STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345278	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN SURRY SNF	830 ROCKFORD STREET MOUNT AIRY, NC 27030

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E 000	Initial Comments An unannounced Recertification survey was conducted 5/21/19 through 5/23/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # QNU911.	E 000		
F 000	INITIAL COMMENTS Tag F578 was amended on 5/30/19. The 2567 was re-posted in EPOC.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		6/7/19

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

Electronically Signed | 06/05/2019

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F 578	Continued From page 1 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately document code status in both the electronic medical record and the paper chart and failed to obtain a physician ' s order for a do not resuscitate for 1 of 13 (Resident #16) residents reviewed for advanced directives. The findings included: Resident #16 was re- admitted to the facility on 3/29/19 with diagnoses of, in part, atrial fibrillation, hypertension, kidney disease and diabetes mellitus type 2. A review of a significant change in assessment dated 4/4/19 revealed Resident 16 was cognitively intact. A review of the care plan dated 4/18/19 revealed Resident #16 desired a do not resuscitate status in the event of cardiac arrest. The goal was for the medical record to reflect proper paperwork	F 578	F578 Plan of Correction For Resident #16 and all resident's having potential to be affected. The Physician Order for Resident #16 was placed back in chart for DNR code status. Code status of DNR was entered on computer and code status reflected red as of 5-24-19. A review of all residents code status was completed by DON. Specific labeling has been added to the order sheet for code status that states, "order not to be removed from chart." To ensure the deficient practice will not occur again. Staff have been educated on Advance Directives policy, obtaining code status order and entering code status on computer to reflect in red. Education began on 5-24-19 with completion by 6-7-19. Corrective action will be monitored to	

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F 578	Continued From page 2 related to her request. A review of the physicians orders for May 2019 revealed no order for a do not resuscitate. A record review revealed a portable Do Not Resuscitate document signed by the physician in Resident #16 ' s paper chart. A review of the electronic medical record revealed a code status was not reflected. An interview on 5/22/19 with Nurse #2 revealed code status was addressed upon admission. She stated an order was obtained by the physician for code status and entered into the computer system. She stated entering it in would then reflect the code status on the screen in red. She stated Resident #16 ' s code status was not put it the computer and stated it must not have gotten put in the computer when Resident #16 was admitted. An interview on 5/23/19 at 3:01 PM with the Director of Nursing revealed she knew Resident #16 was a do not resuscitate, that she had been a do not resuscitate for a long time. She stated Resident #16 had a portable do not resuscitate that was signed by the physician. She stated when Resident #16 was readmitted from the acute floor, the code status must not have been put back in. An interview on 5/23/19 at 3:03 PM with Nurse #3 revealed she did not know the policy for advanced directives. She stated she was unsure if the portable do not resuscitate document was a physician ' s order.	F 578	ensure alleged deficient practice will not reoccur. The DON/Designee will complete weekly audit of all new admits to ensure compliance beginnning 5/27/19 and continue for a total of six weeks. Ongoing random audits will continue. See attached audit sheet Audits for compliance will be reported to the next quarterly QAPI meeting on July 31, 2019.	
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		6/7/19

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F 686 SS=D	Continued From page 3 CFR(s): 483.25(b)(1)(i)(ii) §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 observations, record review and staff and resident interviews, the facility failed to implement pressure reducing interventions for a resident with a current pressure ulcer and at risk for pressure ulcer development for 1 of 5 residents (Resident #34) reviewed for pressure ulcers. The findings included: Resident #34 was admitted to the facility on 5/18/19 with diagnoses of, in part, neuropathy and left hip fracture. A record review revealed a nursing admission assessment indicating Resident #34 was cognitively intact and required assistance with her activities of daily living. Resident #34 was admitted with an unstageable pressure ulcer to her left heel.	F 686	F686 Plan of Correction For Resident #34 and all residents having potential to be affected. Education was immediately provided to nurse and nursing assistants caring for resident #34 for pillows to be placed under heels.Observation of resident by DON/Designee began 5/23/19 at 12:00pm for pillows under heels began and completed until discharge of 5-31-19. A review of all residents with use of pillows to float heels from care plans reviewed and completed on 5-31-19. Remaining nurses, nursing assistants and therapy were educated on the use of pillows to float heels beginning on 5-24-19 to complete by 6-7-19. Education provided on baseline care plans beginning on	

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F 686	Continued From page 4 A record review revealed a skin risk assessment dated 5/18/19 revealing a skin risk score of 17, indicating mild risk. A review of the baseline care plan revealed Resident #34 was admitted to the facility with an unstageable pressure ulcer to her left heel. The baseline care plan summary indicated "staff will keep a pillow under ankles to keep pressure off of heels since you can ' t wear heel protectors". On 5/22/19 at 1:05 PM, an observation was made of wound care to Resident #34 ' s left heel wound. Nurse #2 completed the treatment to Resident #34 ' s left heel and placed her heel directly on the mattress. Nurse #2 was not observed asking Resident #34 if she wanted her heel floated or attempting any type of pressure reducing intervention before leaving the room. An observation on 5/23/19 at 9:17 AM revealed Resident #34 lying in bed with heels directly on mattress. An interview with Resident #34 was completed on 5/23/19 at 12:58 PM. She stated she can ' t wear the heel protectors but was agreeable to using a pillow under her leg to float her heel. She stated the staff don ' t always do it and she isn ' t able to do it herself. An interview with Nurse #1 on 5/23/19 at 2:07 PM revealed when a resident is admitted with a wound, orders and other interventions go in the computer system and are also on the care plans. She stated nurses give nursing assistants information also in report. She did not know why Resident #34 did not have her heel floated.	F 686	5-31-19 to be completed by 6-7-19. To ensure deficient practice will not occur again DON/Designee will complete 100% audit of residents requiring heels to be floated while in bed during day beginning 6-3-19 5 days a week for 3 weeks. Then 3x a week x 2 weeks. Then, ongoing 50% audit will be completed monthly by DON/Designee to ensure continued compliance. Admitting Nurse is required to provide report to NA's on any new admit brought to unit to ensure staff are aware of how to care for new admits until baseline care plan is completed. Once baseline care plan is completed staff caring for resident will be notified by MDS nurse of completion. Staff will need to sign new signature page attached to baseline care plan that they have reviewed the baseline care plan for resident within 5 days of admit. DON/Designee will complete ongoing audit of signature page for completion. Monitoring of compliance will be reported at the next quarterly QAPI meeting on 7/31/2019. See Attached Audit Sheet	

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F 686	Continued From page 5 An interview with Nursing Assistant #1 on 5/23/19 at 2:13 PM revealed she didn ' t have time to check every resident for pressure reduction devices when she came on shift in the morning. She stated she didn ' t know why Resident #34 didn ' t have her heels floated this morning. An interview with the Director of Nursing on 5/23/19 at 11:30 AM revealed it was her expectation that Resident #34 ' s heels be floated.	F 686		
F 758 SS=D	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; §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;	F 758		6/7/19

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F 758	Continued From page 6 §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 staff and pharmacist interviews and record review, the facility failed to follow a gradual dose reduction (GDR) for an anti-anxiety medication as recommended by the pharmacist and ordered by the physician for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #26). Findings included: Resident #26 was admitted to the facility on 5/8/18 with diagnoses that included anxiety and depression. A review of Resident #26's comprehensive minimum data set (MDS) assessment dated	F 758	F758 Plan of Correction For Resident #26 and all residents having potential to be affected. Recommendation MD Order for resident #26 was faxed to pharmacy on 5-23-19 and order was changed from scheduled to PRN. A Review of all residents was completed by DON and Pharmacy for any GDRs that needed review. Education was provided to all staff (RN's and LPN's) and pharmacist on processing of GDRs on 5-24-19.	

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F 758	Continued From page 7 5/1/19 revealed she was cognitively intact and had no negative behaviors. Further review of the assessment revealed Resident #26 received an anti-anxiety medication for seven days out of a seven day look back period. A review of Resident #26's current medications for the month of May 2019 revealed she received Valium (a medication used to treat anxiety), 2.5 milligrams (mg) every night (started 10/29/18). A review of a pharmacy recommendation dated 5/2/19 revealed the pharmacist recommended the "Valium be changed from scheduled to as needed for insomnia, then reassess in four weeks for possible discontinuation." Further review of the pharmacy recommendation revealed the physician (MD) reviewed the recommendation on 5/8/19 and documented that he agreed to change the Valium to as needed. The recommendation form was noted to have been faxed by a facility nurse to the pharmacy. A review of a MD's note dated 5/8/19 revealed, " ...She is seen today for follow up anxiety. This appears stable and no recent exacerbations. She has been on Diazepam (Valium) 2.5mg scheduled at bedtime. We will change to as needed at bedtime as attempt at GDR and reassess in four weeks ..." A review of the medical record on 5/23/19 revealed the order for Valium had not been changed from scheduled to as needed. On 5/23/19 at 11:06 AM an interview was completed with Pharmacist #1. She said that typically orders for medications were faxed to the	F 758	To ensure GDRs are processed correctly pharmacy will place all GDRs in designated folder for Doctor to review. Once GDRs are reviewed by Doctor pharmacist will collect and date. Pharmacist will provide a copy to MDS-RN and DON/Designee for audit trail. DON/Designee will perform 100% audit of all GDRs x 1 month. Ongoing 50% audit will be completed monthly by DON/Designee to ensure compliance. Monitoring of compliance will be reported to the quarterly QAPI meeting on 7-31-19.	

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F 758	Continued From page 8	F 758		

pharmacy. She reported she was unable to locate an order that changed the Valium from scheduled to as needed.

On 5/23/19 at 12:52 PM an interview was completed with Nurse #2. She stated the process that was followed when an order for medication was changed was that the order was faxed to the pharmacy as quickly as possible. She said once the order was faxed a confirmation email was received that indicated the number of pages that was faxed. Nurse #2 said typically there were several orders faxed at one time. She said Resident #26 was not her resident on the day the order was faxed to the pharmacy, but the order was one of several orders she faxed at one time that day. Nurse #2 indicated that she wrote her initials on the order once she faxed it to the pharmacy. She further stated she had not followed up with the pharmacy since she had not worked with Resident #26 on 5/8/19.

On 5/23/19 at 12:57 PM an interview was completed with Pharmacist #2. He said the process of GDR recommendations was once the MD agreed with the recommendation the nurse faxed the signed recommendation to the pharmacy. Pharmacist #2 stated he was unsure what happened and thought the order was inadvertently missed once it was faxed to the pharmacy.

On 5/23/19 at 2:02 PM an interview was completed with the Director of Nursing. She stated the process for GDR's was that once the MD addressed the pharmacy recommendation the nurse immediately faxed it to the pharmacy. She said she thought the order was faxed on 5/8/19 after the MD visited with Resident #26 and

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F 758	Continued From page 9 stated, "I know the process was done correctly."	F 758		
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 observations, record review and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by 3 medication errors out of 29 medication opportunities resulting in a medication error rate of 10.34% for one resident (Resident #36) observed during medication pass. Findings included: A review of Resident #36 ' s physicians orders for May 2019 revealed she was prescribed Percocet 5-325 milligrams one tablet by mouth 5 times a day along with Oxycodone (immediate release) 5 milligrams by mouth five times a day to equal Percocet 10-325 milligrams. Resident #36 was also prescribed Valium 10 milligrams daily. A medication administration pass was observed on 5/23/19 at 7:44 AM with Nurse #1. Nurse #1 prepared and administered to Resident #36 Valium 10 milligrams, Percocet 5-325 milligrams and Oxycodone 5 milligrams by mouth. After Resident #36 received the medication, Nurse #1 was observed exiting the room and sanitized her hands. Nurse #1 was not observed reconciling the controlled substance count sheet to reflect the	F 759	F759 Plan of Correction For Resident #36 and all residents having potential to be affected. Nurse #1 involved wtih medication error was educated by DON prior to survey exit on 5-23-19 on proper documentation timely signing out of narcotic medications when removed. All nurses received education on signing out narcotic medications when removed beginning 5-24-10 completing by 6-7-19. To ensure deficient practice will not occur again DON/Designee will complete a 25 count medication pass audit weekly x 2 months with random audits completed monthly thereafter by DON/Designee to ensure a less than 5% medication pass error rate. Monitoring of compliance will be reported at the next quarterly QAPI meeting on 7-31-19	6/7/19

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F 759	Continued From page 10 administration of Valium 10 milligrams, Percocet 5-325 milligrams and Oxycodone 5 milligrams. An observation on 5/23/19 at 10:46 AM of the controlled substance count sheet revealed Nurse #1 had not reconciled the count for the administration of Valium 10 milligrams, Percocet 5-325 milligrams and Oxycodone 5 milligrams. The controlled substance count sheets revealed Valium 10 milligrams was last administered on 5/22/19 at 8:30 PM, Percocet 5-325 milligrams was last administered on 5/22/19 at 11:30 PM and Oxycodone 5 milligrams was last administered on 5/23/19 at 12:00 AM. An interview on 5/23/19 at 10:44 AM with Nurse #1 revealed she had not signed out the medications she administered to Resident #36 yet. Nurse #1 revealed she should have scanned the medications, administered them and then reconciled the count on the controlled substance count sheets. Nurse #1 revealed she did not reconcile the administered medications immediately because she had had a bad habit of waiting until after the medication pass. An interview on 5/23/19 at 11:30 AM with the Director of Nursing revealed her expectation was for nurses administering controlled substances to reconcile the count on the controlled substance count sheet immediately after administration.	F 759		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		6/7/19

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F 880	Continued From page 11	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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NORTHERN SURRY SNF	830 ROCKFORD STREET MOUNT AIRY, NC 27030

(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 880	Continued From page 12 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to prevent cross contamination by using the same pair of gloves to perform wound care to two separate wounds for 1 of 4 (Resident #34) reviewed for wound care. The findings included: Resident #34 was admitted to the facility on 5/18/19 with an unstageable pressure ulcer to her left heel and a laceration to her left lower leg. A record review revealed Minimum Data Assessment and comprehensive care planning had not been completed.	F 880	F880 Plan of Correction For Resident #34 and all residents having potential to be affected. Nurse #2 was educated on facility policy Hand Hygiene on 6-3-19. Remaining staff have received education beginning 5-24-19 with completion of education by 6-7-19. To ensure deficient practice will not occur again DON/Designee will complete a 100% audit of dressing changes complete by Nurse #2 for 4 weeks with random	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345278	A. BUILDING _____ B. WING _____	05/23/2019

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F 880	Continued From page 13 A review of the Baseline Care Plan dated 5/18/19 revealed Resident #34 was cognitively intact, had an unstageable pressure ulcer to her left heel and a laceration to her left lower leg. An observation of wound care for Resident #34 by Nurse #2 on 5/22/19 at 1:09 PM revealed Nurse #2 removed the dirty dressing to the wound on Resident #34 ' s left lower leg, applied betadine and a clean dressing without changing her gloves. Nurse #2 then removed the dirty dressing to the pressure ulcer on Resident #34 ' s left heel, cleaned the wound and applied an aquacel foam dressing while wearign the same pair of gloves. An interview with Nurse #2 on 5/23/19 at 9:17 AM revealed she completes the treatments as ordered: she gathers her supplies, tells the resident what she is going to do, puts gloves on and does the treatment using clean technique. When asked why she didn ' t change her gloves after removing the soiled dressing on Resident #34 ' s left lower leg or after she completed the left lower leg dressing before moving to the left heel pressure ulcer treatment, she replied that it wasn ' t a sterile technique and she would only change her gloves if the dressing was heavily soiled. An interview with the Director of Nursing on 5/23/19 at 3:05 PM revealed she would have expected Nurse #2 to change her gloves after removing dirty dressings and between wounds.	F 880	audits complete monthly thereafter by DON/Designee to ensure continued compliance. Monitoring of Compliance will be reported to the next quarterly QAPI meeting on 7-31-19. See attached Audit Sheet	