STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD BOX 38 ALBEMARLE, NC 28001

(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 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to honor the resident's right to refuse treatment when the nurse administered Cardiopulmonary Resuscitation (CPR) to a resident despite documentation in the medical record that the resident wished to not be resuscitated for one of one residents (Resident #19) reviewed for death in the facility. The findings included: The facility's policy, with a revision date of 2/2012, titled "Do Not Resuscitate Guidelines", read in part: "It is [facility's] policy that each resident	F 155	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Resident #19 expired prior to citation. On 6/29/2016 a chart audit of all code	7/28/16

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

Electronically Signed | 07/22/2016

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F 155	Continued From page 1 and/or family member has the right to specify their wishes in regard to having cardio-pulmonary resuscitation (CPR-Basic Life Support) performed." Resident #19 was admitted to the facility on 1/6/16 with multiple diagnoses that included gastrointestinal hemorrhage, atrial fibrillation, and a history of heart disease. A review of the medical record indicated Resident #18's medical Responsible Party (RP) was his daughter. Resident #18's Durable Power of Attorney for Healthcare indicated he authorized his healthcare agent to make decisions to withhold life-sustaining procedures, which would allow him to die. The facility's "Advance Care Planning Tracking Form", signed by Resident #18's RP on 1/6/16, indicated discussion about advance care planning was held with the RP and a DNR code status was designated for Resident #18. The facility's "No Code" form, signed by Resident #18's RP on 1/6/16, indicated Resident #18 was not to be resuscitated in the event that vital functions ceased. Resident #18's cover sheet in the hard copy medical record indicated his code status was "no code". Resident #18's Basic Information section of the Electronic Medical Record (EMR) indicated his code status was "no code" . A physician's order in the EMR dated 1/7/16 indicated a DNR code status. The admission Minimum Data Set (MDS) assessment dated 1/13/16 indicated Resident #18 had significant cognitive impairment. The plan of care for Resident #18, dated 1/19/16,	F 155	orders was performed for all active residents in facility to ensure the residents and/or responsible party's wishes for code status were documented along with having physician orders,and if appropriate goldenrod form and Do Not Resuscitate consent form of resident and/or responsible party in chart. Audit was performed by Licensed Practical Nurse and Weekend Day Charge Registered Nurse. 6 charts were noted to have Do not resuscitate signed telephone orders thinned off active chart. Thinned orders were replaced on active chart immediately following audit by the Assistant Director of Nursing. Staff Development Coordinator, Registered Nurse, will conduct in-service on new adopted Code Status Documentation Policy by July 28th for all licensed nursing staff (including Full Time/Part Time/ PRN) and administrative staff responsible for admission process. The administrative staff responsible for admissions process include the Admission Coordinator,Administrator and Resident Liaison. Director of Nursing and/or Assistant Director of Nursing will perform code status audits on new admissions weekly. The audit will include ensuring the code status order is present, and if appropriate the Do Not Resuscitate consent form is signed and goldenrod form is on chart. The Director of Nursing or Admission Coordinator will discuss findings of audit	

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F 155	Continued From page 2 indicated Resident #18 needed to be kept comfortable and had a DNR request. The interventions included adhering to DNR form. A nursing progress note dated 1/24/16 indicated Nurse #1 arrived in Resident #18's room and found him with no chest movement, pale in color, and absent of pulse. CPR was initiated and 911 was contacted. Resident #18's death was pronounced when Emergency Medical Services (EMS) arrived at the facility. An interview was conducted with the facility's Charge Nurse on 6/28/16 at 2:50 PM. She indicated that resident's code status was listed in several locations. She stated the code status was on the cover sheet of the hard copy medical record and EMR and in the basic information section of the EMR. She indicated a physician's order for code status would be in the EMR and the hard copy medical chart. She reviewed the medical record for Resident #18 and indicated his code status was DNR. The nursing progress note for 1/24/16 that indicated CPR was initiated on Resident #18 was reviewed with the Charge Nurse. She stated that she was unable to say why CPR was initiated as she was not in the facility on 1/24/16. A phone interview was conducted with Nurse #1 on 6/28/16 at 3:00 PM. She recalled initiating CPR on Resident #18 on 1/24/16. She stated that prior to initiating CPR she looked in Resident #18's hard copy medical record for a Portable Do Not Resuscitate form, also known as a Goldenrod, and the form was not in his medical record. She indicated that because this form was not Resident #18's hard copy medical record she initiated CPR. She stated she had not known Resident #18's medical record indicated	F 155	monthly at Quality Assurance meetings until three months of compliance is sustained.	

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F 155	Continued From page 3	F 155		

documentation of a "no code" code status. She indicated she had not looked at any other source of information in the medical record for the code status of Resident #18 prior to initiating CPR. She stated she spoke to the RP of Resident #18 after CPR was initiated and she had not voiced any concerns with CPR being provided to Resident #18.

An interview was conducted with the Admissions Coordinator on 6/28/16 at 4:20 PM. She indicated she discussed advanced directives and code status with residents and/or RPs when the admission paperwork was completed. She stated that the resident and/or RP was able to designate a "full code" status or a "no code" status. if the resident and/or RP wanted to designate a "no code" status, also known as DNR, she had them sign the "No Code" form and she prepared the Goldenrod form to be sent to the physician to be signed. She stated she then gave the Goldenrod form to transportation staff or one of the ward secretaries. She indicated they took the form to the physician for signature and then they returned it to the facility and it was filed in the hard copy medical record. She stated she had not followed up on whether the forms were returned to the facility and placed in the hard copy medical records.

An interview was conducted with the ADON on 6/30/16 at 9:05 AM. She indicated she expected resident's documented wishes regarding their code status to be followed. She stated the facility was currently auditing medical records to ensure all residents who designated their wishes of a "no code" code status had the Goldenrod form in their hard copy medical records. She also indicated the facility was in the process of

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F 155	Continued From page 4 adopting a new policy regarding code status to ensure resident's expressed wishes were followed.	F 155		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interview, the facility failed to follow their grievance policy on 1 (Resident #14) 1 of sampled resident reviewed for social services. The findings included: Resident #14 was admitted to the facility on 2/16/16 with multiple diagnoses including Hypertension. The quarterly Minimum Data Set (MDS) assessment dated 4/17/16 indicated that Resident #14's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 15. The grievance policy (undated) was reviewed. The policy read in part " The facility will make prompt efforts to resolve grievances the resident may have, including those with respect to the behavior of other residents. " The policy further indicated that Level 1 grievances are resolved immediately by the employee receiving the grievance while level 11 are documented on the grievance form, investigated and efforts are made to resolve the grievance. Document actions taken and resolution on the form. The doctor's progress notes dated 6/16/16 were	F 166	Resident Liaison met with resident #14 on June 30, 2016 to discuss request for room change and completed a grievance form per grievance policy. Resident Liaison offered multiple room changes but resident elected to stay in same room. Any resident requesting a room change will have a grievance form completed by the Resident Liaison and/or Teammate. Within 5 days the Resident Liaison and/or the Administrator will respond to residents request per facility Grievance Policy. All teammates (Full Time/Part Time/ PRN) will be in-serviced on grievance policy by July 28th by Staff Development RN. Teammates will notify the Resident Liaison and/or Administrator of room change request by completing grievance form. An audit for room changes grievances will be identified and reviewed by Director of	7/28/16

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F 166	Continued From page 5 reviewed. The notes revealed that Resident #14 was not sleeping well secondary to her roommate and another resident down the hall who awakened her frequently. On 6/28/16 at 9:02 AM, Resident #14 was interviewed. The resident stated that she just woke up because she was not able to sleep last night because of her roommate. She stated that her roommate was loud and the staff kept coming in and out of the room to check on her roommate. She added that she had informed the staff about it and nothing had been done. The social service notes were reviewed. There were no documentation regarding Resident #14 requesting for a room change due to her roommate being loud. The grievance forms were reviewed and there was no grievance filed for Resident #14. The grievance log for May 2016 revealed 1 resident who complained about not able to sleep well at night because of the roommate and 1 resident who requested a room change. On 6/29/16 at 10:15 AM, the resident liaison was interviewed. She stated that she was made aware 2 weeks ago that Resident #14 wanted a room change because her roommate was loud. Normally, she didn't fill out a grievance form or document in the resident's medical records when a resident requested a room change. She has a list of residents who wanted a room change and Resident #14 was on the list. She stated that she has no available room to move Resident #14 at this time. On 6/30/16 at 9:00 AM, the assistant Director of Nursing (ADON) was interviewed. She stated that she would talk to the resident liaison to fill out a grievance form when a resident requested a room change due to a roommate issue. The ADON added that the liaison has to document the	F 166	Nursing and/or Administrator to ensure all grievances have been completed and actions have been taken to resolve resident request for room change. This audit will be completed weekly by the Director of Nursing and/or Administrator. The Resident Liaison or Administrator will discuss audit findings monthly at Quality Assurance meetings until three months of compliance is sustained.	

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F 166	Continued From page 6 action taken and the resolution on the grievance form or the resident's medical records. On 6/30/16 at 9:40 AM, Resident #14 was interviewed. The resident stated that nobody had come to talk to her regarding the issue with her roommate. She indicated that she still could not sleep at night. She added that she had no problem changing room and wanted to have a roommate that she can talk with.	F 166		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to follow the plan of care by administering Cardiopulmonary Resuscitation (CPR) on a resident who had a plan of care for a Do Not Resuscitate (DNR) code status for 1 of 1 residents (Resident #18) reviewed for death in the facility. The findings included: Resident #19 was admitted to the facility on 1/6/16 with multiple diagnoses that included gastrointestinal hemorrhage, atrial fibrillation, and a history of heart disease. A review of the medical record indicated Resident #18's medical Responsible Party (RP) was his daughter. Resident #18's Durable Power of Attorney for Healthcare indicated he authorized his healthcare agent to make decisions to	F 282	Resident #19 expired prior to citation. On 7/14/2016 an audit for supportive documentation for Do Not Resuscitate care plans was completed for all active residents by Admission Coordinator and Minimum Data Set Licensed Practical Nurse. The audit included the physician Do Not Resuscitate order, a signed consent Do Not Resuscitate form by resident and/or responsible party, and goldenrod form. In addition the Director of Nursing will audit all active residents Do Not Resuscitated care plans by 7/28/2016, to ensure supportive documentation is present on charts. In-service on new adopted Code Status	7/28/16

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F 282	Continued From page 7 withhold life-sustaining procedures, which would allow him to die. The facility's "Advance Care Planning Tracking Form", signed by Resident #18's RP on 1/6/16, indicated discussion about advance care planning was held with the RP and a DNR code status was designated for Resident #18. The facility's "No Code" form, signed by Resident #18's RP on 1/6/16, indicated Resident #18 was not to be resuscitated in the event that vital functions ceased. Resident #18's cover sheet in the hard copy medical record indicated his code status was "no code". Resident #18's Basic Information section of the Electronic Medical Record (EMR) indicated his code status was "no code" . A physician's order in the EMR dated 1/7/16 indicated a DNR code status. The admission Minimum Data Set (MDS) assessment dated 1/13/16 indicated Resident #18 had significant cognitive impairment. The plan of care for Resident #18, dated 1/19/16, indicated Resident #18 needed to be kept comfortable and had a DNR request. The interventions included adhering to DNR form. A nursing progress note dated 1/24/16 indicated Nurse #1 arrived in Resident #18's room and found him with no chest movement, pale in color, and absent of pulse. CPR was initiated and 911 was contacted. Resident #18's death was pronounced when Emergency Medical Services (EMS) arrived at the facility. An interview was conducted with the facility's Charge Nurse on 6/28/16 at 2:50 PM. She indicated that resident's code status was listed in several locations. She stated the code status	F 282	Documentation policy will be completed by July 28th for all licensed nursing staff (including Full Time/Part Time/ PRN). Education will be provided by Staff Development Coordinator Registered Nurse. An additional in-service on new adopted Code Status Documentation policy will be completed by July 28th by the Staff Development Coordinator Registered Nurse for the Admission Coordinator, Resident Liaison, and Administrator who complete the admission process. Director of Nursing and/or Assistant Director of Nursing will perform code status audit on all new admissions weekly.The audit will include ensuring the code status order is present, and if appropriate the Do Not Resuscitate consent form is signed and goldenrod form is on chart. The Director of Nursing or Admission Coordinator will discuss findings of audit monthly at Quality Assurance meetings until three months of compliance is sustained.	

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F 282	Continued From page 8	F 282		

was on the cover sheet of the hard copy medical record and EMR and in the basic information section of the EMR. She indicated a physician's order for code status would be in the EMR and the hard copy medical chart. She reviewed the medical record for Resident #18 and indicated his code status was DNR. The nursing progress note for 1/24/16 that indicated CPR was initiated on Resident #18 was reviewed with the Charge Nurse. She stated that she was unable to say why CPR was initiated as she was not in the facility on 1/24/16.

A phone interview was conducted with Nurse #1 on 6/28/16 at 3:00 PM. She recalled initiating CPR on Resident #18 on 1/24/16. She stated that prior to initiating CPR she looked in Resident #18's hard copy medical record for a Portable Do Not Resuscitate form, also known as a Goldenrod, and the form was not in his medical record. She indicated that because this form was not Resident #18's hard copy medical record she initiated CPR. She stated she had not known Resident #18's medical record indicated documentation of a "no code" code status. She indicated she had not looked at any other source of information in the medical record for the code status of Resident #18 prior to initiating CPR. She stated she spoke to the RP of Resident #18 after CPR was initiated and she had not voiced any concerns with CPR being provided to Resident #18.

An interview was conducted with the Admissions Coordinator on 6/28/16 at 4:20 PM. She indicated she discussed advanced directives and code status with residents and/or RPs when the admission paperwork was completed. She stated that the resident and/or RP was able to designate

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F 282	Continued From page 9 a "full code" status or a "no code" status. if the resident and/or RP wanted to designate a "no code" status, also known as DNR, she had them sign the "No Code" form and she prepared the Goldenrod form to be sent to the physician to be signed. She stated she then gave the Goldenrod form to transportation staff or one of the ward secretaries. She indicated they took the form to the physician for signature and then they returned it to the facility and it was filed in the hard copy medical record. She stated she had not followed up on whether the forms were returned to the facility and placed in the hard copy medical records. An interview was conducted with the ADON on 6/30/16 at 9:05 AM. She indicated she expected resident's documented wishes regarding their code status to be followed. She stated the facility was currently auditing medical records to ensure all residents who designated their wishes of a "no code" code status had the Goldenrod form in their hard copy medical records. She also indicated the facility was in the process of adopting a new policy regarding code status to ensure resident's expressed wishes were followed.	F 282		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		7/28/16

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F 329	Continued From page 10 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Pharmacy Consultant and Nurse Practitioner interview the facility failed to attempt a gradual dose reduction of Ativan (an antianxiety medication) or to review and document contraindications to a gradual dose reduction of Ativan for 1 of 6 resident ' s (Resident # 29) reviewed for unnecessary medications. The findings included: Resident #29 was admitted 5/21/12 and readmitted 3/12/15. Her cumulative diagnoses included dementia, depressive disorder, anxiety disorder and aphasia following unspecified cerebral vascular disease. Review of the Quarterly Minimum Data Set (MDS) dated 5/25/16 revealed Resident #29 was cognitively impaired and received an antianxiety medication and had an active diagnosis of anxiety. It also revealed Resident #29 had	F 329	Resident #29□s chart reviewed by Pharmacy Consultant and Nurse Practitioner. Nurse Practitioner decreased Ativan to 0.25mg every 8 hours as needed on 7/6/16. Chart audit of all current resident□s receiving psychoactive drugs completed by pharmacy consultant to determine current Gradual Dose Reduction (GDR) status and forwarded to Director Of Nursing on 7/1/2016. Pharmacist consultant will conduct a GDR audit on residents receiving psychoactive medications during monthly chart review. Any irregularities from the audit will be forwarded to the Director of Nursing who will ensure recommendation is followed by	

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F 329	Continued From page 11 displayed some physical, verbal and other behaviors during the look back period. Review of the Physician ' s Orders revealed the following orders dated 3/15/15 for Ativan (Lorazepam): Lorazepam 0/5 mg tablet give ½ tablet (0.25 mg) by mouth at 9:00 AM and 2:00 PM for anxiety or agitation. Omit dose if lethargic. Lorazepam 0.5 mg give one tablet by mouth every hour of sleep (every night at bedtime), for anxiety of agitation. Omit dose if lethargic. Review of the Care Plan dated 7/12/15 revealed a plan of care for anxiety/altered thought process related to dementia. Approaches included listening to the resident ' s concerns, " evaluate individual stress level and deal with it appropriately " , turn of lights at bedtime and medications as ordered. Review of a Note to Attending Physician/Prescriber (7/10/15) revealed " Resident is receiving Ativan 0.5 mg (milligrams) QHS every night. Please review for gradual dose reduction or document need to continue at current dosage (risk versus benefit documentation). " Two options were listed " Consider Ativan 0.25 QHS or Continue without any changes. " The continue option was checked. IN addition under Physician/Prescriber response other was checked and the following was hand written " has attempted GDR (Gradual Dose Reduction) (without) success. " On 6/30/16 at 8:33 AM interview with the Nurse Practitioner revealed that she had no knowledge of an Ativan GDR attempt for Resident #29 however she said that Resident #29' s previous doctor (now retired) had worked with the resident for years and may have had some insight. The NP was unaware of any documentation regarding this.	F 329	Physician / Nurse Practitioner prior to next audit. Pharmacist Consultant and Director of Nursing will audit Physician/ Nurse Practitioner response for accuracy and ensure orders have been carried out or appropriate documentation has been completed regarding risks versus benefits. Director of Nursing and/or Pharmacist will discuss findings at monthly QA meeting until three months of compliance has been sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD BOX 38 ALBEMARLE, NC 28001

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F 329	Continued From page 12 On 6/30/16 at 10:16 AM interview with the Assistant Director of Nursing revealed that there had never been a GDR attempt on Resident #29 ' s Ativan, although Resident #29 had previously been on another antianxiety medication that had been discontinued in November 2014. She added that sometimes physicians did not want to mess with a resident ' s psychotropic medications once a resident seemed stabilized. The ADON also acknowledged that a GDR should have been done unless it was contraindicated and that documentation from the physician to support that was required. Interview with the Pharmacy Consultant on 6/30/16 at 10:32 AM revealed she thought Resident #29 had a gradual dose reduction (GDR) of Ativan previously but added that the facility had been unable to locate any documentation of a GDR.	F 329		