STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING _____ B. WING _____	C 07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 and Complaint survey was conducted on 07/26/21 through 07/29/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #O6N411.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 07/26/21 through 07/29/21. Two of the two complaint allegations were unsubstantiated. See Event ID #O6N411.	F 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 record review and staff interviews, the facility failed to develop a care plan for a resident who self-administered one of her medications for 1 of 1 residents reviewed for self-administration of medications (Resident #26). The findings included: Resident #26 was admitted to the facility on 08/06/19 with diagnoses that included chronic heart failure, gastroesophageal reflux disease and ileostomy status. Review of the Comprehensive Minimum Date Set (MDS) dated 07/03/21 indicated Resident #26 was cognitively intact for all decision making and	F 554	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F tag: F554 The Facility failed to update resident□s care plan to reflect self-administration of	8/26/21

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

Electronically Signed | 08/20/2021

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F 554	Continued From page 1 needed one person physical assistance with all activities of daily living (ADL). Review of the physician's order dated 07/15/21 for Resident #26 read: Colestipol 1 gram (gm) give 3 tablets by mouth before meals and at bedtime for chronic diarrhea, unsupervised self-administration resident to self-administer. Review of the Self-Administration of Medication assessment dated 07/15/21 for Resident #26 revealed she had been approved to self-administer Colestipol as ordered. This assessment had been completed by the Director of Nursing (DON) and the interdisciplinary team. Review of Resident #26's care plan on 07/27/21 revealed no care plan for self-administration of medications. An interview with Resident #26 on 07/27/21 at 9:40 AM revealed she did administer her own Colestipol tablets before each meal and bedtime because she was afraid she wouldn't get it on time, and she didn't want to have diarrhea because of her ileostomy. She further revealed she was evaluated by the Director of Nursing (DON) and was approved to give it to herself. An interview with the DON on 07/28/21 at 3:30 PM revealed she had completed the Self-Administration of Medication assessment for Resident #26 on 07/15/21 and had approved her to self-administer the Colestipol. The DON was asked about the medication self-administration care plan. The DON stated she did not see medication self-administration on the care plan and explained she thought she had put it on the care plan.	F 554	medication. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 7/28/2021 the Minimum Data Set [MDS] Coordinator completed a care plan for resident #26. How the facility will identify other residents having the potential to be affected by the same deficient practice. On 7/28/2021 the Director of Nursing and Minimum Data Set [MDS] Coordinators reviewed 100% of resident medical record for residents that had been assessed to safely self-administer medications and did not have a care plan. No other affected residents were identified and no new care plans were needed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur) On 8/19/2021 the Director of Nursing initiated education on self- administration assessment and care plan process for 100% of all facility and agency registered nurses, licensed practical nurses. This education will be completed by 8/25/2021. Any staff not completing education will not be allowed to work until it has been completed. This education has been added to facility orientation and agency clinical orientation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

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F 554	Continued From page 2 An interview with the Administer on 07/29/21 at 10:31 AM revealed he was aware of the self-administration of medication not being care planned for Resident #26. He further revealed when he had been made aware of Resident #26 being approved for self-medication, he had asked about the care plan and was told it was going to be done.	F 554	Beginning on 8/26/2021 The Director of Nursing or designee will complete Quality assurance tool for self-administration of medications and care plan process to be completed weekly x4 then monthly x 3. The results of this audit will be reviewed at the weekly Quality of Life Meeting. Reports will be presented to the monthly Quality Assurance Team meeting by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated is appropriate. Any immediate concerns will be brought to the Administrator or Director of Nursing for appropriate action. Compliance will be monitored and ongoing auditing program to be reviewed at the Weekly Quality of Life / Quality Assurance Committee meeting attended by Administrator, Director of Nursing Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Social Worker and Dietary Manager. Allegation of compliance 8/26/2021	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 and staff interviews the facility failed to transcribe and administer a blood pressure medication on admission to the facility	F 658	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the	8/26/21

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F 658	Continued From page 3 for 1 of 5 resident reviewed for unnecessary medications (Resident #57). The findings included: Resident #57 was admitted to the facility on 07/05/21 from a local hospice house with diagnoses that included hypertension. Review of the active medication list provided by the local hospice house and printed on 07/05/21 revealed Resident #57 was to receive Lisinopril (used to decrease blood pressure) 5 milligrams (mg) by mouth every morning for high blood pressure. Call the Medical Doctor if systolic blood pressure was less than or equal to 100 or diastolic blood pressure was less than or equal to 60. Review of Resident #57's physician orders dated 07/05/21 revealed that Lisinopril was not on the list of medications that Resident #57 would be receiving in the facility. The orders were entered into the electronic medical record by the Assistant Director of Nursing (ADON). Review of a pharmacy note in Resident #57's electronic medical record dated 07/06/21 at 1:10 PM read in part, new resident admitted on 07/05/21, reviewed hospice admission medication list. Blood pressure 187/83 and 115/57. Recommendations included: Lisinopril order not in electronic medical record. The note was electronically signed by the Consultant Pharmacist (CP). Review of the Consultant Pharmacist Medication Regimen Review report dated 07/06/21 revealed no recommendation from the CP regarding	F 658	alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F tag- F658 The facility failed to transcribe and administer a blood pressure medication on admission to the facility for 1 of 5 resident reviewed for unnecessary medications (Resident #57). How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On Resident #57 was admitted from local Hospice house on 7/5/2021 with active medication list to receive Lisinopril 5 milligrams every morning for hypertension. Medication was not transcribed to MAR by admitting nurse upon admission Order for Lisinopril 5mg by mouth every day for hypertension transcribed to MAR on 7/28/2021 as indicated in 2567. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/2/2021 the Director of Nursing completed an audit of all new admissions and readmissions orders in comparison to facility order listing on admission for the past 30 days This reconciliation was completed on 8/4/2021 to ensure orders transcribed to	

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F 658	Continued From page 4 Resident #57's Lisinopril. Review of Resident #57's blood pressure report from 07/05/21 through 07/28/21 indicated that Resident #57's blood pressures ranged from 89-187/34-83. Review of the comprehensive Minimum Data Set (MDS) dated 07/12/21 revealed that Resident #57 was severely cognitively impaired for daily decision making and required extensive assistance with activities of daily living. The MDS further revealed that Resident #57 had less than 6 months to live and received hospice care. The Nurse Practitioner (NP) was interviewed on 07/28/21 at 11:54 AM. The NP state that the medication on the medication list should have been entered into the electronic record because that was the medications that the resident was supposed to be on. The NP reviewed Resident #57's blood pressure record and stated that she definitely needed to be on something for her blood pressure but needed some parameters because Resident #57's blood pressure was "all over the place." The NP indicated that she would restart the Lisinopril as stated in the hospice medication list. Review of a physician order dated 07/28/21 read, Lisinopril 5 mg by mouth every day for hypertension and hold for systolic blood pressure less than 110. The ADON was interviewed on 07/28/21 at 2:04 PM. The ADON confirmed that she had entered Resident #57's admission orders when she admitted from the hospice house on 07/05/21. The ADON stated that the hospice house had	F 658	the current medication/ treatment record properly. No medciation or care plan discrepancies were found. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Education on new and readmission order process was initiated on 8/19/2021 by the Director of Nursing for 100% of all facility and agency registered nurses, licensed and practical nurses. This education will complete education by 8/25/2021. Any nursing staff that has not completed the education will not be allowed to work until it has been completed. This Education has been added to facility orientation and agency clinical orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. Beginning on 8/26/2021 The Director of Nursing or designee will complete Quality assurance tool for new admission and readmission orders process weekly x4 then monthly x 3. The results of this audit will be reviewed at the weekly Quality of Life Meeting. Reports will be presented to the monthly Quality Assurance Team meeting by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated is appropriate. Any immediate concerns will be brought to the Administrator or Director of Nursing for appropriate action. Compliance will be monitored and ongoing auditing program to be reviewed at the Weekly Quality of	

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F 658	Continued From page 5 sent the facility a medication list and when Resident #57 arrived at the facility the hospice house had send her actual medications. The ADON stated she took the cards of medications and the medication list provided by the hospice house and confirmed each medication with the family. She continued to say that the medications she received from the hospice house did not include Lisinopril and she asked the family who stated that they were not sure but stated the hospice house was trying to stop some of Resident #57's medications and that may have been one they stopped but could not say for sure. The ADON stated that most residents admitted to the facility from the local hospital, and they used the discharge summary provided by the hospital but when a resident admitted from another facility, they used the resident current Medication Administrator Record. The ADON added that she recalled seeing another document titled FL-2 that contained medication as well and she was confused by the documents, the cards of medication and the family's input. She stated she probably should have called the hospice house to clarify the Lisinopril order or spoken to the provider at the facility but was instructed by the Director of Nursing (DON) to use the medications listed on the FL-2 form and it did not include the Lisinopril so ultimately that medication was not ordered for Resident #57 on admission. The ADON stated that it was very confusing with all the documents and the actual medications but stated she should have clarified any discrepancy she found. The CP was interviewed on 07/28/21 at 3:01 PM. The CP confirmed that she had reviewed Resident #57's medication during her monthly review of medications at the facility and when the	F 658	Life / Quality Assurance Committee meeting attended by Administrator, Director of Nursing Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Social Worker and Dietary Manager. Alleging compliance on 8/26/2021	

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F 658	Continued From page 6	F 658		

entire review was complete the report was emailed to the DON for follow up. The CP stated that she reviewed the hospice medication list as stated in her note in the electronic medical record and pointed out that Resident #57's orders in the facility did not contain Lisinopril that was listed on the hospice medication list. She stated it may or may not have been a discrepancy but she put it on her report so the facility could follow up and clear up any discrepancy. The CP could not explain why the recommendation for Lisinopril that she documented in Resident #57's electronic medical record did not appear on her report that was emailed to the DON.

The DON was interviewed on 07/28/21 at 4:08 PM. The DON confirmed that she had received the CP report via email on 07/06/21 and she had printed it out on 07/07/21 and followed up on each recommendation. The DON stated the report contained no recommendation for Lisinopril and she assumed that when she took care of the recommendations on the report, she had followed up on everything that the CP found. The DON stated she knew nothing about the Lisinopril because it was not in the CP report. The DON stated that somehow the facility had several medication lists and the ADON should have called the hospice house and clarified the medication or called the provider at the facility, but the order should have been clarified.

The Administrator was interviewed on 07/29/21 at 10:04 AM. The Administrator stated that the Lisinopril order should have been clarified by the provider at the facility or at the hospice house to ensure Resident #57 received the correct medications.