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	345138	A. BUILDING _____ B. WING _____	03/22/2018

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LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

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F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to complete the administration of a medication for 1 of 1 residents (Resident # 5), reviewed for self-administration of medication. Findings included: Review of a facility policy entitled "Preparation and General Guidelines IIA9: Self-Administration of Medications", read in part: *In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. *If the resident desires to self-administer medications, as assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility, during the care planning process. *The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notation that it may be self-administered.	F 554	F 554 Root Cause Analysis Based on root cause analysis by the facility administrative staff and facility Executive Director it was determined the medication nurse did not fully understand that a resident must be assessed to ensure that they have the ability to safely self-administer medication. The Nurse left medication per the resident□s request, at the bedside of a resident who was deemed not a candidate to self-administer medication. Immediate Action The Medication was removed from Resident #5 room and discarded. Nurse #1 was provided education regarding requirements for having a self-administration of medication assessment that confirms that the resident has been deemed safe for self-administration of the medication. Identification of Others An audit of 100% current residents most recent self-administration of medication assessment was conducted by the Director of Nurses on 4/11/18. This audit was completed to ensure that all residents had a self-administration of medication	4/17/18

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

Electronically Signed | 04/13/2018

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F 554	Continued From page 1 Resident # 5 was re-admitted to the facility on 12/28/17 with diagnoses that included Type 2 Diabetes Mellitus with Diabetic Neuropathy, Cognitive Communication Deficit, Major Depressive Disorder, Generalized Muscle Weakness and Heart Failure. Review of the resident's most recent comprehensive MDS, dated 1/5/18, and coded as an admission assessment, revealed the facility assessed the resident as being cognitively intact, understands others as is understood by others. The assessment, also, had documentation of resident having adequate hearing and vision. During a review of the resident's active care plan, dated 1/5/18, revealed there was no care plan in place for resident to self-administer her own medications or to keep any at the bedside. Review of Resident # 5's Medication Administration Record (MAR) and her Physician Orders for the months of January, February and March 2018 revealed no orders to self-administer her own medication or keep any medications at her bedside. Review of a facility assessment, dated 1/18/18 and entitled "Self Administrator of Medications Determination," revealed the facility had assessed the resident and concluded that she was not a candidate for self- administration of medication due to: the resident did not want to self-administer medications, the resident had a diagnosis that would interfere with the ability to self-administer (Depression), the resident would have difficulty entering doses on a medication	F 554	assessment completed and if any other resident expressed a desire to self-administer. No other residents were identified as expressing a desire to self-medicate. Systemic Changes Beginning 4/9/18 the Self Administration of Medication assessment will be completed upon admission, readmission, and quarterly or with significant change by the MDS coordinator/designee. The facility□s protocol will be followed for any resident who expresses a desire and/or is determined to be a candidate for self-administration. Licensed Nurses were re-educated on the policy of the facility regarding self-administration of medication. This education was completed by the DON on 4/11/2018 and included ensuring that the resident is a candidate for self-administration of medications prior to allowing self-administration. Monitoring Beginning 4/9/18 the DON, Staffing Nurse, and Manager Ambassadors will monitor three times weekly during rounds during rounds to ensure that medications are not left at bedside. The hall nurse, DON or staffing nurse will be notified immediately if there are concerns with meds at the bed side. This monitoring will be documentation on the Ambassador rounds form and reviewed during AM managers meeting if there are concerns. This will continue for 3 months or until a	

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F 554	Continued From page 2 administration record, and the resident had a history of depression or mental illness (Depression). On 03/20/18, at 12:40 PM, approximately 60 milliliters (ml) of pink colored liquid was observed in a cup on resident's bedside tray. The cup had a spoon in it. During the observation, Resident # 5 identified the liquid as her "medicine for her stomach." Interview with medication nurse revealed that the liquid was Miralax. Accompanied by the medication nurse, a second observation of the contents of the cup was done, on 03/20/18 at 12:45 PM. The medication nurse stated that she did leave the cup on Resident # 5's bedside tray. On 03/20/18 at 4:31 PM, during an interview with the resident she stated she was "feeling much better from the stomach medicine I (she) had earlier." When asked about the frequency of medications left at bedside, the resident stated, "she forgot it, it was her mistake for not taking it away." Resident, also, stated "medicines that are liquid in cups, they leave for me to take (finish) some time." On 03/21/18, at 10:24 AM, accompanied by the DON, a second interview with the Medication Nurse was conducted. The Medication Nurse, again, indicated that the medication was Miralax. "I left it on the night stand. The resident didn't drink it but wanted it, so I left it so she could try it later because she was nauseated." During an interview with the DON, on 03/21/18 at 10:30 AM, she stated the medication should not have been left in the room.	F 554	pattern of compliance is achieved. The DON will summarize the results of this monitoring and present to the QAPI committee monthly for three months or until a pattern of compliance is achieved. The QAPI committee will make recommendations and modifications to this plan as necessary.	

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F 554	Continued From page 3 On 03/21/18, at 11:20 AM, an interview with the Administrator, she stated there is an assessment done upon admission to determine if the resident is capable of safely administering their medications. She further added, that the assessment is completed by the nursing department and that there would have had to be physician order to keep medications at the bedside.	F 554		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		4/17/18

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F 580	Continued From page 4 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident representative interview, staff interviews and record reviews, the facility failed to notify the resident's responsible party of a fall with injury for 1 of 3 residents sampled. Resident #31 fell on 3/13/18 and the facility did not notify her responsible party. The Findings Included: Resident #31 was admitted to the facility on 12/16/17. Resident #31's admitting diagnoses included muscle weakness, essential hypertension and type 2 diabetes mellitus. A review of the most recent Minimum Data Set (MDS), dated 1/19/18 which was a quarterly	F 580	F 580 Root Cause Analysis Based on root cause analysis by the facility administrative staff and facility Executive Director it was determined the nurse did not follow the facility policy of notifying a responsible party when a resident has a fall on any shift. The nurse failed to notify the family of resident #3 who fell on 3/13/2018. Immediate Action The family of resident #3 was notified upon arrival to the facility on 3/13/2018 by nursing. The nurse in question did not work for the	

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F 580	Continued From page 5 assessment revealed, Resident #31 was moderately cognitively impaired and required extensive assistance with activities of daily living. The MDS further revealed that Resident #31 had two or more falls with no injury since prior assessment. An interview with Resident #31's responsible party on 3/20/18 at 10:46 am, revealed that the facility failed to notify her of a fall with injury on 3/13/18. The responsible party further stated that she did not know of the fall until she got to the facility on 3/13/18 to visit Resident #31, who was being transported to the hospital for a CT scan. A review of the incident report for Resident #31 dated 3/13/18 revealed no documentation that Resident #31's responsible party was notified of the fall. The area of the form that indicated if the family was notified was left blank with no information indicating the family/responsible party was notified. Review of a nursing note dated 3/14/18 at 6:08 am, revealed that nurse #1 observed Resident #31 sitting on the floor, on the side of her bed. The nursing note further revealed that Resident #31 had a hematoma on the right side of her forehead. A telephone interview was conducted with nurse #1 on 3/21/18 at 8:33 am. Nurse #1 revealed that he did not witness Resident #31's fall. Nurse #1 reported that he worked 3rd shift and was responsible for care for Resident #31 on the date the incident occurred. He stated that he did not notify the physician or Resident #31's responsible party. Nurse #1 revealed that he reported to the oncoming nurse (Nurse #2) to notify the physician	F 580	facility after 3/13/208. Identification of Others An audit of 100% of falls from 2/22/218 to 4/09/2018 was conducted by the Director of Nurses. This audit was completed to ensure that all resident□s responsible parties were notified. No other responsible parties were identified as not being notified. Systemic Changes Beginning 4/10/18, falls will be monitored Monday-Friday in IDT clinical rounds for notification of Responsible Party. Licensed Nurses were re-educated on the policy of the facility regarding notification of families. The education was completed by the DON on 4/11/2018. Monitoring Beginning 4/10/18 the DON will check five days a week to assure families were notified. This will continue for 3 months or until a pattern of compliance is achieved. The DON will summarize the results of this monitoring and present to the QAPI committee monthly for three months or until a pattern of compliance is achieved. The QAPI committee will make recommendations and modifications to this plan as necessary.	

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and the responsible party of Resident #31 fall with injury.

On 3/21/18 at 8:52 am an interview with nurse #2 was conducted. Nurse #2 revealed that she was not the nurse on duty for Resident #31 on 3/13/18. Nurse #2 revealed that nurse #3 was the first shift nurse on duty for Resident #31 on 3/13/18. Nurse #2 stated that when a resident falls she notifies the responsible party "like we're supposed to".

An interview was conducted at 9:00 am on 3/21/18 with nurse #3. Nurse #3 revealed that she did receive notification that Resident # 31 hit her head earlier in the morning by nurse #1 during the nurse report. She reported that she was not aware that nurse #1 did not notify the responsible party and revealed that she did not notify the responsible party.

Interview with the Director of Nursing (DON) on 3/21/18 at 11:34 am revealed that she expected nurse #1 and all nurses to notify the medical provider and the responsible parties for significant changes and any incident such as falls.