STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

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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 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	F 656		6/22/18

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

Electronically Signed | 06/20/2018

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F 656	Continued From page 1 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 medical record review and staff interviews, the facility failed to develop a comprehensive care plan for contracture management/ restorative nursing plan of care for one of three residents reviewed for range of motion/ contracture management (Resident #1). The findings included: Resident #1 was admitted to the facility 3/12/18. Cumulative diagnoses included: hypertensive intracerebral hemorrhage, acute respiratory. failure, obstructive hydrocephalus (abnormal amount of cerebrospinal fluid in the brain), debility, hypertension, pneumonia, convulsions, tracheostomy (opening surgically made in the neck for breathing) and gastrostomy (feeding tube). An admission Minimum Data Set (MDS) assessment dated 3/19/18 indicated Resident #1 ' s hearing and vision was highly impaired. She required total assistance of two people for bed mobility, toileting, eating, personal hygiene, and bathing. No impairment was noted in range of motion. A significant change Minimum Data Set (MDS) dated 4/10/18 indicated Resident #1 ' s hearing and vision was highly impaired. Resident #1 had no speech, long term and short- term memory impairment and she was severely impaired in decision-making. Resident #1 required total assistance of two people for bed mobility, transfers, dressing, eating, personal care and	F 656	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared because it is required by the provision of the Federal & State Law. F656 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)The care plan for Resident #1 was updated on June 7, 2018 by the Resident Care Management Director to include restorative nursing/contracture management. Re-education provided to Resident Care Management Director and all MDS Coordinators by ADON on policies and procedures of developing comprehensive care plans for restorative nursing/contracture management on June 14, 2018. It is alleged that the facility failed to develop a comprehensive care plan for contracture management/restorative nursing plan of care for one resident reviewed for range of motion/contracture management (Resident #1)	

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F 656	Continued From page 2 bathing. There was no impairment of functional range of motion for all extremities. A Physical therapy discharge summary for Resident #1 dated 4/10/18 stated the following discharge recommendations: restorative nursing program for passive lower extremity range of motion. The restorative program was established and training was given in the restorative range of motion program and the restorative bed mobility program. An Occupational therapy discharge summary for Resident #1 dated 4/2/18 stated the following discharge recommendations: restorative nursing program for passive upper extremity exercises and bed mobility. The restorative program was established and training was given for bed mobility and passive range of motion of bilateral upper extremities in all planes to reduce contracture risk. A restorative nursing note dated 4/11/17 stated Resident #1 started the restorative nursing program. A restorative nursing note dated 4/23/18 revealed Resident #1 participated in the restorative program for bed mobility and range of motion to assist in pressure relief and loss of range of motion. Continue with the restorative program. A restorative nursing note dated 5/25/18 indicated Resident #1 continued to participate in the restorative program for bed mobility to assist in pressure relief and range of motion to prevent loss of range of motion of extremities. Continue with the restorative program.	F 656	2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)It is the policy of Randolph Health and Rehabilitation to ensure applicable residents have comprehensive care plans in place for restorative nursing/contracture management. Staff education was provided by the ADON on June 14, 2018 to Resident Care Management Director and all MDS Coordinators on policy and procedure regarding comprehensive care plans for restorative nursing/contracture management. 100% audit completed on all residents receiving restorative services by the Assistant Director of Nursing (ADON) and/or Resident Care Management Director by June 15, 2018. Results of audit updated to ensure all restorative nursing/contracture management comprehensive care plans developed by June 22, 2018. No additional residents noted without restorative nursing/contracture management comprehensive care plans. Assistant Director of Nursing will maintain a communication log to indicate when a resident begins restorative services and meet weekly with Resident Care Management Director to ensure restorative nursing/contracture management care plans developed and updated as needed. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific cited remains corrected and/or in compliance with the regulatory	

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F 656	Continued From page 3 A review of the Rehabilitation/ Restorative Service Delivery records for April 2018, May 2018 and June 2018 revealed Resident #1 received restorative nursing services in the areas of range of motion (passive), bed mobility and passive range of motion to bilateral lower extremities from April 11, 2018 through present. A review of the care plan for Resident #1 was conducted. There was no comprehensive care plan for contracture management/ restorative nursing plan of care. On 6/6/18 at 11:00AM, an interview was conducted with the Director of Nursing who stated she would expect to have a care plan in place for contracture management and restorative nursing range of motion. When a resident was discharged from therapy, therapy services gave their recommendations to the Assistant Director of Nursing (ADON) and she would complete the restorative nursing program for the resident. The ADON informed the Minimum Data Set (MDS) personnel of the resident being on the restorative program and MDS/ ADON updated the care plan for contracture management for restorative nursing. She said the care plan should have been in place within 24 hours. On 6/6/18 at 11:15 AM, an interview was conducted with the ADON who stated there should have been a care plan in place for contracture management/ restorative nursing when the restorative program was put into place.	F 656	requirements. a)The ADON and/or Resident Care Management Director will audit residents on Restorative Caseload care plans for 4 weeks, and then five random care plans weekly for eight weeks to ensure that the facility care plans are developed according to facility policy and that they contain required components needed to care for each resident. b)The ADON and/or Resident Care Management Director will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. 4.Title of person responsible for implementing the acceptable POC. a)The ADON and/or the Resident Care Management Director will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)June 22, 2018	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		6/22/18

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F 686	Continued From page 4 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the facility failed to initiate treatment for a facility acquired pressure ulcer until six (6) days after the pressure ulcer had been identified for one of three residents reviewed for pressure ulcers (Resident #1). The findings included: Resident #1 was admitted to the facility 3/12/18. Cumulative diagnoses included: hypertensive intracerebral hemorrhage, acute respiratory. failure, obstructive hydrocephalus (abnormal amount of cerebrospinal fluid in the brain), debility, hypertension, pneumonia, convulsions, tracheostomy (opening surgically made in the neck for breathing) and gastrostomy (feeding tube). A nursing admission assessment dated 3/12/18 and 3/13/18 stated Resident #1 had no skin problems or pressure ulcers.	F 686	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F686 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)The Assistant Director of Nursing (ADON), Wound Nurse, and Unit Coordinator (UC) reviewed the medical record for (Resident #1) on June 8, 2018 to assure accurate treatment for pressure ulcers. Staff Development Coordinator (SDC) provided education on skin	

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F 686	Continued From page 5 A Braden scale for predicting pressure sore risk dated 3/13/18 indicated a score of 10.0 (high risk 10-12). A head to toe skin check form dated 3/13/18 revealed Resident #1 had no pressure ulcers or skin problems. An admission Minimum Data Set (MDS) assessment dated 3/19/18 indicated Resident #1's hearing and vision was highly impaired. She required total assistance of two people for bed mobility, toileting, eating, personal hygiene, and bathing. Resident #1 had an indwelling catheter and was incontinent of bowel. Skin assessment noted that Resident #1 was at risk for developing pressure ulcer with no pressure ulcers present during the assessment period. A head to toe skin check form dated 3/27/18 completed by Nurse #8 revealed Resident #1 had an open area to the sacrum. There was no further documentation in the electronic medical record regarding the open area to the sacrum. A review of the physician orders for March 2018 revealed no orders for pressure ulcer treatment. A review of the electronic Treatment Administration Record for March 2018 revealed no treatments were documented for pressure ulcer care for the month of March 2018. A Nurse Practitioner note dated 3/29/18 revealed nursing had reported a new stage 2 pressure area on the sacrum. There were no orders noted for pressure ulcer care.	F 686	management policy, to include follow up of pressure ulcer treatment to all full-time, part-time and prn licensed nurses. If education not received by June 22, 2018 licensed nursing staff will not be allowed to work on the floor until education has been provided. It was alleged that the facility failed to initiate treatment for a facility acquired pressure ulcer in a timely manner for (Resident #1). 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)It is the policy of Randolph Health and Rehabilitation to ensure nursing staff adheres to the skin management policy, to include follow up on pressure ulcer treatments. Staff education given by SDC to all full-time, part-time and prn licensed nurses licensed completed by June 22, 2018 on the skin management policy. Visual skin assessments performed on all residents by Unit Coordinators (UC)and/or Unit Managers (UM),and/or Wound Nurse completed by June 15, 2018 with treatments initiated as applicable. Wound Nurse will complete a second visual skin assessment on all new admissions weekly for twelve weeks to validate pressure treatments are in place, as needed, per facility policy. Unit Coordinators (UC)and/or Unit Managers (UM) 3.The monitoring procedure to ensure that	

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F 686	Continued From page 6 A physician order dated 4/2/18 revealed an order for antimicrobial wound gel to be applied every day shift for a stage 2 pressure ulcer on the left buttocks. Cleanse open area with normal saline, pat dry. Apply antimicrobial wound gel and cover with dry dressing. A head to toe skin check dated 4/3/18 by the Unit Manager revealed Resident #1 had an open area to the sacrum. There was no further documentation in the electronic medical record regarding the open area on the sacrum. A Nurse Practitioner note dated 4/3/18 revealed Resident #1 had a stage 2 pressure ulcer to the sacrum. There were no orders noted for pressure ulcer care. A physician order dated 4/3/18 revealed an order for collagenase to be applied every day shift for a stage 2 pressure ulcer on the right buttocks. Cleanse open area to right buttocks with normal saline, pat dry. Apply collagenase ointment and cover with dry dressing. A weekly pressure ulcer record form completed by the Wound Treatment Nurse dated 4/4/18 revealed the following pressure ulcer areas: 1. A facility acquired pressure ulcer to left elbow with date of onset 3/29/18. The area was unstageable(not stageable due to coverage of the wound bed by slough-dead tissue-or eschar-black tissue) and measured 0.2 centimeters (cm) in length x 0.2 cm wide x no depth. Tissue was 100% eschar. No drainage, no odor. The form stated this was a new pressure ulcer. Treatment: foam dressing for protection.	F 686	the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) Wound Nurse will complete a second visual skin assessment on all new admissions weekly for twelve weeks to validate pressure treatments are in place, as needed, per facility policy. Unit Coordinators (UC)and/or Unit Managers (UM)will complete random visual skin checks on 3 residents per week x 12 weeks to validate accuracy of assessment. b)The UC and/or UM will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. 4.Title of person responsible for implementing the acceptable POC. a)The UC and/or UM will be responsible for the implementation of the acceptable plan on correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)June 22, 2018	

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F 686	Continued From page 7	F 686		

2. A facility acquired pressure ulcer to the right buttocks with the date of onset 3/29/18. The area was unstageable and measured 3.0 cm in length x 2.5 cm wide x 0.1 cm depth. Tissue was epithelial tissue with no undermining. The wound bed was red with scant drainage and no odor. This was a new pressure area.

3. A facility acquired pressure ulcer to the left buttocks with the date of onset 3/29/18. The area was a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed) and measured 2.75 cm in length x 4.0 cm wide and 0.1 cm depth. Tissue was epithelial tissue with no undermining. The wound bed was red with scant drainage and no odor. The physician was notified 4/4/18, Nutrition was notified 4/4/18, the Responsible Party (RP) was notified 4/4/18 of all the above pressure ulcers.

A review of the Treatment Administration Record (TAR) for April 2018 revealed the treatment to the left buttocks began on 4/3/18 and the right buttocks on 4/4/18. Treatment for the left elbow was documented as initiated on 4/25/18.

On 6/6/18 at 10:20 AM, an interview was conducted with the Wound Treatment Nurse. She stated any of the nursing staff on the floor and/or the nursing assistants could inform her of any skin changes or open areas. She stated she saw Resident #1" s pressure ulcers on 4/4/18. She could not remember who told her about the pressure ulcers.

On 6/6/18 at 10:48 AM, an interview was conducted with the Nurse Practitioner (NP). She stated she wrote the notes on 3/29/18 and 4/3/18.

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F 686	Continued From page 8	F 686		

She said she did not visualize the pressure ulcers. The NP stated Resident #1 was at risk for pressure ulcers due to her medical condition. She said Resident #1 did not have any pressure ulcers when she was admitted to the facility and, when she developed the sacral pressure ulcer, the facility instituted an air mattress. The NP further stated Resident #1 was at risk for pressure ulcers due to her situation of not being able to turn and move. The pressure ulcers possibly could have been prevented. Because she was at risk, even with turning every 2 hours, she could have developed the pressure ulcers. The NP stated she was not aware of the left elbow pressure ulcer.

On 6/6/18 at 11:00 AM, an interview was conducted with the Director of Nursing who stated she expected nursing staff to notify the family, the physician, complete an SBAR note and obtain orders for pressure ulcer treatment when any change in skin condition was found.

On 6/6/18 at 11:15 AM, an interview was conducted with Nurse #8 who stated weekly head to toe skin checks were documented in the electronic record. Nurse #8 said she completed a visual check prior to completing the head to toe skin assessment form. If there was something that had changed (skin reddened, broken, etc.), nursing completed a SBAR (situation-background-assessment recommendation) note, let the wound nurse know, notified the physician and responsible party (RP) and obtained an order for treatment if it had not been initiated by the wound nurse. Nurse #8 said Resident #1 had an open area on her sacrum on 3/27/18 but she did not remember what it looked like.

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F 686	Continued From page 9 On 6/6/18 at 11:30 AM, an interview was conducted with the Unit Manager who stated she completed the weekly head to toe skin check on 4/3/18. She said she could not recall what the open area on the sacrum looked like when she did the skin assessment on 4/3/18. Regarding the pressure ulcer, she said the Wound Treatment Nurse put the pressure ulcer orders in the computer. The Unit Manager stated some type of treatment must have been done to the sacral pressure ulcer but there was no documentation/ order noted in the computer for the pressure ulcers until the Wound Treatment Nurse put the treatment orders in the computer. A second interview was conducted with Nurse #8 on 6/6/18 at 1:25 PM. She stated she completed the skin assessment on 3/27/18 and Resident #1 had the sacral pressure ulcer at that time. She did not do an SBAR or notify family/ MD or initiate any treatment because she thought that had already been done by the unit manager on 3/27/18.	F 686		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assess and document the effectiveness of pain medication for 3 of 3	F 697	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of	6/22/18

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F 697	Continued From page 10 residents receiving narcotic pain medication, Residents #3, #4, and #5. Findings included: 1. Medical record review revealed Resident #3 was admitted to the facility on 2/10/17 with diagnoses of Chronic Pain, Depression, and Ulcerative Colitis. The most recent Minimum Data Set (MDS) assessment dated 5/15/18 revealed Resident #3 was moderately cognitively impaired. He required limited assistance with moving in bed, transferring to and from the wheelchair, and toileting. Resident #3 had reported occasional pain that had not made it hard to sleep and he had not had to limit his day to day activities. The Minimum Data Set had also revealed Resident #3 had rated his pain as moderate. Review of Resident #3's physician's orders revealed orders for Oxycodone Immediate Release 10 milligram tablets give 1 tablet every 6 hours as needed for pain. Review of Resident #3's May 2018 Controlled Medication Utilization Record for Oxycodone Immediate Release 10 milligrams tablet (give 1 tablets, 10 milligrams, by mouth every 6 hours as needed for pain) revealed there were multiple entries of the medication being given but not recorded on the corresponding Medication Administration Record. The dates of medication recorded as given on the Controlled Medication Utilization Record but not the Medication Administration Record (5/2018) were 5/25/18 at 9:45 pm; 5/26/18 at 10:45 pm; 5/27/18 at 11:00 am; 5/28/18 at 8:00 pm; and 5/29/18 at 8:30 pm. Review of Resident #3's June 2018 Controlled Medication Utilization Record for Oxycodone HCL 10mg tablet (give 1 tablet by mouth every 6 hours as needed), which had a quantity of 30 pills,	F 697	facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by the provision of the Federal & State Law. F697 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)Residents #3, 4, and #5 are currently having their response to as needed pain medication documented on the Medication Administration Record. It was alleged that the facility failed to assess and document the effectiveness of pain medication for three of three residents receiving narcotic pain medication, (Residents #3, 4, and #5). 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)It is the policy of Randolph Health and Rehabilitation to ensure that the facility assesses and documents the effectiveness of pain medication. Staff education given by Staff Development Coordinator (SDC) on the pain management policy to include documenting the effectiveness of pain medication on the Medication Administration Record to include full-time, part-time, and prn licensed nurses by June 22, 2018. Any Licensed nurse not	

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F 697	Continued From page 11 revealed there were multiple entries of the medication being given but not recorded on the corresponding Medication Administration Record. The dates of medication recorded as given on the Controlled Medication Utilization Record but not the Medication Administration Record (6/2018) were 6/1/18 at 4:45 pm; 6/1/18 at 11:00 pm; 6/2/18 at 6:05 am; 6/2/18 at 1:00 pm; 6/2/18 at 7:00 pm; 6/3/18 at 3:10 am; 6/3/18 at 9:59 am; 6/3/18 4:00 pm; 6/4/18 at 4:20 am; 6/4/18 at 10:20 am; 6/4/18 at 4:40 pm; 6/5/18 at 7:11 am; 6/6/18 at 3:10 am; 6/6/18 at 9:18 am; and 6/6/18 at 1:15 pm. An interview with the Unit Manager on 6/6/18 at 4:15 pm revealed she had been an Unit Manager at the facility for one year. She explained the process for administering an as needed narcotic pain medication began with assessing the resident's pain using a numerical scale of 1-10. She stated they documented the pain assessment on the Medication Administration Record before giving the medication. She also stated after the medication was administered the pain assessment was entered again to assure the resident's pain was relieved. The Unit Manager had 1 incidents on 5/28/18 Controlled Medication Utilization Record for Oxycodone Immediate Release 10 milligrams tablet (give 1.5 tablets) that were not documented on the Medication Administration Record. The Unit Manager explained there were times when she had been very busy and had failed to document the pain level before administering of medication and had failed to assess and document the effectiveness of Resident #3's pain medication on the Medication Administration Record. During an interview with Nurse #9 on 6/6/18 at	F 697	receiving education by June 22,2018 will be required to receive education prior to working on the floor. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)As a measure of on going compliance, Unit Managers and/or Unit Coordinators conducted random audits weekly x 2 weeks comparing prn narcotic count sheets to Medication Administration Records to ensure accurate documentation of assessment and prn pain medication effectiveness. Unit Coordinators and/or Unit Manager and /or ADON will audit five narcotic count sheets against Medication Administration Records for medications prescribed on an as needed basis to validate the residents response to the medication is documented on the Medication Administration Record. b)The UC and/or UM will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly times three months for tracking and trending purposes with all follow up action determined by the QAPI team. 4.Title of person responsible for implementing the acceptable POC.	

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F 697	Continued From page 12 3:00 pm she stated she does get very busy and misses documenting on the Medication Administration Record when she gives Resident #3 his medication. She stated she had failed to assess and document Resident #3's pain medication effectiveness. 2. Resident #4 admitted to the facility on to the facility on 10/6/16 with a readmission on 9/9/17 with diagnoses of Diabetes, Bipolar Disorder, and Depression. On the most current Minimum Data Set (MDS) assessment dated 4/5/18 she was noted to be cognitively intact and required only supervision with moving about in bed, transferring to and from the bed, toileting, and eating. The Minimum Data Set assessment also revealed Resident #4 was in constant pain, and had trouble sleeping and completing day to day activities because of pain. Review of Resident #4's physician's orders revealed orders for Oxycodone 5 milligram tablet give 1 tablet every 8 hours as needed for pain. Review of Resident #4's May 2018 Controlled Medication Utilization Record for Oxycodone 5 mg tablet, take 1 tablet by mouth every 8 hours as needed for pain, revealed there were entries of the medication being given but not recorded on the corresponding Medication Administration Record. The dates of medication recorded as given on the Controlled Medication Utilization Record but not on the Medication Administration Record (5/2018) were 5/3/18 at 1:45 pm; 5/3/18 at 9:45 pm; 5/4/18 at 5:45 am; 5/4/18 at 1:45 pm; 5/4/18 at 9:45 pm; 5/5/18 at 6:00 am; 5/5/18 at 2:00 pm; 5/6/18 at 10:00 pm; 5/6/18 at 6:00 am; 5/6/18 at 2:00 pm; 5/7/18 at 8:30 am; 5/7/18 at 4:30 pm; 5/8/18 at 4:30 pm; 5/9/18 at 12:30 am;	F 697	a)The UC and/or UM will be responsible for the implementation of the acceptable plan on correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)June 22, 2018	

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5/9/18 at 8:30 am; 5/9/18 at 4:00 pm; 5/10/18 at 8:30 am; 5/11/18 at 1:30 am; 5/11/18 at 9:30 am; 5/11/18 at 5:30 pm; 5/12/18 at 1:45 am; 5/12/18 at 9:30 pm; and 5/13/18 at 9:30 am.
Review of Resident #4's May 2018 Controlled Medication Utilization Record for Oxycodone 5 mg tablet, take 1 tablet by mouth every 8 hours as needed for pain, revealed there were entries of the medication being given but not recorded on the corresponding Medication Administration Record. The dates of medication recorded as given on the Controlled Medication Utilization Record but not recorded on the Medication Administration Record (5/2018) were 5/15/18 at 11:30 am; 5/15/18 at 7:00 pm; 5/16/18 at 3:30 am; 5/16/18 at 7:00 pm; 5/17/18 at 3:15 am; 5/17/18 at 11:15 am; 5/17/18 at 7:00 pm; 5/18/18 at 3:00 am; 5/18/18 at 11:00 am; 5/18/18 at 7:00 pm; 5/19/18 at 9:00 am; 5/20/18 at 9:00 pm; 5/21/18 at 5:00 am; 5/21/18 at 1:00 pm; 5/21/18 8:30 pm; 5/22/18 at 4:30 am; 5/22/18 at 12:30 pm; 5/22/18 8:30 pm; 5/23/18 at 5:00 am; 5/23/18 at 1:00 pm; 5/23/18 at 8:30 pm and 5/24/18 at 4:30 pm.
Review of Resident #4's June 2018 Controlled Medication Utilization Record for Oxycodone 5 mg tablet, take 1 tablet by mouth every 8 hours as needed for pain, revealed there were entries of the medication being given but not recorded on the corresponding Medication Administration Record. The dates of medication recorded as given on the Controlled Medication Utilization Record but not documented as given on the Medication Administration Record (6/2018) were 6/4/18 at 4:00 am; 6/5/18 at 2:40 am; 6/5/18 at 10:40 am; and 6/6/18 at 2:40 am.

During an interview on 6/6/18 at 3:00 pm with Nurse #9 she acknowledged she had not

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F 697	Continued From page 14 documented in the Medication Administration Record when she had administered Resident #4 her narcotic pain medication nine times in May 2018. She also acknowledged she had not assessed and documented effectiveness of the pain medication because she gets so busy. An interview with Nurse #5 on 6/7/18 at 8:50 am revealed she knew she had a problem with remembering to assess and document the residents pain level on the Medication Administration Record and she was trying to improve. She stated she hadn't assessed or documented Resident #4's pain level 11 times on the May and June 2018 electronic Medication Administration Record after reviewing. An interview with the Director of Nursing on 6/7/18 at 11:15 am revealed her expectation was that all residents would be monitored for pain level and effectiveness of narcotic pain medications and documentation of the medications on the Medication Administration Record. 3. Resident #5 was admitted to the facility on 3/7/18 and readmitted on 4/27/18 with diagnoses that included generalized abdominal pain and chronic pain syndrome. Resident #5 ' s physician ' s orders included an order dated 3/7/18 for Oxycodone (narcotic pain medication) 15 milligrams (mg) every 6 hours	F 697		

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PRN (as needed) for pain related to generalized abdominal pain.

A nursing note dated 3/13/18 indicated a pain assessment was completed for Resident #5. Resident #5 was noted as alert with clear speech. He stated he had pain during the past 5 days that interfered with sleep and daily activities at a severe level.

The admission Minimum Data Set (MDS) assessment dated 3/14/18 indicated Resident #5 ' s cognition was intact. He had no behaviors and no rejection of care. Resident #5 received scheduled pain medications and PRN pain medications during the MDS review period. He reported he had frequent and severe pain that made it difficult to sleep at night and limited his day to day activities. He received opioid medications on 6 of 7 days during the MDS review period.

The Care Area Assessment (CAA) related to pain for Resident #5 ' s 3/14/18 MDS indicated Resident #5 was able to verbalize his pain to the staff. He was noted to be on routine/scheduled Lyrica (nerve pain medication) and PRN Oxycodone. Staff were to monitor the effectiveness of pain interventions.

The plan of care for Resident #5 included the focus area of pain initiated on 3/20/18. The interventions included providing medication as ordered and documenting the effectiveness of medication administration.

The March 2018 electronic Medication Administration Record (MAR) for Resident #5 indicated he was administered PRN Oxycodone

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43 times. The MAR required the nurse to assess and document Resident #5 ' s pain level prior to the administration of the PRN pain medication as well as assessing and documenting the effectiveness of the pain medication after its administration.

A review was conducted of the March 2018 hard copy Controlled Medication Utilization Record for Resident #5. This record indicated Resident #5 was administered PRN Oxycodone 57 times in March 2018. This form required the nurse to document the date and time of the administration, but had not required the nurse to indicate the pain level prior to administration or the effectiveness of the medication after it ' s administration. The March 2018 Controlled Medication Utilization Record was compared to the March 2018 MAR for Resident #5. This revealed 14 instances when the PRN Oxycodone administration was documented on Resident #5 ' s Controlled Medication Utilization Record, but not on the MAR. These 14 instances also revealed there was no indication a pain assessment was completed for Resident #5 prior to the administration of the PRN Oxycodone and no indication an assessment of effectiveness was completed after it ' s administration.

The April 2018 electronic Medication Administration Record (MAR) for Resident #5 indicated he was administered PRN Oxycodone 21 times. The April 2018 hard copy Controlled Medication Utilization Record for Resident #5 indicated he was administered PRN Oxycodone 28 times in April 2018. The April 2018 Controlled Medication Utilization Record was compared to the April 2018 MAR for Resident #5. This revealed 7 instances when the PRN Oxycodone

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administration was documented on Resident #5 ' s Controlled Medication Utilization Record, but not on the MAR. These 7 instances also revealed there was no indication a pain assessment was completed for Resident #5 prior to the administration of the PRN Oxycodone and no indication an assessment of effectiveness was completed after it ' s administration.

Resident #5 was discharged from the facility on 4/16/18 and was readmitted on 4/27/18. His PRN Oxycodone was discontinued when he was readmitted.

An interview was conducted with the Nurse Unit Manager (UM) on 6/6/18 at 4:15 PM. The Nurse UM indicated she had been in her position as one of the facility ' s UMs for about a year. She was asked what the process was for administering a PRN narcotic pain medication. The Nurse UM indicated a pain assessment was completed using a numerical 1-10 scale and was documented on the MAR prior to administration of the medication. She reported the medication was administered, it was documented on the MAR, and documented on the Controlled Medication Utilization Record. She stated after the administration of the medication, the resident was reassessed to determine if the medication was effective in relieving the pain. She reported the effectiveness or ineffectiveness was documented on the MAR. The Nurse UM explained that when a PRN pain medication was documented on the MAR the electronic medical records system automatically populated the questions for pain level prior to administration and the effectiveness after the administration of the medication. She stated the purpose of these questions was to determine if the pain medication

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was effective or not.

This interview with the Nurse UM continued. The March and April 2018 MARs and the Controlled Medication Utilization Records for Resident #5 ' s PRN Oxycodone were reviewed with the Nurse UM. There were 3 instances in which the Nurse UM had documented the administration of the PRN Oxycodone on Resident #5 ' s Controlled Medication Utilization Record and not on the MAR. She explained that there had been times when Resident #5 had requested his PRN Oxycodone when she very busy or was in the middle of another task. She revealed she had not wanted him to wait too long if he was in pain so she expedited the administration by documenting it on the Controlled Medication Utilization Record with plans to enter the administration on the MAR at a later time. She reported in these 3 instances she must have gotten side tracked and forgot to document a pre-administration pain level, the administration of the medication, and had not assessed and documented the effectiveness of the medication on Resident #5 ' s MAR. She stated she expected the nurses to document the administration of PRN narcotic pain medications on the Controlled Medication Utilization Record as well as the MAR to ensure pre-administration pain levels were assessed and documented and a post-administration assessment of the medication ' s effectiveness was completed and documented. The Nurse UM stated she had been monitoring the Controlled Medication Utilization Records to ensure the numerical counts of medications were accurate, but she had not compared these records to the MARs. She reported she was currently working on a plan to implement interventions to correct this issue.

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An interview was conducted with Nurse #2 on 6/6/18 at 4:24 PM. She was asked what the process was for administering a PRN narcotic pain medication. Nurse #2 indicated a pain assessment was completed and was documented on the MAR prior to administration of the medication. She reported the medication was administered, it was documented on the MAR, and documented on the Controlled Medication Utilization Record. She stated after the administration of the medication, the resident was reassessed to determine if the medication was effective in relieving the pain. She reported the effectiveness or ineffectiveness was documented on the MAR. Nurse #2 confirmed that when a PRN pain medication was documented on the MAR the electronic medical records system automatically populated the questions for pain level prior to administration and the effectiveness after the administration of the medication. She indicated the purpose of these questions was to determine if the pain medication was effective or not.

This interview with Nurse #2 continued. The March and April 2018 MARs and the Controlled Medication Utilization Records for Resident #5 ' s PRN Oxycodone were reviewed with Nurse #2. There were 2 instances in which Nurse #2 had documented the administration of the PRN Oxycodone on Resident #5 ' s Controlled Medication Utilization Record and not on the MAR. She revealed that sometimes, if she had been very busy, she forgot to document the administration of the medication on the MAR. Nurse #2 additionally revealed that if she had not documented the administration on the MAR then she also had not documented a pain assessment prior to the administration nor had she

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documented an assessment of the medication ' s effectiveness after the administration.

An interview was conducted with Nurse #3 on 6/6/18 at 4:35 PM. She was asked what the process was for administering a PRN narcotic pain medication. Nurse #3 indicated a pain assessment was completed and was documented on the MAR prior to administration of the medication. She reported the medication was administered, it was documented on the MAR, and documented on the Controlled Medication Utilization Record. She stated after the administration of the medication, the resident was reassessed to determine if the medication was effective in relieving the pain. She reported the effectiveness or ineffectiveness was documented on the MAR. Nurse #3 confirmed that when a PRN pain medication was documented on the MAR the electronic medical records system automatically populated the questions for pain level prior to administration and the effectiveness after the administration of the medication. She indicated the purpose of these questions was to determine if the pain medication was effective or not.

This interview with Nurse #3 continued. The March and April 2018 MARs and the Controlled Medication Utilization Records for Resident #5 ' s PRN Oxycodone were reviewed with Nurse #3. There were 5 instances in which Nurse #3 had documented the administration of the PRN Oxycodone on Resident #5 ' s Controlled Medication Utilization Record and not on the MAR. She stated that when Resident #5 requested his pain medication he wanted it right away. She revealed to expedite the administration she just documented it on the

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F 697	Continued From page 21 Controlled Medication Utilization Record with plans to enter the administration on the MAR at a later time. Nurse #3 reported in these 5 instances she must have gotten side tracked or distracted and forgot to document a pre-administration pain level, the administration of the medication, and had not assessed and documented the effectiveness of the medication on Resident #5 ' s MAR. An interview was conducted with the Director of Nursing (DON) on 6/8/18 at 11:15 AM. She reported she expected staff to document the administration of narcotic pain medication on the Controlled Medication Utilization Record and the MAR. She stated she expected an assessment of pain to be completed prior to the administration of the medication and documented on the MAR. The DON additionally stated she expected a post-administration assessment of the medication ' s effectiveness to be completed and documented on the MAR.	F 697		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		6/22/18

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	345155	A. BUILDING _____ B. WING _____	C 06/07/2018

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RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

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F 842	Continued From page 22 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842		

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F 842	Continued From page 23 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to have complete and accurate records documentation for pressure ulcers for one of three residents reviewed for pressure ulcers (Resident #1). The findings included: Resident #1 was admitted to the facility 3/12/18. Cumulative diagnoses included: hypertensive intracerebral hemorrhage, acute respiratory. failure, obstructive hydrocephalus (abnormal amount of cerebrospinal fluid in the brain), debility, hypertension, pneumonia, convulsions, tracheostomy (opening surgically made in the neck for breathing) and gastrostomy (feeding tube). An admission Minimum Data Set (MDS) assessment dated 3/19/18 indicated Resident #1 ' s hearing and vision was highly impaired. She required total assistance of two people for bed mobility, toileting, eating, personal hygiene, and bathing. Resident #1 had an indwelling catheter and was incontinent of bowel.	F 842	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by the provision of the Federal & State Law. F842 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)The Assistant Director of Nursing (ADON), wound nurse, and Unit Coordinator (UC) reviewed the medical record for (Resident #1) on June 8, 2018 to assure accurate documentation for pressure ulcers. It was alleged that the facility failed to have complete and accurate record documentation for pressure ulcers for one of three residents reviewed (Resident #1). Resident #1	

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F 842	Continued From page 24 Skin assessment noted that Resident #1 was at risk for developing pressure ulcer with no pressure ulcers present during the assessment period. A Nurse Practitioner note dated 3/29/18 revealed nursing had reported a new stage 2 pressure area on the sacrum. There were no orders noted for pressure ulcer care. A head to toe skin check dated 4/3/18 by the Unit Manager revealed Resident #1 had an open area to the sacrum. There was no further documentation in the electronic medical record regarding the open area on the sacrum. A weekly pressure ulcer record form completed by the Wound Treatment Nurse dated 4/4/18 revealed, in part, the following pressure ulcer area: A facility acquired pressure ulcer to the right buttocks with the date of onset 3/29/18. The area was unstageable and measured 3.0 centimeters (cm) in length x 2.5 cm wide x 0.1 cm depth. Tissue was epithelial tissue with no undermining. The wound bed was red with scant drainage and no odor. This was a new pressure area. A weekly pressure ulcer record dated 5/30/18 indicated Resident #1 had a stage 4 pressure ulcer to the left buttocks that measured 5.5 cm in length x 4.75 cm in width x 3.5 cm depth. The area was noted as improved as evidenced by decreased surface area. On 6/7/18 at 10:17 AM, an interview was conducted with the Wound Treatment Nurse. She stated the wound assessment dated 5/30/18 for the left buttocks was entered in the electronic	F 842	Weekly Pressure Ulcer Evaluation documentation was updated to consistently reflect the site of the skin integrity impairment. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)It is the policy of Randolph Health and Rehabilitation to have complete and accurate medical records. The Staff Development Coordinator provided a one to one educational in-service on June 8, 2018 to the Wound Nurse on providing accurate documentation of pressure ulcers. Staff education given by Staff Development Coordinator (SDC) to all licensed nursing staff to include full time, part time, and PRN staff to be completed by June 22, 2018 on providing accurate documentation for pressure ulcers. Any licensed nursing staff who have not received education by June 22, 2018 will be required to receive education prior to working on the floor. b)Unit Coordinators, and/or Unit Manager conducted 100% visual skin assessment audits. Any discrepancies identified were corrected immediately. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements.	

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F 842	Continued From page 25 record by error. She stated resident #1 did not have a pressure ulcer on the left buttocks on 5/30/18 as it had been healed on 5/6/18. The Wound Treatment Nurse stated she had never considered the pressure ulcer on the right buttocks as unstageable. She said the right buttocks presented the same as the left buttocks as a stage 2 as they had both pink epithelial tissue on 4/4/18. She stated that also was a data entry error in the electronic record and noted that the form dated 4/4/18 indicated the tissue type was epithelial tissue which would indicate the pressure ulcer was a stage 2 pressure ulcer. On 6/6/18 at 11:00 AM, an interview was conducted with the Director of Nursing who stated she expected the medical record to be complete and accurate.	F 842	a)The Unit Coordinators (UC) and/or Unit Manager (UM) will audit documentation and accuracy for pressure ulcers. The UC and/or UM will complete ten resident audits to include visual assessment weekly X 12. b)The UC and/or UM will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly times three months for tracking and trending purposes with all follow up action determined by the QAPI team. 4.Title of person responsible for implementing the acceptable POC. a) The UC and/or UM will be responsible for the implementation of the acceptable plan on correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)June 22, 2018	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;	F 865		6/22/18

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F 865	Continued From page 26 §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 2/1/18 recertification survey. This was for a recited deficiency in the area of Resident Records (F842). This deficiency was cited again on the current complaint investigation survey of 6/7/18. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: F842 Resident Records: Based on medical record review and staff interviews, the facility failed to have complete and accurate record documentation for pressure ulcers for one of three residents reviewed for pressure ulcers (Resident #1). During the recertification survey of 2/1/18 the facility was cited at F842 for failing to have	F 865	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by the provision of the Federal & State Law. F865 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)Facility Administrator conducted a Quality Assurance and Improvement (QAPI) Committee meeting on June 18, 2018 to discuss the current survey citations from survey exit. The QAPI Committee determined the alleged process breakdown occurred when the center focused only on the portion of the system that the citation was given and not the entirety of the regulation.	

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F 865	Continued From page 27 accurate Registered Dietician (RD) and physician records and failing to have complete psychiatric records. On the current complaint investigation survey of 6/7/18 the facility was cited for failure to have accurate pressure ulcer documentation records. An interview was conducted with the Administrator on 6/7/18 at 1:20 PM. The Administrator indicated she was the head of the facility ' s QAA Committee. She stated she was aware F842 was a repeat citation from the previous recertification survey. She indicated the Plan of Correction for the previous deficiency was focused on the accuracy of RD notes and physician notes and the completeness of the medical record related to psychiatric notes. She reported the accuracy of pressure ulcer documentation records were not included in the monitoring.	F 865	2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)The QAPI Committee determined after the center the respective disciplines who received a citation needed to perform a comprehensive evaluation of the regulation to determine if there are opportunities to make corrections in areas that were not cited in the 2567. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)The Administrator will educate the Quality Assurance Improvement Committee by June 18, 2018 regarding reviewing the entirety of the regulation to validate compliance with the regulation and not just the portion cited. The QAPI Committee determined audits from the plan of correction will be reviewed in the QAPI Meeting monthly throughout the year to validate sustained compliance ongoing with the entirety of regulation. Should any interdisciplinary team member find that the facility may need an Ad Hoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members in order revise any present action plan or determine the need for a	

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F 865	Continued From page 28	F 865	new action plan in order to maintain compliance in the facility. Quality assurance monitoring will take place at each Quality Assurance Performance Improvement meeting monthly and any Ad Hoc meetings held. This monitoring tool will be signed off by the responsible Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and Performance Improvement Committee. The Vice President of Operations or District Director of Clinical Services will review the facility QAPI meeting minutes at least monthly x 3 months. 4.Title of person responsible for implementing the acceptable POC. a)The Administrator is ultimately responsible for implementing the plan of correction and to ensure the plan of correction is sustained ongoing. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)June 22, 2018	