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
	345061	A. BUILDING ______ B. WING ______	C 04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(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 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to refer 1 of 1 sampled resident with behaviors to a psychiatric services as ordered (Resident #99). Finding included: Resident #99 was admitted to the facility on 10/27/14 with multiple diagnoses including hypertension and dementia with behaviors. The quarterly Minimum Data Set (MDS) assessment dated 1/22/15 indicated that Resident #99 had severe cognitive impairment, had no behaviors and was on antipsychotic medication. The physician ' s orders for November, 2014 were reviewed. The orders included seroquel (antipsychotic drug) 50 milligrams (mgs) by mouth twice a day for dementia with behaviors. The nurse ' s notes from 11/1 - 12/3/14 were reviewed. Resident #99 had 7 episodes of refusal to go bed at night and to be checked for incontinence (11/7 no time, 11/11 at 10:20 PM, 11/14 at 10:05 PM, 11/20 at 6:20 AM, 11/22 at 6:00 AM, 11/23 at 7:00 AM and 11/27/14 at 6:00 AM), one episode of cursing his roommate and pushing his laptop off table (11/13/14 no time) and one episode of using foul language and swinging (12/3/14 no time).	F 250	Provision of Medically Related Social Service This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged set forth on the statemet of deficiencies. The plan of correction is prepared and submitted soley because of requirements understate and federal Law. Corrective Action for those residents that have been affected. Resident #99 had an order for discontinuation of psychiatric services on 04/01/2015. The order for Seroquel for resident#99 was decreased to 50 mg twice a day on 04/01/2015. Corrective action will be accomplished for those residents to be affected by same deficient practice.	4/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/18/2015

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 250	Continued From page 1 On 12/3/14, there was a telephone order to increase seroquel to 75 mgs by mouth twice a day and to refer to psychiatric services (psych) secondary to behavior. Review of the records revealed no documentation that Resident #99 was seen by the psych services. On 4/1/15 at 3:10 PM, Nurse #1 was interviewed. She stated that it was an oversight on her part for not referring Resident #99 for psych services.	F 250	On 4/14/15 the Social Worker and Senior Care partner completed an audit of all 113 residents. Of the 113 residents 50 residents have been identified with psychiatric evaluation orders. Of the 50, 48 are currently being followed by psychiatric services. Two residents refused psych services.(Two residents are being followed by outside psychiatric services per resident and family choice.) Measures put into place or systemic changes made to ensure thatthe deficient practice will not occur. All psychiatric referrals will be reviewed in the daily clinical meeting five times a week for four weeks, then three times a week for four weeks, and then one time a week for four weeks. On 4/14/15 all licensed staff(including PRN), the Social Worker and Senior Care Partner have been educated on the referral process for psychiatric services. Of the 45 staff, all have completed the in-service, As of 5/3/15. The facility plans to monitor its performance to make sure solutions are sustained. The Administrator,DHS, and Social worker will sign off after all psychiatric referrals have been completed, via the Audit Tool. The IDT meets daily and reviews all physician orders for referral to psych services. The Social Worker logs all referral and notifies contracted psych	

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F 250	Continued From page 2	F 250	services. Once the referral is completed, the Administrator, DHS, and Social Worker will sign off on the audit tool. The Social Worker will present the findings of psychiatric services via the Audit Tool to the Quality Assurance and Performance Improvement Committee, monthly for three months or until a pattern is obtained.	
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 record review, observation, resident and staff interview, the facility failed to modify the type of treatment when the pressure ulcer did not show signs of improvement/healing and failed to follow the frequency of treatment as recommended by the wound clinic (every other day) for 1 (Resident #44) of 3 sampled residents with pressure ulcers. Finding included: Resident #44 was originally admitted to the facility on 6/3/11 with multiple diagnoses including diabetes mellitus, depressive disorder and paralysis agitans. The quarterly Minimum Data Set (MDS) assessment dated 1/15/15 indicated	F 314	Treatment and Services to Prevent/Heal Pressure Sores This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal Law.	4/17/15

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F 314	Continued From page 3 that Resident #44 had intact cognition, needed extensive assist with bed mobility and had a stage IV pressure ulcer that was present on admission. The reports of consultation with the wound clinic doctor were reviewed. The report revealed that Resident #44 was seen by the wound clinic doctor on 1/15/14, 3/12/14 and 4/10/14. The report dated 1/15/14 indicated chronic non healing wound on the mid sacrum. The report further indicated under the current wound symptoms: wound healing as expected. The report dated 3/12/14 indicated " wet to dry dressing daily to sacral ulcer, cover with dry gauze. Saline irrigation daily to sacral ulcer at dressing changes. Every 2 hour turns to offload pressure. Return to clinic in 4 weeks. " The report dated 410/14 indicated " wound with increased size. Stop current dressing, causing damage to the interior walls. Silver alginate (antimicrobial) 10 x 6 centimeter (cm) piece to wound bed with foam silicone border cover every other day. " On 4/11/14, there was a telephone order to clean the sacral pressure ulcer with normal saline or wound cleanser, apply silver alginate to wound bed and cover with foam dressing every other day and as needed. There was no other telephone orders written to change the frequency of the treatment to every 3 days. The documentation of wound observation and assessment forms were reviewed. The forms had documentation of the weekly assessments of	F 314	Corrective Action for those residents that have been affected. Resident #44 physician's order for pressure ulcer treatment was reviewed by the attending physician with no changes in current physician order. Current order per March and April 2015 Monthly Physician orders stated "Clean sacral wound with normal saline or wound cleanser, pack wound gently with silver alginate and cover with occlusive dressing every three days and as needed." On 4/2/15 a Physician order read D/C previous dressing for sacral wound and apply hydrocolloid to sacral wound. On 4/2/15 the previous order was clarified and written as follows: Clean sacral wound with wound cleanser or NS, gently pack wound with silver alginate and cover with hydrocolloid Q3days and PRN. On 4/10/15 the treatment administration record was reviewed and reflected the current physician orders. On 4/13/15 an order was given to clean the sacral wound with NS or WC, pack wound gently with silver alginate and cover with hydrocolloid dressing Q3 days and PRN and to meet with resident and her responsible party to discuss wishes/treatment options for the sacral ulcer. On 4/13/15 the Responsible party (RP) was notified via telephone and a voice message for return call was communicated. As of 4/17/15 the Responsible Party (daughter) has not responded to the voicemail message. Staff will continue to attempt to contact	

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F 314	Continued From page 4 the sacral pressure ulcer. The forms had the same assessments from October 26, 2014 to March 26, 2015. The forms indicated that the sacral pressure ulcer was stage IV, measuring 2.5 centimeter (cm) length by 2.5 cm width by 2.5 cm depth. The ulcer had undermining of 2.5 cm. On 4/2/15 at 10:15 AM, Nurse #3 was observed measuring the sacral pressure ulcer. The length of the ulcer was 3.5 cm, width of 2.5 cm and depth of 2.5 cm. The length had increased in size. The form did not indicate the resident was involved in the discussion regarding the treatment to her pressure ulcer including surgery. The doctor ' s progress notes were reviewed. The notes revealed that Resident #44 was seen by the attending physician, nurse practitioner or the physician assistant on 12/9/14, 2/2/15, 2/4/15, 2/26/15, 3/9/15 and 3/17/15. The notes did not address the stage IV pressure ulcer on the sacrum. There was no documentation that surgery to the pressure ulcer was discussed with the resident. The care plan dated 1/19/15 was reviewed. One of the care plan problems was " pressure ulcer due to sacral ulcer related to limited mobility, episodes of incontinence of bowel, nutritional risk and diagnosis of diabetes mellitus. " The goal was " stage IV pressure ulcer to sacrum will be free of infection and reduce in size thru next review. " The approaches included treatment as ordered by the physician, pressure reduction mattress/cushion to bed/chair, supplements as ordered, assist as needed and encourage to turn and to reposition frequently in bed.	F 314	the Responsible Party. Staff attempted to contact the RP on multiple occasions without success or a return phone call as of 04/30/15. On 5/1/15 the DHS attempted to reach the RP to discuss the residentL s sacral wound / treatment options and received a return call. The RP stated Over a year ago me and my mom spoke with the surgeon and he indicated that before surgery could be performed, the wound would have to be a certain size. We were able to get the wound size down to the needed size for flap surgery but the surgeon was very honest and stated it would not last and he would not recommend it. Me and my mom discussed this and decided not to do the surgery and continue with the current treatment. I have been very pleased with her wound. On 5/1/15 the DHS and MDS nurse spoke with the resident and she stated I wish the wound would heal but I do not want to have surgery. Why fix what isnL t broken. I do not have pain and I donL t even know it (wound) is there. I am happy with what is being done. On the MDS dated 2/6/15 and 4/3/15 the residentL s cognition was intact. On 5/1/15 the treatment orders were separated to cover treatment to the sacral wound as well as the skin tear that occurred during the observation of the dressing change on 4/2/15. The order read as follows: 1. Clean sacral wound with NS or WC, pack wound with silver alginate and cover with hydrocolloid dressing Q3 days and PRN. 2. Clean sacral tear with NS or WC, apply hydrocolloid dressing Q3 days and PRN. The residentL s wound is reviewed weekly	

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F 314	Continued From page 5 The Treatment Administration Records (TARs) from April, 2014 to March31, 2015 revealed that the stage IV sacral pressure ulcer was treated with silver alginate every 3 days. On 4/1/15 at 10:53 AM, Resident #44 was observed during the dressing change. The sacral pressure ulcer was deep with brownish drainage to the old silver alginate dressing. The ulcer was cleaned with normal saline, packed with silver alginate and covered with hydrocolloid dressing. On 4/1/15 at 4:20 PM, Nurse #3 was interviewed. She stated that she was the treatment nurse. She indicated that Resident #44 did not go back to the wound clinic because the last visit on 4/10/14 did not indicate a follow up date. She also indicated that the treatment was not changed since 4/11/14 because the wound clinic indicated that the sacral wound was chronic and non healing. She further stated that the resident ' s family member did not want aggressive treatment for the resident ' s sacral pressure ulcer. On 4/1/15 at 4:45 PM, Resident #44 was interviewed. She stated that she would like for her wound to heal. On 4/1/15 at 5:05 PM, the physician was interviewed. He stated that he was aware of the resident ' s stage IV sacral pressure ulcer. He stated that no other treatments could heal the wound except surgery.	F 314	by the IDT team as well as during the monthly QA meeting, with oversight by the MD. Corrective action will be accomplished for those residents to be affected by same deficient practice. On 4/14/15 the DHS, MDS Nurse, and Unit Coordinators audited all 113 residents for physician treatment orders, including the treatment administration records to ensure the orders were transcribed as ordered. Eight transcription errors were identified and MD orders obtained at that time. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. On 4/14/15 the Director of Health Services, the Clinical Competency Coordinator, and Unit Managers began education for all licensed staff, including weekend and PRN staff on transcription of orders to the treatment administration record. Of the 45 licensed staff,45 have completed the in-service as of 5/4/15. Education on order transcription to the treatment administration record has been added to orientation for all new hires. The DHS, Clinical Competency Coordinator, Unit Managers, Nurse Supervisor, MDS Nurse, and SCP will audit all treatment orders to the treatment	

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F 314	Continued From page 6	F 314	administration record to ensure order transcription accuracy, via the audit tool daily times seven days, weekly times 4 weeks, and monthly times three months. The Interdisciplinary Team meets weekly to discuss all pressure ulcers/treatments. The M.D./P.A will be notified weekly of all pressure ulcer/treatments. The facility plans to monitor its performance to make sure solutions are sustained. The Director of Health Services will present the findings of the Audit Tool for order transcription of treatments to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325		4/17/15

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F 325	Continued From page 7 by: Based on record review, observation and staff interview, the facility failed to provide the supplement (standard 2.0) as recommended by the dietician and as ordered by the physician to prevent further weight loss for 1 (Resident #94) of 3 sampled residents reviewed for nutrition. Finding included: Resident #94 was readmitted to the facility on 7/16/12 with multiple diagnoses including hypertension, dementia and depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 1/9/15 indicated that Resident #94 had moderate cognitive impairment and was independent with eating. The weights for Resident #94 were reviewed. The weight on 4/15/14 was 125 pounds (lbs), 118 lbs on 7/14/14 and 116 lbs on 10/13/14. On 11/26/14, the registered dietician had evaluated Resident #94 due to significant weight changes and recommended standard 2.0 - 240 milliliter (ml) by mouth 4 times a day with medications to provide 1920 kilocalories and 80 grams of protein. On 12/4/14, the physician had written an order for standard 2.0 - 240 ml by mouth 4 times a day with medications. The care plan dated 1/13/15 was reviewed. One of the problems was " potential for weight loss due to diagnoses of depression, dementia and therapeutic diet, weight loss noted. The goal was " will not experience significant weight changes thru next review. " The approaches included "	F 325	Maintain Nutrition Status Unless Unavoidable This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal Law. Corrective Action for those residents that have been affected. Resident #94 physician's order for supplements was reviewed by the DHS, MDS Nurse, and Unit Coordinator and corrected on the medication administration record on 3/31/15. Corrective action will be accomplished for those residents to be affected by same deficient practice. On 4/14/15 all 113 residents physician orders for supplements were reviewed, including the medication administration record to ensure orders were transcribed as ordered by the DHS, MDS Nurse, and Unit Coordinators. Two errors were identified and orders were obtained to correct at that time.	

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F 325	Continued From page 8 dietician to evaluate and follow up, offer between meals supplements and supplements as ordered. " The Medication Administration Records (MARs) for December, 2014, January, February and March, 2015 were reviewed. The records revealed that the standard 2.0 supplement was administered once a day instead of 4 times a day as ordered. The weights for Resident #94 were reviewed. The weight on 1/10/15 was 113 lbs, 114 lbs on 2/11/15 and 108 lbs on 3/9/15. On 3/31/15 at 5:15 PM, Nurse #1 was interviewed. She reviewed the MARs and acknowledged that standard 2.0 was transcribed to the MARs incorrectly and therefore was not administered as ordered. On 4/1/15 at 9:08 AM, Resident #94 was observed in bed and was eating breakfast. She had a piece of sausage, eggs, donut, milk and orange juice in her tray. She was able to feed self but ate only small amount of eggs and half of donut and half of orange juice. On 4/2/15 at 11:05 AM, administrative staff #1 was interviewed. She stated that she would change the system in checking the MARs at the end of the month. She indicated that she will have 2 night nurses to check the MARs from now on.	F 325	On 4/17/15 all residents weights were reviewed for weight loss by the DHS, MDS Nurse, Unit Manager, Unit Coordinators, CCC and Senior Care Partner. Five residents triggered for weight loss. All residents have been addressed and interventions in place. Weights will be monitored weekly until stabalized. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. On 4/10/15 the Director of Health Services, the Clinical Competency Coordinator, and Unit Managers began education for all licensed staff, including weekend and PRN staff on transcription of orders to the medication administration record. Of the 45 licensed staff,45 have completed the in-service as of May 4, 2015. Education on order transcription to the medication administration record has been added to orientation for all new hires. The Director of Health Services, Clinical Competency Coordinator, and Unit Managers and Evening and Weekend Supervisors will cross reference all supplement orders, via the audit tool to the medication administration record daily times seven days weekly times 4 weeks, and monthly times three months. All residents with weight loss will be	

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F 325	Continued From page 9	F 325	reviewed weekly until stable by the Interdisciplinary Team Members, to include the DHS, MDS Nurse, CCC, Senior Care Partner, Unit Manager and Unit Coordinators. Weights are audited weekly, to include monthly weights for all residents by the DHS, MDS Nurse, CCC, Unit Manager and Unit Coordinators. Any identified residents will have reweights and review of current interventions by the IDT team and MD notification. Interventions may include but not limited to reweight, supplements, and medication review. The facility plans to monitor its performance to make sure solutions are sustained. The Director of Health Services will present the findings of order transcription and weight loss to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of complianceis obtained.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM 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	F 329		4/17/15

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F 329	Continued From page 10 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 record review, observation and staff interview, the facility failed to consider non pharmacological intervention prior to increasing the dose of antipsychotic medication for 1 (Resident #99) of 5 sampled residents reviewed for unnecessary drugs. Finding included: Resident #99 was admitted to the facility on 10/27/14 with multiple diagnoses including hypertension and dementia with behaviors. The quarterly Minimum Data Set (MDS) assessment dated 1/22/15 indicated that Resident #99 had severe cognitive impairment, had no behaviors and was on antipsychotic medication. The physician ' s orders for November, 2014 were reviewed. The orders included seroquel (antipsychotic drug) 50 milligrams (mgs) by mouth twice a day for dementia with behaviors. The nurse ' s notes from 11/1 - 12/3/14 were reviewed. Resident #99 had 7 episodes of	F 329	Drug Regime is Free from Unnecessary Drugs This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted soley because of requirements under state and federal Law. Corrective Action for those residents that have been affected. Resident #99 had an order for discontinuation of psychiatric services on 04/01/2015. The order for Seroquel for resident#99 was decreased to 50 mg	

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F 329	Continued From page 11 refusal to go bed at night and to be checked for incontinence (11/7 no time, 11/11 at 10:20 PM, 11/14 at 10:05 PM, 11/20 at 6:20 AM, 11/22 at 6:00 AM, 11/23 at 7:00 AM and 11/27/14 at 6:00 AM), one episode of cursing his roommate and pushing his laptop off table (11/13/14 no time) and one episode of using foul language and swinging (12/3/14 no time). The notes did not indicate that non pharmacological interventions were tried to address the behavior. On 12/3/14, there was a telephone order to increase seroquel to 75 mgs by mouth twice a day and to refer to psychiatric services (psych) secondary to behavior. The care plan dated 2/21/15 was reviewed. One of the care plan problems was " resident is at risk for side effects from psychotropic medication use related to psychosis with behaviors, combative with care. " The goal was " resident will have no injury related to medication usage/side effects until next review and he will be able to sleep at night thru next review. " The approaches included " if he refuses care, assure that he is safe and return at a later time. " Review of the records revealed no documentation that Resident #99 was seen by the psych services. On 4/1/15 at 3:10 PM, Nurse #1 was interviewed. She stated that it was an oversight on her part for not referring Resident #99 for psych services. She further indicated that she was informed that Resident #99 was refusing to go to bed at night and she found out from another nursing facility where Resident #99 resided that he was not comfortable in the room with a roommate and	F 329	twice a day on 04/01/2015. Corrective action will be accomplished for those residents to be affected by same deficient practice. On 4/16/15 all 23 residents receiving psychotropic medications were reviewed, including the care plans to ensure non-pharmalogical interventions were in place. The audit was conducted by the DHS and MDS Nurse. Of the 23 residents, there were fifteen residents' Care Plans that were updated to include non-pharmalogical interventions at that time. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. All new orders for psychotropic medication orders, in-cluding increases in medication will be brought to the daily clinical meeting for review by the Inter Disciplinary Team(IDT). The IDT team will audit the medications ordered, Care Plans, non-pharmalogical interventions and appropriateness/need for medication and document findings on the audit tool. The audit will be completed DHS, MDS Nurse, CCC, Senior Care Partner, and Unit Coordinators. This will be done five times a week for four weeks, then three times a week for four weeks, and then one time a week for four weeks, via the audit tool.	

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F 329	Continued From page 12 that he was in a private room. When a private room came available he was moved and his behavior had improved. Nurse #2 agreed that non pharmacological intervention should have been tried prior to increasing the dose of seroquel but she would call the doctor to decrease the dose. On 4/1/15 at 3:30 PM, NA #1 was interviewed. She stated that she was assigned to Resident #99 and that his refusal to be checked for incontinence was very rare, once a week or less. She stated that Resident #99 would prefer to stay up in the chair. On 4/1/15 at 3:40 PM, Resident #99 was observed up in chair in the dining room. On 4/2/15 at 11:30 AM, administrative staff #1 was interviewed. She stated that their system was for nurses to enter the resident ' s behavior in the book and the doctor would read the book and would write orders. She indicated that she would change the system that doctors (nurse practitioner and physician assistant) would discuss the resident ' s behavior in the group meeting (with administrative staff) before changing the dose of any psychotropic drugs.	F 329	On 4/14/15 the Director of Health Services, the Clinical Competency Coordinator, and Unit Managers began education for all licensed staff, including aides, weekend and PRN staff, Social Worker, Senior Care Partner, MD, and Physician Assistants on attempting non-pharmalogical interventions prior to starting or increasing a medication. Of the staff identified, all have completed the in-service with the exception of one aide. This aide has been removed from the schedule until the in-service is completed. All licensed staff will be required to complete the in-service prior to working his/her next scheduled shift. The facility plans to monitor its performance to make sure solutions are sustained. The Director of Health Services will present the findings of psychotropic medication/non-pharm logical interventions to the Quality Assurance Improvement Committee via the audit tool monthly for three months or a until pattern of compliance is obtained.	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs.	F 365		4/17/15

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F 365	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide one of three residents reviewed for nutrition (Resident #111) with thickened liquids as recommended by the speech therapist and ordered by the physician. The findings included: Resident #111 was admitted to the facility 2/28/14 and last readmitted 1/17/15. Cumulative diagnoses included CVA (cerebrovascular accident) and dysphagia (difficulty swallowing). A quarterly Minimum Data Set (MDS) dated 1/1/15 indicated Resident #111 was moderately impaired in decision-making. He was independent with eating. During the assessment period, it was noted Resident #111 was on a mechanically altered diet. No swallowing disorder was noted during the assessment period. A care plan dated 3/24/15 indicated Resident #111 was at risk for aspiration related to the use of thickened liquids and use of a pureed diet. He was noncompliant with the diet. Approaches included, in part, monitor respiratory status. Encourage him to be compliant with diet. Diet as ordered. A review of the physician's orders dated 3/24/15 revealed a diet order of pureed diet with nectar thickened liquids. Speech therapy to evaluate and treat as indicated. The speech therapy evaluation dated 3/24/15 stated Resident #111was discharged from the hospital on pureed diet with nectar thick liquids. Resident #111 was trialed on a pureed diet	F 365	Food in Form to Meet Individual Needs This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal Law. Corrective Action for those residents that have been affected. On 4/1/15 Thin liquids were removed from resident #111's refrigerator and his tray card slip was updated. On 4/14/15 The DHS, CCC, and Unit Manager in-serviced Dietary staff, licensed staff, aides, PRN, and department heads to ensure proper liquids are placed on meal tray per diet slip on tray. Corrective action will be accomplished for those residents to be affected by same deficient practice. On 4/15/15 The DHS, MDS nurse and Unit Coordinators audited all 113 residents' physician orders for liquid consistency and cross referenced them to	

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F 365	Continued From page 14 texture and thin liquids, but refused trial of nectar thick liquids and mechanical soft textures. Resident #111 reported that he did not want anything other than pureed. Further skilled speech therapy services were not warranted at the time based on Resident #111's refusal. He remained on a pureed diet with nectar thickened liquids. A physician's progress note dated 3/27/15 stated Resident #111 was seen for noncompliance with the thickened liquid diet. Resident #111 had reportedly been drinking juices from the ice cooler. A/P (assessment/ plan): Aspiration precautions + thickened liquids. ST (speech therapy) consult--Resident #111 needed to be on a thick liquid diet. Recommendation remained thickened liquids. Medical record review revealed a diet order slip dated 3/31/15 that noted pureed diet with nectar thickened liquids. An observation was conducted on 4/1/15 at 9:00 AM. An empty carton of milk and one empty can of juice was noted on the food tray. Both liquids were of regular consistency. A review of the diet slip on the breakfast tray revealed the following diet: pureed with no restrictions. Beverage: apple or orange, whole milk. When asked about liquids being thickened, Resident #111 stated he had never received thickened liquids. On 4/1/15 at 1:03PM, the dietary manager stated communication with the dietary staff regarding diet orders/ changes was done the same way whether it was a new admission, diet change and/or diet request. The dietary staff was informed of a resident's diet by the nursing staff.	F 365	the tray card slip. No errors were observed during this audit, however it was noted that thin liquids were not referenced on the Physician Orders or tray card slips. All physician orders and tray card slips all have a liquid consistency indicated. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. 4/14/15 DHS, CCC, Supevisors, and Managers initiated an in-service on tray card/liquid consistency for all licensed staff, aides, PRN, and Department Heads. Of the staff identified, all have completed the in-service with the exception of one aide as of 5/4/15. This aide has been removed from the schedule and will not be permitted to work until the in-service has been completed. Tray card/liquid consistency has been added to new hire orientation. All physician orders for liquid consistency will be reviewed in the daily clinical meeting by the IDT for accuracy five times a week, weekly for four weeks, then three times a week for four weeks and then one time a week for one month via the audit tool. The audit tool will cross reference the MD Order, Tray Card Slip, and the Diet Slip. The Dietary Manager will audit fifteen residents for tray card/meal accuracy five times a week for four weeks, three times a week for four weeks, and then one	

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F 365	Continued From page 15 Nursing staff wrote a diet slip, kept the current diet slip in the chart and sent a copy of the diet slip to the dietary department. The change in diet would be reflected with the next meal. He stated he was the person who put the diet orders in the computer and checked the diet orders with the physician's orders to ensure accuracy two to three times a month. The dietary manager reviewed the physician's order and the diet slip that had been on the breakfast tray on 4/1/15 and stated the diet slip should have reflected the order for nectar thickened liquids and nectar thickened liquids should have been on the diet tray as ordered by the physician.	F 365	time a week for four weeks. The facility plans to monitor its performance to make sure solutions are sustained. The DHS will present the finding of the diet orders to the Quality Assurance and Performance Improvement Committee monthly for three months or until pattern is obtained. The Dietary Manager will present the findings of the tray card audit for three months or until a pattern if obtainied.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		4/17/15

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F 520	Continued From page 16 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility ' s quality assessment and assurance committee failed to implement, monitor and revised as needed the action plan developed for the 3/20/14 recertification survey and 10/1/14 complaint investigation survey in order to achieve and sustain compliance. The facility had a repeat deficiency on pressure ulcer (F314) on 10/1/14 complaint survey and on nutrition (F325) on 3/20/14 recertification survey. Findings included: This tag is cross referred to: F314 - Based on record review, observation, resident and staff interview, the facility failed to modify the type of treatment when the pressure ulcer did not show signs of improvement/healing and failed to follow the frequency of treatment as recommended by the wound clinic (every other day) for 1 (Resident #44) of 3 sampled residents with pressure ulcers. During the complaint survey of 10/1/4, the facility was cited for not treating the pressure ulcer as ordered by the physician. F325 -Based on record review, observation and staff interview, the facility failed to provide the supplement (standard 2.0) as recommended by	F 520	QAA Committee Members Meet Quarterly/Plans This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted soley because of requirements under state and federal Law. Corrective Action for those residents that have been affected. 1A. Resident #94 physician's order for supplements was reviewed by the DHS, Wound Nurse, MDS Nurse, Unit Manager and Unit Coordinators and corrected on the medication administration record 3/31/15. 1B. Resident #44 physician's order for pressure ulcer treatment was reviewed by the attending physician with no changes in current physician order. Current order per March and April 2015 Monthly Physician orders stated "Clean sacral wound with	

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F 520	Continued From page 17 the dietician and as ordered by the physician to prevent further weight loss for 1 (Resident #94) of 3 sampled residents reviewed for nutrition During the recertification survey of 3/20/14, the facility was cited for failing to identify and intervene when a resident with tube feeding and was underweight, had a significant weight loss. On 4/2/15 at 10:40 AM, administrative staff #2 was interviewed regarding the facility ' s quality assessment and assurance system. Administrative staff #2 indicated that the committee members consisted of all the department head, the pharmacist and medical director. He stated that they had met monthly. He revealed that the department heads were responsible for the implementation and the monitoring of the action plans developed during the previous surveys. When asked about the pressure ulcer and the nutrition, administrative staff #2 indicated that administrative staff #1 was responsible for the monitoring. On 4/2/15 at 11:30 AM, administrative staff #1 was interviewed. She stated that pressure ulcers had been monitored and she was aware that the pressure ulcer for Resident # 44 was not improving. She added that the physician indicated that there was no other treatment that can heal the pressure ulcer except surgery. Administrative staff #1 indicated that weights had been monitored closely. She added that it was a transcription error, the supplement was not correctly transcribed to the MAR, instead of four times a day, it was transcribed daily and therefore it was administered daily. She indicated that she had changed the system in checking the MARs. Two night nurses were assigned to check the	F 520	normal saline or wound cleanser, pack wound gently with silver alginate and cover with occlusive dressing every three days and as needed." On 4/2/15 a Physician order read D/C previous dressing for sacral wound and apply hydrocolloid to sacral wound. On 4/2/15 the previous order was clarified and written as follows: Clean sacral wound with wound cleanser or NS, gently pack wound with silver alginate and cover with hydrocolloid Q3days and PRN. On 4/10/15 the treatment administration record was reviewed and reflected the current physician orders. On 4/13/15 an order was given to clean the sacral wound with NS or WC, pack wound gently with silver alginate and cover with hydrocolloid dressing Q3 days and PRN and to meet with resident and her responsible party to discuss wishes/treatment options for the sacral ulcer. On 4/13/15 the Responsible party (RP) was notified via telephone and a voice message for return call was communicated. As of 4/17/15 the Responsible Party (daughter) has not responded to the voicemail message. Staff will continue to attempt to contact the Responsible Party. Staff attempted to contact the RP on multiple occasions without success or a return phone call as of 04/30/15. On 5/1/15 the DHS attempted to reach the RP to discuss the residentL s sacral wound / treatment options and received a return call. The RP stated Over a year ago me and my mom spoke with the surgeon and he indicated that before surgery could	

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F 520	Continued From page 18 MARs at the end of the month.	F 520	be performed, the wound would have to be a certain size. We were able to get the wound size down to the needed size for flap surgery but the surgeon was very honest and stated it would not last and he would not recommend it. Me and my mom discussed this and decided not to do the surgery and continue with the current treatment. I have been very pleased with her wound. On 5/1/15 the DHS and MDS nurse spoke with the resident and she stated I wish the wound would heal but I do not want to have surgery. Why fix what isnL t broken. I do not have pain and I donL t even know it (wound) is there. I am happy with what is being done. On the MDS dated 2/6/15 and 4/3/15 the residentL s cognition was intact. On 5/1/15 the treatment orders were separated to cover treatment to the sacral wound as well as the skin tear that occurred during the observation of the dressing change on 4/2/15. The order read as follows: 1. Clean sacral wound with NS or WC, pack wound with silver alginate and cover with hydrocolloid dressing Q3 days and PRN. 2. Clean sacral tear with NS or WC, apply hydrocolloid dressing Q3 days and PRN. The residentL s wound is reviewed weekly by the IDT team as well as during the monthly QA meeting, with oversight by the MD. Corrective action will be accomplished for those residents to be affected by same deficient practice. 1A. On 4/14/15 all 113 residents physician orders for supplements were reviewed including the medication administration	

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F 520	Continued From page 19	F 520	record to ensure orders were transcribed as ordered by the DHS, MDS Nurse, and Unit Coordinators. Two errors were identified and orders were obtained to correct at that time. On 4/17/15 all residents weights were reviewed for weight loss by the DHS, MDS Nurse, Unit Manager, Unit Coordinators, CCC and Senior Care Partner. Five residents triggered for weight loss. All residents have been addressed and interventions in place. Weights will be monitored weekly until stabilized. 1B. On 4/14/15 the DHS, MDS Nurse, and Unit Coordinators audited all 113 residents for physician treatment orders, including the treatment administration records to ensure the orders were transcribed as ordered. Eight transcription errors were identified and MD orders obtained at that time. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. 1A. On 4/14/15 the Director of Health Services, the Clinical Competency Coordinator, and Unit Managers began education for all licensed staff, including weekend and PRN staff on transcription of orders to the treatment administration record. Of the 45 licensed staff, 45 have completed the in-service as of 5/4/15. Education on order transcription to the	

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F 520	Continued From page 20	F 520	medication administration record has been added to orientation for all new hires. All residents with weight loss will be reviewed weekly until stable by the Interdisciplinary Team Members, to include the DHS, MDS Nurse, CCC, Senior Care Partner, Unit Manager and Unit Coordinators. Weights are audited weekly, to include monthly weights for all residents by the DHS, MDS Nurse, CCC, Unit Manager and Unit Coordinators. Any identified residents will have reweights and review of current interventions by the IDT team and MD notification. Interventions may include but not limited to reweight, supplements, and medication review. 1B. On 4/14/15 the Director of Health Services, the Clinical Competency Coordinator, and Unit Managers began education for all licensed staff, including weekend and PRN staff on transcription of orders to the treatment administration record. Of the 45 licensed staff,45 have completed the in-service as of 5/4/15. Education on order transcription to the treatment administration record has been added to orientation for all new hires. The DHS, Clinical Competency Coordinator, Unit Managers, Nurse Supervisor, MDS Nurse, and SCP will audit all treatment orders to the treatment administration record to ensure order	

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F 520	Continued From page 21	F 520	transcription accuracy, via the audit tool daily times seven days, weekly times 4 weeks, and monthly times three months or until a pattern is sustained. The Interdisciplinary Team meets weekly to discuss all pressure ulcers/treatments. The M.D./P.A will be notified weekly of all pressure ulcer/treatments. The facility plans to monitor its performance to make sure solutions are sustained. The Director of Health Services will present the findings of order transcription and weight loss to the Quality Assurance Performance Improvement committee monthly for three months or until a pattern of compliance is obtained.	