STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 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 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.	F 272		7/2/16

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

Electronically Signed | 06/23/2016

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to comprehensively assess the needs of a resident related to a diagnosis of depression and use of an antidepressant for 1 of 5 residents reviewed for unnecessary medications (Resident #38); and, failed to comprehensively assess the use of bed rails coded as a physical restraint on the Minimum Data Set (MDS) assessment for 11 of 13 residents reviewed for Comprehensive MDS assessment (Residents #38, #10, #41, #11, #2, #16, #3, #14, #15, and #26). The findings included: 1) Resident #38 was admitted on 4/1/16 from another nursing facility with a cumulative diagnoses which included depression. The resident ' s admission medication orders dated 4/1/16 included 37.5 milligrams Effexor (an antidepressant) to be given as one tablet every morning for depression. Resident #38's Nursing Assessment Summary dated 4/6/16 included the following, in part: "Effexor daily for depression." A review of Resident #38's admission MDS (Minimum Data Set) assessment dated 4/8/16 revealed the resident was assessed to have severely impaired cognitive skills for daily decision making. He was totally dependent on staff for all of his Activities of Daily Living (ADLs). The resident ' s MDS assessment (Section I) did not indicate the resident had an active diagnosis of depression. Section N of the MDS	F 272	Corrective action to be accomplished for the resident found to be affected by the deficient practice: Resident #38- On May 25, 2016, the assessment was updated by the MDS nurse to include the active diagnosis of depression and the use of antidepressant medication was coded. The care area assessment and care plan were then completed to address the use and monitoring of an antidepressant for depression. Residents #38, #10, #41, #11, #2, #16, #3, #14, #15, #26 were assessed individually by the MDS nurse as to whether or not the bed rails were a physical restraint. The form Evaluation for use of Side Rails was selected as a tool to help guide the assessments and the questions from the sample form were used from May 30, 2016 to June 2, 2016 to complete the assessments. This form guides assessment for side rail use by prompting answers to how and why side rails are being considered for the individual resident and ending with recommendations to use or not use side rails, if side rails are indicated, which type and timing for the resident. It also prompts the person completing the assessment to answer if the side rail will impede the resident□s freedom of movement. On 6/2/16, Section P of the MDS Assessment was updated to remove the coding of bedrails as a physical	

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assessment did not indicate the resident received an antidepressant medication.

A review of Resident #38 ' s Care Area Assessment Summary dated 4/11/16 revealed the care area for Psychotropic Drug Use did not trigger for further review. The resident ' s medical record did not include an assessment related to the diagnosis of depression or use of an antidepressant medication.

A review of Resident #38 ' s care plan (initiated on 4/1/16 with additions made on 4/11/16) revealed neither the diagnosis of depression and/or the use of an antidepressant medication was addressed for Resident #38.

An interview was conducted on 5/26/16 at 10:00 AM with the MDS nurse. The MDS nurse reported she also assumed responsibilities as the Interim Director of Nursing (DON). Upon inquiry and review of the Resident #38 ' s MDS assessment, the MDS nurse confirmed neither the diagnosis of depression nor use of an antidepressant medication was coded. She stated the diagnosis of depression should have been included as an active diagnosis for Resident #38 and the MDS assessment should also have indicated he received an antidepressant. The MDS nurse reported since use of the antidepressant was not coded correctly on the MDS, the topic of psychotropic medications (which included an antidepressant) did not trigger for the resident. Subsequently, a care area assessment and care plan were not completed to address the use and monitoring of an antidepressant for depression. When asked, the MDS nurse indicated she would have expected Resident #38 to be both assessed and care

restraint and the care area assessment summary was updated for Residents #38, #10, #41, #11, #2, #16, #3, #14, #15, #26. This removed the care area trigger #18 Physical Restraints for Residents #38, #10, #41, #11, #2, #16, #3, #14, #15, #26. The care plans for Residents #38, #10, #41, #11, #2, #16, #3, #14, #15, #26 were updated to discontinue physical restraints with the notation that read Side rails are used to define parameters of bed and assist with bed mobility remaining on the care plan.

Corrective actions to be accomplished for residents having potential to be affected by the same deficient practice: Assessments for all residents on psychotropic medications (to include antidepressants) were reviewed to verify an active diagnosis and coding for medication. All residents were found to have an active diagnosis for psychotropic medications (to include antidepressants) and the use of antidepressant medication was coded. The care area assessment and care plan addressed the use and monitoring of an antidepressant for depression.

Each resident in the facility was assessed individually by the MDS nurse as to whether or not the bed rails were a physical restraint. The form Evaluation for use of Side Rails was selected as a tool to help guide the assessments and the questions from the sample form were used from May 30, 2016 to June 2, 2016 to complete the assessments. This form

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F 272	Continued From page 3 planned for the use of an antidepressant medication used to treat depression. 2) Resident #38 was admitted to the facility on 4/1/16 from another nursing facility with a cumulative diagnoses which included a history of cerebrovascular accident (stroke). Resident #38 ' s Nursing Assessment Summary dated 4/6/16 included the following, in part: " He is turned/repositioned every 2 hours and (as needed) ...Hoyer lift is used for all transfers. Gets out of bed to geri-chair as tolerated. He is unable to ambulate. " No notation was included in the Nursing Assessment Summary in regards to the use of bed rails on Resident #38 ' s bed. A review of Resident #38 ' s admission MDS (Minimum Data Set) assessment dated 4/8/16 revealed the resident was assessed to have severely impaired cognitive skills for daily decision making. He was totally dependent on staff for all of his Activities of Daily Living (ADLs), including bed mobility. Section P of the MDS assessment indicated bed rails were a physical restraint for the resident; and, the bed rails were used daily. Section V of the MDS assessment indicated Physical Restraints triggered for the resident and a check mark indicated this would be addressed in his care plan. The Care Area Assessment Summary dated 4/11/16 included a notation which read, " Side rails are used to define parameters of bed and assist with bed mobility. " Resident #38 ' s medical record did not include an assessment related to the use of bed rails as a physical restraint. A review of Resident #38 ' s care plan revealed the problem of Urinary Incontinence/Pressure	F 272	guides assessment for side rail use by prompting answers to how and why side rails are being considered for the individual resident and ending with recommendations to use or not use side rails, if side rails are indicated, which type and timing for the resident. It also prompts the person completing the assessment to answer if the side rail will impede the resident□s freedom of movement. On 6/2/16, Section P of the MDS Assessment was updated to remove the coding of bedrails as a physical restraint and the care area assessment summary was updated for all facility residents. This removed the care area trigger #18 Physical Restraints for all Residents. The care plans for all Residents were updated to discontinue physical restraints with the notation that read Side rails are used to define parameters of bed and assist with bed mobility remaining on the care plan. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: The MDS nurse and consultant pharmacist will complete the assessment for all active diagnoses and psychotropic medications (to include antidepressants) on admission. These will be coded with the care area assessment and care plan addressing the use and monitoring of medications. The consultant pharmacist maintains patient specific lists for psychoactive medications which are shared with the MDS nurse.	

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F 272	Continued From page 4 Ulcer/Physical Restraint was initiated on 4/11/16. An interview was conducted on 5/24/16 at 11:42 AM with Nurse #3. Nurse #3 was the hall nurse assigned to care for Resident #38. During the interview, the nurse reported ½ side rails were used on both sides of the resident ' s bed. She reported the resident could not physically get out of bed on his own. An interview was conducted on 5/26/16 at 11:05 AM with the MDS nurse. The MDS nurse reported she also assumed responsibilities as the Interim Director of Nursing (DON). The MDS nurse reviewed Resident #38 ' s section P of the MDS assessment. When asked how it was determined whether or not the resident had a physical restraint, the MDS nurse reported a "physical restraint" assessment form was not used to aid in the assessment of residents or to determine whether or not the bed rails were a physical restraint. The MDS nurse stated she had been trained to code bed rails (when used) as a physical restraint. She reported bed rails were used for all residents in the facility and all were coded as a physical restraint. However, the nurse then stated, "But it really isn't a restraint." She reported the Care Area Assessment Summary (Section V of the MDS) indicated the bed rails were only used to help Resident #38 with positioning. The MDS nurse also stated, "This is a restraint-free facility." A follow-up interview was conducted on 5/27/16 at 10:58 with the MDS nurse. During the interview, the nurse reiterated that all residents in the facility utilized ½ side rails on both sides and the side rails were always coded as a physical restraint on the MDS assessment. The nurse	F 272	The MDS nurse reviewed guidance for side rails and restraints and demonstrated understanding of proper coding for side rails as part of the comprehensive assessment with the individual assessments of all residents. The MDS nurse and all facility nurses will complete training regarding assessment for side rails for residents and the need for reassessment with change of condition. The training includes education regarding assessment for the use of side rails with the Evaluation for Use of Side Rails form and when side rails would be considered a restraint. This training will be completed by July 15, 2016. Each facility resident will be assessed individually by the MDS nurse or designee as to whether or not the bed rails are a physical restraint. The MDS nurse or designee will utilize the form Evaluation for Use of Side Rails on admission and quarterly or sooner if there is a significant change in condition. The form Evaluation for use of Side Rails was selected as a tool to help guide the assessments regarding side rail use. This form guides assessment for side rail use by prompting answers to how and why side rails are being considered for the individual resident and ending with recommendations to use or not use side rails, if side rails are indicated, which type and timing for the resident. It also prompts the person completing the assessment to answer if the side rail will impede the resident□s freedom of movement.	

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F 272	Continued From page 5 stated, " Technically, these aren ' t restraints. " Upon inquiry, the MDS nurse confirmed Resident #38 could not physically get out of bed on his own. However, she also indicated an assessment had not been completed to determine whether or not the bed rails were a physical restraint. 3) Resident #10 was admitted to the facility on 1/28/13 from a hospital with a cumulative diagnoses which included dementia. The resident ' s annual Minimum Data Set (MDS) assessment (Section P) dated 11/18/15 indicated bed rails were a physical restraint for the resident; and, the bed rails were used daily. Section V of the MDS assessment indicated Physical Restraints triggered for the resident and indicated this would be included in her care plan. The Care Area Assessment Summary included a notation which read, " Bed rails to define parameter of bed. " A review of Resident #10 ' s care plan revealed the following problem was initiated on 11/19/15: Urinary Incontinence/Pressure Ulcer/Physical Restraint. A review of Resident #10 ' s Nursing Assessment Summary dated 11/18/15 included the following notations, in part: " ...She is bed/chair fast and she is turned and repositioned every two hours ...able to move her arms without difficulty. She is non-ambulatory and moves her legs very little. " The use of bed rails was not addressed in the assessment. A review of Resident #10 ' s quarterly Minimum Data Set (MDS) assessment dated 5/4/16 revealed the resident had severely impaired cognitive skills for daily decision making. She was totally dependent on staff for all of her Activities of Daily Living (ADLs), with the	F 272	How we will monitor our performance to make sure that solutions are sustained: A quality assessment tool has been developed to review all admission assessments no later than the next weekly care plan meeting to verify that all active diagnoses have been recorded for any psychotropic medications (to include antidepressants). This review will be completed by the interdisciplinary team members. Any discrepancies will be corrected at that time. This will be completed and reported to the Quality of Life committee and housewide QI committee monthly for one year to ensure compliance has been achieved and sustained. A quality assessment tool has been developed to review all admission assessments, quarterly assessments and residents with a change in condition regarding the use of side rails. This review will be completed by the interdisciplinary team members present at the next weekly care plan meeting. Any discrepancies will be corrected at that time. This will be completed and reported to the Quality of Life committee and housewide QI committee monthly for one year to ensure compliance has been achieved and sustained and extended if indicated.	

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exception of requiring supervision only for eating. Section P of the MDS assessment indicated bed rails were a physical restraint for the resident; and, the bed rails were used daily. Section V of the MDS assessment indicated Physical Restraints triggered for the resident and a check mark indicated this would be addressed in her care plan. A review of Resident #10 ' s care plan (initiated on 11/19/15) revealed the problem of Urinary Incontinence/Pressure Ulcer/Physical Restraint was continued on 5/4/16. The resident ' s Nursing Assessment Summary dated 5/4/16 did not address the use of bed rails. Resident #10 ' s medical record did not include an assessment related to the use of bed rails as a physical restraint.

An interview was conducted on 5/24/16 at 11:42 AM with Nurse #3. Nurse #3 was the hall nurse assigned to care for Resident #10. During the interview, the nurse reported ½ side rails were used on both sides of the resident ' s bed. She reported the resident could not physically get out of bed on her own.

An interview was conducted on 5/26/16 at 11:05 AM with the MDS nurse. The MDS nurse reported she also assumed responsibilities as the Interim Director of Nursing (DON). The MDS nurse reviewed Resident #10 ' s section P of the MDS assessment. When asked how it was determined whether or not the resident had a physical restraint, the MDS nurse reported a "physical restraint" assessment form was not used to aid in the assessment of residents or to determine whether or not the bed rails were a physical restraint. The MDS nurse stated she had been trained to code bed rails (when used) as a physical restraint. She reported bed rails

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were used for all residents in the facility and all were coded as a physical restraint. However, the nurse then stated, "But it really isn't a restraint." The MDS nurse also stated, "This is a restraint-free facility."

A follow-up interview was conducted on 5/27/16 at 10:58 with the MDS nurse. During the interview, the nurse reiterated that all residents in the facility utilized ½ side rails on both sides and the side rails were always coded as a physical restraint on the MDS assessment. The nurse stated, " Technically, these aren ' t restraints. " Upon inquiry, the MDS nurse confirmed Resident #10 could not physically get out of bed on her own. However, she also indicated an assessment had not been completed to determine whether or not the bed rails were a physical restraint.

4) Resident #41 was admitted to the facility on 11/24/15 from another nursing facility with a cumulative diagnoses which included a history of cerebrovascular accident (stroke).

The resident ' s most recent Minimum Data Set (MDS) assessment was for a Significant Change dated 4/20/16. The MDS assessment revealed the resident had severely impaired cognitive skills for daily decision making. She was totally dependent on staff for all of her Activities of Daily Living (ADLs), including bed mobility. Section P of the MDS assessment indicated bed rails were a physical restraint for the resident; and, the bed rails were used daily. Section V (Care Area Assessment Summary or CAA) of the MDS assessment indicated Physical Restraints triggered for the resident and a check mark indicated this would be addressed in her care

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plan. A narrative on the CAA Summary read as follows: " Side rails are used to define parameters of bed and assist with bed mobility. " Resident #41 ' s medical record did not include an assessment related to the use of bed rails as a physical restraint.

A review of Resident #41 ' s Nursing Assessment Summary dated 4/20/16 included the following, in part: " Left sided paralysis noted due to CVA. She is non-ambulatory. Total care for all ADL ' s due to CVA. Two people assist for all lifts, turns and transfers. " The Nursing Assessment Summary did not address the use of bed rails.

A review of Resident #41 ' s care plan revealed the problem of Falls/Physical Restraints was initiated on 4/21/16.

An interview was conducted on 5/24/16 at 11:42 AM with Nurse #3. Nurse #3 was the hall nurse assigned to care for Resident #41. During the interview, the nurse reported ½ side rails were used on both sides of the resident ' s bed. She reported the resident could not physically get out of bed on her own.

An interview was conducted on 5/26/16 at 11:05 AM with the MDS nurse. The MDS nurse reported she also assumed responsibilities as the Interim Director of Nursing (DON). The MDS nurse reviewed Resident #41 ' s section P of the MDS assessment. When asked how it was determined whether or not the resident had a physical restraint, the MDS nurse reported a "physical restraint" assessment form was not used to aid in the assessment of residents or to determine whether or not the bed rails were a physical restraint. The MDS nurse stated she

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had been trained to code bed rails (when used) as a physical restraint. She reported bed rails were used for all residents in the facility and all were coded as a physical restraint. However, the nurse then stated, "But it really isn't a restraint." The MDS nurse also stated, "This is a restraint-free facility."

A follow-up interview was conducted on 5/27/16 at 10:58 with the MDS nurse. During the interview, the nurse reiterated that all residents in the facility utilized ½ side rails on both sides and the side rails were always coded as a physical restraint on the MDS assessment. The nurse stated, " Technically, these aren ' t restraints. " Upon inquiry, the MDS nurse confirmed Resident #41 could not physically get out of bed on her own. However, she also indicated an assessment had not been completed to determine whether or not the bed rails were a physical restraint.

5) Resident #11 was admitted to the facility on 8/1/11 from another nursing facility.

The resident ' s annual Minimum Data Set (MDS) assessment (Section P) dated 11/18/15 indicated bed rails were a physical restraint for the resident; and, the bed rails were used daily. Section V of the MDS assessment indicated Physical Restraints triggered for the resident but did not indicate it would be included in her care plan. The Care Area Assessment Summary included a notation which read, " Bed rails used to define parameters of the bed. " A review of Resident #11 ' s care plan (initiated on 6/8/15) revealed the following problem was continued on 11/19/15: Urinary Incontinence/Pressure Ulcer/Physical Restraint.

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A review of Resident #11 ' s quarterly Minimum Data Set (MDS) assessment dated 5/4/16 revealed the resident had moderate cognitive impairment. She was assessed as independent with bed mobility but required limited staff assistance with transfers and walking. Section P of the MDS assessment indicated bed rails were a physical restraint for the resident; and, the bed rails were used daily. Section V of the MDS assessment indicated Physical Restraints triggered for the resident and a check mark indicated this would be addressed in her care plan. A review of Resident #11 ' s care plan (initiated on 6/8/15) revealed the problem of Urinary Incontinence/Pressure Ulcer/Physical Restraint was continued on 5/4/16. Resident #11 ' s medical record did not include an assessment related to the use of bed rails as a physical restraint.

An interview was conducted on 5/24/16 at 11:42 AM with Nurse #3. Nurse #3 was the hall nurse assigned to care for Resident #11. During the interview, the nurse reported ½ side rails were used on both sides of the resident ' s bed. She reported the resident could physically get out of bed on her own even when the rails were raised.

An interview was conducted on 5/26/16 at 11:05 AM with the MDS nurse. The MDS nurse reported she also assumed responsibilities as the Interim Director of Nursing (DON). The MDS nurse reviewed Resident #11 ' s section P of the MDS assessment. When asked how it was determined whether or not the resident had a physical restraint, the MDS nurse reported a "physical restraint" assessment form was not used to aid in the assessment of residents or to

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determine whether or not the bed rails were a physical restraint. The MDS nurse stated she had been trained to code bed rails (when used) as a physical restraint. She reported bed rails were used for all residents in the facility and all were coded as a physical restraint. However, the nurse then stated, "But it really isn't a restraint." She reported the Care Area Assessment Summary (Section V of the MDS) indicated the bed rails were only used to help Resident #11 with positioning. The MDS nurse also stated, "This is a restraint-free facility."

A follow-up interview was conducted on 5/27/16 at 10:58 with the MDS nurse. During the interview, the nurse reiterated that all residents in the facility utilized ½ side rails on both sides and the side rails were always coded as a physical restraint on the MDS assessment. The nurse stated, " Technically, these aren ' t restraints. " Upon inquiry, the MDS nurse confirmed Resident #11 could get out of bed on her own when the bed rails were raised. However, she also indicated an assessment had not been completed to determine whether or not the bed rails were a physical restraint.

6) Resident #2 was admitted to the facility on 12/12/12 from a hospital with cumulative diagnoses which included dementia, diabetes mellitus, cardio vascular accident and major depressive disorder.

The resident ' s annual Minimum Data Set (MDS) assessment (Section P) dated 1/13/16 indicated bed rails were a physical restraint for the resident; and, the bed rails were used daily. In addition the MDS revealed Resident #2 was cognitively impaired, had no impairment of upper or lower extremities, required supervision for bed mobility

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and extensive assistance for transfers, did not walk during the review period and had no falls since the previous MDS assessment. Section V of the MDS assessment indicated Physical Restraints triggered for the resident and indicated this would be included in her care plan.

The resident ' s quarterly Minimum Data Set (MDS) assessment (Section P) dated 4/6/16 indicated bed rails were a physical restraint for the resident; and, the bed rails were used daily. In addition the MDS revealed Resident #2 was cognitively impaired, had no impairment of upper or lower extremities, required supervision for bed mobility and extensive assistance for transfers, did not walk during the review period and had no falls since the previous MDS assessment.

Resident #2 ' s active medical record was reviewed, including the most recent Nursing Assessment Summary dated 4/6/16; the record and summary did not include an assessment related to the use of bed rails as a physical restraint.

Review of the care plan dated 4/28/16 revealed Physical restraints were included in the care plan however as an intervention the plan of care indicated the bed rails were being used for mobility and to define bed parameters but not as a physical restraint.

An interview was conducted on 5/25/16 at 9:41 AM with Nurse #4. Nurse #4 was the hall nurse assigned to care for Resident #2. During the interview, the nurse reported ½ side rails were used on both sides of the resident ' s bed. She reported the resident could not physically get out of bed on her own.

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An interview was conducted on 5/26/16 at 11:05 AM with the MDS nurse. The MDS nurse reported she also assumed responsibilities as the Interim Director of Nursing (DON). The MDS Nurse indicated that an assessment form was not used to aid in the assessment of residents or to determine whether or not the bed rails were a physical restraint. The MDS nurse stated she had been trained to code bed rails (when used) as a physical restraint. She reported bed rails were used for all residents in the facility and all were coded as a physical restraint. However, the nurse then stated, "But it really isn't a restraint." The MDS nurse also stated, "This is a restraint-free facility."

A follow-up interview was conducted on 5/27/16 at 10:58 with the MDS nurse. During the interview, the nurse reiterated that all residents in the facility utilized ½ side rails on both sides and the side rails were always coded as a physical restraint on the MDS assessment. The nurse stated, "Technically, these aren't restraints." Upon inquiry, the MDS nurse confirmed Resident #2 could not physically get out of bed on her own. However, she also indicated an assessment had not been completed to determine whether or not the bed rails were a physical restraint.

7) Resident #16 was admitted to the facility on 5/12/15 from a hospital with cumulative diagnoses which included rheumatoid arthritis, osteoarthritis and a malignant neoplasm.

The resident ' s annual Minimum Data Set (MDS) assessment (Section P) dated 4/27/16 indicated bed rails were a physical restraint for the resident; and, the bed rails were used daily. In addition the

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MDS revealed Resident #2 was cognitively impaired, had no impairment of upper or lower extremities, required supervision for bed mobility and extensive assistance for transfers, did not walk during the review period and had no falls since the previous MDS assessment. Section V of the MDS assessment indicated Physical Restraints triggered for the resident and indicated this would be included in her care plan.

Resident #16 ' s active medical record was reviewed, including the most recent Nursing Assessment Summary dated 4/27/16; the record and summary did not include an assessment related to the use of bed rails as a physical restraint.

Review of the care plan dated 4/28/16 revealed Physical restraints were included in the care plan however as an intervention the plan of care indicated the bed rails were being used for mobility and to define bed parameters but not as a physical restraint.

An interview was conducted on 5/25/16 at 9:51 AM with Nurse #4. Nurse #4 was the hall nurse assigned to care for Resident #2. During the interview, the nurse reported ½ side rails were used on both sides of the resident ' s bed. She reported the resident could not physically get out of bed on her own.

An interview was conducted on 5/26/16 at 11:05 AM with the MDS nurse. The MDS nurse reported she also assumed responsibilities as the Interim Director of Nursing (DON). The MDS Nurse indicated that an assessment form was not used to aid in the assessment of residents or to determine whether or not the bed rails were a

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physical restraint. The MDS nurse stated she had been trained to code bed rails (when used) as a physical restraint. She reported bed rails were used for all residents in the facility and all were coded as a physical restraint. However, the nurse then stated, "But it really isn't a restraint." The MDS nurse also stated, "This is a restraint-free facility."

A follow-up interview was conducted on 5/27/16 at 10:58 with the MDS nurse. During the interview, the nurse reiterated that all residents in the facility utilized ½ side rails on both sides and the side rails were always coded as a physical restraint on the MDS assessment. The nurse stated, "Technically, these aren't restraints." Upon inquiry, the MDS nurse confirmed Resident #16 could not physically get out of bed on her own. However, she also indicated an assessment had not been completed to determine whether or not the bed rails were a physical restraint.

8) Resident #3 was originally admitted to the facility on 6/10/13 and re-admitted3/10/15 with diagnoses which included: dementia, insomnia, and edema.

The significant change MDS (Minimum Data Set) dated 3/30/16 indicated Resident #3 was severely cognitively impaired requiring total assistance of two staff for transfers. Section P of the MDS indicated bed rails were used as a restraint for the resident.

There was no documentation available indicating Resident #26 was assessed for the use of beds rails as a restraint.

During an interview on 5/24/16 at 2:58pm,

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Nurse#3 stated that the half sized bed rails were used on both sides of Resident #3's bed. The nurse revealed the resident was capable of getting out of bed on his own when the bed rails were in the up position.

During an interview on 5/26/16 at 11:05am, the facility's MDS Nurse revealed there was no "physical restraint" assessment form used to aide in assessment of residents. When asked how it was determined the resident had a physical restraint, the MDS Nurse stated she had been trained to code bed rails (when up) as a physical restraint. However, the nurse then stated, "but it really isn't a restraint." She reported the CAA (Care Area Assessment Summary) indicated the bed rails were used to help resident with positioning. Upon inquiry, the MDS Nurse stated she was trained to code bed rails (when up) as a physical restraint and to explain it in the CAA. The MDS Nurse stated, "This is a restraint-free facility."

During a second interview on 5/27/2016 at 10:58am, the MDS Nurse stated that all of the residents had the halved side rails on their bed and were coded on the MDS as a Physical Restraint. The MDS Nurse reported that "Technically, these aren't restraints." The MDS Nurse confirmed an assessment was not completed to determine whether or not the bed rails were used for the resident as a restraint.

9) Resident #14 was admitted to the facility on 8/1/11 with diagnoses which included: unspecified intellectual disabilities, dizziness and giddiness.

The annual MDS (Minimum Data Set) dated

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1/6/16 indicated Resident #14 had short and long term memory problems with severely impaired decision-making skills, and was totally dependent on two staff with transfers. Section P of the MDS indicated bed rails were used as a restraint for the resident.

There was no documentation available indicating Resident #14 was assessed for the use of beds rails as a restraint.

During an interview on 5/24/16 at 2:34pm, Nurse#5 stated that the half sized bed rails were used on both sides of Resident #14's bed. The nurse revealed the resident was capable of getting out of bed on her own when the bed rails were in the up position.

During an interview on 5/26/16 at 11:05am, the facility's MDS Nurse revealed there was no "physical restraint" assessment form used to aide in assessment of residents. When asked how it was determined the resident had a physical restraint, the MDS Nurse stated she had been trained to code bed rails (when up) as a physical restraint. However, the nurse then stated, "but it really isn't a restraint." She reported the CAA (Care Area Assessment Summary) indicated the bed rails were used to help resident with positioning. Upon inquiry, the MDS Nurse stated she was trained to code bed rails (when up) as a physical restraint and to explain it in the CAA. The MDS Nurse stated, "This is a restraint-free facility."

During a second interview on 5/27/2016 at 10:58am, the MDS Nurse stated that all of the residents had the halved side rails on their bed and were coded on the MDS as a Physical

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Restraint. The MDS Nurse reported that "Technically, these aren't restraints." The MDS Nurse confirmed an assessment was not completed to determine whether or not the bed rails were used for the resident as a restraint.

10) Resident #15 was admitted to the facility on 8/1/11 with diagnoses which included: cerebrovascular accident, diabetes mellitus, transient paralysis, and joint pain.

The annual MDS (Minimum Data Set) dated 12/2/15 indicated Resident #15 had short and long term memory problems and showed modified independence with decision-making skills, and was independent with transfers. Section P of the MDS indicated bed rails were used as a restraint for the resident.

There was no documentation available indicating Resident #15 was assessed for the use of beds rails as a restraint.

During an interview on 5/24/16 at 2:41pm, Nurse#3 stated that half sized bed rails were used on both sides of Resident #15's bed. The nurse revealed the resident was capable of getting out of bed on his own when the bed rails were in the up position.

During an interview on 5/26/16 at 11:05am, the facility's MDS Nurse revealed there was no "physical restraint" assessment form used to aide in assessment of residents. When asked how it was determined the resident had a physical restraint, the MDS Nurse stated she had been trained to code bed rails (when up) as a physical restraint. However, the nurse then stated, "but it

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really isn't a restraint." She reported the CAA (Care Area Assessment Summary) indicated the bed rails were used to help resident with positioning. Upon inquiry, the MDS Nurse stated she was trained to code bed rails (when up) as a physical restraint and to explain it in the CAA. The MDS Nurse stated, "This is a restraint-free facility."

During a second interview on 5/27/2016 at 10:58am, the MDS Nurse stated that all of the residents had the halved side rails on their bed and were coded on the MDS as a Physical Restraint. The MDS Nurse reported that "Technically, these aren't restraints." The MDS Nurse confirmed an assessment was not completed to determine whether or not the bed rails were used for the resident as a restraint.

11) Resident #26 was admitted to the facility on 2/16//15 with diagnoses which included: Parkinson's disease; cerebrovascular accident, and a history of falling.

The annual MDS (Minimum Data Set) dated 2/03/16 indicated Resident #26 was severely cognitively impaired and required supervision for bed mobility and transfers. Section P of the MDS indicated bed rails were used as a restraint for the resident.

There was no documentation available indicating Resident #26 was assessed for the use of beds rails as a restraint.

During an interview on 5/24/16 at 2:24pm, Nurse#5 stated that half sized bed rails were used on both sides of Resident #26's bed. The

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F 272	Continued From page 20 nurse revealed the resident was capable of getting out of bed on his own when the bed rails were in the up position. During an interview on 5/26/16 at 11:05am, the facility's MDS Nurse revealed there was no "physical restraint" assessment form used to aide in assessment of residents. When asked how it was determined the resident had a physical restraint, the MDS Nurse stated she had been trained to code bed rails (when up) as a physical restraint. However, the nurse then stated, "but it really isn't a restraint." She reported the CAA (Care Area Assessment Summary) indicated the bed rails were used to help resident with positioning. Upon inquiry, the MDS Nurse stated she was trained to code bed rails (when up) as a physical restraint and to explain it in the CAA. The MDS Nurse stated, "This is a restraint-free facility." During a second interview on 5/27/2016 at 10:58am, the MDS Nurse stated that all of the residents had the halved side rails on their bed and were coded on the MDS as a Physical Restraint. The MDS Nurse reported that "Technically, these aren't restraints." The MDS Nurse confirmed an assessment was not completed to determine whether or not the bed rails were used for the resident as a restraint.	F 272		
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	F 278		7/2/16

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F 278	Continued From page 21 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 assess and include the active diagnosis of depression and use of an antidepressant in the Minimum Data Set (MDS) for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #38). The findings included: 1) A review of Resident #38 ' s medical record included a 2/8/16 Nurse Practitioner ' s (NP) progress note from another nursing facility where he had previously resided. The NP progress note	F 278	Corrective action to be accomplished for the resident found to be affected by the deficient practice: Resident #38- On May 25, 2016, the assessment was updated by the MDS nurse to include the active diagnosis of depression and the use of antidepressant medication was coded. The care area assessment and care plan were then completed to address the use and monitoring of an antidepressant for depression.	

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F 278	Continued From page 22 indicated the resident had a diagnosis of depression. The date/time stamp on this NP progress note revealed the record was faxed to the facility on 3/31/16. Resident #38 was admitted to the facility on 4/1/16 from another nursing facility with a cumulative diagnoses which included depression. Resident #38 ' s Nursing Assessment Summary dated 4/6/16 included the following, in part: " Effexor daily for depression. " A review of Resident #38 ' s admission MDS (Minimum Data Set) assessment dated 4/8/16 revealed the resident was assessed to have severely impaired cognitive skills for daily decision making. He was totally dependent on staff for all of his Activities of Daily Living (ADLs). The resident ' s MDS assessment (Section I) did not indicate the resident had an active diagnosis of depression. An interview was conducted on 5/26/16 at 10:00 AM with the MDS nurse. The MDS nurse reported she also assumed responsibilities as the Interim Director of Nursing (DON). Upon inquiry and review of the Resident #38 ' s MDS assessment, the MDS nurse confirmed depression was incorrectly omitted from his list of active diagnoses. She stated the diagnosis of depression should have been included as an active diagnosis for Resident #38. 2) Resident #38 was admitted to the facility on 4/1/16 from another nursing facility with a cumulative diagnoses which included depression. The resident ' s admission medication orders dated 4/1/16 included 37.5 milligrams Effexor (an	F 278	Corrective actions to be accomplished for residents having potential to be affected by the same deficient practice: Assessments for all residents on psychotropic medications (to include antidepressants) were reviewed to verify an active diagnosis was documented with the care area assessment and care plan addressing the use and monitoring of medications. This review was completed by the MDS nurse and the consultant pharmacist on 6-23-2016. All residents were found to have an active diagnosis for psychotropic medications (to include antidepressants) and the use of antidepressant medication was coded. The care area assessment and care plan addressed the use and monitoring of an antidepressant for depression. The coordination of verification between the MDS nurse and consultant pharmacist was established on 6-23-2016. The consultant pharmacist completes chart reviews and maintains a spreadsheet of medications with active diagnoses for each medication and any changes in medications monthly. This spreadsheet will be updated monthly and sent to the MDS nurse. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: The MDS nurse and consultant pharmacist will complete the assessment for all active diagnoses and psychotropic medications (to include antidepressants) on admission. These will be coded with the care area assessment and care plan	

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F 278	Continued From page 23 antidepressant) to be given as one tablet every morning for depression. A review of Resident #38 ' s admission MDS (Minimum Data Set) assessment dated 4/8/16 revealed the resident was assessed to have severely impaired cognitive skills for daily decision making. He was totally dependent on staff for all of his Activities of Daily Living (ADLs). The resident ' s MDS assessment (Section N) of the MDS assessment did not indicate the resident received an antidepressant medication. An interview was conducted on 5/26/16 at 10:00 AM with the MDS nurse. The MDS nurse reported she also assumed responsibilities as the Interim Director of Nursing (DON). The MDS nurse reviewed Resident #38 ' s MDS assessment. Upon inquiry, she confirmed the use of an antidepressant (Effexor) should have been included among the medications coded on the MDS.	F 278	addressing the use and monitoring of medications. The consultant pharmacist will complete chart reviews and maintain a spreadsheet of medications with active diagnoses for each medication and any changes in medications monthly. This spreadsheet will be updated monthly and sent to the MDS nurse for changes and residents scheduled for quarterly review. These changes will be coded with the care area assessment and care plan addressing the use and monitoring of medications. This coordination was established on 6-23-2016. How we will monitor our performance to make sure that solutions are sustained: A quality assessment tool has been developed for the CNO or designee to review all admission assessments no later than the next weekly care plan meeting to verify that all active diagnoses have been recorded for any psychotropic medications (to include antidepressants) and coded with the care area assessment and care plan addressing the use and monitoring of medications. The CNO or designee will review that all scheduled quarterly reviews and medication changes recorded on the spreadsheet updated monthly by the consultant pharmacist are coded in the care area assessment and care plan addressing the use and monitoring of medications. Any discrepancies will be corrected at that time. This will be completed and reported to the Quality of Life committee and housewide QI committee monthly for one year to ensure compliance has been	

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F 278	Continued From page 24	F 278	achieved and sustained and extended if indicated.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan to address the diagnosis of depression and use of an antidepressant medication for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #38). The findings included:	F 279	Corrective action to be accomplished for the resident found to be affected by the deficient practice: Resident #38- On May 25, 2016, the assessment was updated by the MDS nurse to include the active diagnosis of depression and the use of antidepressant medication was coded. The care area assessment and care plan were then	7/2/16

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F 279	Continued From page 25 Resident #38 was admitted to the facility on 4/1/16 from another nursing facility with a cumulative diagnoses which included depression. The resident ' s admission medication orders dated 4/1/16 included 37.5 milligrams Effexor (an antidepressant) to be given as one tablet every morning for depression. Resident #38 ' s Nursing Assessment Summary dated 4/6/16 included the following, in part: " Effexor daily for depression. " A review of Resident #38 ' s admission MDS (Minimum Data Set) assessment dated 4/8/16 revealed the resident was assessed to have severely impaired cognitive skills for daily decision making. He was totally dependent on staff for all of his Activities of Daily Living (ADLs). The resident ' s MDS assessment (Section I) did not indicate the resident had an active diagnosis of depression. Section N of the MDS assessment did not indicate the resident received an antidepressant medication. A review of Resident #38 ' s care plan (initiated on 4/1/16 with additions made on 4/11/16) revealed a problem area related to depression and/or the use of an antidepressant medication was not addressed for Resident #38. An interview was conducted on 5/26/16 at 10:00 AM with the MDS nurse. The MDS nurse reported she also assumed responsibilities as the Interim Director of Nursing (DON). Upon inquiry and review of the Resident #38 ' s MDS assessment, the MDS nurse confirmed neither the diagnosis of depression nor use of an antidepressant medication was coded correctly on the MDS. She stated the diagnosis of	F 279	completed to address the use and monitoring of an antidepressant for depression. Corrective actions to be accomplished for residents having potential to be affected by the same deficient practice: Assessments for all residents on psychotropic medications (to include antidepressants) were reviewed by the MDS nurse on 6-23-16 to verify an active diagnosis was documented with the care area assessment and care plan addressing the use and monitoring of an antidepressant for depression. All residents were found to have an active diagnosis for psychotropic medications (to include antidepressants) and the use of antidepressant medication was coded. The care area assessment and care plan addressed the use and monitoring of an antidepressant for depression. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: The MDS nurse and consultant pharmacist will complete the assessment for all active diagnoses and psychotropic medications (to include antidepressants) on admission. These will be coded with the care area assessment and care plan addressing the use and monitoring of an antidepressant for depression. The coordination of verification between the MDS nurse and consultant pharmacist was established on 6-23-2016. The consultant pharmacist will complete chart reviews and maintains a spreadsheet of	

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F 279	Continued From page 26 depression should have been included as an active diagnosis for Resident #38 and the MDS assessment should also have indicated he received an antidepressant. The MDS nurse reported since use of the antidepressant was not coded correctly, the topic of psychotropic medications (which includes an antidepressant) did not trigger for the resident. Subsequently, an assessment and care plan were not completed to address the use and monitoring of a psychotropic medication for this resident. When asked, the MDS nurse indicated she would have expected Resident #38 to be assessed and care planned for the use of an antidepressant medication.	F 279	medications with active diagnoses for each medication and any changes in medications monthly. This spreadsheet will be updated monthly and sent to the MDS nurse for changes and residents scheduled for quarterly review. The MDS will update the care area assessment and care plan to address the use and monitoring of an antidepressant for depression. How we will monitor our performance to make sure that solutions are sustained: A quality assessment tool has been developed for the CNO or designee to review all admission assessments no later than the next weekly care plan meeting to verify that all active diagnoses have been recorded for any psychotropic medications (to include antidepressants) and coded with the care area assessment and care plan addressing the use and monitoring of medications. The CNO or designee will review that all scheduled quarterly reviews and medication changes recorded on the spreadsheet updated monthly by the consultant pharmacist are coded in the care area assessment and care plan addressing the use and monitoring of medications. Any discrepancies will be corrected at that time. This will be completed and reported to the Quality of Life committee and housewide QI committee monthly for one year to ensure compliance has been achieved and sustained and extended if indicated.	
F 334	483.25(n) INFLUENZA AND PNEUMOCOCCAL	F 334		7/2/16

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F 334 SS=D	Continued From page 27 IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 334		

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F 334	Continued From page 28 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to administer pneumococcal vaccine to a resident who met the criteria for administration and who ' s Responsible Party had consented to the vaccine for 1 of 5 residents reviewed for immunizations (Resident #16). The findings included: Review of the facility Pneumococcal and Influenza Vaccine Protocol revealed that Pneumococcal vaccine was to be offered year	F 334	Corrective action to be accomplished for the resident found to be affected by the deficient practice: On 6/22/16, the responsible party (son) for resident #36 was contacted by the staff nurse and notified that the pneumococcal vaccine had not been given. After being provided education from the CDC Pneumococcal Vaccine Information Statement (VIS) regarding the	

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F 334	Continued From page 29 round at the facility to residents 65 years and older. Contraindications included the following: previously immunized after age 65; previously immunized before age 65, but less than 5 year ago; reported allergy to the vaccine, or thimerisol, or mercury; pregnancy; and patient refusal. Upon consent the vaccine " may be given as soon as patient is afebrile (temp less than 100.4 degrees) x 12 hrs (hours). Pre-Medicate with Tylenol 650 mg (milligrams) x 1 dose. The protocol also indicated administration of the vaccine was to be documented on the Medication Administration Record. Resident #16 was admitted Resident #16 was admitted to the facility on 5/12/15 from a hospital with cumulative diagnoses which included rheumatoid arthritis, osteoarthritis and a malignant neoplasm. Her date of birth confirmed she was over 65 years of age.The annual Minimum Data Set (MDS) assessment dated 4/27/16 indicated Resident #16 was moderately cognitively impaired. Review of the facility Annual Immunization Consent Form for 2015-2016 revealed the following: " Influenza and Pneumococcal vaccines will be offered during the month of October. (Resident #16), is eligible for the following immunization unless he or she has an allergy to the vaccines, has an allergy to eggs or has had the pneumococcal vaccine within the past (5) years. " The consent section was checked indicating yes for pneumococcal (pneumonia) vaccine. The signature indicated that the consent was obtained from the Responsible Party via telephone on 10/30/15. Review of the Medication Administration Record for Resident #16 from October 2016 - 5/26/16 revealed there was no documentation of the Pneumococcal vaccine being given to or refused	F 334	benefits and potential side effects of the pneumococcal vaccine, the responsible party gave telephone consent for the pneumococcal vaccine to be given. The facility standing order for pneumococcal vaccine was used to write the physician order for resident #36. The order was transmitted to the pharmacy, dose sent to the nursing unit and the pneumococcal vaccine was administered on 6-22-16. Corrective actions to be accomplished for residents having potential to be affected by the same deficient practice: Medical records of all residents were reviewed for compliance with the facility Influenza and Pneumococcal Immunization policy by staff nurse and verified with consultant pharmacist. One resident of the remaining 39 had unknown history of pneumococcal vaccination. The unit secretary contacted the previous facility on 6-24-16. Resident vaccination records were received on 6-27-16 indicating no pneumococcal vaccination had been administered there and not history was documented per review by MDS nurse. Hospice nurse was contacted by the MDS nurse on 6-27-16 and stated vaccinations may be administered to hospice residents. The MDS nurse will contact the responsible party to discuss vaccination status and review the CDC Pneumococcal Vaccine Information Statement (VIS) regarding the benefits and potential side effects of the pneumococcal vaccine. The MDS nurse will document the decision of the responsible party as either consent or	

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F 334	Continued From page 30 by Resident #16. Review of the Medical record for October 2016 - 5/26/16 revealed no orders for pneumococcal vaccine. Review of the Physician ' s Order summary for May 2016 revealed the following under the section heading " Vaccine/Immunizations Dates of Lase Dose " : " Pneumonia no documentation as of 10/14 " . During interview with the acting Director of Nursing (DON) on 5/27/16 at 11:32 AM she indicated that the facility used a standing order for pneumococcal vaccine, once consent for an eligible resident was obtained, and there was a standing order form that the physician would sign after which the vaccination could be given. The DON acknowledged that for Resident #16 a signed standing order form for pneumococcal vaccine could not be located and there was no documentation of the resident receiving the vaccine. She stated that it was her expectation that residents receive Pneumococcal vaccination if they were eligible, like Resident #16 and had a signed consent.	F 334	refusal of vaccine. If consent is obtained, the facility standing order for pneumococcal vaccine will be used to write the physician order for the resident. The order will transmitted to the pharmacy, dose sent to the nursing unit and the pneumococcal vaccine will be administered. The MDS nurse is responsible to follow up until the vaccination decision is made and either given or documented as declined by the responsible party. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: Influenza and pneumococcal vaccination history will be assessed for each resident on admission per policy with vaccination administration if indicated by the admitting nurse with review by the MDS nurse. If the resident is not aware of vaccine history and records are not readily available, medical records from prior facilities or clinics will be requested by the unit secretary. Nursing staff will request history from the family and/or responsible party. After all reasonable attempts to gather history have been exhausted, pharmacy will enter not known as of that date on the monthly physician order sheet. This documents that the question has been asked/investigated and is not known after investigation complete. Pneumococcal vaccination will be offered upon admission if indicated and Influenza per time frame as indicated per current CDC guidelines. The nurse will document	

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the decision of the resident or responsible party as either consent or refusal of vaccine after review of the current vaccination information statement. If consent is obtained, the facility standing order for pneumococcal and/or influenza vaccine will be used to write the physician order for the resident. The order will transmitted to the pharmacy, dose sent to the nursing unit and the vaccine will be administered. The MDS nurse is responsible to follow up until the vaccination decision is made and either given or documented as declined by the resident or responsible party. If records have to be requested for vaccination history or there is a delay in receiving feedback from the responsible party, the pending vaccination history will be kept on the weekly care plan agenda until resolved.

How we will monitor our performance to make sure that solutions are sustained:
A quality assessment tool has been developed for the CNO or designee to review all admission assessments no later than the next weekly care plan meeting to verify that vaccination history has been determined and vaccinations provided if indicated. If records have to be requested for vaccination history or there is a delay in receiving feedback from the responsible party, the pending vaccination history will be kept on the weekly care plan agenda until resolved. Any discrepancies will be corrected at that time. This will be completed and reported to the Quality of Life committee and

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F 334	Continued From page 32	F 334	Housewide QI Committee monthly for one year to ensure compliance has been achieved and sustained and extended if indicated.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		7/2/16

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This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews, the facility failed to store medications as specified by the manufacturer in 2 of 2 medication carts (201-211 and 212-221 med carts); and, failed to label medications with a shortened expiration date in 2 of 2 medication carts (201-211 and 212-221 medication carts).

The findings included:

1) An observation made on 5/25/16 at 10:17 AM revealed a box of 0.63 milligrams (mg)/3 milliliters (ml) levalbuterol solution for oral inhalation (a medication used to treat chronic obstructive pulmonary disease and asthma) was stored in the drawer for Resident #10 on the 201-211 medication cart. The box contained two vials of medication in an opened, undated foil pouch.

Manufacturer labeling on the levalbuterol pouch indicated once the foil pouch was opened, the vials should be used within two weeks.

A review of Resident #10 ' s May 2016 Physician ' s Orders revealed there was a current medication order for 0.63 mg/3 ml levalbuterol solution to be used as one vial via nebulizer four times daily for shortness of breath and wheezing.

An interview was conducted on 5/25/16 at 10:45 AM with Nurse #1. Nurse #1 was assigned to the 201-211 Hall medication cart. After reviewing the medication labeling, the nurse stated the levalbuterol vials should have been dated as to

Corrective action to be accomplished for the resident found to be affected by the deficient practice:
The unlabeled Levabuterol for Resident #10 was removed by the pharmacist and adequate stock provided as replacement on 5-25-16.

The loose Restasis vials were placed back in the manufacturer box by the pharmacist on 5-25-16 for Resident #10.

The pharmacist located the dispensed date for the latanoprost ophthalmic solution and labeled the medication for the expiration date from time of dispensing on 5-25-16.

The pharmacist located the dispensed date for the Advair for resident #3 and labeled the medication for the expiration from time of dispensing on 5-25-16.

The pharmacist located the dispensed date for the Advair for resident #19 and labeled the medication for the expiration date from time of dispensing on 5-25-16.

The pharmacist placed a statement in the prescription software to automatically print label med with ____ day exp date on 5-25 -16. Stickers for documentation of this information are placed on medication packaging prior to dispensing by the

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F 431	Continued From page 34 when the foil pouch was opened. Nurse #1 reported she did not know when the pouch had been opened. An interview was conducted on 5/25/16 at 2:30 PM with the facility ' s Consultant Pharmacist. During the interview, the pharmacist reported the levalbuterol vials had been removed from the medication cart. She indicated the foil pouch should have been dated as to when it was opened so the shortened expiration date of the medication could be determined. An interview was conducted with the Interim Director of Nursing (DON) on 5/26/16 at 10:08 AM. Upon inquiry, the DON indicated she would expect the medications to be labeled and dated when stored on the medications carts. She also indicated she would expect all medications to be stored in accordance with the manufacturer ' s recommendations. 2) An observation made on 5/25/16 at 10:17 AM revealed 5 vials of 0.05% Restasis ophthalmic emulsion (a medication used to treat dry eyes) were stored loose in the drawer for Resident #10 on the 201-211 medication cart. The manufacturer ' s box for the Restasis vials was stored in another drawer on the medication cart. The manufacturer labeling on the Restasis box included the following statement, " Store vials in the thermoformed tray until use. " A review of Resident #10 ' s May 2016 Physician ' s Orders revealed there was a current medication order for 0.05% Restasis ophthalmic emulsion to be used as one drop to each eye twice daily for dry eyes.	F 431	pharmacy technician or pharmacist. Packages will be labeled with statement leave med in manufacturer□s packaging by the pharmacy technician or pharmacist when applicable (i.e. Restasis unit dose boxes). Staff education by the consultant pharmacist has begun for all nursing staff and dispensing RPhs regarding the dispensing, labeling and storage process changes. This education will be completed by July 15, 2016. Corrective actions to be accomplished for residents having potential to be affected by the same deficient practice: The pharmacist checked all medications for the remaining residents and verified all were properly labeled on 5-25-16. The pharmacist placed a statement in the prescription software to automatically print label med with ____ day exp date on 5-25 -16. Stickers for documentation of this information are placed on medication packaging prior to dispensing by the pharmacy technician or pharmacist. Labels with instructions for documenting expiration dates for specific medications have been placed on the outer label of the medication by the pharmacy technician or pharmacist. The nursing staff or pharmacy staff will label the specific medication per pharmacy direction at the time they open the manufacturer package and fill in the appropriate expiration date. Packages will be labeled with statement	

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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 431	Continued From page 35 An interview was conducted on 5/25/16 at 10:45 AM with Nurse #1. Nurse #1 was assigned to the 201-211 Hall medication cart. After reviewing the medication labeling, the nurse stated she did not know why the Restasis vials were stored outside of the manufacturer ' s box. An interview was conducted on 5/25/16 at 2:30 PM with the facility ' s Consultant Pharmacist. During the interview, the pharmacist reported the Restasis vials, " should never have been removed " from the manufacturer ' s box prior to use. An interview was conducted with the Interim Director of Nursing (DON) on 5/26/16 at 10:08 AM. Upon inquiry, the DON indicated she expected all medications to be stored in accordance with the manufacturer ' s recommendations. 3) An observation made on 5/25/16 at 10:22 AM revealed an opened bottle of 0.005% latanoprost ophthalmic solution (a medication used to treat glaucoma) was stored in the drawer for Resident #19 on the 212-221 medication cart. The bottle was not dated as to when it had been placed in the drawer at room temperature and/or opened. Manufacturer labeling for latanoprost ophthalmic solution indicated intact bottles of the solution should be stored under refrigeration. Once opened, the solution may be stored at room temperature for 6 weeks. A review of Resident #19 ' s May 2016 Physician ' s Orders revealed there was a current medication order for 0.005% latanoprost ophthalmic solution to be given as one drop into both eyes daily for	F 431	leave med in manufacturer□s packaging by the pharmacy technician or pharmacist when applicable (i.e. Restasis unit dose boxes). Statements will automatically appear on the pharmacy screens when the script is entered. Pharmacy staff will read and comply with statements which will also print on computer generated medication administration records (MARS) used by the nursing staff. Staff education by the consultant pharmacist has begun for all nursing staff and dispensing RPhs regarding the dispensing, labeling and storage process changes. This education will be completed by July 15, 2016. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: The pharmacist placed a statement in the prescription software to automatically print label med with ____ day exp date on 5-25 -16. Stickers for documentation of this information are placed on medication packaging prior to dispensing by the pharmacy technician or pharmacist. Labels with instructions for documenting expiration dates for specific medications have been placed on the outer label of the medication by the pharmacy technician or pharmacist. The nursing staff or pharmacy staff will label the specific medication per pharmacy direction at the time they open the manufacturer package and fill in the appropriate expiration date.	

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	345166	A. BUILDING _____ B. WING _____	05/27/2016

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F 431	Continued From page 36 glaucoma. An interview was conducted on 5/25/16 at 10:40 AM with Nurse #2. Nurse #2 was assigned to the 212-221 Hall medication cart. After reviewing the medication labeling on the latanoprost solution, the nurse stated she knew there was a shortened expiration date that needed to be observed for this medication. However, she did not know when the eye drops had been opened. An interview was conducted on 5/25/16 at 2:30 PM with the facility ' s Consultant Pharmacist. During the interview, the pharmacist reported the latanoprost solution should have been dated as to when it had been opened so the shortened expiration date of the medication could be determined. An interview was conducted with the Interim Director of Nursing (DON) on 5/26/16 at 10:08 AM. Upon inquiry, the DON indicated she would expect the medications to be labeled and dated when stored on the medications carts. The DON also indicated she would expect all medications to be stored in accordance with the manufacturer ' s recommendations. 4) An observation made on 5/25/16 at 10:17 AM revealed a 250/50 milligram (mg) Advair Diskus inhaler (a medication used in the management of chronic obstructive pulmonary disease and asthma) was stored in the drawer for Resident #3 on the 201-211 medication cart. The inhaler had 35 doses remaining. The inhaler was not dated as to when it had been removed from the foil pouch. Manufacturer labeling for the Advair Diskus	F 431	Packages will be labeled with statement leave med in manufacturer□s packaging by the pharmacy technician or pharmacist when applicable (i.e. Restasis unit dose boxes). Statements will automatically appear on the pharmacy screens when the script is entered. Pharmacy staff will read and comply with statements which will also print on computer generated medication administration records (MARS) used by the nursing staff. Scripts are entered into pharmacy software prior to dispensing therefore information is available to pharmacy staff. Pharmacists checking medications have been educated about this policy on 5-27-16. Staff education by the consultant pharmacist has begun for all nursing staff and dispensing RPhs regarding the dispensing, labeling and storage process changes. This education will be completed by July 15, 2016. How we will monitor our performance to make sure that solutions are sustained: A weekly medication cart check will be completed to review that all dispensed doses are labeled prior to dispensing and labeling /packaging is maintained on the nursing unit by the MDS nurse or nurse manager designee. Discrepancies will be corrected when/if found. After 3 months, reviews will be completed monthly. The	

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F 431	Continued From page 37 inhaler indicated the Diskus device should be discarded 1 month after removal from the foil pouch, or when the dosing indicator read " 0 " (whichever comes first). A review of Resident #3 ' s May 2016 Physician ' s Orders revealed there was a current medication order for 250/50 mg Advair Diskus inhaler to be used as one inhalation every 12 hours for chronic obstructive pulmonary disease and shortness of breath. An interview was conducted on 5/25/16 at 10:45 AM with Nurse #1. Nurse #1 was assigned to the 201-211 Hall medication cart. After reviewing the medication labeling, the nurse stated the Advair Diskus inhaler should have been dated as to when the foil pouch was opened. Nurse #1 reported she did not know when the pouch had been opened. An interview was conducted on 5/25/16 at 2:30 PM with the facility ' s Consultant Pharmacist. During the interview, the pharmacist indicated the Advair Diskus inhaler should have been dated as to when it had been opened so the shortened expiration date of the medication could be determined. An interview was conducted with the Interim Director of Nursing (DON) on 5/26/16 at 10:08 AM. Upon inquiry, the DON indicated she would expect the medications to be labeled and dated when stored on the medications carts. The DON also indicated she would expect all medications to be stored in accordance with the manufacturer ' s recommendations. 5) An observation made on 5/25/16 at 10:22 AM	F 431	results will be recorded and reported to the Quality of Life Committee and the Housewide QI Committee monthly for one year to ensure compliance has been achieved and sustained and extended if indicated.	

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F 431	Continued From page 38	F 431		

revealed a 250/50 milligrams (mg) Advair Diskus inhaler (a medication used in the management of chronic obstructive pulmonary disease and asthma) was stored in the drawer for Resident #19 on the 212-221 medication cart. The inhaler had 24 doses remaining. The inhaler was not dated as to when it had been removed from the foil pouch.

Manufacturer labeling for the Advair Diskus inhaler indicated the Diskus device should be discarded 1 month after removal from the foil pouch, or when the dosing indicator read " 0 " (whichever comes first).

A review of Resident #19 ' s May 2016 Physician ' s Orders revealed there was a current medication order for 250/50 mg Advair Diskus inhaler to be used as one inhalation every 12 hours for chronic obstructive pulmonary disease.

An interview was conducted on 5/25/16 at 10:40 AM with Nurse #2. Nurse #2 was assigned to the 212-221 Hall medication cart. After reviewing the medication labeling, the nurse stated she knew there was a shortened expiration date that needed to be observed for this medication. However, she did not know when it had been opened.

An interview was conducted on 5/25/16 at 2:30 PM with the facility ' s Consultant Pharmacist. During the interview, the pharmacist indicated the Advair Diskus inhaler should have been dated as to when it had been opened so the shortened expiration date of the medication could be determined.

An interview was conducted with the Interim

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F 431	Continued From page 39 Director of Nursing (DON) on 5/26/16 at 10:08 AM. Upon inquiry, the DON indicated she would expect the medications to be labeled and dated when stored on the medications carts. The DON also indicated she would expect all medications to be stored in accordance with the manufacturer ' s recommendations.	F 431		