STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

(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 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with resident and staff the facility failed to provide a resident with sufficient fluid to maintain hydration by not keeping fluids in the room and within reach for 1 of 1 resident (Resident #18) reviewed for hydration. Findings included: Resident #18 was most recently admitted on 2/23/13. Her diagnoses included diabetes, depression, reflux, dysphagia, stroke and left sided hemiplegia. Record review of the Care Plan revealed the following: · 11/11/13: Resident #18 was on a therapeutic diet with mechanically altered consistency. Interventions included: Monitor intake and record every meal. · 11/19/13: Resident #18 was at risk of falls. Interventions included: " Keep needed items, water, etc, in reach. " · 7/17/14: Resident #18 was at risk for constipation. Interventions included: Encourage resident to drink plenty of fluids each day and " Keep my water pitcher in my reach and refill as needed. " · 8/11/14: Resident #18 had a urinary tract infection. Interventions included: Encourage	F 327	---The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected Resident #18 the facility allegedly failed to provide the resident with sufficient fluid intake to maintain proper hydration and health. This was corrected on August 13, 2014 by placing an insulated cooler at bedside to store chilled thickened liquids to ensure resident #18 has access to fluids as she so desires. In addition, the cooler will be checked every shift to ensure that there is an adequate supply of thickened liquids available for her use. Due to her current heath conditions, staff will provide assistance by opening and making available the thickened liquid containers on bedside table. Based upon manufacturers recommendations, the	9/11/14

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

Electronically Signed | 09/03/2014

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F 327	Continued From page 1 adequate fluid intake A review of the nutritional assessment dated 2/18/14 revealed the resident's daily fluid needs were greater than 1900 milliliters (mls). The Quarterly Minimum Data Set (MDS) dated 5/9/14 revealed Resident #18 was moderately cognitively impaired, had clear speech, made herself understood, and understood others. She required limited assistance with eating and was on a mechanically altered, therapeutic diet. She did not reject care. The Dietary Review dated 8/7/14 indicated Resident #18 was on nectar thick liquids, her oral intake of fluid was less than 1500 mls each day, and she could feed herself after set-up. During an observation on 8/11/14 at 12:34 pm, Resident #18 ' s lips and mucous membranes were dry. There was no water or other liquids within her reach or in her room. There was a sign posted at the head of her bed that stated, " No water pitcher at bedside " and indicated Resident #18 required nectar thick fluids. During an interview on 8/11/14 at 12:34 pm, when asked if she received the fluids she wants in between meals, Resident #18 indicated multiple times that she was thirsty. She further indicated staff will give her water if she rings her call bell, but fluids are not kept in her room for her to drink independently and she is able to do so. During an observation of the lunch meal on 8/11/14 at 12:42 pm, Resident #18 was observed throughout the meal, asleep, with her lunch tray in front of her on her overbed table. There were 2	F 327	thickened liquids that are provided to the resident will remain stable at room temperature. The dietary department also provides thickened liquids at each meal- which consists of 840ml for breakfast and 600ml for lunch and dinner respectively. This amount (2040ml), exceeds the recommended fluid intake of 1900 ml that is ordered by the registered dietitian. Corrective Action for Resident Potentially Affected All residents with orders for thickened liquids have the potential to be affected by this alleged deficient practice. Residents were reviewed by Director of Nursing and Dietary Manager on 8/26/14 to ensure that each resident who has orders for thickened liquids have them in an insulated cooler at bedside at all times so they have access to fluids as they desire. Each resident with orders for thickened liquid now have a task in the computer on the ADL grid for the certified nursing assistance notifying them to ensure fluids are at the bedside each shift. Systemic Changes An in-service will be conducted on 9/4/14 and 9/5/14 by the Director of Nursing. Those who will attend are all RNs, LPNs, and CNAs, FT, PT, and PRN. Hospice providers were included because they do provide fluids to residents in the facility. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: Providing each resident with orders for thicken liquids with sufficient fluid intake to maintain proper hydration	

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F 327	Continued From page 2 containers of buttermilk and a container of thickened water, unopened, on the tray. During an observation on 8/11/14 at 1:10 pm, Nurse Aide (NA) #1 removed Resident #18 ' s meal tray. The resident remained asleep. 0% of the lunch meal, including fluids, was consumed. After the aide removed the lunch tray, including fluids, there were no fluids in the resident ' s room. During an interview with NA #1 on 8/11/14 at 1:12 pm, she indicated Resident #18 was able to eat and drink independently and she would document the amount consumed on the wall kiosk. She further indicated fluids were not kept at the resident ' s bedside. Record review of NA #1 ' s documentation of Resident #18 ' s lunch meal on 8/11/14 indicated Resident #18 consumed "51-75%" of her meal. During an observation on 8/11/14 at 3:00 pm, Resident #18 did not have fluids in her room. During an observation on 8/12/14 at 4:15 pm, Resident #18 did not have fluids in her room. During an observation on 8/13/14 at 8:25 am of the breakfast meal, Resident #18 was sitting up in bed and 100% of the meal, including fluids had been consumed. There were 2 empty 236 ml buttermilk containers on her tray. Resident #18 stated she consumed her meal independently and she preferred to have her fluids within her reach during the day. During an interview on 8/13/14 at 11:18 am, Resident #18 stated, " I am thirsty. I should get	F 327	and health. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nursing employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or Staff Development Coordinator will monitor this issue using the "Survey QA Tool for Maintaining Proper Hydration. The monitoring will include verifying that Resident #18 and all residents with thickened liquids have liquids at bedside will be reviewed. See attached monitoring tool. This will be done daily Monday thru Friday for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of her attendance along with all members of the QA Team and Department Heads.	

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F 327	Continued From page 3	F 327		

more water. I don't hardly get no water unless I beg for it." She indicated staff does not keep water or other fluids in her room or within her reach. There were no fluids in her room.

During an interview on 8/13/14 at 11:40 am, Nurse Supervisor #1 stated, " [Resident #18] does not have thickened liquids kept in her room because she likes it cold. We just go get it out of the nourishment room if she asks." She further indicated fluids are not kept in rooms for residents who are on thickened liquids, even if they are able to independently drink. She indicated thickened liquids are kept in the refrigerator in the nourishment room at the nurses ' station.

During an interview on 8/13/14 at 12:40 pm, the Director of Nursing indicated residents who are able to eat and drink independently, or with set-up only, and are on thickened liquids should have liquids at their bedside and within their reach. She indicated she was not aware of a reason Resident #18 should not, and did not, have fluids within her reach.

During an observation on 8/13/14 at 2:47 pm, Resident #18 was sitting up in her bed. There was a cooler that contained thickened liquids on her overbed table. There was an opened thickened liquid in her hand and she was independently drinking without difficulty. She consumed 4 ounces of the thickened liquid.

During an interview on 8/13/14 at 2:49 pm, when asked about water on her overbed table, Resident #18 stated, "They put water in here now. I can drink it myself and now I am not as thirsty." She further indicated she wanted fluids left within

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F 327	Continued From page 4 her reach. During an interview on 8/14/14 at 9:50 am with the Rehab Director, he indicated Resident #18 gets a quarterly nutritional review. He further indicated that on 10/30/13 Speech Therapy evaluated her due to her history of stroke and the evaluation indicated she was at her baseline and was not having any difficulty with drinking the thickened liquids. During an interview on 8/14/14 at 11:15 am, NA #2 stated, " We open [Resident #18 ' s] buttermilk for her. I have worked with her about 3 days a week since April. I did not work with her yesterday. Before today, she did not have the cooler bag in her room. The kitchen would have [thickened liquids] in the nourishment room, she would have to ask for water. " During an interview on 8/14/14 at 11:30 am, Physician #1 stated, " [Resident #18] definitely needs the fluids beside her. She is usually very with it."	F 327		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE 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 observation, staff interview and record review the facility failed to ensure the medication error rate of 5% or less. There were 8 errors of 41 opportunities (Resident #101, #63, #102, and	F 332	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	9/11/14

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F 332	Continued From page 5 #136) resulting in a medication error rate of 19.5%. Findings Included: 1) Resident #101 diagnosis included Anemia, Hypertension, Hyperlipidemia, Dementia, Malnutrition, Depression, and Chronic Kidney Disease. On 8/13/2014 at 8:50 AM an observation of Nurse #1 revealed she administered Vitamin D3 50,000 units (by mouth) to Resident #101. The Physician orders and Medication Administration Record (MAR) for Resident #101 indicated the Vitamin D3 50,000 units were ordered once every 28 days and Resident #101 ' s was due on 8/22/2014. 2) Resident #63 diagnosis included Anemia, Hypertension, Peripheral Vascular Disease, Hyperlipidemia, Dementia, Depressive Disorder, and Peripheral Autonomic Neuropathy Disorder. 2a. on 8/13/2014 at 8:58 AM an observation revealed Nurse #1 announced the medication Depakote (seizure medication) was a new order for resident #63 and she would need to check if the new medication came in. Nurse #1 proceeded with the medication pass for Resident #63 which included Namenda, Aspirin, Claritin, Ferrous Sulfate, Lexapro, Lisinopril, Multivitamin, Vitamin B12, Vitamin D3, Welbutrin, Colace, Norvasc, Potassium Chloride, Neurontin, and artificial tears. Depakote was not observed being administered during the medication pass. Resident #63 ' s Physician Orders and MAR revealed Depakote 125mg by mouth twice a day was ordered on 8/8/2014 and the order was changed to Depakote 250 mg by mouth twice a	F 332	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected The facility allegedly failed to ensure that it is free of medication error rates of five percent or less. The nurse responsible for the alleged error rate of above five present was removed from the schedule for a period of twelve days, from 8/14/14 to 8/25/14, received a Tools for Improvement written notice of deficiency and has been required to attend mandatory in-servicing on medication pass on 8/26/14 and 8/28/14 conducted by Staff Development Coordinator. Medication pass was observed on 8/26/14 by Staff Development Coordinator and nurse received a 0% error rate. Corrective Action for Resident Potentially Affected All residents who receive medication have the potential to be affected by this alleged deficient practice. On 8/28/14 the facility has begun using electronic medication administration records, eliminating the use of paper MAR□s. All nurses FT, PT and PRN will be required to be reviewed by the Director of Nursing or SDC on the Medication Administration Observation Record (please see attached) beginning the week of 9/1/14 until week on 9/8/14 and have an error rate of five percent or below or they will be removed from the	

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F 332	Continued From page 6 day dated 8/12/2014. On 8/13/2014 at 12:30 PM an observation was made of Resident #63 ' s MAR and indicated the Depakote 250 mg by mouth was administered. Nurse #1 ' s signature initials were in the box for the 9:00 AM medication pass. On 8/13/2014 at 12:30 PM during an interview Nurse #1 was asked to identify if she followed up on Depakote for Resident #63. Nurse #1 pulled a stock card from the medication cart for Resident #63 labeled Divalproex (generic for Depakote) 125 mg and dated 8/8/2014. When asked if Divalproex was Depakote Nurse #1 ' s response was " it was the closest thing to it " Nurse #1 was not observed administering two Divalproex 125 mg 2 capsules to Resident #63 at the 9:00 AM medication pass. Nurse #1 reported her signature initial on the MAR indicated that she gave the medication so she must have given it. 2b. on 8/13/2014 at 9:20 AM an observation of Nurse #1 revealed she verbalized and administered Vitamin B12 500 to Resident #63. Resident #63 ' s Physician Order and MAR revealed the dose of Vitamin B12 250 mcg by mouth one time a day. 2c. on 8/13/2014 at 9:20 AM an observation of Nurse #1 revealed she administered Vitamin D3 50,000 units (by mouth). The Physician orders and MAR for Resident #63 indicated the Vitamin D3 50,000 units were ordered once every 30 days and Resident #63 ' s was due on 8/22/2014. 3) Resident #102 diagnosis included Hypertension, Peripheral Vascular Disease, Diabetes, Hyperlipidemia, Parkinson ' s disease,	F 332	schedule until they can pass the Medication Administration Observation Record with a score of less than five percent. Systemic Changes An in-service will be conducted on 9/4/14 and 9/5/14 by the Director of Nursing. Those who will attend are all RNs, LPNs, FT, PT, and PRN. Hospice providers were not included because they do not provide medication administration in the facility. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: Proper Medication Administration per facility and company policy and State and Federal Guidelines. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all licensed personal and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or Staff Development Coordinator will monitor this issue using the "Survey QA Tool for Medication Administration". The monitoring will include verifying proper technique and ability to follow proper policy for Medication Administration. See attached monitoring tool. This will be done daily for 2 nurses per day, 50% of nursing staff each week for 2 weeks to cover 100% of all nurses. This will be done weekly for 4 months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA	

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F 332	Continued From page 7 Seizure Disorder, and Chronic Kidney Disease. 3a. on 8/13/2014 at 10:08 AM an observation revealed Nurse #1 administered Metoprolol (cardiac medication) 12.5 mg by mouth to Resident #102 without assessing Resident #102 ' s pulse rate or blood pressure. Resident #102 ' s Physician order for Metoprolol read as Metoprolol give 12.5 mg by mouth two times a day, hold for heart rate < 60 or systolic blood pressure <100. Resident # 102 ' s MAR included to check blood pressure and heart rate daily. Nurse #1 was not observed assessing resident #102 ' s pulse and blood pressure or retrieving the numerical values from fellow staff members. 3b. on 8/13/2014 at 10:08 AM an observation of Nurse #1 revealed she administered Vitamin D3 50,000 units (by mouth) to Resident #102. The Physician order for Resident #102 indicated the Vitamin D3-50 50,000 units were ordered as give one cap by mouth one time a day and ending on the 16th start day of 5/20/2014. Resident #102 ' s MAR for August 2014 indicated the same physician order but had marked out all days of the month except one day 8/16/2014 for the nurse to administer a dose once a month on the 16th day. 4) Resident #136 diagnosis included Diabetes, Fracture and Dementia. 4a. on 8/13/2014 at 12:00 PM an observation revealed Nurse #1 announced Resident #136 ' s medications were to be crushed. Nurse #1 attempted to release the gel from Resident #136 ' s stool softener (DOK Plus 50-8.6 mg by mouth two times a day) and was unsuccessful only getting a few drops released from the gel cap and	F 332	committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of her attendance along with all members of the QA Team and Department Heads	

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F 332	Continued From page 8 circled her signature initial indicating the medication was not administered stating it would be okay if the resident went without one dose. 4b. on 8/13/2014 at 12:00 PM an observation revealed Nurse #1 did not administer Glipizide (diabetic medication) to Resident # 136 during the medication pass but indicated on the MAR with signature initial that the medication Glipizide was administered to Resident #136 at 12:15 PM. Nurse #1 was unable to locate the medication stock card she withdrew Resident #136 ' s Glipizide from. The Physician Order indicated the Glipizide 5 mg by mouth was to be administered twice a day and the second dose was scheduled at 5:00 PM. On 8/13/2014 at 12:30 PM during an interview Nurse #1 when asked about signing off Resident #136 ' s Glipizide without administering it Nurse #1 had no response.	F 332		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		9/11/14

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F 431	Continued From page 9 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to properly store resident medications for 2 of 4 residents (Residents #101 and #63) observed during medication pass. The facility policy for Preparation of Medication Administration included: (read in part) · During administration of medication, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. 1. Resident #101 diagnoses included Anemia, Hypertension, Hyperlipidemia, Dementia, Malnutrition, Depression, and Chronic Kidney Disease.	F 431	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected Resident # 101 and #63 the facility allegedly failed to properly store resident medications during the medication pass. The nurse was immediately in-serviced on	

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F 431	Continued From page 10 Record review of Resident #101 ' s Medication Administration Record (MAR) for 8/1/2014 through 8/31/2014 revealed her 9:00 AM medications included Cholestyramine Light Packet 4 Gm (grams); Metoprolol 12.5 mg (milligrams); Norvasc 2.5 mg; and Vitamin B12 500 mcg (micrograms). On 8/13/2014 at 8:46 AM Nurse #1 was observed leaving the Medication Cart unattended to retrieve a stock bottle of Aspirin. Resident # 101 ' s pulled medications Cholestyramine, Metoprolol, Norvasc, Vitamin B12, and Vitamin D for the 9:00 AM medication pass on top of the cart while Nurse #1 was away. On 8/13/2014 at 8:49 AM Nurse #1 returned to the medication cart and completed her medication pass. 2. Resident #63 diagnoses included Anemia, Hypertension, Peripheral Vascular Disease, Hyperlipidemia, Dementia, Depressive Disorder, and Peripheral Autonomic Neuropathy Disorder. Record review of Resident #63 ' s MAR for 8/1/2014 through 8/31/2014 revealed her 8:00 AM and 9:00 AM medications included Namenda 5 mg; Aspirin 81 mg; Claritin 10 mg; and Lisinopril 15 mg. On 8/13/2014 at 9:03 AM Nurse #1 was observed leaving the Medication Cart unattended during the medication pass to retrieve a stock bottle of Claritin. Resident # 63 ' s pulled medications Namenda and Aspirin were left on top of the medication cart while Nurse #1 was away.	F 431	8/13/14 by the Director of Nursing not to leave medication on top of the med cart unattended and if a pill is dropped on the floor to dispose of it immediately in the trash can or sharps container. Corrective Action for Resident Potentially Affected All residents who receive medication have the potential to be affected by this alleged deficient practice. All nurses FT, PT and PRN will be required to be reviewed by the Director of Nursing or designee on the Medication Administration Observation Record (please see attached) beginning the week of 9/1/14 until week on 9/8/14 which entails the proper way to store all drugs and biologicals in locked compartments and permit only authorized personal to have access to the keys and the proper way to dispose of a medication that was dropped on the floor. Systemic Changes An in-service will be conducted on 9/4/14 and 9/5/14 by the Director of Nursing. Those who will attend are all RNs, LPNs, FT, PT, and PRN. Hospice providers were not included because they do not provide medication administration in the facility. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: Proper Medication Administration per facility and company policy and State and Federal Guidelines. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all licensed personal and will be reviewed	

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	345496	A. BUILDING _____ B. WING _____	08/14/2014

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F 431	Continued From page 11 On 8/13/2014 at 9:07: AM Nurse #1 was observed returning to the medication cart. On 8/13/2014 at 9: 28 AM Nurse #1 was observed leaving a single pill identified as Lisinopril (heart medication) that had been dropped on the floor during the medication pass for Resident #63 on top of the medication cart while she entered Resident #63 ' s room to complete the medication pass. On 8/13/2014 at 9:30 AM Nurse #1 was observed returning to the medication cart and disposing the dropped medication in to the trash container. On 8/13/2014 at 2:32 PM an interview with the Director of Nursing (DON) revealed her expectation was for the nurse on the medication cart to keep her eyes on pulled medications at all times. The facility teaches to put the pulled medications in the locked cart or take them with you.	F 431	by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or designee will monitor this issue using the "Survey QA Tool for Medication Administration". The monitoring will include verifying proper technique and ability to follow proper policy for Medication Administration. See attached monitoring tool. This will be done daily for 2 nurses per day, 50% of nursing staff each week for 2 weeks to cover 100% of all nurses. This will be done weekly for 4 months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of her attendance along with all members of the QA Team and Department Heads.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514		9/11/14

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F 514	Continued From page 12 and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to record administered medications for 2 of 4 residents (Resident #101 and #102) directly after the medication was given. Findings Included: The facility policy for Preparation of Medication Administration included: (read in part) · The individual who administered the medication dose records the administration on the resident ' s MAR directly after the medication is given. 1) Record review of Resident #101 ' s Medication Administration Record (MAR) for 8/1/2014 through 8/31/2014 included the 9:00 AM medications as Cholestyramine Light Packet 4 Gm (grams) by mouth one time a day; Metoprolol 12.5 mg (milligrams) by mouth one time a day; Norvasc 2.5 mg by mouth one time a day; Vitamin B12 500 mcg (micrograms) by mouth one time a day; Amantadine 100 mg by mouth two times a day; Ecotrin (aspirin) 325 mg by mouth two times a day; and Tylenol 650 mg by mouth two times a day. On 8/13/2014 at 8:50 AM Nurse #1 was observed completing a medication pass on Resident #101. The medications included Cholestyramine Light Packet, Metoprolol, Norvasc, Vitamin B12, Vitamin D3, Ecotrin, and Tylenol. On 8/13/2014 at 8:55 AM Nurse #1 continued her	F 514	----The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected Resident # 101 and #102 the facility allegedly failed to record administered medications directly after the medication was given. The nurse was immediately in-serviced on 8/13/14 by the Director of Nursing on the proper way to sign out for the medication after they are administered to the resident. Corrective Action for Resident Potentially Affected All residents who receive medication have the potential to be affected by this alleged deficient practice. On 8/28/14 the facility has begun using electronic medication administration records, eliminating the use of paper MAR□s. The electric MAR□s will require the nurse to record the medication as given before being able to move onto the next resident. All nurses FT, PT and PRN will be required to be reviewed by	

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F 514	Continued From page 13 medication pass without placing a signature initial next to the medications administered to Resident #101. A record review of Resident #101 ' s MAR revealed Nurse #1 initialed that she administered Amitriptyline HCL (antidepressant) 25 mg. The medication was ordered at bedtime and she was not observed administering the medication during the 9:00 AM observation of medication pass. 2) Record review of Resident #102 ' s MAR for 8/1/2014 through 8/31/2014 included the 8:00 AM and 9:00 AM medications as Aspirin 81 mg by mouth in the morning; Ferrous Gluconate 325 mg by mouth one time a day; Glucotrol 2.5 mg by mouth one time a day; Lisinopril 40 mg by mouth one time a day; Miraplex 0.125 mg by mouth one time a day; Norvasc 10 mg by mouth in the morning; Selegiline 5mg by mouth in the morning; Colace 100 mg by mouth two times a day; Metoprolol 12.5 mg by mouth two times a day; Neurontin 300 mg by mouth two times a day; Senna S 8.6-50 mg by mouth two times a day; Tylenol 325 mg 2 tabs by mouth two times a day; Artificial tears 1 drop in both eyes three times a day; and Sinement 25-100 mg by mouth 4 times a day. On 8/13/2014 at 10:08 AM Nurse #1 was observed completing a medication pass with out placing a signature initial next to the medications administered to Resident #102. The medications included Aspirin, Vitamin D3, Ferrous Gluconate, Glucotrol, Lisinopril, Mirapex, Norvasc, Selegline, Colace, Metoperol, Neurontin, Senna, Tylenol, Artificial Tears and Sinement. An interview with Nurse #1 at 10:12 AM after she	F 514	the Director of Nursing or Staff Development Coordinator on the Medication Administration Observation Record (please see attached) beginning the week of 9/1/14 until week on 9/8/14 which entails the proper way to sign out for medication immediately after it is administered. Systemic Changes An in-service will be conducted on 9/4/14 and 9/5/14 by the Director of Nursing. Those who will attend are all RNs, LPNs, FT, PT, and PRN. Hospice providers were not included because they do not provide medication administration in the facility. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: Proper Medication Administration per facility and company policy and State and Federal Guidelines. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all licensed personal and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or Staff Development Coordinator will monitor this issue using the "Survey QA Tool for Medication Administration". The monitoring will include verifying proper technique and ability to follow proper policy for Medication Administration. See attached monitoring tool. This will be done daily for 2 nurses per day, 50% of nursing staff each week for 2 weeks to	

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F 514	Continued From page 14 administered Resident #102 ' s medications revealed her plan was to not sign off the medications she administered directly following the medication pass but at a later time. On 8/13/2014 at 2:32 PM an interview with the Director of Nursing (DON) revealed her expectation was for nurses passing medications was to sign off the medication as administered when the medication was given.	F 514	cover 100% of all nurses. This will be done weekly for 4 months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of her attendance along with all members of the QA Team and Department Heads.	