STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345233	A. BUILDING _____ B. WING _____	C 03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE REHABILITATION & CARE	306 DEER PARK ROAD NEBO, NC 28761

(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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 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 interviews the facility failed to accurately code 1 of 1 sampled residents utilizing the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for Resident #61.	F 278	Responses to the cited deficiencies do not constitute an admission or agreement by the Provider of the truth of the facts as alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jw Kan — TITLE: Administrator — (X6) DATE: 4/2/16

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 278	Continued From page 1 Findings included: Resident #61 was admitted to the facility on 12/08/15 with diagnoses including bipolar disease and anxiety disorder. A review of Resident #61's admission Minimum Data Set (MDS) dated 12/15/15 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review were used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility's list of Level II PASRR residents revealed that Resident #61 was included among the residents named on the list. An Interview was conducted with the MDS Nurse #1 on 03/16/16 at 8:28 AM regarding the accuracy of Resident #61's admission MDS. When it was revealed the MDS did not reflect the Level II PASRR determination for this resident, the MDS Nurse #1 stated the MDS should have been coded to reflect Resident #61 was Level II PASRR and was missed for coding. On 03/16/16 at 8:51 AM an interview was conducted with the MDS Nurse #2 who stated Resident #61 was determined as Level II PASRR on admission to the facility on 12/8/15. The MDS Nurse #2 stated the admission MDS dated 12/15/15 should have been coded to reflect Resident #61 was Level II PASRR. A telephone interview was conducted with the MDS Nurse #3 on 03/16/16 at 9:00 AM who	F 278	F 278 Immediate Action: The MDS for Resident #61 was corrected on 3/16/16 to accurately reflect the Level II Preadmission Screening and Resident Review (PASRR). Identification: All residents have the potential to be affected. Corrective Measure: MDS nurses were educated on importance of accurate completion of MDS by the DON/Designee. All PASRR II residents' MDS's were audited to ensure accuracy. MDS Preadmission Screening and Resident Review (PASRR) will be reviewed for accuracy by DON/Designee for every admission to ensure accuracy. Monitoring: Results of the MDS admission assessment reviews will be taken to the QAPI monthly x 3 months to ensure ongoing substantial compliance.	4/8/16

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F 278	Continued From page 2 stated she coded the 12/15/15 MDS admission assessment and did not notice that the hospital discharge summary indicated Resident #61 was determined as Level II PASRR. The MDS Nurse #3 stated it was an oversite and she missed coding the admission MDS to reflect Resident #61 was Level II PASRR. The MDS Nurse #3 stated that MDS Nurse #2 would need to submit a modification of the admission MDS dated 12/15/15 to reflect Resident #61 was Level II PASRR. On 03/16/16 at 9:47 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the MDS Nurse would have reviewed the hospital discharge summary and all pertinent information such as the face sheet from the hospital in order to verify information and would have accurately coded Resident #61's admission MDS dated 12/15/15 to reflect Level II PASRR. The DON stated it was her expectation that the MDS Nurse would submit a modified admission MDS to reflect Level II PASRR determination for Resident #61. On 03/17/16 at 8:16 AM an interview was conducted with the Administrator who stated it was her expectation that the Level II PASRR determination would have been coded accurately on Resident #61's admission MDS.	F 278		
F 286 SS=F	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.	F 286		

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F 286	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain on the residents' clinical record and make available to staff and consultants the most recent 15 months of Minimum Data Set(MDS)assessments for 16 of 16 sampled residents. (Residents #23, #28, #31, #44, #61, #69, #79, #84, #85, #110, #116, #120, #132, #142, #150 and #165.) The findings included: Record review of all the residents included in the Stage 2 Sample revealed no MDS information was available on any resident's current clinical record. An interview on 03/16/16 at 9:40 AM with the Medical Records Coordinator(MRC)about Resident #165 and the location of MDS information, which was not in his closed medical record, revealed the information should have been on the closed record. When informed that there was no MDS information on Resident #165's chart, she looked through her unfiled documents and was unable to locate the information. Review of the open records of the other 15 residents revealed no MDS information available on the current clinical records. An interview on 03/16/16 at 9:45 AM with MDS Nurse #1 and MDS Nurse #2 about the location of MDS assessments for each resident revealed the information was located in the computer and wasn't printed and placed in the residents' clinical records. MDS Nurse #1 stated she had been in	F 286	F286 Immediate Action: Access was granted to AHT/LTC to licensed nurses on 3/17/16. Identification: All residents have the potential to be affected. Corrective Measure: Licensed staff was educated by the MDS nurses regarding access to AHT/LTC. New licensed staff will receive access and education regarding access to AHT/LTC upon hire. Monitoring: HR support will monitor that new licensed staff obtain access and will report these findings to the QAPI committee monthly x 3 to ensure substantial compliance.	4/8/16

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F 286	Continued From page 4 her position a year and the MDS assessments hadn't been printed in the year she had been doing them. When asked how nurses, consultants or other clinical staff had access to the MDS information, MDS Nurse #2 stated: "I have no idea." An interview on 03/16/16 at 9:53 AM with the Director of Clinical Operations(DCO)about the accessibility of MDS information to nurses, consultants and other clinical staff revealed they weren't accessible to nurses, consultants or other clinical staff. The DCO stated department managers had access to MDS information on the computer. The DCO stated she knew the MDS information had to be accessible for 15 months. A second interview on 03/16/16 at 10:37 AM with the DCO revealed a former nurse consultant advised the MDS nurses to stop printing the MDS assessments and putting them on the clinical record. An interview on 03/17/16 at 3:31 PM with the Administrator about her expectation for MDS information being available revealed she expected they should be available to licensed nurses and consultants for 15 months.	F 286		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to prevent a significant medication	F 333		

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F 333	Continued From page 5 error for 1 of 5 residents reviewed for unnecessary medications. Resident #132 was administered an excessive dose of Clonazepam, a medication used to treat anxiety, over the course of 14 days. The findings included: Resident #132 was admitted to the hospital on 12/24/15 and was readmitted to the facility on 02/25/16 with diagnoses including multiple fistulas with infection, dysphoric mood with irritability, depression and anxiety disorder. An Admission Minimum Data Set (MDS) assessment indicated Resident #132 was cognitively intact for daily decision making and had no delirium, psychosis or behavioral symptoms. The MDS indicated Resident #132 had rejection of care daily and required extensive assistance of staff with all activities of daily living except eating for which she was independent. The MDS indicated she received antipsychotic and antianxiety medications for 7 days of the observation period. The Care Area Assessment Summary for Psychotropic Drug Use was reviewed and gave a comprehensive analysis of resident's condition necessitating use of multiple psychotropic medications including bipolar disorder, anxiety and depression. A Care Plan dated 12/30/15 addressed Resident #132's need for psychoactive medications to treat anxiety, depression and bipolar disorder. Interventions were appropriate to address her needs. Review of Resident #132's medication orders revealed an order dated 02/25/16 for	F 333	F 333 Immediate Action: The medication order for Resident #61 was corrected. Resident #61 physician notified of medication transcription error. Identification: All residents have the potential to be affected. Corrective Measure: An audit was completed by the DON/designee to ensure all orders have been transcribed accurately. Licensed staff was educated that physician orders must be dated, initialed and documented in the nurse's notes and the MARs updated to ensure accuracy. Monitoring: DON/Designee will audit physician orders and MAR/TAR weekly x 4, then random audits monthly x 2 months. Results of these audits will be taken to the QAPI committee monthly for 3 months to ensure ongoing substantial compliance.	4/8/16

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F 333	Continued From page 6 Clonazepam 1 milligram (mg) every 12 hours on a scheduled basis. There was no order on Resident #132's medical record for as needed (PRN) Clonazepam. Review of the February 2016 Medication Administration Record (MAR) for Resident #132 revealed an undated entry for Clonazepam 1 mg by mouth twice a day (BID) every 12 hours. Listed in the hour column was "PRN" and no scheduled hours for administration were listed. The medication was documented as given on 02/27/16 - 1 dose, 02/28/16 - 2 doses and 02/29/16 - 1 dose. The MAR didn't list any doses given on 02/25/16 or 02/26/16. Review of the Controlled Drug Record for Resident #132's Clonazepam revealed documentation that the following doses were administered: 02/26/16 at 7:00 PM, 02/27/16 at 8:00 PM, 02/28/16 at 8:30 AM and 8:30 PM and 02/29/16 at 9:00 PM. Review of the March 2016 MAR for Resident #132 revealed Clonazepam 1 mg listed for scheduled administration at 9:00 AM and 9:00 PM. The medication was documented as given at those times through 03/14/16 at 9:00 AM. Also listed on the March 2016 MAR was Klonopin (Clonazepam) 1 mg by mouth BID every 12 hours PRN. PRN doses were documented as given on 03/03/16 through 03/09/16 - 1 dose each day and 03/13/16 - 1 dose. The back of the MAR listed only 6 doses of PRN Clonazepam as given and indicated it was given for increased anxiety. For 4 of the 6 doses, the medication was listed as effective. There was no effect documented for 2 of the 6 doses.	F 333		

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F 333	Continued From page 7 Review of the Controlled Drug Record for Resident #132's Clonazepam revealed documentation that the following PRN doses were administered: 03/02/16 at 1:00 AM in addition to the routinely scheduled doses, 03/03/16 at 6:00 PM in addition to the routinely scheduled doses, 03/04/16 - no PRN doses were signed as given, 03/05/16 at 1:00 AM and 5:00 PM in addition to the routinely scheduled doses, 03/06/15 at 5:00 AM and 5:00 PM in addition to the routinely scheduled doses, 03/07/16 at 5:00 AM in addition to the routinely scheduled doses, 03/08/16 - no PRN doses were signed as given, 03/09/16 at 1:00 AM in addition to the routinely scheduled doses and 03/13/16 at 1:00 PM in addition to the routinely scheduled doses. An interview on 03/16/2016 at 11:59 AM with the Assistant Director of Nursing (ADON) revealed she had contacted the pharmacy and the only order they had on record for Resident #132's Clonazepam was an order dated 02/25/16 for Clonazepam 1 mg every 12 hours on a scheduled basis. An interview on 03/16/16 at 1:37 PM with the Nurse Practitioner (NP) who gave the Clonazepam order on 02/25/16 about her expectation for medications being administered as ordered revealed she expected medications to be given as ordered. The NP stated she expected staff to ask for clarification if they didn't understand an order and she would provide education. She stated she expected to be notified if a medication was not given and the reason so she could discuss it further. When asked about any possible risk to Resident #132 of receiving additional doses of Clonazepam in excess of what was ordered, the NP stated she wouldn't	F 333		

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F 333	Continued From page 8 have agreed to put Resident #132 on a routine dose and PRN dose of Clonazepam because it was way too much because of her low body weight of 95 pounds. The NP stated the additional doses of Clonazepam had the potential for making Resident #132 somnolent and at increased risk of developing pneumonia. The NP stated "that would be a whopping big dose for a normal person without the health problems of Resident #132." An interview on 03/17/16 at 8:15 AM with the Director of Nursing (DON) about the process for doing change-over of MARs from one month to the next revealed the monthly recapitulation of physician orders and MARs for the new month were sent to the facility the last week of the month. She stated the Unit Managers for each unit compared the physician's orders on the chart with the MAR for the coming month and the current MAR. She stated any new orders that came in the last 2 days of the month were added to the recapitulation of orders and the new MAR by the Unit Managers. The DON stated a final check was done by the 11-7 nurses on the last day of the month to ensure all new orders were on the recapitulation of orders and the new MAR. During an interview on 03/17/16 at 11:09 AM, Unit Manager (UM) #1 was asked to review the order for Clonazepam dated 02/25/16 on Resident #132's chart. UM #1 identified Nurse #1 as the nurse who received the verbal order for Clonazepam and transcribed the order. UM #1 was asked to review the March 2016 recapitulation of physician orders and UM #1 stated she did the first check of the March 2016 recapitulation of orders to verify the accuracy of the MARs on 02/28/16. UM #1 stated if there was	F 333		

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F 333	Continued From page 9 a discrepancy, she called the physician for a clarification of the order. When asked if she noticed the Clonazepam was listed as PRN on the February 2016 MAR and as routine on the March 2016 MAR, UM #1 stated she didn't realize it was listed as PRN on the February 2016 MAR. When asked if she added the PRN order to the March 2016 MAR, she stated she didn't add it to the MAR and couldn't identify who did. Attempt to reach Nurse #1 by phone on 03/17/16 at 2:03 PM was unsuccessful and message on answering machine stated mailbox wasn't set up to take messages. In an interview on 03/17/16 at 2:55 PM with the DON about the facility's system for verifying the accuracy of transcription of medication orders, the DON said the unit managers were responsible for using the green copy of the order to verify the accuracy of the transcription. The DON stated the unit managers got the green copies of all new orders every morning and were responsible for checking for accuracy of transcription. When asked about her expectation for documentation/transcription of medication orders, the DON stated the nurse should write the order, write a nurse's note documenting who gave the order, what the order was, that the resident's family was notified and the pharmacy was notified. The DON stated the nurse should then transcribe the order to the MAR and leave the green copy for the unit manager to review. The DON stated she expected the Unit Managers to verify that all orders were transcribed correctly. A phone call was made on 03/17/16 at 3:12 PM to Nurse #2, who was identified by the DON as being the 11-7 nurse who worked 02/29/16 and	F 333		

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F 333	Continued From page 10 was responsible for doing the second check of physician orders and MARs for Resident #132. No answer was received and the voice mail indicated the mailbox was full and couldn't receive any more calls.	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to 1) remove dented cans from the ready to use shelf in the dry storage room 2) date opened containers of food in the walk-in cooler and 3) date an opened bag of frozen food in the walk-in freezer. The facility also failed to 4) remove dented cans of a high calorie supplement and 5) remove expired foods, label and date items in the resident refrigerator in 2 of 2 nourishment rooms. The findings included: 1) During initial tour of the kitchen on 03/14/16, beginning at 10:35 AM, with the Dietary Manager (DM) was observed on the ready to use shelf in the dry storage room 2 dented cans (62 ounces)	F 371		

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F 371	Continued From page 11 of mushroom stems and pieces and 1 dented can (62 ounce) of turnip greens. The DM observed and verified the 3 cans were dented on the ready to use shelf. The DM stated it was her expectation for the staff to have not placed the dented cans on the ready to use shelf. 2) Further tour of the kitchen on 03/14/16 at 10:40 AM, with the DM, in the walk-in cooler was observed 2 (5 pound) tubs of pimento cheese opened with no open date indicated and 1 (16 ounce) container of beef paste opened with no opened date indicated. The DM observed and verified the 3 containers were opened, used, and no opened date indicated on either one of the 3 containers. The DM stated it was her expectation for the staff to have put an opened date on the containers and that the containers should not have been in the cooler without an opened date identified. 3) Continued tour of the kitchen on 03/14/16 at 10:45 AM, with the DM, in the walk-in freezer was observed 1 bag of chicken breasts (4 pieces) opened to the air with no opened date indicated. The DM observed and verified the bag of chicken breasts was opened to air and no opened date was indicated. The DM stated it was her expectation for the staff to have closed the bag to prevent possible freezer burn and an opened date should have been indicated on the bag. 4) On 03/14/16 at 11:07 AM, during the initial tour the 200 hall nourishment room was observed to have 5 (8 ounce) dented cans out of 12 of a high calorie supplement (jevity 1.5 cal) on a shelf ready for use. An interview was conducted on 03/14/16 at 11:12	F 371	F 371 Immediate Action: The dented cans were removed from the ready to use shelf in the dry storage room. The undated opened containers of food in the walk-in cooler were discarded. The undated opened bag of frozen food in the walk-in freezer was discarded. The dented cans of high calorie supplement were discarded. The expired foods, label and date items in resident refrigerator in nourishment rooms were discarded. Identification: All residents have the potential to be affected. Corrective Measure: All dry food storage areas and food storage refrigerators were audited to ensure proper labeling and storage of opened food and ensure there were no dented cans. Staff was educated on proper labeling and dating requirements of opened food. Monitoring: Dietary Manager will monitor kitchen areas for proper storage of dented cans and appropriate dates and labels on opened foods weekly x 12 weeks. DON/Designee will monitor nourishment room areas to ensure dented cans are discarded and appropriate dates and labels on opened foods weekly x 12 weeks. Results of these audits will be taken to the QAPI Committee for 3 months to ensure ongoing substantial compliance.	4/8/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE REHABILITATION & CARE	306 DEER PARK ROAD NEBO, NC 28761

(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 371	Continued From page 12 AM with Unit Manager (UM) #1. She stated it was the nurses responsibility to stock the jevity 1.5 cal on the ready for use shelf and should a can be dented it was supposed to be left out and returned. The UM indicated she was unaware of who would have put the 5 dented cans on the ready for use shelf. She further indicated she was unaware of the dented cans. 5) On 03/14/16 at 11:25 AM, during tour of the 100 hall nourishment room was observed 1 (24 ounce) container of cottage cheese with an expiration date of 03/13/16 in a refrigerator identified as the "residents' refrigerator." Further observation revealed 1 (20 ounce) opened (half empty) bottle of the drink "mountain dew" with no resident name or opened date identified. Also observed was 1 plastic bag which contained an opened pack with 4 hotdogs left in the pack and 1 (4 ounce) container of orange juice in the bottom drawer of the residents' refrigerator with no name or date indicated on the bag or the food items. An interview was conducted on 03/14/16 at 11:37 AM with UM #2. UM #2 stated she was unaware of the food items in the resident refrigerator with no resident name or date. UM #2 indicated the dietary staff was responsible for checking the resident refrigerator. On 03/14/16 at 1:47 PM, a follow-up interview was conducted with the Dietary Manager (DM). The DM stated it was her expectation that the food items in the resident refrigerators be labeled and dated. The DM further stated she was unaware that there was un-labeled and un-dated food in the resident refrigerators. The DM indicated she would have expected her staff to have removed the unlabeled and undated items from the resident refrigerator.	F 371		

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F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to have matching documentation on the front and back of the Medication Administration Record (MAR) and the controlled drug record for the administration of Clonazepam (a controlled substance used to treat anxiety) for 1 of 5 residents reviewed. (Resident # 132). The findings included: Resident #132 was admitted to the hospital on 12/24/15 and was readmitted to the facility on 02/25/16 with diagnoses including multiple fistulas with infection, dysphoric mood with irritability, depression and anxiety disorder. An Admission Minimum Data Set (MDS) assessment indicated Resident #132 was cognitively intact for daily decision making and had no delirium, psychosis or behavioral symptoms. The MDS indicated Resident #132 had rejection of care	F 514	F 514 Immediate Action: The medication order for Resident #61 was corrected. Resident #61 physician notified of medication transcription error. Identification: All residents have the potential to be affected. Corrective Measure: An audit was completed by the DON/designee to ensure all orders have been transcribed accurately. Licensed staff was educated that physician orders must be dated, initialed and documented in the nurse's notes and the MARs updated to ensure accuracy. Monitoring: DON/Designee will audit physician orders and MAR/TAR weekly x 4, then random audits monthly x 2 months. Results of these audits will be taken to the QAPI committee monthly for 3 months to ensure ongoing substantial compliance.	4/8/16

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F 514	Continued From page 14 daily and required extensive assistance of staff with all activities of daily living (ADL) except eating for which she was independent. The MDS indicated she received antipsychotic and antianxiety medications for 7 days of the observation period. The Care Area Assessment (CAA) Summary for Psychotropic Drug Use was reviewed and gave a comprehensive analysis of resident's condition necessitating use of multiple psychotropic medications including bipolar disorder, anxiety and depression. A Care Plan dated 12/30/15 addressed Resident #132's need for psychoactive medications to treat anxiety, depression and bipolar disorder. Interventions were appropriate to address her needs. Review of Resident #132's medication orders revealed an order dated 02/25/16 for Clonazepam 1 milligram (mg) every 12 hours on a scheduled basis. There was no order on Resident #132's medical record for as needed (PRN) Clonazepam. Review of the February 2016 Medication Administration Record (MAR) for Resident #132 revealed an undated entry for Clonazepam 1 mg by mouth twice a day (BID) every 12 hours. Listed in the hour column was "PRN" and no scheduled hours for administration was listed. The medication was documented on the front of the MAR by nurses' initials as given on 02/27/16 - 1 dose, 02/28/16 - 2 doses and 02/29/16 - 1 dose. The MAR didn't list any doses given on 02/25/16 or 02/26/16. Documentation on the back of the February 2016 MAR listed only 2 doses of PRN	F 514		

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F 514	Continued From page 15 Clonazepam: 02/27/16 at 8:00 PM and 02/29/16 at 10:00 PM. There was no documentation on the back of the February 2016 MAR of the doses of Clonazepam that were administered on 02/26/16 at 7:00 PM, 02/28/16 at 8:30 AM and 8:30 PM, the reason for the administration or the effectiveness of the medication. Review of the Controlled Drug Record for Resident #132's Clonazepam revealed documentation that the following doses were administered: 02/26/16 at 7:00 PM, 02/27/16 at 8:00 PM, 02/28/16 at 8:30 AM and 8:30 PM and 02/29/16 at 9:00 PM. Review of the March 2016 MAR for Resident #132 revealed Clonazepam 1 mg listed for scheduled administration at 9:00 AM and 9:00 PM. The medication was documented as given at those times through 03/14/16 at 9:00 AM. Also listed on the March 2016 MAR was Klonopin (Clonazepam) 1 mg by mouth BID every 12 hours PRN. PRN doses were documented on the front of the MAR by nurses' initials as given on 03/03/16 through 03/09/16 - 1 dose each day and 03/13/16 - 1 dose. Documentation on the back of the March 2016 MAR were the following doses: 03/03/16 at 6:00 PM, 03/05/16 at 1:00 AM, 03/06/16 at 5:00 AM, 03/07/16 at 5:00 AM and 03/09/16 at 1:00 AM and 03/13/16 at 1:00 PM. There was no documentation on the back of the March 2016 MAR of the doses of Clonazepam that were administered on 03/05/16 at 5:00 PM, 03/06/15 at 5:00 PM, the reason for administration or the effectiveness of the medication. Review of the Controlled Drug Record for Resident #132's Clonazepam revealed	F 514		

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F 514	Continued From page 16 documentation that the following PRN doses were administered: 03/02/16 at 1:00 AM in addition to the routinely scheduled doses, 03/03/16 at 6:00 PM in addition to the routinely scheduled doses, 03/04/16 - no PRN doses were signed as given, 03/05/16 at 1:00 AM and 5:00 PM in addition to the routinely scheduled doses, 03/06/15 at 5:00 AM and 5:00 PM in addition to the routinely scheduled doses, 03/07/16 at 5:00 AM in addition to the routinely scheduled doses, 03/08/16 - no PRN doses were signed as given, 03/09/16 at 1:00 AM in addition to the routinely scheduled doses and 03/13/16 at 1:00 PM in addition to the routinely scheduled doses. An interview on 03/16/2016 at 11:59 AM with the Assistant Director of Nursing (ADON) revealed she had contacted the pharmacy and the only order they had on record for Resident #132's Clonazepam was an order dated 02/25/16 for Clonazepam 1 mg every 12 hours on a scheduled basis. An interview on 03/16/16 at 1:37 PM Interview with the Nurse Practitioner (NP) who gave the Clonazepam order on 02/25/16 for Resident #132 about her expectation for medications being administered as ordered revealed she expected medications to be given as ordered. The NP stated she expected staff to ask for clarification if they didn't understand an order and she would provide education. She stated she expected to be notified if a medication was not given and why so she could discuss it further. When asked about any possible risk to Resident #132 of receiving additional doses of Clonazepam in excess of what was ordered, the NP stated she wouldn't have agreed to put Resident #132 on a routine dose and PRN dose of Clonazepam because it	F 514		

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F 514	Continued From page 17 was way too much because of her low body weight. The NP stated the additional doses of Clonazepam had the potential for making Resident #132 somnolent and at increased risk of developing pneumonia. The NP stated "that would be a whopping big dose for a normal person without the health problems that Resident #132 had." An interview on 03/17/16 at 8:15 AM with the Director of Nursing (DON) about the process for doing change-over of MARs from one month to the next revealed the monthly recapitulation of physician orders and MARs for the new month were sent to the facility the last week of the month. She stated the Unit Managers for each unit compared the physician's orders on the chart with the MAR for the coming month and the current MAR. She stated any new orders that came in the last 2 days of the month were added to the recapitulation of orders and the new MAR by the Unit Managers. Gail stated a final check was done by the 11-7 nurses on the last day of the month to ensure all new orders were on the recapitulation of orders and the new MAR. During an interview on 03/17/16 at 11:09 AM, Unit Manager (UM) #1 was asked to review the order on Resident # 132's chart for Clonazepam dated 02/25/16. UM #1 identified Nurse #1 as the nurse who received the verbal order for Clonazepam and transcribed the order. UM #1 was asked to review the March 2016 recapitulation of physician orders and UM #1 stated she did the first check of the March 2016 recapitulation of orders to verify the accuracy of the MARs on 02/28/16. UM #1 stated if there was a discrepancy, she called the physician for a clarification of the order. When asked if she noticed the Clonazepam was listed	F 514		

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F 514	Continued From page 18 as PRN on the February 2016 MAR and as routine on the March 2016 MAR, UM #1 stated she didn't realize it was listed as PRN on the February 2016 MAR. When asked if she added the PRN order to the March 2016 MAR, she stated she didn't add it to the MAR and couldn't identify who did. Attempt to reach Nurse #1 by phone on 03/17/16 at 2:03 PM was unsuccessful and message on answering machine stated mailbox wasn't set up to take messages. In an interview on 03/17/16 at 2:55 PM with the DON about the facility's system for verifying the accuracy of transcription of medication orders, the DON said the unit managers were responsible for using the green copy of the order to verify the accuracy of the transcription. The DON stated the unit managers got the green copies of all new orders every morning and were responsible for checking for accuracy of transcription. When asked about her expectation for documentation/transcription of medication orders, the DON stated the nurse should write the order, write a nurse's note documenting who gave the order, what the order was, that the resident's family was notified and the pharmacy was notified. The DON stated the nurse should then transcribe the order to the MAR and leave the green copy for the unit manager to review. The DON stated she expected the Unit Managers to verify that all orders were transcribed correctly. The DON was asked about her expectation for administration of PRN medications and documentation. The DON stated the nurse should initial the front of the MAR and the documentation on the back of the MAR should show the date and time of administration and that it was given	F 514		

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F 514	Continued From page 19 for the appropriate reason or diagnosis and the effectiveness. The DON stated it was important for the date and time of PRN medication administration to be recorded on the back of the MAR so the nurses wouldn't give the resident too much medication or outside of the ordered time frames. She stated the dose should also be recorded on the controlled drug record. The DON stated the time on the back of the MAR and time on the controlled drug sheet should match exactly. A phone call was made on 03/17/16 at 3:12 PM to Nurse #2, who was identified by the DON as being the 11-7 nurse who worked 02/29/16 and was responsible for doing the second check of physician orders and MARs for Resident #132. No answer was received and the voice mail indicated the mailbox was full and couldn't receive any more calls.	F 514		
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.	F 520		

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F 520	Continued From page 20 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. 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 observations, staff interviews and record review the facility's Quality Assessment and Assurance(QA and A)Committee failed to maintain implemented procedures and monitor the interventions that the committee put in place in June of 2015. This was for one deficiency that was cited in June 2015 on a recertification survey. This deficiency was re-cited on the current recertification survey. The deficiency was in the area of Food Procurement, Storage, Preparation and Distribution. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: F371: Food Procurement, Storage, Preparation and Distribution: Based on observations and staff interviews the facility failed to 1)remove dented cans from the ready to use shelf in the dry storage room 2)date opened containers of food in the walk-in cooler and 3)date an opened bag of frozen food in the walk-in freezer. The facility also failed to 4)remove dented cans of a high calorie	F 520	F 520 Immediate Action: The dented cans were removed from the ready to use shelf in the dry storage room. The undated opened containers of food in the walk-in cooler were discarded. The undated opened bag of frozen food in the walk-in freezer was discarded. The dented cans of high calorie supplement were discarded. The expired foods, label and date items in resident refrigerator in nourishment rooms were discarded. Identification: All residents have the potential to be affected. Corrective Measure: All dry food storage areas and food storage refrigerators were audited to ensure proper labeling and storage of opened food and ensure there were no dented cans. Staff was educated on proper labeling and dating requirements of opened food. Monitoring: Dietary Manager will monitor kitchen areas for proper storage of dented cans and appropriate dates and labels on opened foods weekly x 12 weeks. DON/Designee will monitor nourishment room areas to ensure dented cans are discarded and appropriate dates and labels on opened foods weekly x 12 weeks. Results of these audits will be taken to the QAPI Committee for 3 months to ensure ongoing substantial compliance.	4/8/16

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F 520	Continued From page 21 supplement and 5) remove expired foods, label and date items in the resident refrigerator in 2 of 2 nourishment rooms. During the recertification survey of June 2015, the facility was cited for F371 for failure to air dry kitchenware before stacking it in storage, failure to use kitchenware free of food particles during food preparation and failure to dispose of damaged kitchenware. On the current survey the facility was cited for failing to 1)remove dented cans from the ready to use shelf in the dry storage room 2)date opened containers of food in the walk-in cooler and 3)date an opened bag of frozen food in the walk-in freezer. The facility also failed to 4)remove dented cans of a high calorie supplement and 5) remove expired foods, label and date items in the resident refrigerator in 2 of 2 nourishment rooms. During an interview on 03/17/16 at 3:36 PM with the Administrator, she was asked what she thought contributed to continued concerns in the kitchen with failure to removed dented cans from use, not dating opened containers and bags in the walk-in cooler and freezer and not removing expired foods, labeling and dating items in 2 resident refrigerators. The Administrator stated the previous Dietary Manager(DM) left in November 2015. Another DM was hired in December 2015 but didn't pass the certification test the end of January 2016 so she was terminated from employment because that was a condition of employment. The Administrator stated they went 2 weeks without a DM until the current DM was hired on 02/22/16. The Administrator stated she felt the turn-over in DMs had resulted in the continued problems in the kitchen.	F 520		

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