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
	345392	A. BUILDING _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR HEALTH & REHAB OF WADESBORO, LLC	2051 COUNTY CLUB ROAD WADESBORO, NC 28170

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F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to honor resident preference for a shower for two of two residents reviewed for choices (Resident #44 and #38). The findings included: 1. Resident #44 was admitted to the facility 11/30/13 and last readmitted 2/27/14. Cumulative diagnoses included: cerebrovascular accident (CVA), depression, glaucoma, congestive heart failure (CHF), atrial fibrillation, osteoarthritis and degenerative disc disease. A Significant Change Minimum Data Set (MDS) dated 3/13/15 indicated Resident #44 was cognitively intact. No behaviors noted. It was noted under preferences for customary routine and activities that it was very important for Resident #44 to choose whether she received a tub bath, shower or sponge bath. Resident #44 required extensive assistance with bathing. A care plan dated 11/30/13 and last reviewed 3/24/15 indicated Resident #44 required assistance with activities of daily living (ADL's) related to weakness. Approaches included, in	F 242	Preparation and Submission of this plan of correction by **Ambassador Health and Rehab of Wadesboro,** does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. F 242 1. Resident #44 was offered a shower on 4/15/15 by the Certified Nursing Assistant before breakfast as per her request. Resident #44 refused her shower and the shower refusal was documented on the Activities of Daily Living flow sheet. Resident was approached again later by the Certified Nursing Assistant on 4/15/15 and agreed to take a shower and this was documented on the Activities of Daily Living flow record.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE
CORRECTED 5/20/15

* 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 242	Continued From page 1 part, to assist with dressing, bathing and grooming. Do not rush resident and allow extra time to complete ADLs as needed. A review of the facility shower schedule revealed Resident #44 should receive her shower on Wednesday and Saturday on first shift. The February ADL record was reviewed and revealed Resident #44 received bed baths during the month of February with no showers received during the month of February 2015. No refusals of showers were noted during the month of February 2015. The March ADL record was reviewed and revealed Resident #44 received bed baths during the month of March with no showers received during the month of March 2015. No refusals of showers were noted during the month of March 2015. The April ADL record was reviewed and revealed Resident #44 did not receive any showers during the month of April 2015. No refusal of showers were noted. Nursing notes from January 2015 through April 2015 were reviewed. There were no notations of refusal of showers/ care documented. On 4/13/15 at 10:09AM, Resident #44 was interviewed and stated that she had only received 2 showers since she had been at the facility. She stated she would like to have a shower but nursing staff "rushed" her and she did not want to be rushed. She also stated she would like to have her bath prior to breakfast, if possible.	F 242	NA#1 was re-educated by the Staff Development Coordinator on 4/14/2015 related to ensuring residents' bathing preferences and schedules are honored and documentation of acceptance or refusals are documented in the Activities of Daily Living flow sheets as required. Resident #38 was offered a scheduled shower on 4/14/15 by the Certified Nursing Assistant after supper and did receive a shower. NA#2 was re-educated by the Staff Development Coordinator on 4/14/15 related to ensuring residents' bathing preferences and schedules are honored and documentation of acceptance or refusals are documented in the Activities of Daily Living flow sheets as required. 2) All active residents were interviewed and an audit was completed by the Director of Nursing on 4/15/15 to ensure resident's bathing preferences and bathing schedules are being honored.	

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F 242	Continued From page 2 On 4/14/15 at 11:13AM, Nursing assistant (NA) #1 stated she provided care for Resident #44 on 4/14/15 and Resident #44 was on her regular assignment when she was assigned to resident care on the hall. She stated Resident #44 ' s shower days were on Wednesdays and Saturdays and when requested by the resident. NA#1 stated Resident #44 had never refused showers when she was assigned to Resident #44. She stated, if a resident refused a shower, she would ask them again and notify the nurse if a resident continued to refuse a shower. NA #1 also stated she would designate refusal as "r" on the ADL record. On 4/14/15 at 11:19AM, Administrative staff #1 stated showers were given per the shower schedule unless otherwise requested. Showers were documented as given on the ADL record under bathing. If a resident refused any type of bathing, the nursing assistants would let the nurse know and document refused on the ADL sheet. On 4/14/15 at 12noon, an interview was conducted with Resident #44 and Administrative staff #1. Resident #44 told Administrative staff #1 that she did not want to be rushed and did not want to sit in the hallway waiting for her shower and wanted to be able to take her time. She stated she would like her showers done as scheduled. 2. Resident #38 was admitted to the facility 7/10/14. Cumulative diagnoses included: depression, anxiety and intellectual disability. An Admission Minimum Data Set (MDS) dated	F 242	3) Nursing staff will be re-educated by 5/12/15 by the Staff Development Coordinator or Assistant Director of Nursing related to ensuring residents' bathing preferences and schedules are honored and documentation of acceptance or refusals are documented in the Activities of Daily Living flow sheets as required by nursing assistants and the licensed nurses will address in nurses notes. Any staff on vacation or medical leave will be re-educated prior to returning to work. 4) Audits will be completed by the Director of Nursing or Assistant Director of Nursing weekly for 4 weeks and monthly for 2 months to ensure resident preferences continue to be honored related to bathing and bathing schedules. 5 random residents to be audited per week. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow-up. Date of Compliance:	5/13/15

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F 242	Continued From page 3	F 242		

7/17/14 indicated Resident #38 was cognitively intact, did not reject care and was totally dependent for bathing and hygiene. It also revealed that it was very important to the resident that he was able to choose a tub bath, shower or bed bath.

A Quarterly Minimum Data Set (MDS) dated 2/13/15 indicated Resident #38 was cognitively intact, did not reject care and required extensive assistance for personal hygiene and bathing.

The care plan last updated 4/7/15 revealed a plan of care for assistance with activities of daily living (ADL). The goal of care was " I will have my needs met through the next review. The approaches listed in the plan included: " assist me with bathing, grooming, CNA (Nursing Assistant) washing hair, and other ADLs as needed. " There was also a plan of care for " I have a h/o (history of) being resistant to daily care and aggressive behaviors. " A goal of care was " I will allow staff to assist with my care and not resist. " The approaches listed included " record/monitor for patterns of my behaviors. "

A review of the facility shower schedule revealed Resident #38 was supposed to receive his shower on Tuesdays and Fridays on second shift.

The ADL record from January 1, 2015 through April 13, 2015 was reviewed and revealed Resident #38 received bed baths during the months of January, February, March and April. No showers or refusals were documented for these months.

Nursing notes from January 1, 2015 through April 13, 2015 were reviewed. There were no

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F 242	Continued From page 4 notations of refusal of showers/care documented. On 4/13/15 at 3:28 PM resident #38 was interviewed and stated that he had never been offered or given a shower while a resident in the facility. He also indicated that he would like to receive a shower 2 days a week. On 4/14/15 at 5:06 PM NA #2 was interviewed. She indicated that she had just recently put the resident back to bed and had washed his face, gave peri-care, applied a clean brief and put a gown on the resident. She also stated that she thought he was on the shower list for that evening and indicated she was planning to give him a shower after dinner. When asked about the resident ' s shower preferences she said that she had never given him a shower before because he always refused. Resident #38 was then asked, with NA #2 present, if he wanted to have a shower that evening and he told NA #2 that he did want to have a shower. NA #2 stated she would shower the resident that evening. On 4/14/15 at 5:20 PM Administrative Staff #1 was interviewed. She indicated that she expected staff to offer resident ' s showers on their shower days and document any refusals of care. Resident #38 was then asked, with Administrative Staff #1 present, if he wanted to have a shower on his shower days and he stated that he did. On 4/15/15 at 9:30 AM Resident #38 was interviewed and indicated he had his first shower at the facility the previous evening and that he enjoyed it. He added that he then slept very well that night after his shower.	F 242		

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F 278	Continued From page 5	F 278	F 278	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278	1) Resident #38 Admission MDS was corrected and resubmitted to the state to include the Level 2 PASRR on 4/14/2015 by the MDS Coordinator. Staff #5 was re-educated by Director of Nursing on 4/15/15 related to requirements of coding the PASRR levels on the MDS.	

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to accurately assess a resident in the area of preadmission screening and resident review for 1 of 1 residents with a Level II screening (Resident #38). The findings included:

2) An audit was completed on 4/15/15 by the MDS Coordinator of the most recent MDS assessments for the current residents in the facility to ensure PASRR Levels are coded as required. No other corrections were needed.

3) The MDS Coordinators will be re-educated by the Regional Clinical Reimbursement Specialist by 5/12/15 related to ensuring the MDS assessments have PASRR Levels coded as required.

4) Random MDS audits of 10 residents will be completed by the Director of Nursing or Assistant Director of Nursing weekly for 4 weeks and monthly for 2 months to ensure MDS assessments continue to

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F 278	Continued From page 6 Resident #38 was admitted 7/10/14 and had a Preadmission Screening and Resident Review Level II (PASRR Level II) number. Cumulative diagnoses included depression, anxiety and intellectual disability. An Admission Minimum Data Set (MDS) assessment dated 7/17/14 indicated preadmission screening and resident review (PASRR) as "0. No". No behaviors were noted during the assessment period and the resident was cognitively intact. On 4/14/15 at 5:15 PM Administrative Staff #5 stated that if a resident has a PASRR Level II number the preadmission screening and resident review section of the Admission or other comprehensive assessment should be coded as " 1. Yes " . She added that the Admission MDS for Resident #38, dated 7/17/14, should have indicated his PASRR Level 2 status but acknowledged that it did not and was therefore inaccurately coded. Administrative Staff #5 indicated that if the PASRR information was in the medical record at the time of the assessment then she was aware and could code the section correctly but if it was not yet in the medical record she would be unaware of the resident ' s PASRR Level II status.	F 278	be coded for PASRR Levels as required. The Director of Nursing or the Assistant Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow-up. Date of Compliance:	5/13/15
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	F 281		

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F 281	Continued From page 7 by. Based on record review and staff interviews, the facility failed to correctly transcribe an order for Seroquel for 1 of 5 residents reviewed for unnecessary medications (resident #67) and failed to verify dosage of medication prior to medication administration for 2 of 2 residents (resident #67 and resident #56). The findings included: 1a. Resident #67 was admitted to the facility on 3/4/15 and readmitted on 3/27/15 with multiple diagnoses including delirium, psychosis, a history of alcohol abuse and dementia. A review of the Physician ' s Orders revealed an order dated 3/13/15 which read " Seroquel 50 milligrams (mg) by mouth every evening. Diagnosis: delirium psychosis. " A review of the Medication Administration Record (MAR) dated March 2015 revealed a medication transcription which read " Seroquel 30 mg by mouth every evening. Diagnosis: delirium psychosis to be administered at 8:00 PM. " An interview was conducted with Administrative Staff #2 on 4/14/15 at 2:21 PM. She stated the medication order dated 3/13/15 for Seroquel 50 mg by mouth every evening was incorrectly transcribed onto the MAR dated March 2015 as Seroquel 30 mg by mouth every evening. An interview was conducted with Administrative Staff #1 on 4/14/15 at 5:03 PM. She stated she expected the nursing staff to correctly transcribe medication orders. An interview was conducted with Nurse #1 on	F 281	F281 1) Resident #67's physician was notified by the charge nurse on 4/14/15 and a clarification order was written for the Seroquel. Nurse #1, Nurse #2, and Nurse #3 will be re-educated by the Staff Development Coordinator or Assistant Director Of Nursing by 5/11/15 on transcription and dosage verification of medication. Resident #56's physician was notified on 4/14/15 by the charge nurse and the Omega 3 fish oil medication order was clarified. Nurse #4 will be re-educated by the Staff Development Coordinator or Assistant Director Of Nursing by 5/11/15 on transcription of orders and making sure medication dosages are clarified as needed.	

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F 281	Continued From page 8 4/15/15 at 8:19 AM. Nurse #1 stated she misread the order dated 3/13/15 for Seroquel 50 mg by mouth every evening as Seroquel 30 mg by mouth every evening. Nurse #1 stated she incorrectly transcribed the order for Seroquel onto the MAR dated March 2015. 1b. Resident #67 was admitted to the facility on 3/4/15 and readmitted on 3/27/15 with multiple diagnoses including delirium, psychosis, a history of alcohol abuse and dementia. A review of the Physician ' s Orders revealed an order dated 3/13/15 which read " Seroquel 50 milligrams (mg) by mouth every evening. Diagnosis: delirium psychosis. " A review of the MAR dated March 2015 revealed a medication transcription which read " Seroquel 30 mg by mouth every evening. Diagnosis: delirium psychosis to be administered at 8:00 PM. Seroquel 30 mg by mouth was documented as administered by the nursing staff at 8:00 PM on 3/13/15, 3/14/15, 3/15/15, 3/16/15, 3/17/15, 3/18/15, 3/19/15, 3/20/15 and 3/21/15. A review of the Pharmacy Shipping Manifest dated 3/13/15 indicated Seroquel 50 mg tablets were sent to the facility for administration to resident #67. An interview was conducted with Nurse #2 on 4/15/15 at 10:55 AM. Nurse #2 stated she administered medication to resident #67 on the evening of 3/19/15. She stated she did not remember administering Seroquel to the resident on 3/19/15. She stated she may have " misread " the dosage of the medication order for Seroquel on the MAR.	F 281	2) An audit of Physician orders and Medication records of the current residents was completed on 4/16/15 and 4/17/15 by the Medical Records Nurse and the Assistant Director of Nursing and orders were verified and clarified as needed. 3) The licensed nurses were re-educated on 4/14/15 by the Staff Development Coordinator on the requirements of medication administration, medication transcription, verification and clarification of medications dosage. Any nurse on vacation or medical leave will be re-educated prior to returning to work. 4) Random audits of 10 residents will be completed by the Assistant Director of Nursing or Assistant Director of Nursing weekly for 4 weeks and monthly for 2 months to ensure physician's orders continues to be transcribed to the medication records and administered as orders by the physician. The Director of Nursing will submit a report to the Quality assurance Committee monthly for 3 months. The director	

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F 281	Continued From page 9 An interview was conducted with Nurse #3 on 4/15/15 at 11:53 AM. Nurse #3 stated she administered medication to resident #67 on the evenings of 3/13/15, 3/16/15, 3/17/15 and 3/18/15. She was unable to explain why she failed to verify the dosage of Seroquel prior to administration. An interview was conducted with Administrative Staff #2 on 4/15/15 at 8:52 AM. She stated she expected the nursing staff to verify the dosage of all medications prior to administrating to the residents. 2. Resident #56 was readmitted to the facility on 3/21/15 with diagnoses including Alzheimer ' s disease, hypertension and cerebral vascular disease. The Admission Minimum Data Set (MDS) Assessment dated 3/20/15 revealed Resident #56 was cognitively impaired. Review of the Admission Orders dated 3/21/15 revealed an order for Omega 3 1000 mg (milligrams) by mouth daily. Review of the Admission Medication Administration Record revealed Omega 3, 1000 mg was signed off as given daily from 3/21/15 through 3/31/15. Review of the Physician ' s Orders Summary for April 2015 revealed an order for Omega 3 Fish Oil 1 by mouth daily. The dosage was not specified in the order.	F 281	of Nursing is responsible for monitoring and follow up. Date of Compliance:	5/13/15

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F 281	Continued From page 10 Review of the Medication Administration Record for April 1 through April 15th revealed Omega 3 Fish Oil 1 by mouth daily was signed off as given April 1 through April 15th. Nurse # 4 was interviewed on 4/15/15 at 11:45 AM, she had already given the resident his dosage of Omega 3 fish oil for the day. She was asked to review the medication description on the Medication Administration Record and then stated that the description did not indicate whether the dosage was to be 500 or 1000 mg. She stated that the facility ' s house stock Fish Oil was 500 mg and that she gave 2 tablets as she was aware that the previous order had said 1000 mg. She then said that the resident was actually admitted with his own supply and pulled the bottle of the resident ' s supply of 1000 mg Fish Oil out of the medication cart, along with the house stock fish oil that said 500 mg. She acknowledged that the description of the medication in the Medication Administration Record should have been clarified and corrected. Administrative Staff # 2 was interviewed on 4/15/15 at 11:55 AM and stated that she expected Nursing staff to clarify medication and supplement orders as well as Medication Administration Record medications and supplements, such as Fish Oil, that do not specify a dosage.	F 281		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid	F 285		

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(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 285	Continued From page 11 duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission: (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.	F 285	F285 1) Resident #38 PASRR application was resubmitted and the requested additional information was faxed on 4/14/15 by the Admissions Coordinator. 2) An audit was conducted on 4/15/15 by the Admissions Coordinator to ensure current resident Level 2 PASSR were updated as required. The one PASRR found was corrected on 4/14/2015 by the MDS Coordinator and resubmitted to state on 4/14/2015. 3) The Admissions Coordinator and the Social Worker were re-educated on 4/14/15 by the Administrator and Director of Nursing related to level 2 PASRRs, re-evaluation and updating of PASRRs as required. 4) The Director of Nursing or Assistant Director of Nursing will complete audits of current resident's PASRRs weekly for 4 weeks and monthly for 2 months to ensure PASRRs continue to be updated as required. The Social Worker will submit a report to Quality Assurance	

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	345392	A. BUILDING _____ B. WING _____	04/15/2015

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F 285	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to coordinate with the Preadmission Screening and Resident Review Program (PASRR) for reevaluation of PASRR for continued stay at the facility for one of one sampled residents with a level two screening (Resident #38). The findings included: Resident #38 was admitted to the facility 7/10/14. Cumulative diagnoses included: depression, anxiety and intellectual disability. An Admission Minimum Data Set (MDS) dated 7/17/14 indicated preadmission screening and resident review (PASRR) as "0. No". No behaviors were noted during the assessment period and the resident was cognitively intact. The medical record was reviewed and revealed the following PASRR and screening history: A PASRR Level II Determination Notification dated 7/9/14 with the following PASRR Number: 2014190204F and an expiration date of 10/7/14 and a PASRR Level II Determination Notification dated 10/7/14 with the following PASRR Number: 2014190204F and an expiration date of 1/5/15. Review of information in the NC MUST electronic screening tool application reveled: a resubmission for reevaluation of PASRR for continued stay at the facility was submitted late on 1/23/15 and additional information was requested from the PASRR Program on 1/25/15. A message dated 1/25/15 indicated the facility could fax the requested documentation and " then respond back in NC MUST. " On 1/27/15 a	F 285	Committee monthly for 3 months. The Administrator is responsible for monitoring and follow-up. Date of Compliance:	5/13/15

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F 285	Continued From page 13	F 285		

notation from the facility indicated " faxed documents " but there was no reply message from the facility to respond back to the PASARR Program, as directed, after submitting the documents. On 2/24/14 the case was auto closed after a 30 day period of waiting for the response that the additional information had been submitted and the workflow was completed.

On 4/15/15 at 2:15 PM interview with Administrative Staff #4 revealed that another staff member had been responsible for ensuring PASRR rescreening was completed timely but that staff member left and Administrative Staff #4 took on this role. She stated that once she discovered that Resident #38 ' s PASRR Level II authorization for continued stay had expired she initiated the process of rescreening, on 1/23/15. She added that the PASRR Program requested additional information which she faxed but because she was new to the process she did not realize that if she did not send a reply message within NC MUST, indicating that she had submitted the information, then the Program would not be aware that it had been submitted and close the case out within 30 days. She added that she had just assumed that they were backlogged and that it was taking a long time to get the rescreening done. Administrative Staff #4 indicated that she realized on 4/14/15 that the case had been closed and said that she was initiating steps to resubmit the request for rescreening.

On 4/15/15 at 2:33 PM during interview with Administrative Staff #1 she stated that she was aware that PASRR Level II residents need to have a current, unexpired PASRR number for continued stay in a skilled nursing facility. She

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F 285	Continued From page 14 said that the reason Resident #38 ' s PASRR rescreening had not been reviewed timely was because the staff member who was currently responsible was unfamiliar with the PASRR system. She acknowledged that staff required training if they were unfamiliar with an aspect within their scope of responsibility.	F 285		