months period. The Pharmacy Consultant had recommended to consider changing Remeron to Marinol (appetite stimulant) in an effort to further increase appetite. The form did not have a response from the physician.

Resident #71's electronic Medication Administration Records (eMARs) from May through October 2017 revealed that she had received Remeron 15 mgs at bedtime.

On 10/24/17 at 3:03 PM, the Director of Nursing (DON) was interviewed. She stated that the recommendations made by the Pharmacy Consultant were given to the unit manager and to the Physician to be acted upon. The DON added that today (10/24/17) she had reviewed the pharmacy recommendations since November

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2016 and realized that the recommendations had not been consistently followed through. She acknowledged that the facility had no system in place to make sure the recommendations made by the pharmacy consultant were responded by the Physician or by Nursing. The DON indicated that as of today (10/24/17) per their new Quality Assurance (QA) plan, she would be responsible for monitoring the responses to the pharmacy recommendations. The DON indicated that there was no evidence that the Physician had acted upon the recommendation dated 7/25/17 made by the Pharmacy Consultant for Resident #71.

10/24/17 at 3:04 PM, the facility's Nurse Consultant was interviewed. She stated that she expected the recommendations made by the Pharmacy Consultant to be acted upon by Nursing and by the Physician and to document their response on the Consultant Pharmacist Communication form.

On 10/25/17 at 10:26 AM, Resident #71's Physician was interviewed. He stated that he had not seen the recommendation dated 7/25/17 made by the Pharmacy Consultant for Resident #71. He added that if the recommendation was regarding a psychotropic medication, the psychiatric team was responsible to respond to the recommendation.

On 10/25/17 at 1:55 PM, the Pharmacy Consultant was interviewed. She stated that she started coming to facility in September 2017. She indicated that she had copies of the monthly drug regimen review notes from the previous Pharmacist and she assumed that the recommendation dated 7/25/17 to change

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Remeron to Marinol was rejected by the Physician because there was no change in the Remeron order. The Pharmacist added that in the future, she would make sure that the response from the Physician was documented including their rationale if the recommendation was rejected.

On 10/25/17 at 3:16 PM, the Psychiatrist was interviewed. She stated that she started coming to facility 6 months ago. She indicated that she had not seen the recommendation dated 7/25/17 made by the Pharmacy Consultant for Resident #71.

On 10/25/17 at 3:50 PM, the Family Nurse Practitioner (FNP) was interviewed. She stated that she had not seen the recommendation dated 7/25/17 made by the Pharmacy Consultant for Resident #71.

On 10/2517 at 5:05 PM, the Mental Health Nurse Practitioner was interviewed. She stated that she had not seen the recommendation made by the Pharmacy Consultant dated 7/25/17 for Resident #71.

2. Resident #85 was admitted to the facility on 3/11/16 with diagnoses that included major depressive disorder.

The quarterly Minimum Data Set (MDS) assessment dated 8/19/17 indicated Resident #85 ' s cognition was intact. He had no mood issues, no behavior issues, and no rejection of care. Resident #85 received antidepressant medication on 7 of 7 days during the MDS review period.

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A Consultant Pharmacist Communication to Physician form dated 4/28/17 indicated a recommendation for a Gradual Dose Reduction (GDR) of Lexapro (antidepressant) 20 milligrams (mg) once daily for Resident #85 in an effort to use the lowest effective dose. There was no response from the physician on the form.

A Consultant Pharmacist Communication to Physician form dated 8/23/17 indicated a repeat recommendation for a Gradual Dose Reduction (GDR) of Lexapro 20 mg once daily for Resident #85 in an effort to use the lowest effective dose. There was no response from the physician on the form.

A review of Resident #85 ' s electronic Mediation Administration Record (eMAR) from April 2017 to October 2017 revealed he was receiving Lexapro 20mg once daily.

On 10/24/17 at 3:03 PM, the Director of Nursing (DON) was interviewed. She stated the recommendations made by the Pharmacy Consultant were given to the unit manager and to the Physician to be acted upon. The DON added she had reviewed the pharmacy recommendations since November 2016 and realized the recommendations had not been consistently followed through. The DON indicated there was no evidence the Physician had act upon the recommendations dated 4/28/17 or 8/23/17 made by the Pharmacy Consultant for Resident #85.

On 10/24/17 at 3:04 PM, the facility's Nurse Consultant was interviewed. She stated she expected the recommendations made by the Pharmacy Consultant to be acted upon by

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F 428	Continued From page 44	F 428		

Nursing and by the Physician and for their responses to be documented on the Consultant Pharmacist Communication form.

On 10/25/17 at 10:26 AM, Resident #85's Physician was interviewed. He stated he had not seen the recommendations dated 4/28/17 or 8/23/17 made by the Pharmacy Consultant for Resident #85. He added if a recommendation was regarding a psychotropic medication, the psychiatric team, including the Psychiatrist, was responsible for responding.

On 10/25/17 at 1:55 PM the Pharmacy Consultant was interviewed by phone. She stated she started coming to facility in September 2017. She indicated she had copies of the monthly drug regimen review notes from the previous Pharmacy Consultant. She assumed the recommendations dated 4/28/17 and 8/23/17 to attempt a GRD of Lexapro for Resident #85 had been rejected by the Physician because there was no change in the Lexapro order. The Pharmacy Consultant added that in the future, she would make sure the response from the Physician, including the rationale if the recommendation was rejected, was documented on the form.

On 10/25/17 at 3:16 PM, the Psychiatrist was interviewed. She stated she started coming to the facility 6 months ago. She indicated she had not seen the recommendations dated 4/28/17 or 8/23/17 made by the Pharmacy Consultant for Resident #85.

On 10/25/17 at 5:05 PM, the Mental Health Nurse Practitioner was interviewed. She stated that she had not seen the recommendations made by the

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ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

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F 428	Continued From page 45 Pharmacy Consultant dated 4/28/17 or 8/23/17 for Resident #85.	F 428		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) 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 (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	F 431		11/17/17

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F 431	Continued From page 46 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 observations and staff interviews, the facility failed to discard expired insulin in 1 of 4 medication carts (Rose Avenue) and failed to store medications at the refrigerator temperature specified by the manufacturer in one of three medication rooms (Sunflower). The findings included: 1. On 10/25/17 at 2:30 PM, an observation of the medication cart on Rose Avenue was conducted with Nurse #2. A vial of Humalog insulin was observed with an open date of 9/2/17 and a discard date of 9/30/17. The dates were written on the box that contained the insulin. On 10/25/17 at 2:30 PM, an interview was conducted with Nurse #2 who stated she looked at the bottle and did not look on the box for the expiration date. She stated she usually wrote the	F 431	F 431 1) On 10/25/17, the expired insulin for Resident #71 was removed from the medication cart by Nurse #2. A new bottle of insulin was replaced on the cart by Nurse #2 and was dated 10/25/17 when opened. The expired insulin was removed from the cart on 10/24/17 to be re-ordered and the nurse put the expired bottle back in the medication cart in error. The error occurred due to the nurse preparing an insulin dose before checking the expiration date of the medication. All medication storage areas were audited for expired medications by the Regional clinical Manger, Unit Manger and DON on 10/25/17 to ensure there were no other	

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F 431	Continued From page 47 dates when opened on the bottle. Nurse #2 indicated the insulin should have been discarded 9/30/17 according to the expiration date written on the box. On 10/25/17 at 2:30 PM, an interview was conducted with Unit Manager #1 who stated the insulin should have been discarded on 9/30/17. 2. On 10/25/17 at 2:20 PM, an observation was made of the Medication Room refrigerator on Sunflower. There was no thermometer in the refrigerator. The contents of the refrigerator at the time of the observation included, in part: three Latanoprost 0.005% unopened vials (eye medication) and ten injections of influenza vaccine. The medications were on a tray and water droplets were observed on the plastic bags that contained the medication. On 10/25/17 at 2:22 PM, an interview with the Unit Manager #1 was done who stated the Supply Clerk was the person who checked the temperatures and the temperature should be between 36 degrees Fahrenheit and 46 degrees Fahrenheit. A review of the manufacturer ' s product information for the Latanoprost eye medication included the following storage requirements: Store unopened bottle(s) under refrigeration at 2 degrees to 8 degrees Celsius (36 degrees to 46 degrees Fahrenheit). A review of the manufacturer ' s product information for the influenza vaccine included the following storage requirements: Store at 36 degrees to 46 degrees Fahrenheit.	F 431	expired insulins or medication in medication storage areas within the facility. The audit was completed on 10/25/17. On 11/1/17, the Regional Clinical Manager provided an in-service to the Director of Nursing and Unit Managers on the Medication Storage Policy. The Director of Nursing initiated an in-service to 100% of licensed nurses on 11/1/17 to check medications for an expiration date before administering. The in-service was completed 11/17/17. No licensed staff will be allowed to work until they have completed the in-service. The in-service will be incorporated into the nurse orientation packet. New hires will receive the education during orientation Starting 11/13/17. The Unit Manager, Pharmacy Consultant, or Regional Clinical Consultant will complete a Medication cart audit weekly x 1 month, then monthly x 2 months to ensure there are no expired medication in Medication Storage areas in the facility. Any expired medication found will be appropriately discard and staff will be reeducated as appropriate by the Director of Nursing. The Director of Nursing will review and initial the Audit Tool weekly to include weekends x 1 month, then monthly to include weekends x 2 months for trends and concerns. The Director of Nursing will present the results of the monitoring at the monthly QI committee meeting x 3	

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F 431	Continued From page 48 On 10/25/17 at 2:45 PM, an interview was conducted with the Supply Clerk. She stated she had been checking the medication refrigerator temperatures since June 2017. She said the temperature in the refrigerator should be between 36 degrees Fahrenheit and 46 degrees Fahrenheit. The Supply Clerk stated the thermometer was not working when she checked the medication refrigerator on Sunflower this morning. She had removed the thermometer and had forgotten to replace it. The Supply Clerk reviewed her monthly temperature log and noted that the temperature in the Sunflower medication refrigerator was 41 degrees on 10/24/17. On 10/25/17 at 2:45 PM, the Supply Clerk replaced the thermometer in the medication refrigerator on Sunflower. An observation of the medication refrigerator was conducted on 10/25/17 at 3:33 PM and revealed a temperature of 50 degrees. The Supply Clerk removed the medications at that time and stated she would get maintenance to check the refrigerator.	F 431	months for trends and the need for continued monitoring. 2) On 10/25/17, the Maintenance Director checked the refrigerator on Sunflower hall for proper working order with no concerns and replaced the thermometer. On 10/25/17 at 4:30pm, the temperature was rechecked by Regional Clinical Manger and the refrigerator was at 38 degrees. On 10/25/17 the Regional Clinical Manager and Unit Coordinator checked 100% of all medication refrigerators to ensure all have thermometers and the temperature was within an acceptable level. No concerns were noted at that time. The problem occurred as the Supply Clerk failed to replace the thermometer on 10/25/17 after discovering it was not working. The temperature was not checked and the high temperature was not corrected. On 11/1/17, the Regional Clinical Manager provided an in-service to the DON and Unit Manager on the new temperature logs. New temperature logs were posted on all medication refrigerators on 11/10/17 by the Unit Manager. The DON initiated an in-service to 100% of nursing staff on Medication Storage and Refrigerator temperatures. The 7PM to 7AM shift nursing staff will begin checking medication refrigerator temperatures and documenting the temperature on the log beginning 11/12/17. The in-service was completed by 11/17/17. No nursing staff will be allowed to work until they have received the in-service. All newly hired	

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F 431	Continued From page 49	F 431	nurses will receive the education during orientation. Utilizing a Medication Refrigerator QI Audit Tool, the Unit Manager will complete a medication refrigerator audit to ensure a thermometer is in the refrigerator and the temperatures are within the 36 to 46 degree range. The Unit Manager will notify the Administrator and the Maintenance Director timely if the refrigerator temperatures are not in the acceptable range. Monitoring will be done twice weekly x 1 month to include weekends then weekly x 4 weeks to include weekends, then monthly x 1 month to include weekends. The Administrator will review the Audit Tool weekly x 8, then monthly x 1 for trends or concerns. The Administrator will present the results of the monitoring at the monthly QI committee meeting x 3 months for trends or concerns, the need for continued monitoring, and review and recommendation for any modification of the monitoring process.	
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services;	F 520		11/17/17

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F 520	Continued From page 50 (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, physician interview, nurse practitioner interview, and facility staff interviews, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place	F 520	F Tag 520 The facility will monitor and evaluate effectiveness of the identified QAPI programs by achieving and maintaining identified thresholds for F tags 278, 329,	

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F 520	Continued From page 51 following the 11/19/15 and 10/20/16 recertification surveys for 2 recited deficiencies in the areas assessment accuracy (F278) and unnecessary medications (F329), and following the 10/20/16 recertification survey for 1 recited deficiency in the area of care provided by qualified persons in accordance with care plan (F282). These 3 deficiencies were cited again on the current follow up recertification survey of 10/26/17. The continued failure of the facility during 2 or more federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. 278 - Assessment Accuracy: Based on record review and staff interviews, the facility failed to accurately code Resident #64 for the diagnosis of depression on her admission Minimum Data Set (MDS) for 1 of 14 MDS assessments reviewed. During the recertification survey of 11/19/15 the facility was cited F278 for failure to code the MDS accurately in the areas of medications and therapy services. During the recertification survey of 10/20/16 the facility was again cited F278 for failure to code the MDS accurately in the area of prognosis/life expectancy. On the current recertification survey of 10/26/17 the facility failed to code the MDS accurately in the area of active diagnoses. 2. 282 - Care Provided by Qualified Persons in Accordance with Care Plan: Based on staff interview, physician interview, and record review the facility failed to follow the plan of care interventions related to seizure medication for 1	F 520	282 F 278 The last Minimum Data Set (MDS) assessment completed for resident #64 was reviewed by MDS Coordinator on 10/25/17 and Section I was modified to include the diagnosis of Depression to accurately reflect the residents current condition. A 100% audit of the last completed MDS assessment for all residents, to include resident # 64, will be conducted by Regional Reimbursement Managers (RRMs) to be completed by 11/17/17 to ensure coding of the minimum data set accurately reflects the residents. No errors were found in the diagnosis coding in section I of the MDS by 11/17/17. For all areas of concern identified, a modification or significant correction of prior assessment (Quarterly/Comprehensive) will be completed by the facility MDS Nurse by 11/17/17. The MDS Nurse, Dietary Manager (DM), and Activities Director (AD) will be re-in-serviced on proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual by the RRM to be completed by 11/17/17. When coding the MDS assessment the MDS Nurses and Care Plan Team will follow the instructions for proper coding found in the Resident Assessment	

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F 520	Continued From page 52 of 5 residents (Resident #85) reviewed for unnecessary medications and related to Preadmission Screening and Resident Review (PASRR) Level II for 1 of 1 residents (Resident #86) reviewed for PASRR. During the recertification survey of 10/20/16 the facility was cited F282 for failure to follow the plan of care for evaluation by a mental health provider as needed for behaviors to address assaultive behaviors. On the current recertification survey of 10/26/17 the facility failed to follow the plan of care interventions related to seizure medications and PASRR Level II. 3. F329 - Unnecessary Medications: Based on record review and Nurse Practitioner and staff interview, the facility failed to ensure resident was free from duplicate antibiotic therapy (Resident #71) and failed to attempt a gradual dose reduction (GDR) for an antidepressant medication (Resident # 85) for 2 of 5 sampled residents reviewed for unnecessary medications. During the recertification survey of 11/19/15 the facility was cited F329 for failure to utilize non-pharmacological approaches to address behaviors, failure to evaluate the underlying cause of behaviors either before or during treatment with antipsychotic medication, and failure to reassess the ongoing clinical rationale for antipsychotic medication in the absence of a clinical indication. During the recertification survey of 10/20/16 the facility was again cited F329 for failure to have a clinical indication for the administration of an antipsychotic medication. On the current recertification survey of 10/26/17 the facility failed to ensure resident was free from duplicate antibiotic therapy and failed to attempt a	F 520	Instrument (RAI) Manual and ensure that the assessment accurately reflects the resident□s current condition. An audit of 25% of completed Minimum Data Set (MDS) assessments will be conducted weekly x 4 weeks, then bi-weekly for 4 weeks, then 10% monthly x 1 month by RRM to ensure compliance and accuracy utilizing a MDS audit Tool. All identified areas of concern will be addressed immediately by the RRM by retraining appropriate staff responsible for the coding error and by the MDS Nurse with modification or significant correction of the MDS. The Administrator will review and initial the MDS Audit Tool weekly x 4 weeks, then bi-weekly x 4 weeks then monthly x 1 month. The results of the MDS Audit Tool will be compiled by the Administrator and presented to the Quality Improvement Committee monthly x 3 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring. F 282 The lab results for a Keppra level of 9/14/17 for Resident # 85 was reviewed by the physician on 10/25/17 with no new orders. The lab results were inadvertently filed in the resident□s record before being reviewed by the physician and with no follow up for assuring labs have been drawn, received, reviewed, and any new orders carried out.	

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F 520	Continued From page 53 GDR for an antidepressant medication. An interview was conducted with the Administrator on 10/26/17 at 9:00 AM. He indicated he was the head of the facility ' s QAA Committee. He stated the QAA Committee consisted of the himself, the Director of Nursing, MDS Coordinator, Unit Manager #1, Unit Manager #2, Admissions/Marketing Director, Dietary Manager, Social Worker, Activities Director, Rehabilitation Manager, Business Office Manager, Environmental Services, Maintenance Director, Medical Records, Medical Director, and Pharmacy Consultant. He reported he began working at the facility at the end of April 2017 and since that time he had implemented monthly QAA meetings. The Administrator indicated he was aware F278, F282, and F329 were repeat citations. He stated he had not worked at the facility at the time of the previous recertification surveys and was not aware of the specific plans of correction for each citation. He reported the facility had hired a new MDS Coordinator and she began working in late July/early August 2017. He indicated he felt the facility was moving in the right direction in regard to the deficiencies cited for F278 and F282. The Administrator stated a new physician, new psychiatrist, and a new pharmacy consultant had all began working with the facility within the last year. He reported the numerous changes may have attributed to the deficiency at F329, but he reported his confidence in the new providers.	F 520	A 100% audit of all ordered labs for 10/10/17 through 11/10/17 were reviewed by the Director of Nursing (DON) to assure all lab results were obtained as ordered, received in the facility timely, reviewed by the physician timely and all new orders were carried out by the licensed nurse. The lab audit was completed on 11/10/17. There were 22 identified concerns with the initial audit completed by the Director of Nursing. All concerns were addressed/corrected by the Director of Nursing and the Unit Manger by 11/10/17. A new lab log was created by the Regional Clinical Consultant on 11/17/17 include: Date Patient Name" Room # Test Ordered Date Specimen Obtained Tech/Nurse Initial Date Report Received Check If Abnormal Date MD Notified MD Response: New Order or No New Order Nurse Note: Family Notified An In-service was initiated by the Director of Nursing on 11/8/17 to 100% of all licensed nurses related to the process they will follow once they receive an order for a lab to be obtained. Nurses will not work until they have received the in-service and this in-service will be included in new nurse orientation. The Unit Manager will review the lab log Monday through Friday x 2 weeks, then	

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F 520	Continued From page 54	F 520		

twice weekly to include weekends x 6 weeks, then monthly x 1 to include weekends to assure all lab results have been received, the physician has been notified of the results, and any new orders were carried out.

The Lab Diagnostic Log will be turned in to the Director of Nursing for review weekly x 8, then monthly x 1 for trends and concerns to ensure the facility practice is compliant with current Plan of Correction. Any concerns will be corrected at the time of discovery and the staff will be re-educated. The Plan of Correction will be revised as deemed necessary to maintain Regulatory Compliance. The Director of Nursing will review and initial the results of the Lab monitoring tool x 8 weeks, then monthly x 1 for trends and/or concerns.

The Director of Nursing will report the results of the Lab monitoring tool to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process.

2) A PASRR screening was submitted to NC Must with the appropriate paperwork for Resident # 86 by the Social Worker on 10/30/17 due to his Significant Change in Condition as indicated in the care plan. A response was received on 10/30/17 from NC Must to retain the resident□s existing PASRR number.

The Social Worker was re-educated

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F 520	Continued From page 55	F 520	related to Level 11 PASRR for Significant Change in Condition by the Regional Clinical Manager on 11/1/17. This information will be included in the Social Worker orientation packet for new Social Work hires. A 100% audit of all residents with a PASRR Level II was completed on 10/31/17 by the Regional Clinical Manager for the past 6 months to assure no significant change of condition had occurred without notification to NC Must as the care plans indicates. No other resident with a Level II PASRR were noted to have had a significant change in condition. The Regional Clinical Manager provided an in-service to the Social Worker and MDS Nurse on 11/1/17 on reporting a significant change in condition for any PASRR Level II resident to NC Must at the time of the discovery of the significant change per the resident care plan. As the Social Worker has resigned at the facility, the new Social Worker will be educated on the process during orientation and prior to working the floor. The MDS nurse will update the care plans and submit a Level II PASRR request to NC Must in the event a resident has a significant change in condition until the new Social Worker starts on 12/12/17 and is educated on the requirements of a Level II PASRR by the Director of Nursing upon hire.	

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(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 520	Continued From page 56	F 520	Utilizing a Significant Change of Condition PASRR Level II QI Audit Tool, the DON will review the MDS schedule of completed assessments weekly x 8 weeks, and then monthly x 1 to ensure that any significant change of condition assessment that was completed for a PASRR Level II resident, that the MDS Nurse or Social Worker has notified NC Must of the significant change as indicated on the resident care plan. The Director of Nursing will review and initial the QI Audit tool weekly x 8, then monthly x 1 month for trends or concerns. The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process. F 329 1) The Physician was notified of the duplicate antibiotic therapy for Resident #71 on 10/24/17 by the Unit Manager and orders were received to discontinue Augmentin at that time. The resident completed the course of Doxycycline on 10/29/17 as ordered. The duplication of orders was due to failure of the staff to notify the physician of the previously ordered antibiotic. The Regional Clinical Manager provided an in-service to the Unit Manager and Director of Nursing on duplicate medication therapy on 11/01/17. A 100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING _____ B. WING _____	10/26/2017

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F 520	Continued From page 57	F 520	in-service of the nursing staff was initiated 11/01/17 by the Director of Nursing on documenting in the order the indication for medications ordered by the physician and also reviewing to see if multiple antibiotics are being used, and reporting antibiotic duplication orders to the Physician. The in-service was completed on 11/17/17. Licensed nursing staff will not work the floor until they have signed the in-service. Newly hired licensed nurses will receive the education during orientation. On 10/30/17, the Unit Manager initiated a 100% audit of the Medication Administration Records for unnecessary duplication of antibiotic medications ordered in the past 30 days. The in-service was completed on 11/17/17. No instances of duplicate therapy were found. All newly hired licensed nurses will receive the education during orientation. Licensed nursing staff will not work the floor until they have signed the in-service. A Duplicate Antibiotic Monitoring QI audit tool will be completed by the Unit Manager Monday through Friday x 2 weeks, then twice weekly x 6 weeks to include weekends, then twice monthly to include the weekend x1 month. Identified concerns will be corrected by the Unit Manger as they are discovered. The Director of Nursing will review and initial the weekly audits x 8 weeks, then monthly x 1 for trends and concerns and adjust the plan of correction as needed to ensure	

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F 520	Continued From page 58	F 520	regulatory compliance. The Director of Nursing will present the results of the monitoring at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for 3 months for review and recommendations for any modification of the monitoring process. 2)Resident #85's pharmacy recommendation of 8/23/17 for a gradual dose reduction of Lexapro was reviewed by the Psychiatric Nurse Practitioner on 10/26/17. The Nurse Practitioner has scheduled the resident for a full review on her next visit on 11/9/17 for dose reduction. The error was due to the lack of oversight to assure recommendations were reviewed timely by the physician and Psychiatric Nurse Practitioner. The Director of Nursing reviewed all pharmacy consults for the months of August 2017 and September 2017. The audit was completed on 10/31/17. Multiple recommendations were not completed prior to the next pharmacy review. All pharmacy recommendations that were found not completed in the audit were followed up on by the Director of Nursing by 10/31/17. On 10/24/17, the Regional Clinical Manager completed an in-service with the Director of Nursing and Unit Manager on pharmacy recommendation completion and follow up process. The attending Physician received an in-service by the	

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F 520	Continued From page 59	F 520	Regional Clinical Manager on 10/31/17 on timely responses to pharmacy recommendations, and the Psychiatric Nurse Practitioner received the in-service by the Director of Nursing on 11/2/17. Utilizing a Pharmacy Recommendation QI Audit Tool, the Unit Manager will review the pharmacy report monthly to ensure that all recommendations have been returned completed appropriately by the physician and Psychiatric Nurse Practitioner prior to the next pharmacy review. The Director of Nursing will review and initial the QI Audit Tool monthly x 3 for trends and concerns. The Director of Nursing will report the results of the monitoring at monthly Quality Assurance Quality Improvement (QAPI) Committee meeting X 3 months for review and recommendations for any modification of the process.	