FEB 17 2014

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

PRINTED: 01/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345505	A. BUILDING ______ B. WING ______	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the failed to develop a care plan for a resident who was admitted into the facility with a left humerus fracture with refusals to participate in occupational therapy for 1 of 2 residents reviewed for rehab services (Resident #2). The findings included: Resident #2 was admitted into the facility on 12/2/13. Diagnoses included a left humerus fracture and general weakness. The admission minimum data set completed on 12/9/13 indicated Resident #2 was cognitively intact.	F 279	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. **F279-How corrective action will be accomplished for each resident found to have been affected by the deficient practice –** Resident #5 plan of care was revised 1/16/14 to reflect ROM exercise to left upper extremity and refusals of care and therapy. Completion date: 1/16/14	1-16-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Schascoo F Caina

TITLE: Administrator

(X6) DATE: 2-17-14

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 279	Continued From page 1 Extensive assistance of one person physical assist was required with bed mobility, dressing, and personal hygiene. Extensive assistance of two person physical assist was required with transfers and toilet use. Range of motion to the upper extremity was indicated as impaired on one side (shoulder, elbow, wrist, hand) with the use of a cane/crutch/wheelchair. Fracture was listed as an active diagnosis. No rejection of care was listed. The care area assessment narrative note for activities of daily living (ADL) signed on 12/3/13 in part read "fall at home which resulted in left humerus fracture, has muscle weakness and thus requires extensive assistance for ADL completion." The plan of care dated "12/2/13" to 1/15/14 revealed no specific care approaches/interventions that addressed a left humerus fracture or refusals to participate in occupational therapy. A review of the physician progress notes dated 12/3/13 in part read "patient is status post fall and had a fracture of the left humerus. She is wearing a sling at this time and tells me he pain is under relatively good control." A review of the occupational therapy (OT) progress notes revealed on 12/8/13 at 3:02 pm, Resident #2, "refused to participate in OT services at her scheduled time and later in the day." On 12/9/13 at 12:27 pm, notes in part read "refused skilled OT, consistent refusals of scheduled therapy, impacting progress with OT plan of care." On 12/13/13 at 8:46 am, notes in part read "refusing further therapy (OT)." On 1/6/14 at 1:20 pm, notes in part read "refused OT services." During a tour observation on 1/13/14 at 1:30 pm,	F 279	**How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –** An audit of assistive devices will be conducted for all residents. The device assessment will be updated to reflect the residents' use of assistive devices and the plan of care will be revised to accurately reflect devices in use. Completion date: 2/7/14 **Measures to be put in place or systemic changes made to ensure practice will not re-occur** Assistive devices for admissions and changes in assistive devices will be reviewed in risk management weekly. Completion date: 2/7/14 **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-** The RN Unit manager for each unit will conduct weekly random audits of device use,	2-7-14 2-7-14

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F 279	Continued From page 2 Resident #2's left arm was observed supported in a sling device. Her left arm was positioned lying against her body, supported by her right arm when she reached for the cordless phone on her bed side table. During an observation on 1/13/14 at 2:00 pm, Resident #2 was observed resting in the bed. The arm sling was located on the bed and not intact to the left arm. In an interview on 1/13/14 at 2:05 pm, Resident #2 when questioned was she suppose to have her sling on at all times stated that she thought that she was, however, she had been instructed by the staff (no specific names mentioned) that she had to wear it and by other staff that she did not have to wear it (no specific names mentioned). She added that sometimes the support sling came off due to it was too loose. She concluded her thoughts was that since she had a shoulder fracture she needed to wear it to support her arm. Resident #2 proceeded during the interview to put her left arm into the sling, supporting her left arm with her right hand. In an interview on 1/14/14 at 3:47 pm, unit manager #2 when questioned regarding when the arm sling was supposed to be applied to Resident #2 stated "there is no specific order when to remove the sling. We keep it on all the time and the nursing assistants usually will let the nurses know if the sling is not on and the nurse will put it on or therapy." During an observation on 1/15/14 at 9:20 am, the occupational therapy assistant instructed Resident #2 that she was suppose to wear the arm sling at all times, unless in therapy and/or	F 279	device assessment, & care plan for 4 weeks. Completion date: 2/7/14 DON will complete monthly random audits of device use, device assessment, & care plan for 2 months. Completion date: 2/9/14. Results of audits will be presented in facility QA meeting. Completion date: 2/9/14	2-7-14 2-9-14 2-9-14

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F 279	Continued From page 3 dressing. In an interview on 1/15/13 at 11:30 am, Nurse #5 (accompanied by the director of nursing), acknowledged that she completed the minimum data set (MDS) for Resident #2. When further questioned regarding a care plan for the left humerus fracture, she indicated that her process for developing a resident's plan of care did not include medical information from outside sources. She stated that she initiated plans of care based on internal documentation. Nurse #5 acknowledged that she did not complete a care plan for the left arm fracture. The director of nursing added that her understanding was that information that is included on the MDS is assessed in-house.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, resident, and family interviews, the facility failed to clarify a therapy referral ordered by the physician, which resulted in a delay in treatment to a left humerus fracture for 1 of 1 resident reviewed for fracture (Resident #2). The findings included: Resident #2 was admitted into the facility on 12/2/13. Diagnoses included a left humerus fracture and general weakness. The admission minimum data set completed on 12/9/13	F 281	**F281 - How corrective action will be accomplished for each resident found to have been affected by the deficient practice –** 1/9/14, the consulting MD was contacted to clarify recommendations from office visit on 12/13/13. Range of motion exercises were provided to resident #2 on 1/15/14. Completion date: 1/15/14 **How corrective action will be accomplished for those residents having the potential to be affected by the same**	1-15-14

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F 281	Continued From page 4 indicated Resident #2 was cognitively intact. Extensive assistance of one person physical assist was required with bed mobility, dressing, and personal hygiene. Extensive assistance of two person's physical assist was required with transfers and toilet use. Range of motion to the upper extremity was impaired on one side (shoulder, elbow, wrist, hand) with the use of a cane/crutch/wheelchair. A fracture was listed as an active diagnosis. There was no care plan for a left humerus fracture on the care plan initiated on 12/2/13. A review of the physical/occupational therapy referral - ordered by physician #1 dated 12/13/13 in part read "left two part humerus fracture" with instructions that in part read "1) set up independent home exercise program, 2) evaluate and treat one - two visits per week for total of eight weeks, 3) shoulder: develop rotator cuff program focused on internal, external rotation, scapular strengthening and stabilization, 4) begin active range of motion: flexion to 120, external rotation 45, internal rotation 20." During an observation on 1/15/14 at 9:20 am, the occupational therapy assistant (OTA) provided range of motion exercises to Resident #2's left arm/shoulder. The resident stated "this service should have begun a long time ago." In an interview on 1/15/14 at 9:37 am, the OTA stated this was the first day that therapy exercises had been provided to Resident #2's left arm/shoulder. In an interview on 1/15/14 at 9:42 am, the rehab manager stated that she was not aware that there were therapy referral orders dated 12/13/13,	F 281	**deficient practice –** Residents with outside appointments will be reviewed to ensure that outside office visit or outside referral source recommendations have been initiated as ordered. Completion date: 2/9/14 **Measures to be put in place or systemic changes made to ensure practice will not re-occur** Nurses and therapist staff will be educated to obtain recommendations upon residents' return from office visits or outside referral sources upon resident's return to the facility. If clarification is needed the nurse or therapist will attempt to make initial contact within 24 hours. Completion date 2/7/14. New recommendations will be copied upon residents' return from office visits or outside referral sources and will be reviewed by the unit manager or rehab director in morning stand	2·9·14 2·7·14

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F 281	Continued From page 5 which instructed for therapy services to begin due to a left humerus fracture, until being made aware by Resident #2's relative on 1/9/14. When further questioned related to her expectation of received orders brought back after a resident's appointment, she indicated that she expected the orders to have been carried out as ordered on 12/13/13. She added that if any clarification needed to be done, she expected the staff to have clarified the orders immediately, to prevent a delay in treatment. She concluded that no therapy services had been provided to the left shoulder due to she thought there were no orders. In an interview on 1/15/14 at 10:30 am, Resident #2 stated that she recalled on 12/13/13, when she returned from her appointment back into the nursing facility, her relative handed the therapy referral orders to the physical therapist, and the physical therapist commented "I can not read the orders clearly." Resident #2 concluded that she did not recall the physical therapist gave the orders back to her relative. In an interview on 1/15/14 at 10:50 am, the physical therapist revealed that she recalled Resident #2's relative presented therapy referral orders to her on 12/13/13, however, parts of the orders were not readable, therefore, she informed the relative that clarification was needed, and she thought the relative informed the primary nurse. The PT concluded that she did not clarify the therapy orders with the ordering physician. In an interview on 1/15/14 at 11:42 am, the director of nursing when questioned regarding the process for referral orders that accompanied a resident from an appointment, stated that she	F 281	up meeting. Completion date 2/9/14. A copy of orders or recommendations for therapy services will be placed in the plan of care book located in the rehab director's office as a reference point. Completion date 2/9/14. **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-** Rehab Director/DON or designee will conduct audit of new orders or recommendations received from outside sources weekly X 4weeks. Results will be reviewed in facility risk/QA meeting for further recommendations. Completion date: 2/9/14.	2-9-14 2-9-14

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F 281	Continued From page 6 expected if a resident came back into the facility with referral orders that were questionable by the staff, she expected the orders to have been clarified with the referring physician, so that therapy services could have been initiated as ordered. In a telephone interview on 1/15/14 at 8:40 pm, Resident #2's relative revealed that on 12/13/13, she physically gave the therapy referral orders received from her appointment, to the physical therapist on 12/13/13, in the physical therapy room sometime after dinner. She added that she also made the therapist aware that the resident's left humerus was fractured. The relative added that the therapist responded that she could not read the order in its entirety, and that she would call the ordering physician to clarify the order. She added that she did not recall the therapist giving her back the orders, nor did the therapist follow back up with her regarding any clarification completed. In a telephone interview on 1/15/14 at 8:55 pm, Nurse #6 stated that she was the primary nurse for Resident #2 on 12/13/13. She indicated that Resident #2 and a relative returned to the facility on 12/13/13, around dinner, and she observed the resident's left arm was in a sling. Nurse #6 added that she was not aware that therapy referral orders accompanied the resident, and she was not aware of any needed clarification related to therapy orders. She concluded that no orders were given to her by the relative or the physical therapist.	F 281		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		

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F 332	Continued From page 7 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain a medication error rate less than 5% for 1 of 7 residents observed during a medication pass, by not administering medications as ordered by mouth and failed to flush the gastrostomy tube (GT) with water after administering each medication separately. There were 6 medication errors out of 25 medication opportunities, which resulted in a 24 % medication error rate (Resident #5). The findings included: Resident #5 was admitted into the facility on 10/16/13. Diagnoses included psychosis, hypertension, convulsions and dysphagia. A review of the physician orders for January 2014 revealed the following medications were ordered to be administered by mouth 1) carvedilol 25 milligrams (mg) one tablet (9:00 am), 2) hydralazine 50 mg one tablet (8:00 am), 3) lisinopril 20 mg one tablet (8:00 am), 4) namenda 5 mg one tablet (9:00 am), 5) famotidine 40 mg one tablet (6:30 am), 6) multivitamin liquid 10 milliliters (ml) (8:00 am). A review of the medication administration record for January 2014 instructed for the following medication to be administered by mouth: carvedilol 25 mg, hydralazine 50 mg, lisinopril 20 mg, namenda 5 mg, famotidine 40 mg and multivitamin liquid 10 ml.	F 332	**F332 - How corrective action will be accomplished for each resident found to have been affected by the deficient practice –** An order from the attending physician was received on 1/15/14 for resident #5 to have medications administered via enteral tube as indicated in the physician's risk benefit statement. Completion date: 1/15/14 **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –** Medication orders for all residents receiving enteral nutrition will be reviewed to clarify if resident is to receive medications via enteral tube or by mouth. If residents receiving enteral feedings are receiving medications by mouth, the care plan and the EMAR will reflect such. Completion date: 2/7/14 A med pass observation will be completed for residents	1-15-14 2-7-14

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F 332	Continued From page 8 During a medication pass observation on 1/14/14 at 9:05 am, Nurse #1 crushed the following medications after taken from the original medication packets: carvedilol 25 mg one tablet, hydralazine 50 mg one tablet, lisinopril 20 mg one tablet, namenda 5 mg one tablet, famotidine 40 mg one tablet and then poured the medications into a cup, including multivitamin liquid 10 ml. Nurse #1 once in Resident #5's room, poured water into the cup where the medications had been mixed, verified placement of the resident GT, flushed the GT with 30 ml of water, and then poured the mixed medications from the cup into the GT, followed by 120 ml of water. In an interview on 1/14/14 at 1:00 pm, Nurse #1 stated that he had been instructed by the staff development coordinator "3 - 6 months ago" that the medications he administered could be crushed, flushed and administered as he did via the GT. In an interview on 1/14/14 at 1:12 pm, the staff development coordinator, accompanied by the director of nursing indicated that the staff was taught to administer medications as ordered by the physician. She added that if medications were ordered to be given via the GT, the expectation was that each medication is administered separately and in accordance with the facility policy dated 9/16/13, which in part read "pour one medication at a time into the syringe and instill into feeding tube; follow with 15 ml water flush, or as ordered by the physician, repeat other medications one at a time."	F 332	receiving enteral feedings. Completion date: 2/9/14 **Measures to be put in place or systemic changes made to ensure practice will not re-occur** At time of admission the medication orders for the resident will be reviewed to ensure accurate transcription to the EMAR. Completion date: 2/7/14 Each nurse will be in-serviced on administering medications via gtube and a med pass observation will be completed for each nurse. Completion date: 2/9/14 **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-** SDC and/or UM for each unit will conduct med pass observation for 2 residents weekly for 4 weeks and Pharmacy RN will conduct monthly observation of med	2.9.14 2.7.14 2.9.14
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	F 406		

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F 332	Continued From page 8 During a medication pass observation on 1/14/14 at 9:05 am, Nurse #1 crushed the following medications after taken from the original medication packets: carvedilol 25 mg one tablet, hydralazine 50 mg one tablet, lisinopril 20 mg one tablet, namenda 5 mg one tablet, famotidine 40 mg one tablet and then poured the medications into a cup, including multivitamin liquid 10 ml. Nurse #1 once in Resident #5's room, poured water into the cup where the medications had been mixed, verified placement of the resident GT, flushed the GT with 30 ml of water, and then poured the mixed medications from the cup into the GT, followed by 120 ml of water. In an interview on 1/14/14 at 1:00 pm, Nurse #1 stated that he had been instructed by the staff development coordinator "3 - 6 months ago" that the medications he administered could be crushed, flushed and administered as he did via the GT. In an interview on 1/14/14 at 1:12 pm, the staff development coordinator, accompanied by the director of nursing indicated that the staff was taught to administer medications as ordered by the physician. She added that if medications were ordered to be given via the GT, the expectation was that each medication is administered separately and in accordance with the facility policy dated 9/16/13, which in part read "pour one medication at a time into the syringe and instill into feeding tube; follow with 15 ml water flush, or as ordered by the physician, repeat other medications one at a time."	F 332	pass for at least 1 resident receiving medications via enteral tube for 2 months. Completion date: 2/9/14 Results of weekly audits will be presented at facility risk/QA meeting for further recommendations. Completion date: 2/9/14.	2-9-14 2-9-14
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	F 406		

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F 406	Continued From page 9 If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide therapy related services as medically indicated for a resident with a left humerus fracture for 1 of 2 residents reviewed for rehab services (Resident #2). The findings included: Resident #2 was admitted into the facility on 12/2/13. Diagnoses included a left humerus fracture and general weakness. The admission minimum data set completed on 12/9/13 indicated Resident #2 was cognitively intact. Extensive assistance of one person physical assist was required with bed mobility, dressing, and personal hygiene. Extensive assistance of two person's physical assist was required with transfers and toilet use. Range of motion to the upper extremity was indicated as impaired on one side (shoulder, elbow, wrist, hand) with the use of a cane/crutch/wheelchair. A fracture was listed as an active diagnosis. Restorative nursing program with range of motion exercises; splint or brace device was not indicated. Occupational therapy was indicated with 254 minutes of therapy	F 406	**F406 - How corrective action will be accomplished for each resident found to have been affected by the deficient practice –** 1/9/14, the consulting MD was contacted to clarify recommendations from office visit on 12/13/13. Range of motion exercises were provided to resident #2 on 1/15/14. Completion date: 1/15/14 **How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –** Residents with outside appointments will be reviewed to ensure that outside office visit or outside referral source recommendations have been initiated as ordered. Completion date: 2/9/14 **Measures to be put in place or systemic changes made to ensure practice will not re-occur** Nurses and therapist staff will be educated to obtain	1.15.14 2.9.14

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	345505	A. BUILDING ______ B. WING ______	C 01/15/2014

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F 406	Continued From page 10 received. Physical therapy was indicated with 310 minutes of therapy received. The care area assessment narrative note for activities of daily living (ADL) signed on 12/3/13 in part read "fall at home which resulted in left humerus fracture, has muscle weakness and thus requires extensive assistance for ADL completion." The plan of care dated "12/2/13" to 1/15/14 did not indicate a left humerus fracture. A review of the physical/occupational therapy referral - ordered by physician #1 dated 12/13/13 in part read "left two part humerus fracture" with instructions that in part read "1) set up independent home exercise program, 2) evaluate and treat one - two visits per week for total of eight weeks, 3) shoulder: develop rotator cuff program focused on internal, external rotation, scapular strengthening and stabilization, 4) begin active range of motion: flexion to 120, external rotation 45, internal rotation 20." During an observation on 1/15/14 at 9:20 am, the occupational therapy assistant (OTA) provided range of motion exercises to Resident #2's left arm/shoulder. The resident flexibility in her arm was observed to be limited when range of motion exercises was performed. The resident stated "this service should have begun a long time ago." After the therapy session ended at 9:34 am, the OTA applied a left arm sling and educated the resident that the arm sling was to remain on at all times, except for when she was in therapy sessions and/or being assisted with dressing. In an interview on 1/15/13 at 9:37 am, the OTA stated this was the first day that therapy exercises had been provide to Resident #2's left shoulder/arm.	F 406	recommendations upon residents' return from office visits or outside referral sources upon resident's return to the facility. If clarification is needed the nurse or therapist will attempt to make initial contact within 24 hours. Completion date 2/7/14. New recommendations will be copied upon residents' return from office visits or outside referral sources and will be reviewed by the unit manager or rehab director in morning stand up meeting. Completion date 2/9/14. A copy of orders or recommendations for therapy services will be placed in the plan of care book located in the rehab director's office as a reference point. Completion date 2/9/14. **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-** Rehab Director/DON or designee will conduct audit of	2-7-14 2-9-14 2-9-14

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F 406	Continued From page 11 In an interview on 1/15/14 at 9:42 am, the rehab manager acknowledged that she was aware that Resident #2 was admitted into the facility with a fractured left humerus, with her left arm supported in a sling, and that, no therapy services had been provided to the left shoulder/arm until 1/15/14. The rehab manger added that she was not aware that there were therapy referral orders, that were received from the orthopaedic physician on 12/13/13, which instructed for therapy services to begin to the shoulder, until made aware by Resident #2's relative on 1/9/14. In an interview on 1/15/14 at 10:30 am, Resident #2 stated that she was upset that she had not received therapy to her left shoulder/arm until 1/15/14. She added that she felt therapy should have began much sooner, being that the physician had sent the facility a therapy referral order with specific instructions regarding care to her shoulder. In an interview on 1/15/14 at 10:50 am, the physical therapist after shown the physician referral order form dated 12/13/13 instructing for therapy services to begin to the shoulder; acknowledged that she recalled the resident's relative presented similar orders to her on 12/13/13. The PT added that the orders were not readable, therefore, she informed the relative that clarification was needed, and she thought the relative informed the primary nurse. The PT concluded that she did not clarify the therapy orders with the ordering physician, nor did she provide any related care services. In an interview on 1/15/14 at 11:42 am, the director of nursing when questioned regarding the	F 406	new orders or recommendations received from outside sources weekly X 4weeks. Results will be reviewed in facility risk/QA meeting for further recommendations. Completion date: 2/9/14.	2-9-14

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F 406	Continued From page 12 delay in rehab services to the left fracture humerus, stated that she expected if a physician referral order for therapy was received, she expected the order to have been clarified and therapy services initiated as ordered. In a telephone interview on 1/15/14 at 8:40 pm, Resident #2's relative revealed that on 12/13/13, she physically gave the therapy referral orders to the physical therapist in the physical therapy room sometime after dinner. She added that she also made the therapist aware that the resident's left humerus was fractured. The relative added that the therapist responded that she could not read the order in its entirety, and that she would call the ordering physician to clarify the order. She added that she did not recall the therapist giving her back the orders, nor did the therapist follow back up with her regarding any clarification completed. In a telephone interview on 1/15/14 at 8:55 pm, Nurse #6 stated that she was the primary nurse for Resident #2 on 12/13/13. She indicated that on 12/13/13 Resident #2 and a relative returned to the facility around dinner and she observed the resident's left arm was in a sling. Nurse #6 added that she was not aware that therapy referral orders accompanied the resident, and that she was not aware of any needed clarification related to therapy orders. She concluded that no orders were given to her by the relative or the physical therapist.	F 406		
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	F 425		

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F 425	Continued From page 13 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.	F 425	**F425 - How corrective action will be accomplished for each resident found to have been affected by the deficient practice –** 1/14/14, nurse #3 received order to administer ranitidine when arrives form pharmacy and pharmacy was contacted by nurse #3 to obtain medication ranitidine syrup through a stat delivery. The medication arrived at 1220 pm and was administered to resident #6 at 1230pm.	1.14.14
	This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and pharmacist interviews, the failed to have available medication (ranitidine liquid) to be administered as ordered for 1 of 7 residents observed during a medication pass observation (Resident #6). The findings included: Resident #6 was admitted into the facility on 11/29/09. Diagnoses included dementia and stomach protection. A review of the physician order for January 2014 revealed that ranitidine 10 milliliters (ml) was to be administered daily for stomach protection. A review of the medication administration record for January 2014 instructed that ranitidine 10 ml		**How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –** Each residents' medications were reviewed to ensure that all medications were available for administration. Completion date: 2/7/14 **Measures to be put in place or systemic changes made to**	2.7.14

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F 425	Continued From page 14 was to be administered daily at 8:00 am. During a medication pass observation on 1/14/14 at 9:15 am, Nurse #2 indicated that she did not see ranitidine liquid medication available on the medication cart. She then proceeded to the medication room and was unable to locate the medication. She stated that the medication was "not available" and that she had to reorder the medication from pharmacy. Nurse #2 added that the medication was last administered on 1/13/14 at 8:00 am per the medication electronic administration record. At 9:45 am, Nurse #2 called the pharmacy and notified that there was no ranitidine liquid available to be administered as ordered. In an interview on 1/14/14 at 11:03 am with Nurse #3, who administered ranitidine to Resident #6 on 1/13/14 acknowledged that after she administered ranitidine 15 ml to the resident on 1/13/14, she called Nurse #4 at home and Nurse #4 informed her that she reordered the medication. When further questioned, Nurse #3 indicated that she did not recall what day Nurse #4 said she reordered the medication, and that she did not verify with pharmacy if the medication had been reordered. Nurse #3 concluded that she discarded the empty bottle on 1/13/14 and acknowledged that she was aware that there was no additional ranitidine available on the medication cart on 1/13/14. On 1/14/14 at 11:55 am, the unit manager #1 reported that the medication (ranitidine) had arrived from the pharmacy. A review of the medication administration record reflected that on 1/14/14 at 12:30 pm, Resident	F 425	**ensure practice will not re-occur** Nurses will be in-serviced on the procedure for obtaining medications from the pharmacy and ensuring all medications are available or ordered each shift. Completion date: 2/7/14 **How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-** SDC will conduct med pass observation for 1 nurse per unit weekly for 4 weeks and Pharmacy RN will conduct monthly med pass observation for 1 nurse. Completion date: 2/7/14 Results of weekly audits will be presented at facility risk/QA meeting for further recommendations. Completion date: 2/9/14.	2-7-14 2-7-14 2-9-14

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F 425	Continued From page 15 #6 received ranitidine 10 ml, which was originally scheduled to be administered at 8:00 am. In an interview on 1/15/14 at 11:43 am, the director of nursing stated that she expected the resident's medication to be available and administered as ordered. In an interview on 1/15/14 at 4:13 pm, the pharmacist revealed per review of Resident #6 pharmacy profile the last time that ranitidine liquid was dispensed to the facility was on 12/9/13. The pharmacist added that a 45 - 47 day supply was dispensed and that the facility should have had 100 milliliters of medication still available to be administered on 1/14/14. The pharmacist concluded if the medication was being administered as ordered, the facility should have only exhausted 35 days of supply. Nurse #4 who administered the last supply of ranitidine on 1/13/14 was not available to be interviewed.	F 425		