STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 01/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SVCS PINEHURST	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 01/16/18 to conduct a recertification/complaint investigation survey and was unable to return to the facility on 01/19/18 due to adverse weather of snow and unsafe travel conditions. The survey team returned to the facility on 01/19/18 and completed the survey on 01/22/18. Event ID #B4BR11.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		2/19/18

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

Electronically Signed | 01/30/2018

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F 656	Continued From page 1 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to develop a comprehensive care plan for bilateral hand contractures (Resident # 27) for 1 of 22 residents reviewed for comprehensive care planning. The findings included Resident #27 was admitted 07/05/16 with cumulative diagnoses of quadriplegia, aphasia and contractures. A review of a physician order from Occupational Therapy dated 10/19/17 read "carrot splint to bilateral hands at all times. Remove for hand hygiene." The order was signed by the physician. A review of a physician order from Occupational Therapy dated 10/26/17 read -blue carrots in bilateral hand for four or more hours daily or as tolerated by Resident #27. The order was signed by the physician. The most recent quarterly Minimum Data Set (MDS) dated 11/17/17 indicated Resident #27	F 656	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to develop comprehensive care plans that address contractures. 1. Resident #27 comprehensive care plan related to contractures was developed by the Director of Nursing and the Minimum Data Set Nurse on January 22, 2018. 2. An audit was conducted on January 29,2018 of residents with contractures for	

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F 656	Continued From page 2 was cognitively intact with no behaviors and required total assistance with all his activities of daily living (ADLs). There was no care plan addressing Resident #27 ' s bilateral hand contractures. In an interview and observation on 1/16/18 at 11:10 AM, Resident #27 was noted to have bilateral hand contractures. Resident #27 was cognitively intact and capable of participating in the interview process. Resident #27 confirmed he was to wear bilateral hand carrots as much as he could tolerate. He confirmed no staff offered to place his bilateral hand carrots in place and he did not refuse to wear them. In an observation on 01/16/18 at 3:18 PM, Resident #27 was in the activity room in his wheelchair. He was not wearing the bilateral hand carrots for his hand contractures. In an observation on 01/17/18 1:10 PM, an aide was assisting Resident #27 with his lunch. There were no bilateral hand carrots in use. NA #1 stated she was aware he should have them on his hands but unaware of how often or duration. NA #1 stated Resident #27 was never known to refuse the hand carrots and when he wore them, he would let the staff know when he wanted them removed. In an interview on 01/17/18 at 3:30 PM, Unit Manager #1 stated Resident #27 was to wear bilateral hand carrots as much as he could tolerate. She stated she was not aware of any refusals to wear the hand carrots and Resident #27 was very cooperative.	F 656	like residents by the Director of Nursing and the Unit Managers. A comprehensive care plan was developed for any patients identified in the audit who did not have contracture care plans/loss of range of motion by the Director of Nursing. Nine (9) residents were reviewed and seven (7) care plans were either developed or revised. These were completed January 29-30, 2018. 3. Director of Nursing and/or Unit Managers will educate Licensed Nurses to include full time, part time, and per diem nurses, Minimum Data Set Nurse, and Interdisciplinary Team (Activities Director, Director of Therapy, Social Service Director, Food Service Director, and Dietician on comprehensive care planning and updating residents with contractures. Education to begin on January 30, 2018. Nurses who have not received education will be unable to work until education is completed. 4. Director of Nursing or Unit Managers will conduct audits on comprehensive care plans for contractures weekly x4 and monthly x2. These audits will also include visual observations that the care plan is complete and accurate regarding contractures and contracture devices. The results of these audits will be reviewed by the facility's QA&A committee monthly x3 months. Recommendations for further action will be reviewed and implemented as indicated. 5. Date of compliance will be February	

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F 656	Continued From page 3	F 656		

In an observation and interview on 1/19/18 at 11:30 AM, Resident #27 was not wearing the bilateral hand carrots. He confirmed the staff did not offer to put them on. Resident #27 confirmed he never refuses them and they do not cause any discomfort or impede him in any way due to his quadriplegia.

In an interview on 01/19/18 at 11:50 AM, NA #2 stated she was assigned Resident #27 but she did not get him up for the day because she was called in to assist on first shift. She stated she was familiar with Resident #27 and he was very cooperative with his care. She stated she knew Resident #27 was supposed to wear his bilateral hand carrots but not sure how often. NA #2 stated she referred to the Kardex to know what to do for Resident #27.

In an interview on 01/19/18 at 12:00 PM, NA #3 stated she got Resident #27 up this morning but he wasn ' t feeling very well. She stated she thought she offered to put the carrots on Resident #27 ' s hands and if they were not there, he may have refused them. NA #3 stated Resident #27 was very cooperative with his care and she was not aware of him refusing the hand carrots or any other aspect of his care.

In an observation and interview on 1/22/18 at 9:20 AM, Resident #27 was not wearing his bilateral hand carrots. He indicated the staff had not yet offered to place them.

In an interview on 01/22/18 at 9:55 AM, NA #4 stated Resident #27 never refuses to wear his hand carrots when she was assigned to care for him. She stated he should wear the hand carrots as much as he could tolerate and if he wanted

19, 2018.

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F 656	Continued From page 4 them removed, he would let the staff know. NA #4 stated she followed what was indicated on the Kardex in the computer. In an interview on 01/22/18 at 10:05 AM, the MDS Nurse stated Resident #27 had bilateral hand contractures and he was ordered bilateral hand carrots as tolerated daily. The MDS nurse stated the contractures and hand carrots should have been care planned on his last MDS assessment dated 11/17/17 but was obviously overlooked. The MDS Nurse stated Resident #27 did not have a care plan for any refusals because she was aware he ever refused any care or intervention. In an interview on 01/22/18 at 10:30 AM, the Administrator stated it was her expectation that Resident #27 bilateral hand contractures with hand carrots would be been care planned.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		2/19/18

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F 657	Continued From page 5 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to review and revise plans of care related to diuretic therapy and anticoagulant therapy for 1 of 5 residents (Resident #29) reviewed for unnecessary medications. The findings included: Resident #29 was most recently readmitted to the facility on 2/6/17 with diagnoses that included persistent vegetative state. The quarterly Minimum Data Set (MDS) assessment dated 11/9/17 indicated Resident #29 was in a persistent vegetative state. He had not received anticoagulant medication or diuretic medication during the 7 day MDS review period. Resident #29 ' s plan of care was reviewed on 1/18/18. The plan of care included the focus areas of diuretic therapy (initiated on 1/30/17) and anticoagulant therapy (initiated on 2/2/17). A review of Resident #29 ' s physician ' s orders from 2/6/17 through 1/19/18 indicated he had not received diuretic therapy or anticoagulant therapy.	F 657	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to review and revise plans of care related to diuretic therapy and anticoagulants after each assessment, including comprehensive and quarterly review assessments. 1. Resident #29 comprehensive care plan related to diuretic therapy and anticoagulants were reviewed on January 22, 2018 and updated by the Minimum Date Set Nurse. 2. An audit was conducted on January	

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F 657	Continued From page 6 An interview was conducted with the MDS Nurse on 1/19/18 at 1:30 PM. The care plans related to diuretic therapy and anticoagulant therapy for Resident #29 were reviewed with the MDS Nurse. The physician ' s orders for Resident #29 that indicated he had not received diuretic therapy or anticoagulant therapy since his readmission on 2/6/17 were reviewed with the MDS Nurse. The MDS Nurse stated she was unsure if Resident #29 had received diuretic medication and anticoagulant medication in the past. She indicated she needed to review Resident #29 ' s record. A follow up interview was conducted with the MDS Nurse on 1/19/18 at 1:48 PM. The MDS Nurse revealed the care plans related to diuretic therapy and anticoagulant therapy for Resident #29 were inaccurate. She stated she was not sure why these focus areas were on Resident #29 ' s care plan as he had not received either type of medication since his most recent readmission on 2/6/17. She indicated she was going to revise the care plan for Resident #29 and discontinue the focus areas of diuretic therapy and anticoagulant therapy. An interview was conducted with the Administrator on 1/19/18 at 2:11 PM. The Administrator indicated she expected care plans to accurately reflect the status of the resident and to be reviewed and revised to reflect any changes in their status.	F 657	30,2018 by the Director of Nursing to review the care plans which reflect current status for residents who are on diuretic and/or anticoagulant therapy. A comprehensive care plan will be developed for any patients who are identified. There were 16 patients on Diuretic therapy and 5 care plans were either developed or updated. These care plans were update January 30-31, 2018 by the Director of Nursing. There were 17 patients on Anticoagulant therapy and all 17 patients had accurate and comprehensive care plans. No revisions or updates needed. 3. The Director of Nursing, Administrator or Unit Managers will educate Licensed Nurses to include full time, part time and per diem , Minimum Data Set Nurse and the Interdisciplinary team (Director of Rehab, Activities Director and Social Services Director) on the accuracy of comprehensive care plans to reflect current status for residents who are identified as not having an accurate care plan or no longer needing a care plan. Education to begin on January 30, 2018 and be completed by February 19, 2018. Nurses who do not receive the education will be unable to work until education is completed. 4. The Director of Nursing or Minimum Data Set Nurse will conduct audits on residents who require care plans for diuretic and/or anticoagulants and resolve care plans of any resident who is no longer on diuretic and/or anticoagulant	

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F 657	Continued From page 7	F 657	therapy weekly x4 weeks and then monthly x2. Results of these audits will be reviewed by the Quality Assurance Committee monthly x3 months. Recommendations for further action will be reviewed and implemented as indicted. 5. Date of compliance will be February 19, 2018	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to utilize bilateral hand contracture management devices (carrots) as ordered for 1 (Resident #27) of 3 residents reviewed for mobility. The findings included:	F 688	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will	2/19/18

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F 688	Continued From page 8 Resident #27 was admitted 07/05/16 with cumulative diagnoses of quadriplegia, aphasia and contractures. A nursing note dated 10/17/17 read the Resident #27 was alert and oriented. He was non-verbal but able to communicate. His body was stiff with contractures. A review of a physician order from Occupational Therapy dated 10/19/17 read "carrot splint to bilateral hands at all times. Remove for hand hygiene." The order was signed by the physician. A review of the October 2017 medication administration record (MAR) read beginning 10/25/17 Resident #27 was to wear carrot splints to his bilateral hands at all time and to remove for hand hygiene. This was only listed as "For Your Information" (FYI) and required no nurse initials. A review of the undated electronic Kardex for the nursing assistants (NA) to follow read Resident #27 was to wear carrot splints to his bilateral hands at all time and to remove for hand hygiene. This was only listed as FYI and required no NA initials. A review of a physician order from Occupational Therapy dated 10/26/17 read -blue carrots in bilateral hand for four or more hours daily or as tolerated by Resident #27. The order was signed by the physician. A review of the November 2017 MAR read "carrot splint to bilateral hands at all times-Remove for hand hygiene. There was evidence of the nurses ' initials as completed on 7:00 AM-7:00 PM and	F 688	take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility that a resident with limited mobility receives appropriate services, equipment, and assistance to main or improve mobility. 1. Resident #27 orders for contracture management devices were reviewed. Orders were to apply splint/device to bilateral hands as tolerated Care plan was created January 19 2018 by the Minimum Data Set Nurse. Direct observation was completed by Director of Nursing on January 29, 2018. 2. An audit was conducted by the Director of Nursing on January 29, 2018 for patients with contracture management devices. Contracture management devices were reviewed for orders, placement, and appropriateness for any patients identified on the audit. Nine (9) residents were audited for splint/device and/or for loss of range of motion. And of those nine (9) residents, seven (7) residents had a care plan either developed or updated as needed by the Director of Nursing on January 29-30, 2018. 3. Director of Nursing, Administrator and/or Unit Managers began education on January 23, 2018 with Licensed nurses	

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F 688	Continued From page 9 again 7:00 PM-7:00 AM daily. The most recent quarterly Minimum Data Set (MDS) dated 11/17/17 indicated Resident #27 was cognitively intact with no behaviors and required total assistance with all his activities of daily living (ADLs). There was no care plan addressing Resident #27 ' s bilateral hand contractures. A review of the December 2017 MAR read "carrot splint to bilateral hands at all times-Remove for hand hygiene. There was evidence of the nurses ' initials as completed on 7:00 AM-7:00 PM and again 7:00 PM-7:00 AM daily. A review of the January 2018 MAR read "carrot splint to bilateral hands at all times-Remove for hand hygiene. There was evidence of the nurses ' initials as completed on 7:00 AM-7:00 PM and again 7:00 PM-7:00 AM daily. In an interview and observation on 1/16/18 at 11:10 AM, Resident #27 was noted to have bilateral hand contractures. Resident #27 was cognitively intact and capable of participating in the interview process. Resident #27 confirmed he was to wear bilateral hand carrots as much as he could tolerate. He confirmed no staff offered to place his bilateral hand carrots in place and he did not refuse to wear them. In an observation on 01/16/18 at 3:18 PM, Resident #27 was in the activity room in his wheelchair. He was not wearing the bilateral hand carrots for his hand contractures. In an observation on 01/17/18 1:10 PM, an aide	F 688	which include full time, part time, and per diem, Minimum Data Set Nurse, and inter disciplinary team (Director of Rehab, Social Services Director, and Activities Director) on contracture management devices, orders, placement, and monitoring. Nurses who do not receive the education will be unable to work until education is completed 4. The Director of Nursing and/or Unit Managers will conduct paper audits and visually audit to determine accuracy of contracture management devices and proper documentation weekly x4 weeks, and then monthly x2 months. Results of these audits will be reviewed by the facility's Quality Assurance Committee monthly x3 months. Recommendations for further action will be reviewed and implemented as indicated. 5. Date of compliance will be February 19, 2018	

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F 688	Continued From page 10	F 688		

was assisting Resident #27 with his lunch. There were no bilateral hand carrots in use. NA #1 stated she was not assigned Resident #27 and did not get him up on 01/17/18. She stated she was aware he should have them on his hands but unaware of how often or duration. NA #1 stated Resident #27 was never known to refuse the hand carrots and when he wore them, he would let the staff know when he wanted them removed.

In an interview on 01/17/18 at 3:30 PM, Unit Manager #1 stated Resident #27 was to wear bilateral hand carrots as much as he could tolerate. She stated she was not aware of any refusals to wear the hand carrots and Resident #27 was very cooperative.

In an observation and interview on 1/19/18 at 11:30 AM, Resident #27 was not wearing the bilateral hand carrots. He confirmed the staff did not offer to put them on. Resident #27 confirmed he never refuses them and they do not cause any discomfort or impede him in any way due to his quadriplegia.

In an interview on 01/19/18 at 11:50 AM, NA #2 stated she was assigned Resident #27 but she did not get him up for the day because she was called in to assist on first shift. She stated she was familiar with Resident #27 and he was very cooperative with his care. She stated she knew Resident #27 was supposed to wear his bilateral hand carrots but not sure how often. NA #2 stated she referred to the Kardex to know what to do for Resident #27.

In an interview on 01/19/18 at 12:00 PM, NA #3 stated she got Resident #27 up this morning but he wasn ' t feeling very well. She stated she

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MANOR CARE HEALTH SVCS PINEHURST	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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F 688	Continued From page 11	F 688		

thought she offered to put the carrots on Resident #27 ' s hands and if they were not there, he may have refused them. NA #3 stated Resident #27 was very cooperative with his care and she was not aware of him refusing the hand carrots or any other aspect of his care.

In an interview on 1/19/18 at 1:20 PM, The Director of Nursing stated that when the original order was put into the electronic medical record, the Kardex was populated with the new order for the bilateral hand carrots but whoever entered it into the computer did not mark it as a task but rather as an FYI. She stated entering the order in this way would not have triggered the hand carrots as a task for the aides to document. The DON stated she was interim and had only been at the facility a week or so. She stated she was unaware how the order was placed on the nursing MAR for the nurses to sign off on each shift.

In an interview on 01/19/18 at 1:52 PM, the Rehabilitation Director confirmed occupational therapy was involved for hand contracture management and orders were written for Resident #27 to have bilateral blue hand carrots as tolerated and to remove for hand hygiene.

In an interview on 01/19/18 at 3:50 PM Nurse #1 stated when she initialed off on the MAR that Resident #27 ' s hand carrots were in place it was either because she observed them in place or the aides reported they were in use. She stated Resident #27 did not have a history of refusal of care.

In an observation and interview on 1/22/18 at 9:20 AM, Resident #27 was not wearing his bilateral hand carrots. He indicated the staff had

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F 688	Continued From page 12 not yet offered to place them. In an interview on 01/22/18 at 9:55 AM, NA #4 stated Resident #27 never refuses to wear his hand carrots when she was assigned to care for him. She stated he should wear the hand carrots as much as he could tolerate and if he wanted them removed, he would let the staff know. NA #4 stated she followed what was indicated on the Kardex in the computer. In an interview on 01/22/18 at 10:30 AM, the Administrator stated it was her expectation Resident #27 be applied his bilateral hand carrots as ordered.	F 688		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		2/19/18

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F 758	Continued From page 13 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, physician interview, and Pharmacy Consultant interview, the facility failed to ensure physician ' s orders for as needed (PRN) psychotropic medications were time limited in duration for 3 of 5 residents (Residents #13, #66, and #77) reviewed for unnecessary medications. The findings included: 1. Resident #13 was initially admitted to the	F 758	The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes at the center's allegation of compliance such that all alleged deficiencies cited have been or	

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F 758	Continued From page 14 facility on 10/8/15 and most recently readmitted on 5/4/17 with diagnoses that included dementia, delusional disorder, and personality and behavioral disorders. A physician ' s order for Resident #13 dated 9/20/17 indicated Ativan (antianxiety medication) 1 milligram (mg) as needed (PRN) every 6 hours. There was no stop date for this PRN Ativan order. A Pharmacy Consultation Report dated 12/19/17 and written by the Pharmacy Consultant indicated Resident #13 had a PRN order for Ativan which had been in place greater than 14 days and had no stop date. The Pharmacy Consultant ' s recommendation was to discontinue the PRN Ativan or to document the indication for use, the intended duration, and the rationale for the extended time period. The physician signed the form on 1/4/18 and indicated he declined the recommendation. The annual Minimum Data Set (MDS) assessment dated 1/11/18 indicated Resident #13 ' s cognition was severely impaired. Resident #13 was assessed with no behaviors and no rejection of care. He received antipsychotic medication on 7 of 7 days and antianxiety medication on 7 of 7 days. A review of the current physician ' s orders for Resident #13 was conducted on 1/17/18. The current physician ' s orders included the order dated 9/20/17 for PRN Ativan with no stop date. A phone interview was conducted with the Pharmacy Consultant on 1/19/18 at 12:04 PM. He stated he was aware of the new regulations regarding PRN psychotropic medications. He	F 758	will be corrected by the date indicated. It is the practice of the facility that PRN antipsychotic medications are limited to 14 days. Except as provided in 483.45. 1. Residents #13, #66, and #77 still reside in the facility. PRN psychotropic orders were reviewed by the Director of Nursing on January 22,2018 and adjusted by Medical Director according to current regulations which is to include time limiting of 14 days unless Doctor believes it is appropriate and then he will document the rationale and indicate the duration of the PRN order. No adverse reactions noted. 2. An audit was completed on January 30, 2018 by the Director of Nursing for patients who have orders for psychotropic prn medications. PRN orders will be reviewed for any patients identified in the audit. There were 13 residents who were on psychotropic as needed (prn) medication. All 13 residents were reviewed by Medical Director and orders to be obtained to make them time limited and if longer than 14 days, Medical Director to document rationale. Doctor orders will be reviewed by Director of Nursing and/or Unit Managers. 3. Administrator, Director of Nursing and Unit Managers began educated on January 22, 2018 for the Licensed nurses which include full time, part time, and per diem, Minimum Data Nurse and the Interdisciplinary Team (Director of Rehab,	

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F 758	Continued From page 15 indicated he had been making recommendations for all PRN orders for psychotropic medications to be time limited in duration as per the regulations. The Pharmacy Consultant indicated for any PRN psychotropic medication (excluding antipsychotic medications) the prescriber was required to document a rationale and indicate a time limited duration if the order was to extend past 14 days. An interview was conducted with the physician on 1/19/18 at 12:48 PM. The physician ' s order for Resident #13 dated 9/20/17 for PRN Ativan was reviewed with the physician. The Pharmacy Consultation Report dated 12/19/17 for Resident #13 that recommended a discontinuation of the PRN Ativan or documentation of the indication for use, the intended duration, and the rationale for the extended time period was reviewed with the physician. The physician reported he declined the recommendation as he believed the PRN Ativan was necessary to treat Resident #13 ' s intermittent episodes of extreme agitation and anxiety. He stated he had not implemented a stop date for the PRN Ativan for Resident #13. The physician revealed he thought that an indefinite duration was an acceptable time frame and was unaware a more specific stop date was required. He stated he was going to adjust the PRN Ativan order for Resident #13 with the inclusion of a stop date. An interview was conducted with the Administrator on 1/19/18 at 2:11 PM. She indicated she expected all PRN orders for psychotropic medications to have a time limited duration as per the regulations. She additionally indicated she expected the prescriber to document a rationale and indicate the time limited duration if the PRN psychotropic order was to	F 758	Activities Director, Dietician, and Social Service Director) on psychotropic drugs requiring end date and re-evaluation. Any nurse who did not attend the education will be unable to work until the education has been completed. Administrator reviewed with the Medical Director, the regulations on January 22, 2018 and again during Quality Assurance Committee Meeting on January 31, 2018. Medical Director voiced understanding of regulations. Any nurse who did not attend the education will be unable to work until the educations has been completed. 4. Director of Nursing and/or Unit Managers will conduct audits on PRN psychotropic orders weekly x4 weeks and then monthly x2. Results of the audits will be reviewed by the facility's Quality Assurance Committee monthly x3 months. Recommendations for further action will be reviewed and implemented as indicated. 5. Date of Compliance will be February 19, 2018.	

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F 758	Continued From page 16	F 758		

extend past 14 days.
2. Resident #66 was admitted on 10/10/15.

The quarterly Minimum Data Set (MDS) dated 12/19/17 revealed Resident #66 had adequate hearing and vision and an intact cognition. The diagnoses were, non-Alzheimer's dementia, anxiety, depression.

The care plan dated 12/14/17 revealed Resident #66 was at risk for behaviors due to dementia and depression, can be non-compliant with insulin administration, and at risk for adverse effects of psychotropic medication.

The physician medication order for Resident #66 dated 1/1/18 revealed Lorazepam 1 mg every 12 hours as needed for anxiety. The order did not have a stop date for reevaluation.

A review of Resident #66 ' s January 2018 medication administration record revealed the resident received Lorazepam as needed several times a week.

3. Resident #77 was admitted on 1/6/16.

Resident #77 ' s physician's note dated 11/28/17 revealed nursing reported the resident had increased behaviors. The physical assessment was negative.

Resident #77 ' s annual MDS dated 12/26/17 revealed the resident had adequate hearing and vision and was able to make himself understood and understood others. The resident had impaired cognitive skills for daily decision making and short and long-term memory deficit. The resident had no psychosis or behaviors. The

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F 758	Continued From page 17	F 758		

diagnoses were, non-Alzheimer's dementia, depression, and anxiety.

Resident #77 ' s care plan updated 1/8/18 revealed an intervention for behaviors related to dementia, inappropriate undressing, non-compliance with care, potential for wandering, difficulty communicating, and anti-psychotic medication administration.

A review of Resident #77 ' s January 2018 medication administration record revealed the resident received Lorazepam as needed several times a week.

Nurses' note dated 1/4/18 revealed Resident #77 was observed by staff in his room naked and carrying his brief across the room. Upon assessment brief was dry. Staff applied a new brief and redressed resident. Resident continued to wander around his room and attempt to move furniture around room. Ativan was administered for agitation and effective on recheck. No further signs and symptoms of agitation was noted.

Resident #77 ' s physician medication order dated 1/1/18 revealed Lorazepam 1 mg every 6 hours as needed for agitation. The order did not have an end date for reevaluation.

On 1/19/18 at 1:45 pm an interview was conducted with the physician. The physician stated that he provided a rationale to continue the Lorazepam, but had not provided an end date for review for Residents #66 and #77.

On 1/19/17 at 4:00 pm an interview was conducted with the Administrator. The Administrator stated she was not aware that the

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F 758	Continued From page 18 psychotropic medication did not have an end date. The Administrator stated she was aware of the regulation change that all psychotropic medication ordered as needed required an end date for reevaluation.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer's instructions and staff interview, the facility failed to label and date opened/ thawed items and discard expired food in the walk-in cooler and failed to label and date food in one of two nourishment rooms (Carolina Hall). The findings included: 1. On 1/16/18 at 9:20 AM, a tour of the kitchen	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's	2/19/18

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F 812	Continued From page 19 was conducted with the cook. Observation revealed the following: a total of 65 cartons of strawberry health shakes thawed and undated, 25 cartons of vanilla great shakes thawed and undated and 52 cartons of orange juice thawed and undated. Manufacturer's instructions on the carton for the health shakes and the orange juice read to discard fourteen (14) days after thawing. Also noted in the cooler was 1/2 bucket of macaroni salad dated to discard 1/14/18, a package of sliced ham opened with a use by date of 1/7/18 and 1 package of salami meat unwrapped and undated. On 1/16/18 at 9:20 AM, an interview was conducted with the cook who stated dietary staff would bring out the frozen great shakes and orange juice and would use them until the box was empty. She said it was everyone ' s responsibility to check for outdated/ expired items. A second observation of the kitchen was conducted with the Dietary Manager on 1/19/18 at 10:10 AM. There was ½ carton of individual sour cream packets with an expiration date of 1/8/18. An interview was conducted with the Dietary manager on 1/19/18 at 12 noon. She stated she had been responsible for checking for labeled, dated and expired foods in the kitchen. She said she checked for items the first thing in the morning and before she left at night. 2. On 1/19/18 at 12 noon, an observation of the nourishment refrigerator on Carolina Hall was conducted with the Dietary Manager. There was a bag that contained ½ of a rotisserie chicken. It was not labeled or dated. The Dietary Manager	F 812	allegation of compliance such that all alleged deficiencies citied have been or will be corrected by the date indicated. It is the practice of the facility to store, prepare, distribute, and serve food in accordance to professional standards for food service safety. 1. No residents were identified. Outdated items were immediately thrown away on January 16, 2018. Items with no dates were also immediately thrown away on January 16, 2018 and again on January 19, 2018. 2. All residents have the potential to be affected by this practice. 3. Administrator educated on January 16, 2018 and January 19, 2018 the Food Service Director and on January 31, 2018 with the Interdisciplinary Team, which included Director of Nursing, Unit Managers, Director of Rehab, Food Service Director, Activities Director, and Social Service Director on labeling and storage and discard of food items. Food Service Director educated all dietary staff on labeling and storage and discarding of food items. This education began on January 28, 2018. 4. Administrator and/or Food Service Director will conduct audits on labeling, storage, and discarding of food items weekly x4 weeks and then monthly x2 months. These audits will also be done on off shifts and on weekends. Results of	

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F 812	Continued From page 20 said nursing staff usually checked the refrigerator in the nourishment rooms and all items in the refrigerator were supposed to be labeled and dated.	F 812	these audits will be reviewed by the facility's Quality Assurance Committee monthly x3 months. Recommendations for further action will be reviewed and implemented as indicated. 5. Date of Compliance will be February 19, 2018	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification survey of 020/3/17. This was for two deficiencies which were recited during the recertification survey of 01/22/18 in the area of Resident Assessment at F656 and F657. The third deficiency recited was in the area of Pharmacy Services at F758. The continued failure of the facility during two federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This citation is cross referenced to:	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. It is the practice of the facility to develop and implement appropriate plans of action to correct identified quality deficiencies. 1. Residents #27 care plans were developed and implemented on January	2/19/18

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F 867	Continued From page 21 F656- Based on observations, staff interviews and record review, the facility failed to develop a comprehensive care plan for bilateral hand contractures (Resident # 27) for 1 of 22 residents reviewed for comprehensive care planning. F657-Based on record review and staff interview, the facility failed to review and revise plans of care related to diuretic therapy and anticoagulant therapy for 1 of 5 residents (Resident #29) reviewed for unnecessary medications. F758-Based on record review, staff interview, physician interview, and Pharmacy Consultant interview the facility failed to ensure physician ' s orders for as needed (PRN) psychotropic medications were time limited in duration for 3 of 5 residents (Residents #13, #66, and #77) reviewed for unnecessary medications. In an interview on 01/22/18 at 11:11 AM, the Administrator acknowledged understanding of the reciting of F656, F657 and F758 during the recertification survey of 01/22/18. The Administrator stated the facility recently included the nurses in the care planning process rather than leaving it solely up to the Minimum Data Set nurse. The Administrator stated there had been recent changes in the administration of the nursing department with the hiring of a new Director of Nursing and Unit Managers. She added the facility also planned to expand the ability of the electronic medical records program to reduce inaccuracies in the care plan. The Administrator stated with the new regulations	F 867	22, 2018. Resident #29 care plans were removed relating to diuretic therapy and anticoagulant therapy on January 22, 2018. Residents #13, #66 and #77 were reviewed by Medical Director. Resident #13 medication was discontinued on January 23, 2018. Resident #66 medication was discontinued on January 23, 2018. Resident #77 was changed to read give for 14 days. This was done on January 23, 2018. 2. All Residents have the potential to be affected by this practice who have contractures, diuretic therapy and/or anticoagulant therapy 3. Administrator educated Interdisciplinary (Director of Nursing, Director of Rehab, Minimum Data Set Nurse, Unit Managers, Food Service Director, Social Service Director and Activities Director Team on January 23, 2018 on Quality Assurance process and follow up. 4. Administrator will review validation audits that were completed by Director of Nursing and/or Unit Managers to ensure that issues have been resolved or to address concerns weekly x4 weeks and monthly x2 months. Quality Assurance Committee will meet monthly x3 months and quarterly thereafter to review findings, trends, and to review issues identified with appropriate action plans and resolution. 5. Date of Compliance will be February 19, 2018.	

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F 867	Continued From page 22 regarding the as needed psychotropic medications, they had been working closely with the Medical Director.	F 867		