STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, resident observation and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 14 residents reviewed in the area of oral care (Resident #56) and unnecessary medications (Resident #157).	F 278	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken	10/7/16

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

Electronically Signed | 09/23/2016

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F 278	Continued From page 1 Findings included: 1. Resident #56 had been admitted on 1/30/2015. Diagnoses included chronic obstructive pulmonary disease, coronary artery disease, hypertension, adult failure to thrive, anemia, bipolar, dementia, depression, and osteoarthritis. A physician note dated 12/11/2015 noted "dental decay and plaque, broken teeth." Resident #56's most recent Annual MDS dated 1/27/2016 did not indicate she had any dental problems. An interview with the MDS nurse was conducted on 8/9/16 at 9:30 AM. The nurse stated the assessment had not been coded correctly and should indicate Resident #56 had dental problems. An interview with the Administrator (AD) was conducted on 9/09/2016 at 11:37 AM. The AD stated it was her expectation that the MDS be coded correctly and accurately. 2. Resident #157 was admitted 10/9/15 with diagnoses which included retention of urine and enlarged prostate. His most recent Minimum Data Set (MDS) of 7/10/16 indicated he was moderately cognitively impaired. It further indicated he had a suprapubic catheter and received antibiotics 3 of 7 days in the look back period. A review of the July 2016 orders indicated Resident 157# was receiving Trimethoprim 100 milligrams (mg) (antibacterial medicine	F 278	or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Resident Affected: For Resident #56 MDS assessment with ARD of 3/13/16 was modified by the MDS Coordinator to reflect resident's current dental status in Section L. For resident #157, the MDS with ARD of 7/10/16 was modified by the MDS Coordinator in order to correctly reflect the number of days that he received antibiotic treatment in Section N during the 7 day ARD lookback period. This was completed by 09/30/2016. Corrective Action for Residents Potentially Affected All current residents have the potential to be affected by this practice. On 10/3/2016, the Nurse Managers began an audit of all current residents' oral/dental status. Once the audit is completed, the MDS Coordinator will compare the findings to the residents' most recent MDS assessment to assess for inaccurate coding. If incorrect coding is noted, a modification assessment will be completed by the MDS Coordinator by 10/7/16. All MDSs for current residents who have received an antibiotic medication within the 3 month period from 06/01/16 – 09/09/16 will be audited to validate that Section N of MDS is accurately coded. This audit will be conducted by the Nurse Consultant. Once the audit is completed, any MDS that is found to be inaccurately coded will	

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F 278	Continued From page 2 prescribed for treating infections) daily. On 9/9/16 at 1:10 PM, an interview was conducted with the MDS Nurse. She stated she used the Medication Administration Record (MAR) to obtain information for the medication section of the MDS. She reviewed the reference chart identified as the Drug Class Index List. She stated she probably missed the Trimethoprim. She stated Resident #157 should have been coded as receiving an antibiotic 7 out of 7 days on the MDS. On 9/9/16 at 1:16 PM, an interview was conducted with the Director of Nursing (DON). She stated she was not sure if a prophylactic antibiotic that was not treating an active urinary tract infection would be coded on the MDS. She reviewed the order with the MDS nurse and stated the MDS nurse thought she had coded it correctly because the start date of the prophylactic antibiotic did not catch her attention. The DON stated she would expect an antibiotic to be coded as received 7 out of 7 days in the look back period if the resident was on chronic (long term) therapy.	F 278	be modified and corrected by the MDS Nurse. These actions will be completed no later than 10/7/16. Systemic changes: On 10/04/16, the MDS Coordinator and Assistant MDS Nurse were in-serviced by the MDS Consultant on accurate coding of MDS item Sections L and N. This information has been integrated into the standard orientation training for MDS Coordinators and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The MDS Consultant will audit 5 residents for MDS accuracy of sections L and N. This will be completed weekly x 4 weeks then monthly x two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the MDS Consultant to ensure corrective action(s) are appropriately initiated. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
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		10/7/16

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F 329	Continued From page 3 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 staff, pharmacist, and physician interviews and medical record review, the facility failed to discontinue an antibiotic after two urine sensitivity reports showed it was resistant to the cultured bacterium for 1 of 6 residents (Resident #157) reviewed for unnecessary medications. The findings included: Resident #157 was admitted to the facility on 10/9/15 with diagnoses which included hypertension, benign prostatic hyperplasia (enlarged prostate), urinary tract infection in the last 30 days, dementia, Parkinson ' s disease, urinary retention and insertion and maintenance of urinary device. A review of a verbal order dated 10/30/15 read Trimethoprim (an antibiotic used to treat urinary tract infections) 100 milligrams (mg) Give 1 tablet by mouth one time a day for an undetermined period of time.	F 329	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Resident Affected On 9/3/16, the order for Trimethoprim was discontinued for Resident #157 per order received from Urologist, Adel Mohamed, M.D. Corrective Action for Residents Potentially Affected	

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F 329	Continued From page 4 A review of a urinalysis report from 6/25/16 indicated the presence of Klebsiella pneumoniae (a gram-negative bacteria). A sensitivity report showed the bacteria was resistant to Trimethoprim. His Quarterly Minimum Data Set (MDS) of 7/10/16 showed he was severely cognitively impaired. His diagnoses included urinary tract infection (last 30 days). He was noted to have a suprapubic catheter. His medication assessment indicated he received antibiotics 3 of 7 days in the look back period. A review of a urinalysis report from 7/29/16 indicated the presence of Proteus mirabilis (a gram-negative bacteria). A sensitivity report showed the bacteria was resistant to Trimethoprim. On 9/8/16 at 3:58 PM, an interview was conducted with Nurse #6. She stated she was not sure why Resident #157 was still on Trimethoprim if his urine cultures indicated a resistance. On 9/9/16 at 10:19 AM, an interview was conducted with the Nurse Practitioner. She stated Resident #157 was seeing a urologist for his chronic urinary tract infections (UTI) at the family ' s request. She stated because of this she had deferred to him to address the antibiotic suppression therapy. On 9/9/16 at 2:40 PM, an interview was conducted with the facility ' s consulting pharmacist. She stated long term antibiotic therapy for a resident with diagnoses of chronic UTI, benign prostatic hypertrophy (enlarged prostate) and urinary obstruction would not be uncommon. She indicated the culture and sensitivity reports would be reviewed but she did not recall noticing that the last two were resistant to Trimethoprim.	F 329	All residents receiving antibiotic medications have the potential to be affected by this practice. All residents who are actively being treated with antibiotic medication will be audited to ensure that he/she is receiving appropriate antibiotic, based on culture and sensitivity reports. The medical provider will be notified of any resident whose lab work indicates resistance to the antibiotic that they are receiving. This will be conducted by Nurse Managers and will be completed by 10/7/16. Systemic Changes On 10/3/16, Nurse Managers initiated education for all Full-Time, Part-Time and PRN RN's and LPN's on importance of reviewing all antibiotic orders and corresponding culture/sensitivity reports to ensure that residents receive appropriate treatment. This education will also be provided to any agency LPN or RN. This will be completed by 10/7/16. Any nursing staff member who did not receive in-service training by 10/7/16 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all RN's and LPN's and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The DON will be responsible for auditing five residents receiving antibiotic medication to ensure that residents are not receiving antibiotics that are resistant to the bacteria for which the resident is being treated for. This will be done weekly	

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F 329	Continued From page 5 On 9/19/16 at 1:45 PM, an interview was conducted with the consulting urologist ' s nurse. She stated the facility had contacted their office regarding the Trimethoprim order but it was not originally ordered by this physician. She stated the facility called back and stated that the original ordering physician wanted the urologist to decide whether or not to continue the medication so he had given orders to discontinue it.	F 329	for one month then monthly times two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the DON in order to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to administer a medication as prescribed for 1 of 6 observed residents (Resident #231). Findings included: Resident #231 was admitted to the facility 8/31/16 with diagnoses which included anxiety disorder. A review of Resident #231's medical record revealed a hand written physician order date 08/31/16. The order was signed the by Nurse Practitioner (NP) and prescribed Xanax 0.5 milligrams (mg) 1 tablet by mouth 3 times a day. A review of the facility's Narcotic Count Sheet dated 8/31/16 revealed Xanax 0.5 mg was signed out for Resident #231 on eight occasions between 9/1/16 - 9/8/16.	F 333	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Resident Affected On 9/8/2016 immediate action was taken by the facility staff to review the patient's hospital discharge summary orders,	10/7/16

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F 333	Continued From page 6 A review of the electronic physician orders dated 8/31/16 revealed Resident #231 was recorded as receiving Xanax 0.25 mg 1 tablet by mouth as needed (PRN) for anxiety three times a day. A review of Resident #231's electronic medication administration record revealed the resident had received 8 doses of Xanax 0.25 mg as needed since 8/31/16. The Xanax order had not been transcribed to reflect the increased dosage or frequency as ordered by the NP. During the medication administration observation on 9/8/16 at 12:02 PM, Nurse #1 was observed giving 0.5 mg of Xanax to Resident #231. The blister pack containing the Xanax was observed labeled as Xanax 0.5 mg and contained the resident's name. Eight tablets were missing from this blister pack. During a staff interview on 9/8/16 at 2:30 PM, Nurse #1 confirmed the medication blister pack of Xanax and the narcotics declining dated 8/31/16 was labeled 0.5 mg. The nurse stated she gave 0.5 mg to the resident on 9/8/16 at 12:02 PM as a PRN medication for the resident's anxiety. During an interview on 9/8/16 at 4:00 PM the resident's NP stated that she changed Resident #231's Xanax order from 0.25 mg to 0.5 mg on 8/31/16 due to pain from a surgical procedure, and transition from a different nursing home which caused the resident to have increased anxiety. On 9/9/2016 at 1:10 PM in an additional interview, the NP stated that the prescription was written as Xanax 0.5 mg 1 tablet by mouth 3 times daily. She further stated that it was her intention for the medication to be given as scheduled instead of	F 333	speak with the prescribing NP, review the patients SNF medical record orders and medication card. In consulting with the NP it was discovered her hard script to fill the medication from the pharmacy was not the same order as the patient received when discharging from the hospital. Immediately following this review the order was clarified and updated in the electronic medication administration record to reflect the NPs intended medication order. Corrective Action for Resident Potentially Affected On 9/8/2016 a root cause analysis was completed with NP, DON, NHA, Unit Manager and support nurse in attendance to explore events which occurred to prevent reoccurrence of medication errors for potential affected residents. This analysis meeting determined this error to have occurred because the provider decided to increase the patient's medication regimen by writing a hard script order to be sent to the pharmacy but did not write a medication administration order increasing the medication for the facility staff to enter into the medical record. Further review determined the only residents with potential for this practice to have affected are those on controlled substances requiring a hard script for order or refill. On 9/8/2016 the DON and designated support staff reviewed all controlled medications in the building to ensure the filled medication orders match the electronic medical record and subsequent administration record.	

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F 333	Continued From page 7 as needed. The nurse practitioner stated that her order superseded all previous orders. During an interview on 9/9/2016 at 1:21 PM the Director of Nursing (DON) stated the order for Xanax dated 8/31/16 read Xanax 0.5 mg 1 tablet by mouth 3 times daily. The DON further stated that the resident was receiving the medication PRN and the resident was not receiving the medication as ordered. The DON stated that her expectation was that the resident would receive the medication as ordered.	F 333	9 of 126 medications were identified to have this same concern as outlined above. All identified medications orders and records were clarified by the prescribing provider. Systematic Changes Starting 9/8/2016 any discrepancies found between medications filled and medication administration record orders will be reviewed with the prescribing provider for clarification and instruction; and reported to the DON for trends and . From the quality assessment review meeting, the committee recommended ensuring all controlled substances coming into the building from the pharmacy were checked against the electronic medication administration record to ensure the filled medication matches the order and administration record. This was completed immediately following the quality assurance review on 9/8/2016. An in-service was conducted on 9/13/2016 and 914/2016 by the unit manager and Director of Nursing. Those who attended were all RNs, LPNs, and FT, PT, and PRN. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed.	

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F 333	Continued From page 8	F 333	The in-service included: safe medication administration practices which include checking the medication frequency, quantity and when medications are delivered from pharmacy against orders. Quality Assurance The DON reviews all medication errors for identification of facility trends and opportunities to improve performance. Additionally, all medication errors are reviewed during Quarterly QA for recommendations and tracking trends for improvement.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to keep the ice machines free from mildew buildup for 3 of 3 ice machines located in 3 nourishment rooms. The findings included: During an interview with the dietary manager on 9/9/16 at 10:24 AM she reported maintenance was responsible for cleaning the ice machines. On 9/9/16 at 11:15 AM observations of the ice	F 371	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of	10/7/16

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F 371	Continued From page 9 machines located in the nourishment rooms was conducted with the Maintenance Director (MD). An observation of the ice machine in the 100-200 hall nourishment room revealed the white ice bin shield had black residue along the lower edge touching the ice. Next an observation of the ice machine in the 400-500 hall nourishment room revealed it also had black residue on the white ice bin shield. An observation of the ice machine in the 600 hall nourishment room revealed it had pink and black debris along the bottom of the white ice bin shield. The MD stated the black debris was mildew and the pink residue was called red mold. During an interview with the Maintenance Director on 9/9/16 at 12:15 PM he stated he was responsible for cleaning the ice machines on a monthly basis. He added he usually did the cleaning during the second week of each month but he did not document the cleaning until the end of the month. He then reported he had documented that he cleaned the internal coils on the 12th (8/12/16) so that was the actual day he had cleaned the bin including the white bin shield. He added that the ice was always in contact with the ice bin shield which caused the red mold and black mildew to build up on the shield. He stated he had not completed the September cleaning yet because it was planned for the following week. On 9/9/16 at 2:15 PM the Maintenance Director provided a copy of the procedure for ice machines maintenance which revealed he marked the cleaning as completed on 8/29/16.	F 371	compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action On 9/14/2016, the Maintenance Director cleaned the bins and bin lid/covers for all ice machines in nourishment rooms. Corrective Action for Residents Potentially Affected All residents have the potential to be affected by this alleged deficient practice. Ice machines in all nourishment rooms will be cleaned on a bi-monthly basis by the Maintenance Director. This cleaning will include the bin and the bin cover/lid. The Maintenance Director will document each time that this task is performed on the designated cleaning log. This documentation shall be completed on the actual date of cleaning and will include the date, Maintenance Director's initials and the unit that the ice machine is located. Systemic Changes Educated was provided to Maintenance Director, as well as all other Management Employees who conduct facility rounds. This education was provided by the Administrator on 9/9/2016 and included the following: Importance of properly cleaning ice maker bins and covers/lids in order to prevent contamination with bacteria; Importance of thoroughly inspecting ice machines during facility rounds for any signs of mold/mildew or other debris and the reporting process for concerns found. All other facility staff members were also educated on importance of observing ice machine bins and lids/covers for any	

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F 371	Continued From page 10	F 371	signs of mold/mildew or other debris when they are using them. This education also included the proper process for reporting any concerns to the Maintenance Director. This education was provided by Nurse Managers to be completed by 10/7/16. This information has been integrated into the standard orientation training for all new employees. Quality Assurance Nourishment room ice machine audits will be performed during facility rounds 5x week x 4 weeks and then weekly x 8 weeks. This audit will be completed for each unit by the staff member designated by the Administrator. Audit results and any issues will be reported to the Maintenance Director and Administrator and corrective action will be taken as needed.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview, consultant pharmacist	F 428	The statements made on this plan of	10/7/16

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F 428	Continued From page 11 interview and record review, the facility ' s consultant pharmacist failed to address duplicate antibiotic therapy and failed to address the resident received an antibiotic that the bacteria was not effective for 1 of 6 residents (Resident #157) reviewed for unnecessary medications. The findings included: Resident #157 was admitted to the facility on 10/9/15 with diagnoses which included, benign prostatic hyperplasia (enlarged prostate), urinary tract infection in the last 30 days, dementia, urinary retention and insertion and maintenance of urinary device. A review of a verbal order dated 10/30/15 read Trimethoprim (an antibiotic used to treat urinary tract infections) 100 milligrams (mg) Give 1 tablet by mouth one time a day for an undetermined period of time. A review of a urinalysis report from 6/24/16 indicated the presence of Klebsiella pneumoniae (a gram-negative bacteria). A sensitivity report showed the bacteria was resistant to Trimethoprim. His Quarterly Minimum Data Set (MDS) of 7/10/16 showed he was severely cognitively impaired. His diagnoses included urinary tract infection (last 30 days). He was noted to have a suprapubic catheter. His medication assessment indicated he received antibiotics 3 of 7 days in the look back period. A review of the pharmacist progress note of 7/13/16 indicated Resident #157 had a urine culture and sensitivity report on 6/24/16 which showed a sensitivity to Augmentin. The note indicated Augmentin had been ordered on 6/27/16. There was no documentation of duplicate therapy or resistance to Trimethoprim. There was no documentation indicating a physician was notified of Resident #157 ' s	F 428	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Resident Affected On 9/3/2016, the order for Trimethoprim was discontinued for Resident #157 per order received from Urologist, Adel Mohamed, M.D. Corrective Action for Resident Potentially Affected All residents receiving antibiotic medications have the potential to be affected by this practice. All residents who are actively being treated with antibiotic medication will be audited to ensure that he/she is receiving appropriate antibiotic, based on culture and sensitivity reports. The medical provider will be notified of any resident whose lab work indicates resistance to the antibiotic that they are receiving. This will be conducted by Nurse Managers and will be completed by 10/7/16. Systemic Changes On 10/3/16, Nurse managers initiated education for all Full-Time, Part-Time and PRN RN's and LPN's on importance of reviewing all antibiotic orders and corresponding culture/sensitivity reports to ensure that residents receive appropriate treatment. This education will also be	

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F 428	Continued From page 12 duplicate antibiotic therapy or the bacterial resistance to Trimethoprim. A review of a urinalysis report from 7/29/16 indicated the presence of Proteus mirabilis (a gram-negative bacteria). A sensitivity report showed the bacteria was resistant to Trimethoprim. A review of the pharmacist progress note of 8/8/16 indicated Resident #157 had a urine culture (UC) and sensitivity report on 7/29/16. Medication notes included that the resident was receiving Amoxicillin for 10 days (UC sensitive). There was no documentation of duplicate therapy or resistance to Trimethoprim. On 9/9/16 at 2:40 PM, an interview was conducted with the facility ' s consulting pharmacist. She stated long term antibiotic therapy for a resident with diagnoses of chronic UTI, benign prostatic hypertrophy (enlarged prostate) and urinary obstruction would not be uncommon. She indicated the culture and sensitivity reports would be reviewed but she did not recall noticing that the last two were resistant to Trimethoprim.	F 428	provided to any agency LPN or RN. This will be completed by 10/7/16. The pharmacist was educated on the importance of reviewing all antibiotic usage and lab sensitivity reports timely with every monthly visit. Any nursing staff member who did not receive in-service training by 10/7/16 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all RN's and LPN's and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The DON will be responsible for auditing five residents receiving antibiotic medication to ensure that residents are not receiving antibiotics that are resistant to the bacteria for which the resident is being treated for. These reviews will ensure the pharmacist is also addressing antibiotic review against sensitivity lab reports. This will be done weekly for one month then monthly times two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the DON in order to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		10/7/16

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F 441 SS=D	Continued From page 13 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews, and record reviews, the facility failed to post signage indicating the type of precautions to be taken for 1 of 3 residents (Resident #21) observed on isolation. The findings included: A review of the facility policy titled "Initiating Transmission Based Precautions", dated 7/1/02 and last revised 6/2014 stated in part, "4. When isolation is ordered, the primary nurse will be responsible for labeling the resident's door appropriately. " On 9/7/16 at 4:00 PM, an observation of Resident #21's room revealed a portable cart containing disposable gowns, gloves and hand sanitizer placed in the hallway to the left of the door. There was no sign posted on the door or in the hallway. On 9/8/16 at 8:30 AM, an observation of Resident #21's room revealed the portable cart continued to be in the hallway to the left of the door. There was no sign on the door or wall outside the door. On 9/8/16 at 9:11 AM, NA #2 was observed retrieving a breakfast tray from Resident #21's room. She stated the resident had Clostridium difficile (an intestinal bacteria). On 9/8/16 at 12:03 PM, an observation of Resident #21's room revealed the portable cart continued to be in the hallway to the left of the door. There was no sign on the door or wall outside the door. On 9/8/16 at 12:05 PM, a family member was observed in Resident #21's room wearing a disposable gown and gloves. The family member stated the resident had C-diff. She stated the staff had educated her to wear a gown and	F 441	Corrective Action for Affected Residents The appropriate Isolation Sign was posted outside of the door of the room for Resident # 21. This was done by Hall nurse on 9/8/2016. Corrective Action for Potentially Affected Residents All residents have the potential to be affected. The DON will complete an audit of all residents to determine those who have active infections that require specific isolation precautions. All residents identified as having such an infection will be audited to ensure that appropriate signage is posted outside of his/her room indicating the type of isolation precautions and personal protective equipment that are required prior to entering resident's room. This will be completed by 10/7/16. Systematic Changes Education for all Full-Time, Part-Time and PRN nurses, including RN's and LPN's was initiated on 10/7/16 by Nurse Managers. The education included the importance of ensuring that anytime a resident has an active infection that requires specific isolation precautions, appropriate isolation signs are posted outside of the resident's room. The posted sign should include what isolation precautions are to be taken as well as the type(s) of personal protective equipment that is required prior to entering room. The education also included the storage location of the signs in the top drawer of all the isolation carts. These signs should	

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F 441	Continued From page 15 gloves. She stated she wasn't sure why there had not been a sign on the door this time, but sometimes there were signs posted. She stated Resident #21 had been on isolation in the past and there was a sign posted so she knew what was expected. On 9/8/16 at 2:07 PM Nurse #1 was interviewed. She stated Resident #21 had been transferred to her current room on the previous day and she was not sure of when the isolation had been ordered. On 9/8/16 at 2:08 PM, the family member was interviewed a second time. She stated the isolation had been ordered on 9/7/16 and Resident #21 was moved to her current room. She stated the staff had called the Responsible Party (RP) to explain the type of isolation and the Nurse Practitioner had also explained it when she made rounds. On 9/8/16 at 2:17 PM, an interview was conducted with Nurse #3. She stated she had been responsible for Infection Control in the facility for a month. She stated Resident #21's culture report came back at 5:20 AM on 9/7/16 and she had been moved to her current room and placed on Contact Isolation at that time. She stated the nurse assigned to that room was responsible for setting up the cart and posting a sign on the door of the room. On 9/8/16 at 2:29 PM, the Administrator joined the interview and stated it was her expectation for signs to be posted notifying visitors of precautions or to see the nurse before entering the room of a resident on isolation. On 9/9/16 at 12:27 PM, an interview was conducted with NA #3. She stated she was assigned to Resident #21's care on 9/7/16 from 7 AM to 3 PM. She stated the isolation cart was outside the door when she started her shift and	F 441	be posted immediately when resident is placed on isolation restrictions. This education will be completed by 10/7/16. Any LPN or RN who does not receive this training by 10/7/16 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The DON will monitor this issue using the Quality Assurance tool "Monitoring Infection Control Practices." The monitoring will include observing staff practices for properly placing isolation precaution signs outside of resident rooms for those residents who have diagnoses of active infection requiring such precautions. This audit will be conducted for 5 residents with active infections weekly for 4 weeks then monthly times 2 months. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Manager, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

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F 441	Continued From page 16 she received information in report from the previous shift about the type of isolation that had been ordered. She stated she did not recall if a sign had been posted. She stated if visitors came in, they would not know what personal protective equipment was required without a sign. She further stated, "They don't even know what the cart is for sometimes." On 9/9/16 at 12:31 PM, an interview was conducted with the Director of Nursing. She stated it was her expectation that a sign be posted on the door at the time the isolation was initiated.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to accurately transcribe the Nurse Practitioner's hand written order to an electronic order for 1 of 6 residents (Resident #231).	F 514	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal	10/7/16

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F 514	Continued From page 17 Findings included: Review of Resident #231's medical record revealed the resident was admitted to the facility on 8/31/16 with a diagnosis of anxiety disorder." Review of the hand written order dated 8/31/16 revealed the Nurse Practitioner (NP) prescribed Xanax 0.5 milligrams (mg) 1 tablet by mouth 3 times daily upon the resident's admission to the facility. Review of the electronic orders dated 8/31/16 revealed the electronic order was incorrectly transcribed from the written order. The electronic order read 0.25 mg 1 tablet by mouth as needed for anxiety three times a day instead of 0.5 mg 3 times per day Review of the resident's electronic Medication Administration Record (eMAR) for September revealed the eMAR was also incorrect. The eMAR indicated the resident received 0.25 mg of Xanax as follows: -2 doses on 9/1/16, -1 dose on 9/2/16, -1 dose on 9/3/16, - 1 dose on 9/5/16, - 1 dose on 9/6/16, -1 dose on 9/7/16, and -1 dose on 9/8/16 for a total of 8 doses of Xanax. However, during medication administration observation on 9/8/16 at 12:02 PM, Nurse #1 was observed giving 0.5 mg of Xanax to Resident #231 not 0.25 mg as documented on the eMAR. Further observation on 9/8/16 at 12:05 PM revealed the blister pack of Xanax for Resident #231 was labeled Xanax 0.5 mg and eight tablets had been dispensed. During a staff interview on 9/8/16 at 2:30 PM, Nurse #1 stated that the medication blister pack dated 8/31/16 was labeled 0.5 mg. The Nurse stated the narcotics declining count sheet, dated	F 514	and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Resident Affected On 9/8/2016 immediate action was taken by the facility staff to review the patient's hospital discharge summary orders, speak with the prescribing NP, review the patients SNF medical record orders and medication card. In consulting with the NP it was discovered her hard script to fill the medication from the pharmacy was not the same order as the patient received when discharging from the hospital. Immediately following this review the order was clarified and updated in the electronic medication administration record to reflect the NPs intended medication order. Corrective Action for Resident Potentially Affected On 9/8/2016 a root cause analysis was completed with NP, DON, NHA, Unit Manager and support nurse in attendance to explore events which occurred to prevent reoccurrence of medication errors for potential affected residents. This analysis meeting determined this error to have occurred because the provider decided to increase the patient's medication regimen by writing a hard script order to be sent to the pharmacy but did not write a medication administration order increasing the medication for the facility staff to enter into	

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F 514	Continued From page 18 8/31/16, was also labeled Xanax 0.5 mg. Nurse #1 further stated she had being giving 0.5 mg of Xanax, including the dose on 9/8/16 at 12:02 PM. During a staff interview on 9/8/16 at 4:00 PM the Nurse Practitioner stated that she changed the resident's Xanax order from 0.25 mg to 0.5 mg 3 times daily on 8/31/16 due to pain from an amputation and the transition from a different nursing home, which caused the resident to have increased anxiety. During a staff interview on 9/9/16 at 8:18 AM, the Director of Nursing (DON) stated that the resident's order was 0.5 mg 3 times daily since entering the facility on 8/31/16. The DON further stated that the nurses use the eMAR to verify the correct order during medication administration. The DON stated that if the resident was transferred to another facility or to the hospital, the electronic health record would be transferred with the resident and not the hand written order. The DON stated the nurses transcribe the hand written order into the electronic health record (eHR) which is then transferred to the eMAR. The DON further stated the eMAR and eHR for Resident #231 were incorrect and had been transcribed incorrectly from the NP's hand written order. The DON stated that her expectation is that the eMAR and eHR would be transcribed correctly.	F 514	the medical record. Further review determined the only residents with potential for this practice to have affected are those on controlled substances requiring a hard script for order or refill. On 9/8/2016 the DON and designated support staff reviewed all controlled medications in the building to ensure the filled medication orders match the electronic medical record and subsequent administration record. 9 of 126 medications were identified to have this same concern as outlined above. All identified medications orders and records were clarified by the prescribing provider. Systematic Changes On 9/9/2016 any discrepancies found between medications filled and medication administration record orders will be reviewed with the prescribing provider for clarification and instruction; and reported to the DON for trends and review. From the quality assessment review meeting, the committee recommended ensuring all controlled substances coming into the building from the pharmacy were checked against the electronic medication administration record to ensure the filled medication matches the order and administration record. This was completed immediately following the quality assurance review on 9/8/2016. An in-service was conducted on 9/13/2016 and 9/14/2016 by the unit manager and Director of Nursing. Those who attended were all RNs, LPNs, and FT, PT, and PRN. The facility specific	

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F 514	Continued From page 19	F 514	in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service included: safe medication administration practices which include checking the medication frequency, quantity and when medications are delivered from pharmacy against orders. Quality Assurance The DON reviews all medication errors for identification of facility trends and opportunities to improve performance. Additionally, all medication errors are reviewed during Quarterly QA for recommendations and tracking trends for improvement.	