STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 05/23/2019

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E 000	Initial Comments The facility was found in compliance with requirements of CFR483.73. Emergency Preparedness for Recertification/Complaint survey of 5/23/19. Event ID#GD6K11. FRI #NC00151311 and Complaint Intake # NC00150997.	E 000		
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the Recertification/Complaint survey of 5/23/19. Event ID#GD6K11. FRI#NC00151311 and Complaint Intake # NC00150997.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to code Section I of the MDS (Minimum Data Set) accurately for diagnosis for 1 of 2 residents reviewed for receiving antipsychotic medication. (Resident #36). The findings included: Resident #36 was originally admitted to the facility on 12/9/06 with diagnoses including Parkinson's Disease, Unspecified Dementia with Behavioral Disturbance, Unspecified Psychosis not due to a substance or known physiological condition and Major Depressive Disorder. Review of Resident #36's Quarterly MDS, Section I dated 4/12/19 revealed Section I coded diagnoses of Depression (other than bi-polar disorder) and	F 641	Standard Disclaimer: This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. The MDS of Resident #36 was modified by the MDS nurse on 05/23/2019 to include the diagnosis of psychosis The MDS nurse was retrained by the Nurse Consultant on 05/21/2019 on the accurate coding of MDS according to the RAI 3.0 Version Manual Section I, Active Diagnosis. Any new hires completing	6/12/19

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

Electronically Signed | 06/06/2019

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F 641	Continued From page 1 Non-Alzheimer's Dementia. Review of the Annual MDS, Section I dated 10/8/18 coded diagnoses of Depression (other than bipolar) and Non-Alzheimer's Dementia. Review of Resident#36's Care Plan dated 2/27/19, read in part, "At risk for side effects from psychotropic drug use, Dx: Major Depressive Disorder." Review of a Psychiatric Periodic Evaluation dated 4/8/19 revealed Resident #36 had a diagnosis of Psychosis. Review of Resident #36's May Medication Administration Record revealed Resident #36 was receiving Quetiapine Fumarate (generic Seroquel) 50mgs. at bed time, which was reduced to Seroquel, 25mg's at bedtime on 5/1/19. During an interview on 5/23/19 at 9:53 AM, the facility MDS Nurse stated one episode of psychosis did not indicate a psychotic disorder. She revealed she had not talked to the physician to confirm a diagnosis and she would try to get a psychiatric consult to consider taking Resident #36 off of Seroquel. During an interview on 5/23/19 at 10:59 AM, the Administrator stated her expectation was to code the MDS accurately.	F 641	MDS assessment will be in-serviced by the Nurse Consultant on the accurate coding of MDS according to the RAI 3.0 Version Manual Section I, Active Diagnosis. The Nurse Consultant completed a 100% audit of current OBRA assessments on 05/30/2019 to ensure accuracy in coding, to include Section I Active Diagnosis. Any inaccuracies were modified during the audit. The MDS nurse and Nurse Consultant will audit 25% of the completed OBRA assessments completed weekly for accuracy in coding. Any inaccuracies will be modified to accurately reflect the resident. Results of the audits will be reviewed by the Administrator weekly x 4 weeks then monthly x 2 months. The audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations monthly x 3 months.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a	F 756		6/12/19

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F 756	Continued From page 2 licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff and pharmacist interviews the facility failed to follow the consulting pharmacist ' s recommendations for a	F 756	A Discus was completed on Resident #57 on 05/28/2019. Psych Services completed a Gradual Dose Reduction on 05/30/2019	

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F 756	Continued From page 3 DISCUS (Dyskinesia Identification System) test for 1 of 2 residents reviewed for antipsychotic medications (Resident #57). The findings included: Resident #57 was admitted to the facility on 8/21/18 and had a diagnosis of depression. The most recent Minimum Data Set (MDS) Assessment dated 4/26/19 noted the resident had moderate cognitive impairment and had delusions. The MDS revealed the resident had no behaviors during the 7 day assessment period. The MDS revealed the resident received an antipsychotic medication daily on a scheduled basis. Review of the physician ' s orders revealed an order dated 8/21/18 for Seroquel 25 mg (milligrams) every evening for depression. The Care Plan updated on 11/19/18 for Resident #57 noted the resident was at risk for side effects related to the use of psychotropic medications. Monitor behaviors and report significant findings to the physician. Assess for involuntary movements and report significant findings to the physician. Seroquel is an antipsychotic medication that can cause side effects of abnormal involuntary movements called Tardive Diskinesia. A DISCUS is a test that would assess a person for abnormal involuntary movements. Review of the clinical record revealed a monthly medication review by the consulting pharmacist dated 7/24/18 with recommendations for a DISCUS this month. The monthly medication pharmacy reviews dated 8/21/18 and 9/18/18	F 756	discontinuing resident's Seroquel and increasing Zoloft to 100mg daily for anxiety.The Director of Nursing, QA Nurse, Treatment Nurse and MDS Nurse were retrained on the quarterly completion of DISCUS on all resident□s receiving an Antipsychotic Medications on 05/21/2019 by the Nurse Consultant. The Administrator and QA Nurse completed a 100% audit of all residents on Antipsychotic Medications on 05/30/2019 to ensure DISCUS had been completed on each resident. Any new staff hired with the responsibility of completing DISCUS will be trained on the quarterly completion of DISCUS on all resident□s receiving an Antipsychotic Medications. The Director of Nursing and Quality Assurance Nurse will complete a Discus tool to monitor for antipsychotic medications, completion of and scheduling of quarterly DISCUS during daily clinical meeting 5 x per week. The Quality Assurance nurse will complete a monthly DISCUS audit. Results will be forwarded to the QAPI committee monthly for three months for review and recommendations.	

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F 756	Continued From page 4 revealed a recommendation for a DISCUS test to be done. The facility provided a DISCUS test dated 10/4/18 that revealed no abnormal involuntary movements for Resident #57. The facility was unable to provide other results of a DISCUS test for Resident #57. On 5/22/19 at 10:34 AM an interview was conducted with the facility ' s consulting pharmacist. The Pharmacist stated she recommended a DISCUS test be done during her monthly medication reviews for Resident #57 during the months of July, August and September 2018 before a DISCUS test was done. On 5/23/19 at 9:00 AM the Administrator stated in an interview they had policies in place that antipsychotics were monitored through the use of a DISCUS test. The Administrator further stated different administrative staff have the responsibility for pharmacy recommendations but could not say who was responsible at the time of the pharmacist requests due to a turnover in staff.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to have a medication error rate of less than 5 percent as evidenced by	F 759	Resident #54 was administered Miralax and the second Lidocaine patch was applied by the Med Aide on the morning of	6/12/19

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F 759	Continued From page 5 3 medication errors out of 26 medication opportunities resulting in a medication error rate of 11.5 percent for 2 of 5 residents observed during a medication pass (Resident #54 and Resident #18). The findings included: 1a. Resident #54 was admitted to the facility on 4/10/19 and had a diagnosis of hip fracture and constipation. The most recent Minimum Data Set (MDS) Assessment dated 4/23/19 revealed Resident #54 was cognitively intact. On 5/21/19 at 8:15 AM, Medication (Med) Aide #1 was observed to prepare and administer medications to Resident #54. The Med Aide prepared the following medications: Keppra 750mg (milligrams) 1 tablet (tab), Colace 100mg 1 capsule, Geri-Kot 8.6mg- 2 tablets, Magnesium Oxide 400mg, Aspirin 81mg, Spironolactone 25mg 1 tab, Potassium Chloride 20 milliequivalents- 1 tab, Memantine 10mg 1 tab, Januvia 50mg 1 tab and one Lidocaine 5 percent patch. The Med Aide was observed to enter the room of Resident #54 and administer the PO (by mouth) medications to Resident #54. The Med Aide was observed to don gloves and place one Lidocaine 5 percent patch on the resident ' s right lateral upper thigh. The Med Aide was observed to return to the medication cart and sign off the medications on the electronic Medication Administration Record. Review of the physician ' s orders for Resident #54 revealed an order dated 4/11/19 for Lidocaine patch 5 percent. Apply 2 patches to the right hip in the AM (morning). An interview was conducted with Med Aide #1 on	F 759	05/21/2019. Resident #18□s blood sugar was 168 when rechecked at 8:00pm on 05/22/2019. Med Aide #1 was retrained on by the Director of Nursing to the facility Medication Administration Review policy on 06/05. A Medication Pass Observation was completed by the Treatment Nurse on 05/29/2019 with Med Aide #1 to include 1) accurate triple check on all medication before administration; and 2) all medications signed off at the time of administration. Nurse #1 was retrained on by the Director of Nursing to the facility policy on Insulin Pen Administration 06/06/2019. A Insulin Pen Observation was completed by the Director of Nursing on 06/06/2019 Nurse #1 to include 1) priming the pen to two units, discarding, pulling up the correct dose and administering by holding until dose indicates 0 and nurse had counted to 10. 100% of nurses and medication aides administering medications have been retrained on the facility Medication Administration Review Policy and the facility policy on Insulin Pen Administration, to include priming the insulin pen to two units, discarding, pulling up the correct dose and administering by holding until dose indicates 0 and Nurse has counted to 10, by the Pharmacy Consultant, Director of Nursing, QA Nurse	

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F 759	Continued From page 6 5/21/19 at 8:20 AM. The Med Aide stated she thought the box of Lidocaine patches gave directions for 1 patch and it was the last patch in the box and she gave the box to the Director of Nursing (DON) to re-order the medication. An interview was conducted with Med Aide #1 and the DON on 5/21/19 at 8:28 AM. The Director or Nursing was observed to review the physician ' s orders for Resident #54 and stated the order was for 2 Lidocaine 5 percent patches. On 5/21/19 at 8:28 AM, Resident #54 stated in an interview she sometimes got 2 patches (Lidocaine) but got 1 today. 1b. On 5/21/19 at 8:15 AM, Medication (Med) Aide #1 was observed to prepare and administer medications to Resident #54. The Med Aide prepared the following medications: Keppra 750mg (milligrams) 1 tablet (tab), Colace 100mg 1 capsule, Geri-Kot 8.6mg 2 tablets, Magnesium Oxide 400mg, Aspirin 81mg, Spironolactone 25mg 1 tab, Potassium Chloride 20 milliequivalents- 1 tab, Memantine 10mg 1 tab, Januvia 50mg 1 tab and one Lidocaine 5 percent patch. During the preparation and administration of the medications, the Med Aide did not mention she needed to give a medication that was not on the medication cart. The Med Aide was observed to enter the room of Resident #54 and administer the PO (by mouth) medications to Resident #54. The Med Aide was observed to don gloves and place one Lidocaine 5 percent patch on the resident ' s right lateral upper thigh. The Med Aide was observed to return to the medication cart and sign off the	F 759	or Treatment Nurse. Medication Pass Observations and Insulin Pen Observations have been completed on 100% of nurses and medication aides by the Pharmacy Consultant, Director of Nursing, QA Nurse or Treatment Nurse. Any new hires administering medications will be trained on the facility Medication Administration Review Policy and the facility policy on Insulin Pen Administration. Random Medication Pass Observations and Insulin Pen Observations will be completed one per shift per week times 4 weeks and one per shift per month times 1 month by the Pharmacy Consultant, Director of Nursing, QA Nurse or Treatment Nurse. The results of the observations will be forwarded to the QAPI committee monthly for 2 months for review and recommendations.	

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F 759	Continued From page 7	F 759		

medications on the electronic Medication Administration Record.

Review of the physician ' s orders revealed an order for Miralax 17 grams mixed in 4-8 ounces of water.

Review of the electronic Medication Administration Record revealed MIralax 17 grams was to be given at 9:00 AM and had been electronically signed with the initials of the medication aide observed during the morning medication pass that the Miralax had been given on 5/21/19 at 9:00 AM.

An interview was conducted with Med Aide #1 on 5/21/19 at 8:20 AM. The Med Aide stated she did not give the Miralax because there was none on the medication cart. The Med Aide stated she signed it off as given and that was a mistake.

On 5/21/19 at 10:59 AM an interview was conducted with the Director of Nursing (DON). The DON stated the Med Aide should have come to him if she did not have Miralax on the cart and he would have gotten the medication as they had some in the building. The DON continued and stated the Med Aide should not have signed the medication as given so it would show up as a visual reminder to give the medication.

2. Resident #18 was admitted to the facility on 11/6/17 and had a diagnosis of diabetes mellitus. There was a physician ' s order dated 5/13/19 for Novolog 100 units per milliliter Flexpen, inject 5 units under the skin three times a day before meals.

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F 759	Continued From page 8	F 759		

A Novolog Flexpen is a device that is prefilled with Novolog Insulin and provides multiple doses of Insulin. The manufacturer ' s instructions included the following: Attach a new needle and prime the pen. Turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears at the tip of the needle. Turn the dose selector to select the number of units you need to inject and administer the insulin.

On 5/21/19 at 3:45 PM, Nurse #1 was observed to prepare medications for Resident #18. The Nurse was observed to put a new needle on a Novolog Flexpen and turned the dose selector to 5 units and administered the insulin to Resident #18.

On 5/21/19 at 3:57 PM an interview was conducted with Nurse #1. The nurse was asked if he primed the Flexpen prior to giving the insulin. Nurse #1 stated sometimes he did and sometimes he did not and stated he did not prime the needle prior to giving Resident #18 the Novolog Insulin. The Nurse further stated a while back they had an in-service at the facility on using Flexpens.

An interview was conducted with the facility ' s consulting pharmacist on 5/22/19 at 4:12 PM. The Pharmacist stated when giving insulin with a Flexpen the pen should be primed to remove air and to ensure the pen and needle were working correctly and would ensure the resident was receiving the correct amount of insulin.

An interview was conducted with the Director of Nursing (DON) on 5/23/19 at 8:42 AM. The DON stated they got "dinged" on not priming the needle of the Flexpen last year and the consulting

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F 759	Continued From page 9 pharmacist came in and did in-services at that time. The DON continued and stated he expected the nurse to prime the Insulin Flexpen prior to administering the insulin.	F 759		
F 867 SS=D	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 4/19/18. This was for one deficiency which was recited during the recertification survey of 5/23/19 in Drug Regimen Review, Report Irregularities, F-756. 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-756 Based on record review and staff and pharmacist interviews the facility failed to follow the consulting pharmacist's recommendations for a DISCUS (Dyskinesia Identification System) test for 1 of 2 residents reviewed for antipsychotic	F 867	Members of the facility□s QAA Committee met on 05/30/2019 to review the repeated deficiency cited from the recertification survey on 4-19-2018 □ F-756 (Drug Regimen Review, Report Irregularities). The Plan of Correction from F-756 was reviewed and updated based on team member feedback and record reviews. The QAA Committee will review all active Plans of Correction and Performance Improvement Projects to ensure interventions put in place by the committee are being implemented and followed accordingly. An in-service was conducted by the Regional Clinical Director regarding the facility□s policies and procedures related to the QAPI program. The Administrator or designee will review all Plans of Correction and Performance Improvement	6/12/19

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F 867	Continued From page 10 medications (Resident #57). F-756 was originally cited on 4/19/18 for failing to request a gradual dose reduction of an antipsychotic medication and failed to identify and report a drug irregularity that a medication was being given twice a day instead of once a day as ordered for 1 of 5 residents whose medications were reviewed. (Resident #43). During an interview on 5/23/19 at 12:07 PM, the Administrator revealed as part of the plan of correction from last year everyone else was scheduled for a gradual dose reduction and monitoring was also done. She stated they reviewed telephone orders every morning and made sure to review behavior and behavior side effects. She said Nursing notes were read everyday for falls. The Administrator stated the Pharmacist does reviews and monitoring. She stated the new Physician was given a report from the Pharmacist of who got antipsychotics. She stated they already pulled all Seroquel for appropriate diagnoses. She said they reviewed the last diagnosis and checked the pharmacist review and they developed a tool to monitor DISCUS and dose reduction. She stated information was given to the Nurse Practitioner.	F 867	Projects, including the F-756 repeat citation, weekly for six weeks then monthly for three months, to ensure all recommendations and interventions from the QAA Committee are being implemented in accordance with guidelines agreed upon by the committee. Any areas found to be out of compliance will be addressed with the QAA Committee at the next scheduled meeting for further review and to make any necessary changes to the plan. The Administrator or designee will provide updates to the QAA Committee concerning the results of the weekly and monthly scheduled audits--monthly for three months and quarterly until the next annual survey. The QAA Committee will review and make any necessary changes or updates to this Plan of Correction to ensure ongoing compliance.	