STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345331	A. BUILDING ______ B. WING ______	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARDIS OAKS	**5151 SARDIS ROAD** **CHARLOTTE, NC 28270**

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the Complaint Investigation. Event ID #2PHJ11.	F 000		
F 242 SS=D	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 medical record review, resident and staff interviews the facility failed to assess and honor the choice for shower frequency for 1 of 4 sampled residents (Resident #31). The findings included: Resident #31 was admitted on 10/22/10 with diagnosis which included hypertension, and diabetes. Resident #31 most recent Minimum Data Set (MDS) dated 03/31/15 assessed her as being cognitively intact for daily decision making and able to make her decisions. The MDS indicated resident #31 required extensive assistance with bed mobility, transfers, dressings and personal hygiene and total dependence with toilet use. On 06/03/15 at 9:16 AM an interview was conducted with Resident #31. Resident #31 stated when she was admitted she was informed that she would get two showers per week on her scheduled days. She stated she would like to have three showers per week and indicated she	F 242	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Interim Director of Nursing met with Resident #31, to assess shower frequency preference. Resident #31 decided her showers would be scheduled each week on Wednesday, Friday, and Sunday. Facility wide audit was conducted with residents and/or Responsible Party to evaluate shower/bath frequency preferences. Shower/bath schedules were	7/1/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 06/25/2015

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 242	Continued From page 1 was unaware she had a choice regarding the frequency of showers. Resident #31 stated no staff person had asked her about her shower preference. Review of shower schedule posted at the nurse's station revealed Resident #31 was scheduled for showers on Wednesday and Sunday on 7-3 shift. An interview was conducted on 06/03/15 at 11:40 AM with Nursing Assistant (NA) #1. NA #1 stated she was familiar with Resident #31. She stated her assigned shower days were Wednesday and Sunday on the 7-3 shift. NA#1 stated there was a shower book which told what day residents received showers. NA #1 stated residents could receive more showers if they requested them. Interview with Nurse #1 on 06/03/15 at 4:15 PM revealed showers are scheduled twice a week for residents unless they request. Nurse #1 stated she did not ask residents or families about shower frequency preferences. Nurse #1 stated she was not aware of Resident #31's shower preferences. Interview conducted with the nurse Unit Supervisor on 06/03/15 at 4:33 PM stated that residents received two showers a week as scheduled and could change the time of their shower based on their preference and could get more frequent showers if they requested them. The Unit Supervisor stated she adjusted the shower schedule to accommodate any specific resident requests. She further stated she was not sure if residents had been assessed for frequency of showers on admissions. An interview was conducted with the Admissions Director on 06/04/15 at 8:32 AM revealed when residents were admitted residents and families were made aware they could have two showers per week and request for more. Review of the facility's admission packet revealed	F 242	updated in accordance with each resident's frequency preference. The Admission Packet was updated to include information regarding shower/bath frequency, based on resident's preference. Unit Coordinators will conduct weekly 10% audits of residents to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 242	Continued From page 2 and read in part, "you will be scheduled for a shower/bath two times per week. If you would like to change this schedule or receive a shower/bath more frequently, please speak with your nurse." An interview was conducted with the Activity Supervisor on 06/04/15 at 9:03 AM revealed she asked resident's about their preference between a tub bath/shower when they were admitted but did not ask their preference regarding the frequency of showers. An interview was conducted on 06/04/15 at 9:18 AM with the MDS Nurse #1 stated the standard is for residents to have two showers per week unless they request for more and the facility will accommodate those requests. She stated she assessed how much assistance residents required with bathing/showers but did not assess preferences for frequency of bathing/showers. She stated the nurses assessed it. An interview was conducted with the interim Director of Nursing (DON) on 06/04/15 at 10:24 AM revealed residents received two showers per week unless they requested for more or preferred a different shower schedule. The DON stated she was not aware of Resident #31 shower preferences. She stated the expectation is that residents be assessed upon admission about their preferences specific to frequency of showers.	F 242		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive	F 272		7/2/15

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F 272	Continued From page 3 assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to conduct a comprehensive assessment for 4 of 10 sampled residents to identify and analyze how condition affected each resident's function and quality of life	F 272	Resident #156 Care Area Assessment in the area of Urinary Incontinence was reviewed and analyzed by the MDS Coordinator to ensure there was a comprehensive assessment and an	

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F 272 Continued From page 4

related to urinary incontinence (Resident #156) psychoactive medication (Resident #99) and falls (Resident #178).

The findings included:

1. Resident #156 was admitted to the facility on 01/23/15 with diagnoses which included osteoarthritis and an overactive bladder. Admission medications included Detrol LA (used to treat symptoms of urinary urgency) 4 milligrams (mg.) daily, Lasix (a diuretic) 20 mg daily and oxybutynin extended release (used to reduce muscle spasms of the bladder and urinary tract) 10 mg. daily

Review of Resident #156's admission Minimum Data Set (MDS) dated 01/30/15 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #156 required the extensive assistance of one person with toilet use and frequent bladder incontinence. The MDS triggered the Care Area Assessments (CAA) in the area of urinary incontinence.

Review of the CAA revealed there was no documentation of an assessment which included input from Resident #156 or a family member and medication use. The CAA did not indicate an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

Interview on 06/04/15 at 3:57 PM with MDS Coordinator #2 revealed the facility changed to a software program which listed risk factors and information regarding Resident #156. MDS Coordinator #2 explained she thought the checklist and decision to proceed to care plan met the requirement of a comprehensive

F 272

analysis of the findings to support the decision to not proceed to the care plan.

Resident #99 Care Area Assessment in the area of Psychoactive Medications was reviewed and analyzed by the MDS Coordinator to ensure there was a comprehensive assessment and an analysis of the findings to support the decision to not proceed to the care plan.

Resident #178 Care Area Assessment in the area of Falls was reviewed and analyzed by the MDS Coordinator to ensure there was a comprehensive assessment and an analysis of the findings to support the decision to proceed to the care plan.

MDS Coordinators will be provided education by the Director of Clinical Operations and Outcomes, regarding Federal and State regulation on completing a comprehensive assessment and an analysis of the findings to support the decision to proceed or not to proceed to the care plan.

MDS Coordinators will review Care Area Assessments for all newly completed comprehensive assessments for June and forward to ensure there was a comprehensive assessment and an analysis of the findings to support the decision to proceed or not to proceed to the care plan.

Director of Nursing or designee, will conduct weekly 10% audits of the Care

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F 272	Continued From page 5 assessment. Interview on 06/04/15 at 4:25 PM with the interim Director of Nursing revealed the CAA should contain a comprehensive assessment which included an analysis of the findings. 2. Resident #99 was admitted to the facility on 01/23/15 with diagnosis of Alzheimer's disease, depression and anxiety disorder. Review of the Quarterly's Minimum Data Set (MDS) dated 01/30/15 revealed Resident #99 had short and long term memory loss and severely impaired to daily decision making. The MDS indicated Resident #99 triggered the Care Area Assessment (CAA) in the area of psychoactive medications. The MDS indicated Resident #99 received antipsychotic and antidepressant medications. Review of Resident # 99's CAA dated 01/30/15 revealed there was no documentation of an analysis of the findings with a description of the problem, causes and contributing factors related to the care plan. The CAA's analysis of findings assessment dated 01/30/15 concerning psychotropic drug use informed that Resident #99 was prescribed psychotropic medication Risperdal 0.5 milligram (mg) orally at bedtime (an antipsychotic) and Lexapro 20mg every morning (an antidepressant). The analysis of findings stated Resident #99 was at risk for taking psychotropic meds daily and at risk for adverse side effects which could predispose her to fall. Comments under the heading of care plan consideration stated no specific careplan for psychotropic meds, however will address in fall careplan to monitor for adverse side effects to prevent fall. Interview on 06/04/15 at 3:57 PM with Minimum Data Set Coordinator #1 revealed the facility	F 272	Area Assessments to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 272	Continued From page 6	F 272		

changed to a software program which listed risk factors and information regarding Resident #99. MDS Coordinator #1 explained she thought the checklist and decision to proceed to care plan met the requirements of a comprehensive assessment.
An interview was conducted with the interim Director of Nursing (DON) on 06/04/15 at 4:25 PM. She stated her expectation was for the MDS Coordinators to follow the federal guidelines and complete the CAA summaries correctly. The DON stated the computer company that was presently used provided inservices for the MDS staff. The DON explained their instructions included to complete the requirements for CAA summaries, they had to fill in the spaces provided under the Analysis of Findings provided in the computer program.
3. Resident # 178 was admitted to the facility 05/20/14 with diagnoses which included syncope, coronary artery disease, depression, and history of stroke.

A review of Resident #178's medical record was conducted. The Physician's Monthly orders dated 04/01/15 through 04/30/15 revealed the following medications were ordered: hydrochlorothiazide (a water pill) 25 milligrams (mg) daily, lexapro (an antidepressant) 40 mg at bedtime, and trazodone (used as a sleep aid) 50 mg at bedtime. Per manufacturer's information, these medications' side effects included drowsiness, dizziness, and faintness or lightheadedness when getting up from a lying or sitting position.

An annual Minimum Data Set (MDS) dated 04/16/15 indicated Resident #178's cognition was moderately impaired. The MDS specified the resident was independent with ambulation but did

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	345331	A. BUILDING ______ B. WING ______	C 06/04/2015

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F 272	Continued From page 7	F 272		

require a walker. The MDS further specified staff supervision was required for toileting, personal hygiene, and dressing and was at risk for falls but had not had a fall in the past 90 days.

A review was conducted of the Care Area Assessment (CAA) associated with the annual MDS regarding falls. The CAA form contained Care Plan Decisions written in dark print. Listed under this were other headings with spaces available to write under each heading. One heading was Analysis of Findings. Written under this heading was " The problem is , related to as evidenced by " . Nothing was written under the heading of Causes / Contributing factors. Under Risk Factors was written "Use of high risk meds, med dxs (diagnoses) of bradycardia, known syncope hx (history)." The Care Plan Consideration heading was written "Will proceed/continue with POC (plan of care) resident remains at increased risk to fall due to above stated risk factors. Will continue to refer to falls team prn (as needed) for recommendations." The information that was provided was in the form of a check list. A synthesized summary that identified the problems why Resident #178 was at risk for falls and complications that contributed to the resident being at risk for falls were not provided. The high risk medications were not identified in the CAA.

An interview was conducted with MDS Coordinator #1 on 06/03/15 at 4:23 PM. MDS Coordinator #1 stated the Care Plan Consideration box was the summary written for the CAA. She stated risk factors were not added to this summary because they were listed in the check box identified as Risk Factors.

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	345331	A. BUILDING ______ B. WING ______	C 06/04/2015

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F 272	Continued From page 8 An additional interview was conducted with MDS Coordinator #1 and MDS Coordinator #2 on 06/04/15 at 3:57 PM. MDS Coordinator #1 confirmed the Care Plan Consideration was the summary written for the CAA. Both MDS Coordinators stated they thought they were completing the analysis of findings that was required. Both MDS Coordinators confirmed when they went to the present computer program for writing MDS assessments, the company representatives informed them this form was all that was required for a CAA summary. An interview was conducted with the interim Director of Nursing (DON) on 06/04/15 at 4:25 PM. She stated her expectation was for the MDS Coordinators to follow the federal guidelines and complete the CAA summaries correctly. The DON stated the computer company that was presently used provided inservices for the MDS staff. The DON explained their instructions included to complete the requirements for CAA summaries, they had to fill in the spaces provided under the Analysis of Findings provided in the computer program.	F 272		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced	F 318		7/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 318	Continued From page 9 by: Based on observation, record review, resident and staff interviews, the facility failed to provide restorative ambulation for 1 of 2 sampled residents (Resident #202). The findings included: Resident #202 was initially admitted to the facility on 10/17/14 and readmitted on 03/12/15 with diagnoses including Brown-Sequard ' s syndrome (due to late effect spinal cord injury), orthopedic brace-right short leg to dorsiflex ankle, and anxiety state. The most recent Minimum Data Set (MDS) dated 04/09/15 coded the resident as cognitively intact with no mood or behavior problems. She required extensive assistance with assist of 2 for locomotion on the unit and her balance was unsteady with impairment of upper and lower extremities. The care plan dated 04/22/15 revealed Resident #202 required assistance with mobility and ADL needs due to functional limitations. An approach included assist with bed mobility, transfers, ambulation and wheel chair mobility every shift as needed, encourage resident to do what tasks she can, and provide verbal cueing and safety instructions as needed. On 06/03/15 at 11:20 AM Resident #202 was observed being ambulated with restorative Nurse Aide (NA) # 3 and restorative aide (NA) #4. The two restorative aides were observed holding onto Resident #202 with a gait belt and bringing her wheel chair behind while the resident, with her brace on her right foot and leg and her foot turned inward, was slowly being ambulated. The resident let the nurse aides know she needed to	F 318	Interim Director of Nursing reviewed Resident #202's restorative plan. Physical Therapy order was clarified and the restorative plan was reviewed with Restorative Aides to ensure order implemented, seven days per week. Interim Director of Nursing reviewed additional residents that received the restorative ambulation program. Two additional residents identified and determined program was being implemented as ordered. During weekly restorative meetings, residents receiving restorative ambulation will be reviewed with Restorative Aides, to ensure modality being met. Director of Rehabilitation Therapy will conduct a series of inservices to include: Restorative Nursing modalities, ambulation, transfers, and splints. Assistant Nurse Manager and Nurse Supervisor will conduct weekly 10% audit of residents receiving restorative ambulation to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 318	Continued From page 10	F 318		

be seated back in her wheel chair and the aides guided her back with the gait belt into the wheelchair. At this point, the resident was observed to place her hands on the bilateral arm rests, raise herself up, and position herself further back into the wheel chair. She had been observed to ambulate approximately 15 to 25 feet.

On 06/03/15 at 3:31 PM an interview was conducted with Nurse Aide (NA) #2 who had provided care for Resident #202. She stated she would do range of motion exercises with the resident when providing care. NA #2 said the range of motion exercises included having the resident raise her right arm and wash under her arm pits and raise her feet up and down when she was in bed. The aide revealed she did not ambulate the resident.

On 06/03/15 at 3:43 PM an interview was conducted with Nurse #2, Unit Supervisor, familiar with Resident #202. She stated Resident #202 had been ordered therapy when she was first admitted in October 2014 for a problem of weakness from her Brown Sequard ' s Syndrome. She stated the range of motion exercise have been recorded in the care tracker computer system. Observed the care tracker computer system for Resident #202 with Nurse # 2 and Resident #202 was to receive passive range of motion, transfers from bed to wheel chair and wheel chair to bed and ambulation. Observed print out of restorative services and resident had only been ambulated on 06/03/15.

On 06/03/15 at 4:42 PM an interview was conducted with Resident #202. She stated she used to ambulate approximately 425 feet when

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F 318	Continued From page 11	F 318		

she arrived at the facility. She said her goal was to keep ambulating and gain strength in her legs and feet. She revealed she was supposed to be ambulated 7 days per week. She reported she was supposed to be ambulated last week with the restorative aide and the aide had to cancel the ambulation. She said that today was the first time she had been ambulated in approximately one month.

On 06/04/15 at 8:35 AM an interview was conducted with restorative NA # 3. She stated her restorative duties for residents included cueing and supervision for eating, transfers and ambulation. She said she does rounds to make sure residents who need splinting devices and braces have them on. She stated the facility does not have enough nurse aide staff and she has not done all of her restorative duties because she has been pulled to the floor to perform nurse aide assignments. She revealed the main restorative work not being done has been ambulation. Resident #202 should be ambulated 7 days a week and maybe she has received ambulation only once a week. The NA said when she has had to cancel ambulation with Resident #202 she has informed her she had been assigned nurse aide duties on the hall. NA # 3 revealed she has discussed with Resident #202 her desire to ambulate further and further and not decline in making progress with ambulation. The restorative NA #3 stated she had reported to Nurse # 2 , Unit Supervisor and the acting Director of Nursing her concern of not being able to perform her restorative duties because of being short staffed with nurse aides. NA #3 was told more staff were being hired and when they were oriented she would return to her restorative duties. NA # 3 stated Resident #202

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345331	A. BUILDING ______ B. WING ______	C 06/04/2015

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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 318	Continued From page 12	F 318		

needs 2 person assist with ambulation and NA #4, who had assisted her yesterday with ambulating Resident #202, was oriented a couple weeks ago and had only assisted her yesterday for the second time with residents who needed ambulation including Resident #202.

On 06/04/15 at 10:36 AM an interview was conducted with Nurse #2, Unit Supervisor. She stated there was a turnover of staff in January , 2015 when changed Director of Nurses. There have been times when
direct care staff had been short and the restorative aide was put back on the floor. The nurse said she and another nurse would assist ambulating residents to the dining room when the restorative aide was not available. She stated she had not assisted Resident #202 with ambulation recently and Resident #202 had not received consistent ambulation. Nurse # 2 said the staff had a meeting the other day and discussed the need for more consistent restorative ambulation.

On 06/04/15 at 11:04 AM an interview was conducted with the Occupational Therapist (OT). The OT stated for residents needing restorative services the nurse manager has assigned range of motion services to include transfers and ambulation to and from the toilet at least 2 x daily with a plan to refer a resident to restorative 7 times per week for passive range of motion, transfers and ambulation. Instructions to restorative nurse aides for ambulation was to cue Resident #202 to straighten hip and knee on standing leg prior to advancing the opposite leg and encourage the right toes in a forward position rather than turning inward while being ambulated and follow with a wheel chair. The OT stated

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F 318	Continued From page 13 Resident #202 was evaluated on 05/02/15 for work on upper extremity strength and she completed the OT therapy on Thursday 05/11/15. The OT revealed that Resident #202 would have to be evaluated by Physical Therapy for ambulation. On 06/04/15 at 11:59 AM an interview was conducted with the Director of Nursing (DON). She stated staff had been short and new staff have recently been hired and have received training. The DON said the facility has their own pool of nurses and nurse aides that come to assist if more staff has been needed. She revealed anytime a restorative aide has been pulled to other nurse aide duties other nurse aides on the hall should be ambulating a resident. The expectation was Resident #202 should have been ambulated 7 days a week. On 06/04/15 at 2:34 PM a follow-up interview was conducted with Resident #202 concerning being ambulated 7 days per week. The resident stated she had not been ambulated by any other nurse aide on the floor or nurse supervisor when she had not been able to be ambulated by the restorative aide.	F 318		
F 332 SS=D	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 observations, record review, and staff	F 332	Pharmacy Manager and Nurse	7/1/15

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F 332	Continued From page 14 interviews, the facility medication error rate was greater than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8%, for 2 of 6 Residents observed during medication pass. (Residents #187 and Resident #99). The Findings included: 1. Resident #187 was admitted to the facility 04/02/14 with diagnoses which included high blood pressure. A review of Resident #187's medical record revealed a physician's order on the 06/01/15 through 06/30/15 physician's monthly orders for metoprolol ER (extended release) 50 milligrams (mg) daily. An observation on 06/03/15 at 8:23 AM revealed Nurse #1 preparing medications for Resident #187. Nurse #1 placed a tablet from a container labeled metoprolol ER 50 mg. The container had a sticker on it that instructed staff "do not crush". She was observed mixing the tablet with other medications and crushing the medications together. Nurse #1 mixed the crushed medications in applesauce and proceeded into the resident's room with the intent of administering the medication to the resident. Nurse #1 was stopped before administering the medication. An interview with Nurse #1 on 06/03/15 at 8:25 AM revealed she was Resident #187's regular nurse Monday through Friday. Nurse #1 stated Resident #187 was unable to swallow pills whole so she crushed them. Nurse #1 stated she did not know of any other way to administer medications to this resident. She added she had always crushed the resident's medications including the metoprolol ER. An interview was conducted with the facility's Registered Pharmacist (RP) on 06/03/15 at 11:29	F 332	Practitioner reviewed Resident #187's pulses & blood pressure which were determined to be within normal parameters. Nurse Practitioner reviewed Resident #99's orders and followed-up with the resident. Order was changed to apply topical medication to lower back and neck. Pharmacy Consultant conducted inservices with nursing staff on following proper process for administration of extended/controlled/sustained release medication (medication is not crushed) and applying topical medication per physician order. Pharmacy Consultant will conduct two Med Pass observations per month to include opportunities to observe nurses administering extended/controlled/sustained release medication and topical medications. Assistant Nurse Manager and Nurse Supervisor will conduct weekly 10% audit of nurses to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 332	Continued From page 15 AM. The RP stated crushing the metoprolol could lower the blood pressure and pulse at once and not be effective throughout the day. An interview was conducted with the interim Director of Nursing (DON) on 06/03/15 at 12:56 PM. The DON stated extended released medications should not be crushed. The DON confirmed Nurse #1 was the regular nurse on Resident #187's hall. 2. Resident #99 was admitted to the facility 04/03/14 with diagnoses which included arthritis. A review of Resident #99's medical record revealed a physician's order dated 05/09/15. The order was a clarification order for Voltaren (a medication utilized in the treatment of arthritis) 1% gel apply 4 grams (GM) topically to lower back area three times a day. An observation on 06/03/15 at 8:39 AM revealed Nurse #1 applied Voltaren 1% gel to Resident #99's neck and shoulders. An interview with Nurse #1 on 06/03/15 at 11:50 AM revealed she was unaware the physician's order instructed the Voltaren to be applied to Resident #99's lower back. The Medication Administration Record (MAR) was reviewed at this time. The physician's order for Voltaren contained 4 GM to be applied to the lower back 3 times a day. Nurse #1 stated she should have looked at the order before applying the Voltaren. An interview was conducted with the interim Director of Nursing (DON) on 06/03/15 at 12:56 PM. The DON stated she expected nurses to follow the physician's order as written on the MAR.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333		7/1/15

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F 333	Continued From page 16 any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow instructions regarding crushing of an extended release medication for 1 of 6 residents reviewed during medication administration observations. (Resident #187). The findings included: Resident #187 was admitted to the facility 04/02/14 with diagnoses which included high blood pressure. A review of Resident #187's medical record revealed a physician's order on the 06/01/15 through 06/30/15 physician's monthly orders for metoprolol ER (extended release) 50 milligrams (mg) daily. An observation on 06/03/15 at 8:23 AM revealed Nurse #1 preparing medications for Resident #187. Nurse #1 was observed placing a tablet from a container labeled metoprolol ER 50 mg. The container had a sticker on it that instructed do not crush. She was observed mixing the tablet with other medications and crushing the medications together. Nurse #1 mixed the crushed medications in applesauce and proceeded into the resident's room with the intent of administering the medication to the resident. Nurse #1 was stopped before administering the medication. An interview with Nurse #1 on 06/03/15 at 8:25 AM revealed she was Resident #187's regular nurse Monday through Friday. Nurse #1 stated Resident #187 was unable to swallow pills whole so she crushed them. Nurse #1 stated she did not know of any other way to administer the	F 333	Pharmacy Manager and Nurse Practitioner reviewed Resident #187's pulses & blood pressure which were determined to be within normal parameters. Pharmacy Consultant conducted inservices with nursing staff on following proper process for administration of extended/controlled/sustained release medication (medication is not crushed) and applying topical medication per physician order. Pharmacy Consultant will conduct two Med Pass observations per month to include opportunities to observe nurses administering extended/controlled/sustained release medication and topical medications. Assistant Nurse Manager and Nurse Supervisor will conduct weekly 10% audit of nurses to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 333	Continued From page 17 medication and had always crushed the resident's medications including the metoprolol ER. An interview was conducted with the facility's Registered Pharmacist (RP) on 06/03/15 at 11:29 AM. The RP stated crushing the metoprolol ER could lower the blood pressure and pulse at once and not be effective throughout the day. An interview was conducted with the facility's Nurse Practitioner (NP) on 06/03/15 at 12:16 PM. The NP stated crushing the metoprolol ER was not dangerous but less effective. She explained by the end of the day the medication was less effective. The NP stated this medication lowers blood pressure and pulse. She added Resident #187's blood pressure would be monitored twice a day until the vital signs were controlled. The NP stated she was unaware Resident #187 was unable to swallow pills. She added the nurses should let the physicians know if a resident was unable to swallow pills. An interview was conducted with the interim Director of Nursing (DON) on 06/03/15 at 12:56 PM. The DON stated extended released medications should not be crushed. The DON confirmed Nurse #1 was the regular nurse on Resident #187's hall.	F 333		