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	345446	A. BUILDING _____ B. WING _____	01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHAB CENTER	95 LOCUST STREET CONNELLY SPG, NC 28612

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 1/14/18 through 1/17/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID 810D11.	E 000		
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 and resident and staff interviews the facility failed to assess 1 of 1 resident for self-administration of over the counter medications (Resident # 61). Findings included: Resident #61 was originally admitted to the facility on 09/28/18 with diagnoses including hypertension (high blood pressure), arthritis, infection of the right hip, and heart disease. Review of the admission Minimum Data Set (MDS) dated 10/11/18 revealed Resident #61 was cognitively intact. Review of Resident #61's medical record revealed there were no Physician's orders for eye lubricant or eye drops. An observation of Resident #61's over bed table on 01/14/19 at 2:49 PM revealed a tube of eye lubricant and a bottle of eye drops sitting on top.	F 554	Interview with resident and family revealed resident's sister did supply medications to resident as mentioned in the observation. Medications removed and no orders sought for self administration or for OTC meds provided per resident request. Reviewed policy with family and resident r/t bringing in medication either OTC or prescription. Reviewed admission summary with family as well. Education provided to CNAs Nurses EVS by DON or designee as follows by 2/14/2019: * any medication observed in resident's room must be reported to the nurse * Nurse should seek order for med to be at bedside per policy if appropriate or call RP to pick medications up. Residents that are alert and oriented	2/14/19

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

Electronically Signed | 02/07/2019

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F 554	Continued From page 1 An interview with Resident #61 on 01/14/19 at 2:49 PM revealed he did not use the eye lubricant or eye drops himself and that staff did not administer them to him. An observation of Resident #61's over bed table on 01/15/19 at 1:17 PM revealed a tube of eye lubricant and a bottle of eye drops sitting on top. An observation of Resident #61's bedside table on 01/16/19 at 8:32 AM revealed a clear container sitting on top of the table with a tube of eye lubricant and a bottle of eye drops inside. An observation of Resident #61's bedside on 01/17/19 at 9:11 AM revealed a clear container sitting on top of the table with a tube of eye lubricant and a bottle of eye drops inside. An interview with Resident #61's Nurse #1 on 01/17/19 at 1:09 PM revealed Resident #61 did not self-administer any medications. An observation of Resident #61's bedside table on 01/17/19 at 1:24 PM revealed a clear container sitting on top of the table with a tube of eye lubricant and a bottle of eye drops inside. An interview with Nurse #1 on 01/17/19 at 1:27 PM revealed she was not aware Resident #61 had a tube of eye lubricant and a bottle of eye drops in a container on top of the bedside table. Nurse #1 removed the tube of eye lubricant and bottle of eye drops from Resident #61's room. An interview with the Director of Nursing (DON) on 01/17/19 at 3:16 PM revealed she was not sure where the tube of eye lubricant and bottle of	F 554	have the potential to be affected and will have rooms cleaned, as resident allows, and conversation with residents, as appropriate, r/t medication availability and policy, to be completed by DON, SW, and or designee. Reminder letter and or calls to families as appropriate to review policy and expectation r/t care and medication, either prescription or OTC, completed by Administrator and or designee. Medication safety to be reviewed at Care-Plan with resident and/or responsible party and documented on IDT summary by SW or designee. Reports of medications in rooms to be reviewed at QA x 1 year Rooms cleaned and resident interviews Q1 month X 3 months then randomly by SW and EVS or other designee with reports of medication at bedside to be tracked and continued education with staff, residents, and families to assure medications are only available as ordered. Potential problem areas to be reviewed at QA X 1 year	

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F 554	Continued From page 2 eye drops came from. The DON stated the tube of eye lubricant and bottle of eye drops could have been left at Resident #61's bedside if he had been deemed safe to keep them at the bedside and if Resident #61 had a Physician's order to leave those medications at the bedside. The DON stated Resident #61 did not have a Physician's order to administer the eye lubricant or the eye drops and they should not have been left at the bedside.	F 554		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights 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	F 656		2/14/19

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F 656	Continued From page 3 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. (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 observations, record review and staff interviews the facility failed to implement a care planned intervention to off load heels while in bed for 1 of 5 residents reviewed for pressure ulcers (Resident #52). The Findings Included: Resident #52 was admitted to the facility on 04/04/18 with diagnoses that included unspecified dementia without behaviors, major depressive disorder, epilepsy and anxiety disorder among others. A review of Resident #52's significant change Minimum Data Set (MDS) Assessment dated 12/07/18 revealed Resident #52 to be severely impaired cognitively with no behaviors or rejection of care noted. Resident #52 required extensive assistance with bed mobility. This assessment also identified that Resident #52 was at risk for developing pressure ulcers and was utilizing	F 656	Interventions updated for standard care for resident #52 Air Matress continued to offload pressure for comfort and to promote skin integrity. All residents with order for air mattress and or to float heels to be reviewed for standard care practice and appropriateness of orders for standard care practices completed by 2/11/2019 with no discrepancies. DON and or designee to train nursing team r/t standard practice of off loading with air mattress in place--to be completed by 2/14/2019 Care Plans & staff assignment sheets of residents with orders for air mattress reviewed by DON and/or designee as to assure correct interventions are utilized by	

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F 656	Continued From page 4 pressure reducing devices to her chairs and bed. A review of Resident #52's care plan for skin impairment risk related to limited mobility and weakness last revised 12/07/18 revealed with a goal of preventing skin breakdown. Interventions included off load heels on pillows while in bed. A review of Resident #52's physician order summary for January 2019 revealed orders that included to off load her heels on a pillow while in bed, use of a safety air mattress. A review of a facility document entitled "N.A. (Nursing Assistant) Worksheet" dated 01/17/19 revealed Resident #52 had special needs that included: "float heels, and safety air mattress." An observation on 01/15/19 at 3:43 PM revealed Resident #52 was observed to be in bed resting. Resident #52 was observed lying flat on her back with a thin blanket over her body. Further observation at this time revealed Resident #52's heels were not off loaded on pillows per the care plan and there were no pillows observed under the blanket. Resident #52 was noted to be on an air mattress at this time. An additional observation of Resident #52 was completed on 01/16/19 at 1:43 PM. Resident #52 was observed at this time to be in bed lying flat on her back, on an air mattress with her heels resting on the bed. There were no pillows observed under the blanket. During an interview with Nurse #2 on 01/17/19 at 11:25 AM it was revealed it was the responsibility of the nurse aides to make sure that treatments assigned to them remained in place. Nurse #2	F 656	nursing team by 2/14/2019. Residents with orders for off loading/air mattress to be assessed by DON and/or designees every week for 4 weeks then every month for 3 months then randomly to assure interventions utilized appropriately. Potential problems and accomplishments to be reviewed as appropriate at QA X 1 year	

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F 656	Continued From page 5 stated she signed off on the Treatment Administration Record (TAR) that Resident # 52's heels were off loaded on pillows but she did not go in after nurse aides (NAs) provided care to verify Resident #52's heels were off loaded on pillows while she was in bed. She also stated that it was difficult at times to keep pillows under Resident #52's heels due to Resident #52 occasionally drawing her knees up, especially during care. An interview conducted on 01/17/19 at 1:21 PM with NA #1 revealed she provided care for Resident #52 often and was assigned to Resident #52 on 01/15/19 and 01/16/19. She also reported there were days when there were no pillows under Resident #52's heels. NA #1 reported she was made aware of the special needs of each resident on her hall by looking at a document called the NA Worksheet. NA #1 reported she was made aware the previous day (1/16/19) by the MDS Nurse #1 to make sure Resident # 52 had pillows under her heels while in bed. An interview with the Director of Nursing (DON) on 01/17/19 at 3:04 PM revealed the nurse who had worked on Resident #52's hall had reported to her that pillows were placed in the bed with her but that Resident #52 moved around a lot and that it was difficult to keep them underneath her heels. She continued, stating that Resident #52 was on an air bed and reported the air bed should be better than pillows for off-loading of Resident #52's heels. The DON reported it was expected that care outlined on the NA Worksheet be followed.	F 656		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		2/14/19

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F 842	Continued From page 6 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		

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F 842	Continued From page 7 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to document a physician ordered intervention had been completed on the treatment administration record and failed to document a medication had been administered on the medication administration record for 1 of 5 residents reviewed for pressure ulcers (Resident #52). The Findings Included:	F 842	Staff responsible for medication administration interviewed with correct documentation added. Jan MARs for each resident reviewed for potential documentation errors with staff coached/educated on standards of practice for med administration documentation and the delay or deletion of documentation. Policy reviewed for expectation to document meds and	

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F 842	Continued From page 8 1a. Resident #52 was admitted to the facility on 04/04/18 with diagnoses that included unspecified dementia without behaviors. A review of Resident #52's significant change Minimum Data Set (MDS) Assessment dated 12/07/18 revealed Resident #52 to be severely impaired cognitively with no behaviors or rejection of care noted. Resident #52 required extensive assistance with bed mobility, transfer locomotion on the unit, dressing, toilet use and personal hygiene. This assessment also identified that Resident #52 did not have a pressure ulcer but was at risk for developing pressure ulcers and was utilizing pressure reducing devices to her chairs and bed along with the application of ointments or medications. A review of Resident #52's physician order sheet for January 2019 revealed order to off load her heels on a pillow while in bed and use of a safety air mattress A review of Resident #52's care plan revealed a care plan area for "skin impairment risk related to limited mobility and weakness". Interventions included moisturizing cream to bilateral heels for dryness and off load heels on pillows while in bed. A Review of Resident #52's Treatment Administration Record (TAR) for January 2019 revealed no initials to indicate that a nurse signed off 1/9/19, 1/11/19, 1/14/19, 1/15/19, and 1/16/19 on the 7:00 AM to 7:00 PM time frame for the treatment of off loading heels on pillow while in bed. An interview with Nurse #1 on 01/17/19 at 7:35	F 842	interventions as ordered and administered DON and or designee trained Nursing Staff responsible for MED ADMINISTRATION on documentation of medication administration per policy by 2/14/2019 10 MARs to be reviewed weekly x 4 weeks then monthly X 3 months then randomly by DON, Pharmacist and or designee for documentation errors. Random medication administration review by nursing manager, pharmacist or designee to continue. Peer review to be utilized for identification of delayed charting. Potential concerns and accomplishments to be reviewed at QA meetings X 1 year	

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F 842	Continued From page 9	F 842		

AM revealed she was working on the hall where Resident #52 resided on 01/11/19. She reported she remembered ensuring Resident #52's heels were floated on pillows as ordered but forgot to sign off on it. She reported she should have signed off on the TAR. She reported there were times when she "couldn't see the forest because of the trees" when asked why she had forgotten to sign off on the treatment.

An interview with Nurse #2 on 01/17/19 at 11:25 AM revealed she was working on the hall where resident #52 resided on 01/14/19, 10/15/19, 01/16/19. She reported Resident #52 had begun to decline and had spent most of her time in bed. She reported on the 01/14/19, 01/15/19, and 01/16/19 Resident #52 had not gotten out of bed. She continued, stating that she ensured Resident #52's heels were floated but must have missed signing off on the TAR for floating Resident #52's heels on pillows while she was in bed. She stated she should have signed off on the treatment record.

An interview with Nurse Manager #1 on 01/16/19 at 1:57 PM revealed if the TAR was initialed then it indicated the treatment had been provided. She reported if the TAR was not initialed then it did not necessarily mean that it was not given. She continued, stating it should be signed off on and reported if the TAR was not signed off on then it would be difficult to determine if the medication or treatment had been provided.

An interview with the Director of Nursing on 01/17/19 at 3:04 PM revealed she expected if a treatment was provided, then the nurse should have signed off on the TAR. She reported she could not speak to whether or not Resident #52's

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F 842	Continued From page 10	F 842		

heels were floated on the days there was no sign off on TAR. She reported the nursing standard would be that a nurse would sign off on TAR for treatments provided.

b. Review of Resident #52's Medication Administration Record (MAR) for January 2019 revealed there was no staff sign off on January 01/01/19, 01/03/19, 01/04/19, and 01/05/19 to confirm the Omeprazole DR (for heart burn) 20 milligrams (mg) capsule had been administered.

During an interview with Nurse #3 on 01/17/19 at 3:54 PM it was revealed she was working on 01/01/19 and was responsible for giving Resident #52 her dose of Omeprazole at 6:30 AM. She reported she had given Resident #52 her dose of omeprazole but had forgotten to sign off on the MAR that it had been given. She stated she should have signed off on the MAR that the omeprazole was given and stated it would be difficult to determine if a medication was given if it was not signed off on the MAR.

A phone call was attempted on 01/17/19 at 9:27 AM to reach Nurse #4, who was determined to have worked on 01/03/19, 01/04/19, and 01/05/19 as the medication nurse and did not sign off as administering the Omeprazole to Resident #52. It was reported by the Director of Nursing (DON) that Nurse #4 was on a leave of absence from the facility due to illness. Nurse #4 was unable to be reached for an interview.

An interview with Nurse Manager #1 on 01/16/19 at 1:57 PM revealed if the MAR was initialed then it indicated the medication had been administered. She reported if the MAR was not initialed then it did not necessarily mean that it

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F 842	Continued From page 11 was not given. She continued, stating technically it should be signed off on and reported if the MAR was not signed off on then it would be difficult to determine if the medication had been administered. An interview with the Director of Nursing on 01/17/19 at 3:04 PM revealed she expected if a medication was given, the nurse should have signed off on the MAR. She reported she could not speak to whether or not the Omeprazole was given where there was no sign off on the MAR was not signed. She reported the nursing standard would be that a nurse would sign off on the MAR for medications administered.	F 842		