STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 09/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F- 272 (D) 1.) How corrective action will be accomplished for the resident affected: Resident #10 MDS updated and CAA completed for ADLs by MDS Coordinator. Res#10 Care Plan completed to include problems requiring extensive assistance with ADLs of eating, bed mobility and transferring by MDS Coordinator. 2.) How corrective action will be accomplished for those residents having the potential to be affected: All residents are potentially affected. A review of resident MDSs conducted by the MDS Coordinator to ensure no CAAs or Care Plans are missing for all residents on the survey sample as well as any resident having a comprehensive assessment since 9-9-13. No CAAs or Care Plans found missing. MDS assessments for new admissions reviewed to ensure complete for CAAs and Care Plans. Inter-disciplinary Team consisting of the Social Worker, Dietary Manager and Activities Director were in-serviced by the MDS Coordinator that educated the team on their responsibilities, how to complete MDS sections, as well as facility procedures for MDS and Care Plan calendars. 3.) What measures will be put in place or systemic changes made to ensure correction:	10/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Reginald J. Faddoul — TITLE: Administrator — (X6) DATE: 10/30/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to complete the assessment process and develop a care plan for one of five sampled residents who required assistance with activities of daily living. Resident #10 The findings included: Resident #10 was admitted to the facility on 12/21/11 with diagnoses including arthritis, coronary artery disease and hypertension. The Minimum Data Set (MDS), an annual, dated 8/12/13 indicated Resident #10 required extensive assistance with eating, bed mobility, transfer and toileting. Resident #10 had problems with short and long term memory. The Care Area Assessments (CAAs) for Activities of Daily living (ADL) were blank. A care plan had not been developed for this care area. Interview with the MDS nurse on 9/19/13 at 5:46 PM revealed the MDS had been completed by the previous MDS nurse. That nurse no longer worked at the facility. Continued interview revealed the CAAs had not been reviewed, and a care plan decision had not been made. It was further revealed the CAA section was not signed as being completed. There was not a care plan for a problem of requiring extensive assistance by staff for activities of daily living for Resident #10.	F 272	Developed audit tool to monitor new admissions and other comprehensive assessments due according to the MDS calendar and verify CAAs and care plans are accomplished according to the scheduled monthly MDS calendar. Audit is completed weekly times four weeks, and monthly times three months by MDS Coordinator, DON or designee. A review of all residents conducted to ensure no CAAs or Care Plans are missing. MDS assessments for new admissions reviewed to ensure complete for CAAs and Care Plans. Inter-disciplinary Team consisting of the Social Worker, Dietary Manager and Activities Director were in-serviced by the MDS Coordinator that educated the team on their responsibilities, how to complete MDS sections, as well as facility procedures for MDS and Care Plan calendars. 4.) How the facility plans to monitor its performance to make sure that solutions are ensured: The MDS Coordinator, DON or designee will compile audit results and present to the Quality Assurance Process Improvement (QAPI) Committee Meeting monthly times four months and quarterly thereafter. Subsequent plans of action will be developed as directed by the QAPI Committee. The Director of Nursing is responsible for overall compliance.	10/18/13
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities	F 311		

RJ Fadden
10/30/13

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F 311	Continued From page 2 specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide meal set up and reposition one of five sampled residents for assistance with activities of daily living. Resident #10. The findings included: Resident #10 was admitted to the facility on 12/21/11 with diagnoses including arthritis, coronary artery disease and hypertension. The Minimum Data Set (MDS), an annual, dated 8/12/13 indicated Resident #10 required extensive assistance with eating, bed mobility, transfer and toileting. Resident #10 had problems with short and long term memory. The Care Area Assessments (CAAs) for Physical Functioning were blank. A care plan had not been developed for this care area. Observations on 9/18/13 at 8:15 AM revealed Resident #10 was in bed with the head of bed elevated about 35 degrees. Resident #10 was lying in bed with the tray table positioned to his left side parallel to the bed. The tray table was positioned at the resident's shoulder level and Resident #10 could not visualize the food on his tray. Observations of Resident #10 revealed he had to reach up with his right hand/arm and over to the left to get food and drink. Continued observations revealed Resident #10 pushed the tray table away at 8:23 AM. An interview on 9/18/13 at 8:30 AM with Resident #10 revealed he had eaten all he wanted. There was about 50% of his breakfast consumed.	F 311	F- 311 (D) 1.) How corrective action will be accomplished for the resident affected: Resident #10 received assistance with meals by Nursing Assistants and supervised by staff nurse. Resident #10 MDS updated and CAA completed for ADLs by MDS Coordinator. Res#10 Care Plan completed to include problems requiring extensive assistance ADLs of eating, bed mobility and transferring by MDS Coordinator. Resident #10 Care Card updated and completed. 2.) How corrective action will be accomplished for those residents having the potential to be affected: Residents requiring assistance with ADLs for meal set up are affected. DON and QA Nurse reviewed the Resident Care Cards to ensure that appropriate resident care information is available, by re-establishing new care cards for each resident based on their actual care plan. Care Card procedures reviewed and staff in-serviced by the QA Nurse or DON to ensure staff is able to properly use the resident information on the Care Card. 3.) What measures will be put in place or systemic changes made to ensure correction: DON and QA Nurse reviewed the Resident Care Cards to ensure that	10/18/13

RJ Faddon 10/30/13

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F 311	Continued From page 3 Resident #10 did not make appropriate responses when asked how he usually had the tray table positioned. Observations at 12:13 PM on 9/18/13 revealed Resident #10 was set up for lunch in the same position as he was for breakfast that morning. Interview with aide #8 on 9/18/13 at 12:15 PM revealed she worked on the hall but was not assigned to Resident #10. Aide #8 asked the two aides on the hall " who gave the resident his tray? " Aides #8, 12, and 15, went into Resident #10 ' s room. The resident allowed the staff to raise the head of his bed. The tray table was placed over his lap at an appropriate height. Resident #10 ate his lunch in an upright position and was able to feed himself. Interview with aide #15 at 12:16 PM on 9/18/13 revealed she had passed the tray to Resident #10 for the breakfast meal. She further explained the resident refused to sit up on the side of the bed. That he usually sat on the side of the bed to eat. Observations at 8:33 AM on 9/19/13 revealed Resident #10 was laying down eating breakfast. The tray table was at his chin level and to the left side. Aide#8 came out of a room and looked at Resident #10. Aide #8 asked for assistance from another aide to reposition Resident #10 in bed. The two aides pulled him up in bed, placed the tray table with the breakfast tray over his lap at an appropriate height. Resident #10 was able to see the food and eat in an upright position. No explanation was provided as to why Resident #10 had not been positioned correctly for meals for two days of the survey. Aide #8 shook her head " no. "	F 311	**appropriate resident care information is available, by re-establishing new care cards for each resident based on their actual care plan. Care Card procedures reviewed and staff in-serviced by the QA Nurse or DON to ensure staff is able to properly use the resident information on the Care Card. Care Card procedures will be part of all clinical staff new hire orientation. An audit tool is developed to monitor residents requiring assistance with meals and meal set up in the common dining rooms and individual resident rooms and covers resident positioning and meal set up. The DON or designee completes audits at least three times weekly for three weeks, then weekly for four weeks and monthly times two months.** **4.) How the facility plans to monitor its performance to make sure that solutions are ensured:** **The DON or designee will compile audit results and present to the Quality Assurance Process Improvement (QAPI) Committee Meeting monthly times four months and quarterly thereafter. Subsequent plans of action will be developed as directed by the QAPI Committee. The Director of Nursing is responsible for overall compliance.**	10/18/13
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

RJ Faddoul
10/30/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 4 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to maintain a dressing on a pressure ulcer, turn and reposition one of two sampled residents with pressure ulcers. Resident #8. The findings included: Resident # 8 was re-admitted to the facility on 7/22/13 with diagnoses of stroke, diabetes dysphagia, aphasia and pressure ulcers. Review of the Minimum Data Set dated 7/29/13 revealed Resident #8 was incontinent of bowel and bladder. This MDS indicated Resident #8 required extensive assistance of two persons for bed mobility, transfer, toileting and personal hygiene. Resident #8 had impaired short and long term memory problems. The MDS revealed that Resident #8 had a stage 3 pressure sore. Review of the Care Area Assessments (CAAs) dated 8/2/13 for the area of pressure sores revealed " Care Plan Considerations were " Resident is incontinent of bowel and bladder without the ability of being retrained r/t (related to) CVA (stroke) with hemiparesis ...She currently	F 314	F- 314 (D) 1.) How corrective action will be accomplished for the resident affected: Resident #8 is no longer a resident at this facility. 2.) How corrective action will be accomplished for those residents having the potential to be affected: All residents are potentially affected. DON and QA Nurse reviewed the Resident Care Cards to ensure that appropriate resident care information is available, by re-establishing new care cards for each resident based on their actual care plan. Pressure ulcer treatments reviewed. In-Service has been conducted for facility staff regarding Care Cards, turning and positioning, wound treatments and incontinent care. 3.) What measures will be put in place or systemic changes made to ensure correction: DON and QA Nurse reviewed the Resident Care Cards to ensure that appropriate resident care information is available, by re-establishing new care cards for each resident based on their actual care plan. Care Card procedures reviewed and staff in-serviced by the QA Nurse or DON to ensure staff is able to properly use the resident information on the Care Card. Care Card procedures will be part of all clinical staff new hire orientation. Any change in a resident	10/10/13

RJ Faddis
10/30/13

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F 314	Continued From page 5 has three stage III (3) wounds that she was admitted with and is at risk for further skin breakdown r/t multiple diagnoses and immobility. She is checked frequently and changed as needed. She receives wound treatments as ordered and protective ointment as needed. Review of the care plan dated 8/2/13 revealed a problem of " Stage 3 pressure sores in the location of sacrum and right calf related to immobility and multiple diagnoses. " The interventions for this problem included " Turn every 2 hours or more often if necessary to maintain adequate circulation to all pressure points and position resident off affected areas. " Review of the wound specialist ' s progress note dated 9/5/13 revealed the sacral wound was unstageable, with 95% slough. Review of the physicians orders dated 9/17/13 revealed a clarification order to cleanse the sacrum pressure sore, apply calcium alginate (chemical debridement agent) and cover with an ABD (abdominal pad) dressing every day. Observations on 9/18/13 at 8:30 AM, 10:30 AM, 11:22 AM and 12:11 PM revealed Resident #8 remained in bed with the head of bed elevated and was positioned on her back. Observations on 9/18/13 at 11:10 AM revealed Resident #8 received incontinent care due to a bowel movement. A dressing was not covering the sacral wound and stool was in the wound. An interview was conducted on 9/18/13 at 11:24 AM with aide #15 who was assigned to provide care for Resident #8. Aide #15 reported Resident	F 314	condition such as a dressing coming off is conveyed between staff through the use of the "Early Warning Tool called Stop and Watch". This tool is used to communicate, document change, requires the nurse to sign-off and act, and for the Nurse Administration team to follow-up to ensure action is taken by the QA Nurse updating any Care Card requiring a change. An audit tool is developed to monitor residents requiring turning and positioning which includes all those with wounds and who require assistance to turn; this turning assistance is reflected on their care card. The DON or designee completes audits at least three times weekly for three weeks, then weekly for four weeks and monthly times two months. 4.) How the facility plans to monitor its performance to make sure that solutions are ensured; The DON or designee will compile audit results and present to the Quality Assurance Process Improvement (QAPI) Committee Meeting monthly times four months and quarterly thereafter. Subsequent plans of action will be developed as directed by the QAPI Committee. The Director of Nursing is responsible for overall compliance.	10/10/13

RJFaddis 10/30/13

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F 314	Continued From page 6 #8 did not have a dressing covering the wound when incontinent care was provided earlier that morning. Aide #15 was asked if she had reported that to the nurse and she stated " no." She further stated the " dressing does not stay on the wound because of where the wound is " (located). Observations on 9/19/13 at 8:36 AM, 9:39 AM, 10:44 AM and 1:15 PM revealed Resident #8 remained in bed with the head of bed elevated and was positioned on her back. Interview with Aide #15 on 9/19/13 at 1:19 PM revealed she had not turned the resident today except when she changed her brief that morning. She stated she knew she was supposed to turn her, but had not done so. No explanation was provided as to why Resident #8 was not turned and repositioned.	F 314		10/18/13
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to prevent 1 of 7 cognitively impaired residents (Resident #1) from exiting the facility without the knowledge of staff.	F 323		

R Waddell 10/20/13

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F 323	Continued From page 7 Resident #1 was found across the street from the facility, crossing a two lane road with a speed limit of 45 miles per hour. The immediate jeopardy began on 9/9/13 for Resident #1. The immediate jeopardy was identified on 9/18/13 at 5:28 PM and removed 9/19/13 at 7:00 PM. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete implementation of system changes and monitoring the corrective action stated in the credible allegation. The findings included: Review of policy and procedure dated 9/17/13 and named Elopement Response, included general information as follows: Unsafe Wandering: When a resident wanders into an unsafe, unsupervised area of the facility such as a stairway, courtyard, on the premises yet outside the building or services area. Although the resident has not left the premises, unsafe wandering can be just as dangerous as elopement. Resident #1 was originally admitted on 11/28/12 and readmitted 2/8/13 with diagnosis that included vascular dementia, osteomyelitis-shoulder region, seizures, fracture cervical vertebra of C-5 and C-6, diabetes mellitus and chronic kidney disease. Review of the Elopement/Unsafe Wandering Risk Assessment dated 2/8/13 revealed that Resident #1 was not considered to be at risk for	F 323	F- 323 **1.) How corrective action will be accomplished for the resident affected:** **Resident #1 was redirected by two Nurse Aides and returned to the facility at 7:40 PM, 9/9/13. The Charge Nurse (RN#1) completed and documented a head-to-toe physical assessment tool upon reentering the facility to rule out any physical or mental harm. Resident #1 was assessed as unharmed and in good spirits as well as showing no signs of being scared. RN#1 also completed an assessment upon Res#1's return to include vital signs. Resident #1's WanderGuard bracelet was checked by RN#1 on 9/9/2013 at approximately 8:00 PM and validated that it functioned properly. The resident's family and the physician were contacted at 7:55 PM on 9/9/13 and notified of the incident. It was also validated by a Restorative Aide on 9/9/2013 at approximately 2:00 PM that all exit doors and associated alarms were functioning properly. On 9/9/2013 at 8:00 PM, RN#1 assigned CNA#1to perform one-on-one supervision to directly and continuously monitor resident #1's location and safety until he was asleep in his bed. RN#1 documented this activity in her nurse note. 1-on-1 monitoring ceased when Res#1 was assisted to bed at 10:30 pm on 9/9/2013. LPN#1 personally conducted 30-minute documented observations commencing at 11:00 PM on 9/9/13 and during resident #1's period of sleep through 7:15 AM on 9/10/13. All these checks confirmed his safety in the**	10/18/13

R Faddon
10/30/13

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F 323	Continued From page 8 elopement. Review of physician orders indicated that on 2/8/13 an order was written for 1:1 care 24 hours a day x 7 days a week and on 3/20/13 a telephone order was written to discontinue 1:1 care. Review of the nurse ' s notes written by Nurse #2 dated 4/30/13 at 1:15 PM revealed that Resident #1 was noted In the courtyard (courtyard was observed on 9/17/13 at 3:00 PM to be enclosed with a ramp going down from dining room door to the yard) and a wanderguard was ordered and placed. A physician ' s telephone order was written on 4/30/13 by Nurse #2. During an Interview with Nurse #2 on 9/18/13 at 12:17 PM revealed that she could not remember writing the order, her position at the facility was Minimum Data Set (MDS) Coordinator and Quality Assurance and could have written the order during a chart review. Nurse #2 further indicated that Resident #1 needed 1:1 supervision because he was unsafe and tried to get out of his wheelchair. The MDS dated 6/27/13 revealed that Resident #1 required extensive assistance to complete activities of daily living. The MDS further identified Resident #1 as being moderately cognitively impaired for daily decision making. Resident #1 did not exhibit wandering during the assessment period. Review of Resident #1 ' s care plan dated 7/2/13 indicated a problem of wandering and approaches included attempt to re-direct resident when undesirable or unsafe behaviors are	F 323	facility. Res#1 woke up at approximately 7:15 AM on 9/10/13, and was monitored by LPN#1 until the designated 1-on-1 Staff arrived at 8:00 AM to begin Res#1's one-on-one. The Social Worker immediately began on 9/10/13 at 10:00 AM a search for a SNF with an open bed on a secured and locked unit. That was located at 11:30 AM on 9/10/13, necessary transfer forms were exchanged, Res#1's family was consulted at 1:00 PM on 9/10/13 and granted permission for Res#1 to be transferred to a SNF with a secured and locked unit. The 1-on-1 Staff remained constantly with Res#1 until he loaded onto the transportation van at 3:30 PM on 9/10/13 for his discharge to a local SNF with an appropriate secured unit capable of providing him with adequate security and safety. Facility Incident Report completed on 9/9/13 at approximately 8:00 PM by RN#1. The facility's investigation into how Res#1 was able to exit the building and an alarm not be heard has not been determined. 2.) How corrective action will be accomplished for those residents having the potential to be affected: On 11-7 shift on 9/9/13 and 9/10/13, a 100% resident head count was completed by 4:30 AM (the 10th) by LPN#1 for units 1&2 and RN#2 for unit 3 that "all" residents are present and accounted for inside the facility. This 100% headcount confirmed and validated that all residents were accounted for in the facility. A new Elopement Risk Assessment was initiated	10/10/13

RJ Faddon
10/30/13

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F 323	Continued From page 9 observed and prior to administration of psychoactive medications, offer to ambulate or change location, offer activity of interest, offer rest period, apply safety alert device per order, check presence and and function. See Treatment Adminstration Record (TAR). The September 2013 (TAR) indicated to Apply Wanderguard- check placement and functioning every shift. There was no documentation for placement and functioning six times during the first 10 days of September to include 9/9/13 during the 7am-3pm shift. Review of nurse ' s notes written by Nurse #3 dated 7/7/13 at 7:48 PM revealed that the physician was notified of Resident #1 ' s increasing sundowners, resident had been very agitated, constantly on the move, wandering around the unit attempting to elope, going into other residents ' rooms and continuously getting out of chair. Resident taking clothes off and unable to sit still and nursing notes on 7/25/13 further indicated that Resident #1 ' s wandering behaviors increased, pulling self in wheelchair into other residents ' rooms, even with their doors closed. An interview with the Staffing Coordinator on 9/18/13 at 1:00 PM revealed that she started her position on August 15, 2013 and at that time Resident #1 was requiring 1:1 monitoring. She had a verbal agreement with NA #7 and Housekeeper #1 to provide the 1:1 with Resident #1. NA #7 was to sit from 8:00 AM to 6:00 PM and Housekeeper #1 was to sit with Resident #1 from 6:00 PM to 9:00 PM. The Staffing Coordinator further indicated that 1:1 was not assigned after 9:00 PM because Resident #1	F 323	and completed on 9/10/13 for every resident in the facility by the Interim DON assisted by a new RN Unit Manager and LPN#2 to identify any other residents in the facility that might be at risk for elopement. The Assessments were evaluated and six Residents (#2, 3, 4, 5, 6, & 7) were initially identified on 9/11/13 by LPN#2. Resident #5 previously had had a WanderGuard bracelet placed on her, and Residents #3 and #4 refused to allow the bracelet to be placed on 9/11/13, and Residents #2, #6 and #7 had their bracelets placed on 9/17/13. New Wander Guard bracelets were placed by the RN Unit Manager assisted by the Central Supply Clerk. The Social Worker wrote a note in each of the six resident's medical records. This was completed by September 12, 2013 referencing elopement risk status. All current residents as of 9/10/13 with WanderGuard bracelets (#1, #5, #9, #10, #11) were checked on 9/10/13 by the Central Supply Clerk for functionality and expiration dates, and those checks were documented on a spreadsheet. All were determined to be properly functioning, and within the expiration dates. All facility exit doors with WanderGuard locks and alarms were also checked by the Central Supply Clerk on 9/10/13. All doors checked and validated that they function properly, and those checks are documented. Elopement risk for all residents being established on 6:00 PM on 9/11/13 by the Interim DON and her nurse team, and on 9/17/13 at 6:15 PM, a clinical team consisting of the RN Director of Nursing, RN Staff	10/18/13

R Fadden 10/30/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 09/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 10 slept through the night. Review of the staffing assignment sheet dated 9/9/13 indicated that Resident #1 was to have a sitter 1:1 from 8:00 AM to 9:00 PM An interview with Housekeeper #1 on 9/17/13 at 2:30 PM revealed that he did not sit with Resident #1 on 9/9/13 at 6:00 PM because he was working in housekeeping and he reported that to the staffing coordinator. He further indicated that Resident #1 was very mobile in his wheelchair and a couple months ago, he could not remember the date, he found Resident #1 in the kitchen at the exit door going toward the back dock that drops off about 4 feet. Housekeeper #1 revealed that Resident #1 would go through the dining room, through the kitchen doors that would not lock and to the exit doors. Housekeeper #1 happened to be checking all the doors and heard something in the kitchen and it was Resident #1 and he reported this to Nurse #1. Housekeeper #1 further indicated that he found Resident #1 in the courtyard going down a ramp to the court yard and had been outside about six times and management was aware. Review of nurse ' s notes written by Nurse #4 dated 9/9/13 revealed that Resident #1 was found outside the facility alone at 7:40 PM. A visitor reported that the resident was across the two lane road in front of the facility standing in the grass near the subdivision and Nursing Aide (NA) #1 and (NA) #2 quickly went to Resident #1. Nurse #4 was alerted and went to grassy area to transport Resident #1 back into building. Resident #1 had a wanderguard on and it tested active. The nurse ' s note further indicated that Nurse #4 assigned NA #2 to do 1:1 sitter care	F 323	**Development Coordinator, RN Unit Manager, RN MDS Coordinator, and Director of Operations (an RN) reviewed and re-evaluated the designated seven residents alleged to be an elopement risk. For Residents #1, #2, #3, #4, #5, #6, #7 affected the following was to be initiated:** • **Resident #1 is discharged on 9/10/13, and Residents #9, #10, #11 bracelets were removed by 6:00 PM on 9/11/13 by the Central Supply Clerk since their Elopement Risk status was downgraded to safe in the facility.** • **Placement of a WanderGuard bracelet on each affected resident. Resident #5 previously had had a WanderGuard bracelet placed on her and as of 9/11/13 remained unchanged, Residents #3 and #4 refused to allow the bracelet to be placed on 9/17/13 so none was placed, and Residents #2, #6 and #7 had their bracelets placed on 9/17/13 by 6:00 PM. New WanderGuard bracelets were placed by the RN Unit Manager assisted by the Central Supply Clerk. Residents #3 & #4 had not special handling and on 9/17/13 were evaluated as not being an elopement risk.** • **Telephone orders written for Residents #2, #3, #4, #5, #6, #7 to be placed on the MAR by the RN Unit Manager and RN DON at 8:30 AM on 9/17/13 for q-shift checks for placement and functioning of bracelet and doors. Residents #3 & #4 refused placement and their telephone orders were d/c'd by 9:30 PM on 9/17/13. No**	10/18/13

RJ Faddon
10/30/13

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F 323	Continued From page 11 with Resident #1 during remainder of the shift. Nurse #4 contacted the Administrator and Acting Director of Nurses at 7:50 PM on 9/9/13. Nurse #4 further documented that no staff member saw Resident #1 leave the building and Nurse #4 did not hear the door alarm. During an interview with Nurse #4 on 9/23/13 at 5:00 PM revealed that on 9/9/13 she last saw Resident #1 in the dining room at dinner, he had a 1:1 sitter until 6:00 PM. She further revealed that there were no 1:1 sitter assigned after 6:00 PM. She understood that the 1:1 sitter was to give the staff a break because Resident #1 was a fall risk. Nurse #4 also indicated that on 9/9/13 at approximately 7:40 PM she was alerted that Resident #1 was outside across the street, when she responded he was across the street standing behind his wheelchair. Nurse #4 could not recall if the door alarm sounded when they came back into the facility, but after she did her assessment she checked Resident #1 wanderguard bracelet and it was functioning and indicated that Resident #1 had no injury, his clothes were clean and he was not frightened. Nurse #4 further revealed that she received no orientation or education on the wanderguard system and did not know the code for a missing resident or how to check the wanderguard bracelet for function. Interview with NA #5 on 9/18/13 at 4:15 PM who was assigned to Resident #1 on 9/9/13 revealed that it was reported to her that Resident #1 was outside across the street. She did not hear the wanderguard alarm sound. She indicated that she last saw Resident #1 around 6:00 PM in the dining room when picking up supper trays. NA #5 revealed that Resident #1 did not have a 1:1 sitter that evening, but he did have 1:1 the day before.	F 323	alternate management of Residents #3 & #4. Residents #3, #4, #7 were re-assessed on 9/19/13 for elopement risk by the DON & Unit Mgr and found to not be at risk. • Telephone orders d/c'ing WanderGuard bracelets for Residents #2, #5, #6, #7 on 9/18/13 by 11:30 AM by RN Unit Manager. The d/c order was written after confirmation none of these residents were evaluated as being a risk for elopement. • Placement checks documented q-shift on the MAR by the Charge Nurse began on 9/17/13 and ended 9/18/13. • Unit Elopement Risk Binders are updated by the Medical Records Clerk with each resident being included whose elopement risk scores support their being placed in the binder. These binders are in place on each nurse station, Reception Desk, Social Work office, DON office and Therapy office the latest update is on 9/19/13. AS of 9/19/13 there are no residents determined to be at-risk and the binders reflect that status. • For residents #2, #3, #4, #5, #6, and #7 evaluated as at risk for elopement, Care Plan updates were completed by the RN MDS Coordinator to reflect wander/elopement risk and appropriate interventions by 8:30 PM on 9/17/13. Those care plans are now d/c's on 9/19/13 at 11:30 AM by the RN MDS Coordinator. On 9/18/13 at 10:00 AM Res#8 was further evaluated for elopement risk by the RN Director of Nursing and the RN	10/18/13

RJ Faddis
10/30/13

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F 323	Continued From page 12 She recalled the wandeguard bracelet being on Resident #1 ' s left wrist. NA #5 indicated she was aware of the elopement protocol and had recent education regarding the elopement protocol. Interview with Nurse #1 on 9/18/13 at 9:15 AM revealed that a couple months ago it was reported to him by Housekeeper #1 that Resident #1 was in the kitchen and at the exit doors to the back dock. Nurse #1 indicated that he redirected Resident #1 but did not document the behavior, he reported it to his assigned nurse, Nurse #4. Nurse #1 further indicated that Resident #1 was very quick in his wheelchair and had to be placed on 1:1 supervision. He liked to sit in the dining room across from the front lobby door. He further revealed that at night it is very busy with visitors and kids and then demonstrated that when the door is opened it closes very slowly and observation revealed that it took 5-6 seconds for the door to close. Nurse #1 indicated that the night that Resident #1 went out of the facility he did not hear the wanderguard alarm. A phone interview with the Medical Director on 9/18/13 at 4:58 PM revealed that Resident #1 was on 1:1 supervision for his safety and he was aware that the 1:1 was discontinued on 3/20/13 because Resident #1 ' s behavior improved with medication adjustments and didn ' t need it anymore. The Medical Director further indicated that he was aware of the order for the wanderguard on 4/30/13, he recalled that Resident #1 was always into something, could not think of anything specifically, but would try and go out the front door. He also revealed that he was notified of Resident #1 ' s elopement on 9/9/13.	F 323	Unit Manager. Res#8 is a new admission whose admission assessment was reviewed in greater detail. Res#8 was classified as a safe wanderer in the facility who exhibited no elopement risk on 9/18/13. The Social Worker completed social notes on 9/18/13 that reflects their updated and true elopement status that reflected they are not an elopement risk. The Elopement Response Policy and Procedure will be updated by the Administrator by 9/19/13 to reflect any changes recommended by the QAPI Committee to include a change in who checks the functionality of door alarms. 100% of working staff (including all temporary agency staff) will be in-serviced by the RN SDC, RN DON or DON Designee to educate them on the proper procedures to follow should any resident be found to have eloped or attempted an elopement or be found in an unsafe location on the premises. This training begins on 9/19/13 with staff present (permanent and agency) and for all new employees in orientation on 9/19/13 and future orientations. Other employees not having received this training will be in-serviced at the beginning of their next work shift and prior to their beginning work. 3.) What measures will be put in place or systemic changes made to ensure correction: An inventory of spare bracelets has been	10/18/13

R Haddon
10/30/13

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F 323	Continued From page 13 Observation on 9/18/13 at 9:30 AM revealed that the dining room door where Resident #1 had his meals was approximately 12 feet from the front lobby door. The door was approximately 5 feet wide and when opened wide closed slowly taking approximately 6 seconds to close. On 9/18/13 at 3:37 PM the Unit Manager was observed checking all 7 doors that had a wanderguard alarm which included an alarm on each hall, the 100, 200, 300 hall and both dining room doors to the outside secured courtyard and the front lobby door. She indicated that she checks all the alarms on all the doors. All the doors alarmed and locked down except for the front lobby door, the front lobby door was not set up to lock down. The door was tested with a resident that had a wanderguard on and the door did not lock, it only alarmed. The Unit Manager indicated that the front lobby door did not lock down when it alarms. An interview with the Administrator on 9/17/13 at 10:20 AM revealed that Resident #1 had 1:1 care not for exit seeking, but due to Resident #1 ' s wandering into other resident rooms and for whatever reason the night of 9/9/13 the 1:1 assignment messed up and Resident #1 eloped. The Administrator further indicated that after the elopement the facility validated that Resident #1 wanderguard was functioning, all doors with wanderguards were tested and functioning, all residents identified with wanderguards were also checked. He further indicated that all residents had an Elopement Risk Assessment completed. The policy and procedure for elopement was reviewed and updated and an emergency Quality Assurance meeting was held on 9/11/13 to review the Quality Improvement plan. The Administrator	F 323	completed, and an additional seven bracelets ordered on 9/10/13 by the Central Supply Clerk. WanderGuard system components for checking residents are as follows: • An Elopement Risk Assessment will be completed on admission by the RN Unit Manager and updated at least quarterly or when a significant change has occurred, also done by the RN Unit Manager or another RN designated to do so by the RN Director of Nursing. Late evening or weekend admissions assessments will be accomplished by the admitting nurse and validated by the RN Unit Manger on their next work day. • When the Assessment dictates or identifies a resident as being at-risk for elopement or unsafe wandering, a WanderGuard bracelet will be placed on a resident having been assessed as at risk by the Charge Nurse. Placement will be in accordance with manufacturer's recommendations. • The Charge Nurse will write a telephone order for checking the placement of the WanderGuard bracelet to be placed on the TAR and to have the q-shift placement to be checked by the Charge Nurse. • The MAR will be annotated to require the nurse to check placement of a WanderGuard bracelet q-shift and to initial if properly placed. • The MAR will further reflect that on third shift (11p-7a) the nurse will initial after having verified the proper functioning of the resident's	10/10/13

R J Faddis
10/30/13

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F 323	Continued From page 14 further indicated that we have agency nurses and not all the in-services are complete. The Administrator and Director of Nurses were notified of immediate jeopardy on 9/18/13 at 5:28 PM. The allegation of compliance was received on 9/19/13 at 4:35 PM. The allegation of compliance was accepted on 9/19/13 at 7:00 PM. Credible Allegation: A. Address how corrective action will be accomplished for those resident found to have been affected by the deficient practice. On 9/9/13 at 7:40 PM Resident #1 discovered outside the facility unsupervised and in an unsafe location off the premises. The last " confirmed " observation of Res#1 was by HK#1 at 7:05 PM while sitting at Unit Two nurses station prior to being discovered missing. CNA#2 recalls seeing Res#1 at that nurse station while performing her rounds, but cannot recall clearly enough to confirm those observations were between 7:05 PM and 7:40 PM. The Interim Director of Nurses and Administrator were notified at 7:50 PM, 9/9/13, and they ensured the following actions were accomplished: · The resident was redirected by two Nurse Aides and returned to the facility at 7:40 PM, 9/9/13. · The Charge Nurse (RN#1) completed and documented a head-to-toe physical assessment tool upon reentering the facility to rule out any physical or mental harm. Resident #1 was assessed as unharmed and in good spirits as well as showing no signs of being scared.	F 323	WanderGuard bracelet as well as its placement. Elopement Risk is re-evaluated at least quarterly or when the resident's condition changes and risk of elopement is suspected. This is completed in conjunction with the resident's quarterly MDS assessment and completed by the RN Unit Manager or an RN designated by the RN Director of Nursing. The RN MDS Coordinator makes appropriate changes (if any) and updates on the resident's care plan following the new quarterly Elopement Risk Assessment. The Maintenance Director contacted the WanderGuard manufacturer on 9/10/13 to schedule a technician visit to perform a complete/independent technical system check. The Maintenance Director will supervise his staff in performing and documenting a daily exit door alarm system check (exit doors) and document on a daily log from Monday through Friday. This procedure begins 9/19/13. These checks will be completed by the Manager on Duty or Administrator Designee for weekends. Maintenance Director creates the log by 9/19/13. An Elopement Risk Alert Binder is placed at each Nurse Station, in the Social Services office, at the Reception Desk, Therapy Office and in the DON office. The Medical Records Clerk is responsible for updating the Elopement Risk Alert Binder at the direction of the Director of Nursing. The Director of Nursing takes responsibility to communicate updates to this binder through the Nursing Administration chain of command. These	10/18/13

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F 323	Continued From page 15 · RN#1 also completed an assessment upon Res#1 ' s return to include vital signs. · Resident #1 ' s WanderGuard bracelet was checked by RN#1 on 9/9/2013 at approximately 8:00 PM and validated that it functioned properly. · The resident ' s family and the physician were contacted at 7:55 PM on 9/9/13 and notified of the incident. · It was also validated by a Restorative Aide on 9/9/2013 at approximately 2:00 PM that all exit doors and associated alarms were functioning properly. · On 9/9/2013 at 8:00 PM, RN#1 assigned CNA#1to perform one-on-one supervision to directly and continuously monitor resident #1 ' s location and safety until he was asleep in his bed. RN#1 documented this activity in her nurse note. 1-on-1 monitoring ceased when Res#1 was assisted to bed at 10:30 pm on 9/9/2013. · LPN#1 personally conducted 30-minute documented observations commencing at 11:00 PM on 9/9/13 and during resident #1 ' s period of sleep through 7:15 AM on 9/10/13. All these checks confirmed his safety in the facility. · Res#1 woke up at approximately 7:15 AM on 9/10/13, and was monitored by LPN#1 until the designated 1-on-1 Staff arrived at 8:00 AM to begin Res#1 ' s one-on-one. · The Social Worker immediately began on 9/10/13 at 10:00 AM a search for a SNF with an open bed on a secured and locked unit. That was located at 11:30 AM on 9/10/13, necessary transfer forms were exchanged, Res#1 ' s family was consulted at 1:00 PM on 9/10/13 and granted permission for Res#1 to be transferred to a SNF with a secured and locked unit. · The 1-on-1 Staff remained constantly with Res#1 until he loaded onto the transportation van at 3:30 PM on 9/10/13 for his discharge to a local	F 323	binders are in place 9/19/13. Their contents include: • Properly functioning test devices for checking the function of WanderGuard bracelets. One is located for use on Units 1&2, and one for Unit 3. • An Elopement Response Policy and Procedure is at the front of every binder. • Blank sheets called Elopement Risk Alert are available in the binder to document any new residents that is to be added to those at risk for elopement. • Completed Elopement Risk Alert sheets which include those residents deemed at risk will have the resident's picture, personal physical description, and reasons they are at risk for elopement. (There are none on 9/19/13). • An updated resident care plan that addresses the elopement risk and interventions. (There are none on 9/16/13). • All binders are identical. Medical Records is responsible for maintaining and keeping these binders. • Staff in-service training is started 9/19/13 and is ongoing and required to ensure all staff maintains a proper understanding of the Elopement Risk procedures, and all newly incorporated changes to the P&P. This training for all working staff (all departments) as follows: • All Staff and Agency Staff:	10/18/13

R Faddoul
10/30/13

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F 323	Continued From page 16 SNF with an appropriate secured unit capable of providing him with adequate security and safety. · Facility Incident Report completed on 9/9/13 at approximately 8:00 PM by RN#1. The facility ' s investigation into how Res#1 was able to exit the building and an alarm not be heard has not been determined. B. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. · On 11-7 shift on 9/9/13 and 9/10/13, a 100% resident head count was completed by 4:30 AM (the 10th) by LPN#1 for units 1&2 and RN#2 for unit 3 that " all " residents are present and accounted for inside the facility. This 100% headcount confirmed and validated that all residents were accounted for in the facility. · A new Elopement Risk Assessment was initiated and completed on 9/10/13 for every resident in the facility by the Interim DON assisted by a new RN Unit Manager and LPN#2 to identify any other residents in the facility that might be at risk for elopement. · The Assessments were evaluated and six Residents (#2, 3, 4, 5, 6, & 7) were initially identified on 9/11/13 by LPN#2. Resident #5 previously had had a WanderGuard bracelet placed on her, and Residents #3 and #4 refused to allow the bracelet to be placed on 9/11/13, and Residents #2, #6 and #7 had their bracelets placed on 9/17/13. New WanderGuard bracelets were placed by the RN Unit Manager assisted by the Central Supply Clerk. · The Social Worker wrote a note in each of the six resident ' s medical records. This was completed by September 12, 2013 referencing elopement risk status.	F 323	a. Policy and Procedures for Elopement Response. b. Elopement Drills – what to do. c. How to initiate a proper search. d. Notification procedures. • Nurses (to include Agency): (use of testing devices) a. When and how to check placement and functioning of WanderGuard bracelets. b. How to document and frequency An audit tool called Audit of Elopement Policy is developed to monitor compliance. The audit tool includes monitoring of placement and functioning of the Wander-Guard bracelet on the resident and the proper functioning of the door alarms at all exit doors. The DON or designee completes audits at least three times weekly for three weeks, then weekly for four weeks and monthly times two months. 4.) How the facility plans to monitor its performance to make sure that solutions are ensured: The Administrator initiated a Process Improvement (PI) of the Elopement Response Policy and Procedures on 9/10/13. A PI Plan was completed on 9/11/13. As the PI is a continuous improvement process, further adjustments to the plan are expected to ensure all components work as expected. An Emergency QAPI Committee meeting	10/18/13

RJ Faddon
10/30/13

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F 323	Continued From page 17 · All current residents as of 9/10/13 with WanderGuard bracelets (#1, #5, #9, #10, #11) were checked on 9/10/13 by the Central Supply Clerk for functionality and expiration dates, and those checks were documented on a spreadsheet. All were determined to be properly functioning, and within the expiration dates. · All facility exit doors with WanderGuard locks and alarms were also checked by the Central Supply Clerk on 9/10/13. All doors checked and validated that they function properly, and those checks are documented. · Elopement risk for all residents being established on 6:00 PM on 9/11/13 by the Interim DON and her nurse team, and on 9/17/13 at 6:15 PM, a clinical team consisting of the RN Director of Nursing, RN Staff Development Coordinator, RN Unit Manager, RN MDS Coordinator, and Director of Operations (an RN) reviewed and re-evaluated the designated seven residents alleged to be an elopement risk. For Residents #1, #2, #3, #4, #5, #6, #7 affected the following was to be initiated: a. Resident #1 is discharged on 9/10/13, and Residents #9, #10, #11 bracelets were removed by 6:00 PM on 9/11/13 by the Central Supply Clerk since their Elopement Risk status was downgraded to safe in the facility. a. Placement of a WanderGuard bracelet on each affected resident. Resident #5 previously had had a WanderGuard bracelet placed on her and as of 9/11/13 remained unchanged, Residents #3 and #4 refused to allow the bracelet to be placed on 9/17/13 so none was placed, and Residents #2, #6 and #7 had their bracelets placed on 9/17/13 by 6:00 PM. New WanderGuard bracelets were placed by the RN Unit Manager assisted by the Central Supply Clerk. Residents #3 & #4 had not special	F 323	convened on 9/11/13 to consider and accept the Process Improvement Plan for Elopement. The Administrator is responsible for the functioning of the QAPI Committee. On 9/10/13, the Administrator initiated a review and revision to the facility Elopement Response Policy. That policy was accepted by the Facility Quality Assurance Committee on 9/11/13 with the proviso that it will be continuously evaluated for updates and changes as required to obtain the desired results. Any changes to the P&P will be discussed in the next scheduled QA Meeting. Most recent updates to the P&P completed by the Administrator on 9/19/13. The QA Audit of Elopement Policy is developed to document that all "at risk" residents will have their protective WanderGuard bracelets checked and to ensure they function properly ensuring compliance with facility P&P. The RN DON or designee will compile audit results and present to the QAPI Committee monthly for three months and then quarterly thereafter. Any trends identified will be addressed by the QAPI Committee. Subsequent changes or improvements to this Plan of Action will be developed as needed or directed by the QAPI Committee. The Director of Nursing is responsible for overall compliance	10/19/13

R Fadden
10/30/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 09/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS NURSING & REHAB CENTER	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 323	Continued From page 18 handling and on 9/17/13 were evaluated as not being an elopement risk. b. Telephone orders written for Residents #2, #3, #4, #5, #6, #7 to be placed on the TAR by the RN Unit Manager and RN DON at 8:30 AM on 9/17/13 for q-shift checks for placement and functioning of bracelet and doors. Residents #3 & #4 refused placement and their telephone orders were d/c ' d by 9:30 PM on 9/17/13. No alternate management of Residents #3 & #4. Residents #3, #4, #7 were re-assessed on 9/19/13 for elopement risk by the DON & Unit Mgr and found to not be at risk. c. Telephone orders d/c ' ing WanderGuard bracelets for Residents #2, #5, #6, #7 on 9/18/13 by 11:30 AM by RN Unit Manager. The d/c order was written after confirmation none of these residents were evaluated as being a risk for elopement. d. Placement checks documented q-shift on the TAR by the Charge Nurse began on 9/17/13 and ended 9/18/13. e. Unit Elopement Risk Binders are updated by the Medical Records Clerk with each resident being included whose elopement risk scores support their being placed in the binder. These binders are in place on each nurse station, Reception Desk, Social Work office, DON office and Therapy office the latest update is on 9/19/13. AS of 9/19/13 there are no residents determined to be at-risk and the binders reflect that status. f. For residents #2, #3, #4, #5, #6, and #7 evaluated as at risk for elopement, Care Plan updates were completed by the RN MDS Coordinator to reflect wander/elopement risk and appropriate interventions by 8:30 PM on 9/17/13. Those care plans are now d/c ' s on 9/19/13 at 11:30 AM by the RN MDS Coordinator.	F 323		10/18/13

R Haddon
10/30/13

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F 323	Continued From page 19 · On 9/18/13 at 10:00 AM Res#8 was further evaluated for elopement risk by the RN Director of Nursing and the RN Unit Manager. Res#8 is a new admission whose admission assessment was reviewed in greater detail. Res#8 was classified as a safe wanderer in the facility who exhibited no elopement risk on 9/18/13. · The Social Worker completed social notes on 9/18/13 that reflects their updated and true elopement status that reflected they are not an elopement risk. · The Elopement Response Policy and Procedure will be updated by the Administrator by 9/19/13 to reflect any changes recommended by the QAPI Committee to include a change in who checks the functionality of door alarms. · 100% of working staff (including all temporary agency staff) will be in-serviced by the RN SDC, RN DON or DON Designee to educate them on the proper procedures to follow should any resident be found to have eloped or attempted an elopement or be found in an unsafe location on the premises. This training begins on 9/19/13 with staff present (permanent and agency) and for all new employees in orientation on 9/19/13 and future orientations. Other employees not having received this training will be in-serviced at the beginning of their next work shift and prior to their beginning work. The credible allegation was verified on 9/19/13 at 7:00 PM as evidence by staff interviews of the understanding of the policy and procedure on Elopement and the understanding of the policy and procedure for Elopement response, elopement drills, how to check placement and functioning of the wanderguard bracelet.	F 323		10/18/13
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

R Faddis
10/30/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329 SS=D	Continued From page 20 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic 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 staff interview and record review, the facility failed to prevent a resident from receiving seven doses of a medication (Metformin tablets, a medication for treating diabetes) that was not ordered for the resident, for 1 of 3 residents (Resident # 9). The findings included: Resident # 9 was admitted 11/7/12 with diagnosis including dementia, atrial fibrillation,	F 329	F- 329 (D) 1.) How corrective action will be accomplished for the resident affected: Resident #9 experienced no negative outcomes. Review of Res#9 MAR ensured all medications have corresponding and appropriate orders and MAR is accurate. A Medication Error Report was completed by the Director of Nursing for this affected resident. 2.) How corrective action will be accomplished for those residents having the potential to be affected: Any resident receiving medications is potentially affected. A review of 100% of all MARs was completed by 9-30-13 ensuring all medications have a corresponding physician order. This month-end changeover process review was supervised by the Director of nursing and executed by the DON, QA Nurse, Unit Manager, Staff Development Coordinator and other designated nurses. Director of Nursing reviewed facility procedures for verifying physician orders for medications or changes are properly followed to include: • Orders for new or changed medications • MAR updates for medications changes • Medications errors and documentation • Ordering or discontinuing a medication	10/18/13

RJ Faddon
10/30/13

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F 329	Continued From page 21 hypothyroidism and depression. The most recent Minimum Data Set (MDS), a Quarterly Assessment dated 6/23/13, revealed Resident # 9 was cognitively impaired. The MDS indicated that diabetes was not an active diagnosis for Resident # 9. Review of the Physicians Orders from 6/1/13 - 9/19/13 revealed that there was no order for Resident # 9 to receive Metformin. There was an order to discontinue Metformin written on 8/4/13 and signed as received by Nurse # 6. Review of the Medication Administration Record (MAR) for 8/1/13 - 8/31/13 revealed a handwritten entry for Resident # 9 to receive Metformin 1000 mg (milligrams) by mouth twice a day at 9 AM and 9 PM; there was no signature with this entry. The medication was signed off (initialed) as given a total of 7 times; twice on 8/1/13 through 8/3/13, with the last dose signed off as given on 8/4/13. A hand written note next to the signed off Metformin revealed " D/C (discontinue) no order 8/4/13. " Review of the Consultant Pharmacist Drug Regimen Review dated 8/12/13 revealed, in part, " 8/4 D/C Metformin (?). " Telephone interview with the Physician on 9/18/13 at 4:48 PM revealed that he did not recall being told anything about Resident # 9 receiving Metformin without an order, or about having been asked for an order to discontinue Metformin for Resident # 9. Telephone interview with the Consultant Pharmacist on 9/19/13 at 3:40 PM revealed that	F 329	**3.) What measures will be put in place or systemic changes made to ensure correction:** **Nurses received in-service education by the DON, SDC, QA Nurse or designee regarding:** • **Medication change communications and follow-Up** • **Procedures when detecting a questionable medication** • **Validating / reconciling MAR with physician order** • **Medication errors** • **Documenting on a MAR** • **Ordering and discontinuing medications with Pharmacy** • **Emergency pharmacy procedures** **An audit tool is developed to monitor resident MAR and physician orders. The audit randomly checks MARs on all units and all carts and is designed to detect when omissions or errors occur with orders or administration of medications. A second check occurs during the Director of Nursing clinical meetings where all new orders are reviewed and checked as having been correctly documented. A third check happens when the MDS Coordinator evaluates all new orders during admissions assessments. The DON or designee completes audits at least three times weekly for three weeks, then weekly for four weeks and monthly times two months.**	10/18/13

RJ Faddon

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F 329	Continued From page 22 when she did her drug regimen review for Resident # 9 in August, 2013 she noticed that there was documentation indicating that Resident # 9 received Metformin without a physician's order. She also indicated that Metformin is used in treating diabetes and Resident # 9 was not diabetic. The Consultant Pharmacist stated that she wrote up a recommendation for nursing to investigate the Metformin that it appeared Resident # 9 had received to determine if there was a medication error that needed to be addressed. She stated that normally she would give the nursing recommendations that she wrote up to the Director of Nursing but she recalled that the DON had recently left and their was an Interim DON so she gave the recommendation to the Administrator to pass onto the interim DON. The Consultant Pharmacist stated that there was no negative outcome for Resident # 9 if she did receive Metformin as it does not lower blood sugar and that Metformin acts to allow the body to use insulin more efficiently. Interview with the Administrator on 9/19/13 at 5 PM revealed he did not recall being informed of a medication error concerning Resident # 9 having received Metformin without an order and the facility did not have a medication error report related to this. Telephone Interview with Medication Aide # 1 on 9/19/13 at 6:11 PM revealed that she had given Metformin to Resident # 9 as indicated by her initials on the MAR (4 of the 7 doses). She stated that she was the staff member that asked the Nurse (Nurse # 6) to see if Resident # 9 should be on Metformin, after the resident had been on it for a few days, as she recalled that Resident # 9	F 329	**4.) How the facility plans to monitor its performance to make sure that solutions are ensured:** **The DON or designee will compile audit results and present to the Quality Assurance Process Improvement (QAPI) Committee Meeting monthly times four months and quarterly thereafter. Subsequent plans of action will be developed as directed by the QAPI Committee. The Director of Nursing is responsible for overall compliance.**	10/18/13

R J Fadden
10/30/13

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F 329	Continued From page 23 had not been getting Metformin previously. Medication Aide # 1 stated she had been giving the Metformin until it was discontinued but she did not recall if she had to borrow it from another resident or if Resident # 9 had her own supply from pharmacy. Nurse # 6 could not be contacted for an interview.	F 329	F- 425 (D) 1.) How corrective action will be accomplished for the resident affected: Resident #19 & #20 medications available. Res#20 no longer resides in the facility. 2.) How corrective action will be accomplished for those residents having the potential to be affected:	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) 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 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and pharmacy consultant interview the facility failed to have medications available for administration for	F 425	All residents are potentially affected. A facility review of MARs was conducted by a nurse selected by the Director of Nursing confirming medications on all carts for all three units: (1) Resident had the correct drug, (2) the physician order and medication matched, and (3) the drug was present and accurate. This process has continued weekly. Director of Nursing reviewed nurse and pharmacy procedures for ordering, receiving and documenting medications. The Director of Nursing investigated the root cause of missed medications and determined the source was missed faxes resulting from a severed fax line causing transmissions to not be completed. This has been corrected through the consistent use of alternate fax lines. 3.) What measures will be put in place or systemic changes made to ensure correction: Director of nursing reviewed nurse procedures for ordering and receiving medications to include: • Ordering and discontinuing new	10/18/13

R Faddon
10/30/13

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F 425	Continued From page 24 two of five sampled residents for medication availability. Residents #19 and #20. The findings included: Review of the pharmacy procedures entitled " 3.2 Ordering and Receiving Non-Controlled Medications Policy " dated 09/10 revealed " Medications and related products are received from the provider pharmacy on a timely basis. The nursing care center maintains accurate records of medication order and receipt. " Review of the " Procedures " included " b. If utilizing a ' cycle fill ' or ' anniversary fill ' system, all routinely used dosage forms are provided by ' automatic ' dispensing and no reorder is required of these medications. For remaining routine and PRN (as needed) orders, repeat medications (refills for a new supply) are ordered by writing the medication name and prescription number, or applying the peel-off bar coded label from t he prescription label on the reorder sheet and faxing or otherwise transmitting the order to the pharmacy. Reorder routine medications by the re-order date on the label to assure an adequate supply is on hand. " 1. Resident #20 was admitted to the facility on 8/21/12 with diagnoses of Rheumatoid Arthritis, bronchitis, Diabetes Mellitus type II and chronic pain. Review of the Medication Administration Records (MAR) for the month of June revealed three medications had not been available for administration. Fentanyl 50 microgram (mcg) patch, Methotrexate 2.5 milligrams (mg) 9 tabs and Duo nebs for a hand held nebulizer had not been administered as ordered.	F 425	or changed medications • Proper MAR documentation • Medication errors • Use of pharmacy FAX machines • Use of E-Kit • Off hour emergency delivery system Nurses received in-service education by the DON, SDC, QA Nurse or designee covering the same nurse policy and procedures for ordering and receiving medications confirmed by the Director of Nursing P&P review, including: • Medication change communications and follow-Up • Procedures when detecting a questionable medication • Validating / reconciling MAR with physician order • Medication errors • Documenting on a MAR • Ordering and discontinuing medications with Pharmacy • Emergency pharmacy procedures An audit tool is developed to monitor resident MAR and availability of medications which also includes if medications are missing or not available. Any audit discrepancies result in follow-up to ensure any nurse follows proper P&Ps. The DON or designee completes audits at least three times weekly for three weeks, then weekly for four weeks and monthly times two months	10/10/13

R Maddox
10/30/13

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F 425	Continued From page 25 Methotrexate 2.5 mg 9 tabs at 8:00 AM on 6/5/13 were not administered as ordered. The explanation on the back of the MAR was " on order. " This medication was to be administered one time a week on Wednesday for the treatment of rheumatoid arthritis. Fentanyl 50 mcg patch was not administered as ordered at 8:00 AM on 6/24/13. The explanation on the back of the MAR for not applying the medication revealed the pharmacy was contacted and would deliver the medication at 4:00 PM on 6/24/13. Review of the MAR revealed documentation of a one time dose of Fentanyl 50 mcg patch at 5:00 PM on 6/24/13. This medication was to be administered for chronic pain, and was to be applied every 72 hours. The Duo nebs on 6/27/13 at 8:00 PM were not administered as ordered. The explanation on the back of the MAR documented " consulting pharmacy for delivery. " The nebulizers were ordered to be given four times a day for bronchitis. Review of the July MAR revealed on 7/31/13 the Methotrexate 2.5mg 9 tabs had not been administered. Review of the documentation on the back of the MAR revealed " med not available. consulting pharmacy 9 AM. " Review of the September MAR revealed the medication Abilify 10 mg on 9/2/13 was not administered as ordered. Review of the back of the MAR revealed the medication was " not available. " This medication was for depression. Interview on 9/19/13 at 2:20 PM with agency nurse #1 revealed the pill cards from the pharmacy have a tab to pull off when reordering the medication. The tab is about 5 or 6 above the	F 425	**4.) How the facility plans to monitor its performance to make sure that solutions are ensured:** **The DON or designee will compile audit results and present to the Quality Assurance Process Improvement (QAPI) Committee Meeting monthly times four months and quarterly thereafter. Subsequent plans of action will be developed as directed by the QAPI Committee. The Director of Nursing is responsible for overall compliance.**	10/18/13

R Fiddler
10/30/13

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F 425	Continued From page 26 last tablet. The tabs are placed on a reorder sheet. The pharmacy can be called if the medication is needed that day. The nurse further explained " The pharmacy is located in Greensboro and would be close to us." At the end of the shift, the reorder sheet is faxed to the pharmacy. An emergency kit was located in the medication room. Interview on 9/19/13 at 3:17 PM with the consulting pharmacist revealed she was not aware the nurses did not have medications available. A pharmacist was on call 24 hours a day, 7 days a week. The pharmacy was thirty minutes away from the facility, and medications could be delivered when needed. There was also an emergency kit for some medications that might be needed. Interview with the Director of Nursing on 9/19/13 at 3:45 PM revealed he was not aware nurses did not have medications available. 2. Resident #19 was admitted to the facility on 1/29/10 with diagnoses including Alzheimer ' s and hypertension. Review of the Medication Administration Record for September revealed the medication Viactiv was not given on 9/1, 9/2, 9/3 and 9/19/13. The back of the MAR documented "awaiting from pharmacy." This medication was a calcium supplement. Interview on 9/19/13 at 2:20 PM with agency nurse #1 revealed the pill cards from the pharmacy have a tab to pull off when reordering the medication. The tab is about 5 or 6 above the last tablet. The tabs are placed on a reorder	F 425		10/18/13

R J Faddon
10/30/13

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F 425	Continued From page 27 sheet. The pharmacy can be called if the medication is needed that day. The nurse further explained " The pharmacy is located in Greensboro and would be close to us. " At the end of the shift, the reorder sheet is faxed to the pharmacy. Interview on 9/19/13 at 3:17 PM with the consulting pharmacist revealed she was not aware the nurses did not have medications available. A pharmacist was on call 24 hours a day, 7 days a week. The pharmacy was thirty minutes away from the facility, and medications could be delivered when needed. Interview with the Director of Nursing on 9/19/13 at 3:45 PM revealed he was not aware nurses did not have medications available.	F 425		10/18/13

R Waddell
10/30/13