STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 07/03/2013

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F 000	INITIAL COMMENTS 483.25 (F309) at J Immediate Jeopardy began on 06/23/13 when facility discharged Resident #3 to the Emergency Department as FULL CODE. The interim Administrator was informed of Immediate Jeopardy on 07/02/13 at 12:15 PM. Immediate Jeopardy was removed on 7/03/13 at 4:45 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective.	F 000	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to make a referral for community follow up when facilitating a discharge for 1 of 6 sampled discharged residents. Resident #13, known to be noncompliant with treatments and medications, was discharged to an address that was not verified as existing, without medications and without community oversight. The findings included:	F 250	1. Resident #13 no longer resides at facility. 2. Residents who are homeless or have no caregiver, if necessary have the potential to be affected by this alleged deficient practice will be identified thru the admission process and 72 hour Admission Care conference. 3. The residents who are identified through the admission process and 72 hour admission care conference will be discussed during morning meeting to begin the discharge planning process and identify the post discharge needs.	7/30/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Luther Watts — TITLE: Administrator — (X6) DATE: 07/26/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DHSR NC Asheville Mountain Region
Received
JUL 29 2013
by: SKH

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F 250	Continued From page 1 Review of hospital records dated 06/19/13 revealed Resident #13 presented in the emergency department, homeless, and requesting to be placed in a skilled nursing facility. The report noted that, per the resident, ever since his discharge from a skilled nursing facility in April, he had been homeless and bouncing back and forth between friends and was then unable to care for himself. The hospital report indicated he was accepted by this facility. Resident #13 was admitted to this facility on 06/19/13. Diagnoses included urinary tract infection, lack of coordination, iron deficiency anemia, a stage IV pressure ulcer, muscle weakness, spinal cord injury, neurogenic bladder, and paraplegia. It was also noted he had a suprapubic catheter. Review of the admission face sheet revealed Resident #13 was his own responsible party and signed his own admission papers. Nursing notes dated 06/19/13 revealed Resident #13 was alert and oriented. Nursing notes also noted Resident #13 refused wound care and catheter care on 6/19/13. He did allow the nurse to measure his pressure sores. This assessment noted 4 pressure ulcers on his right and left buttocks, clustered and Stage IV. Medications included an antibiotic, multi-vitamins, vitamin C, iron, a protein supplement, an antidepressant and an anxiety medication. Per the Medication Administration Records and Treatment Administration Records, on 06/20/13 Resident #13 refused catheter care and wound	F 250	Adult Protective Services will be notified prior to discharge by Social Service Director or Assistant if resident identified in 72 hour Admission Care Conference is homeless, unsafe environment, without appropriate caregiver, refuses home health or community oversight upon discharge. Address will be verified prior to discharge. The Social Service Director and Social Service Assistant will be educated by the Administrator on the above process. This education will be done by July 30, 2013. The Administrator will audit the discharge charts of residents identified to be homeless or without appropriate caregiver monthly for one month, then 10% of those discharged for 2 additional months post discharge. To ensure that the process of validating address and calling Adult Protective Services was followed. 4. Administrator will report results of audit to Quality Assurance Performance Committee for a period of 3 months or until substantial compliance as been Achieved and maintained. As determined by the QAPI Committee.	

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F 250	Continued From page 2 care. He was on leave from the facility from 06/21/13 through 06/24/13. Resident #13 refused all his evening medications on 06/25/13 and on 06/26/13 he refused wound care, catheter care and all morning and evening medications. The MAR revealed he refused his evening medications and catheter care on 06/27/13. Social service notes dated 06/24/13 at 1:00 PM, revealed the resident expressed his desire to the social worker on 06/20/13 and 06/21/13 to transfer to a homeless shelter. Social Service notes dated 06/25/12 at 2:30 PM revealed Resident #13 asked the social worker to find him an apartment by Friday (06/28/13). A social service note dated 06/28/13 at 4:00 PM, stated late on 06/27/13 Resident #13 wanted the social worker to find him a motel room or boarding house to discharge to the next day. The social worker explained it was after 5 PM and the resident would have to choose a motel and check for availability. On this morning (06/28/13) the resident stated he wanted to discharge to a friend's house this same date. The resident gave the social worker an address and phone number to his planned location. The note stated the nurse obtained transportation per the resident's request and the resident verified the address. The resident declined home health services. Resident #13 was discharged on 06/28/13. Interview with the social worker (SW) on 07/03/13 at 11:59 AM revealed normally with a discharge, therapy would make a home visit to ensure safety of the residence and the SW would meet with the	F 250		

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F 250	Continued From page 3 family or responsible party and try to set up home health care. She stated Resident #13 had been talking of leaving by Friday for awhile, wanting to go to an apartment, motel, or homeless shelter. Then on Friday 06/28/13 Resident #13 told her he was leaving the facility to stay with a friend. He was able to give the address and phone number where he would be staying, however, the SW never called or checked to see that the address existed, had necessary amenities like water, toilets, accessibility for his wheelchair or that the phone number provided was legitimate. The SW offered him home health care which he declined. Resident #13 also declined to take medications with him upon discharge. The SW did not think he needed any referral for community follow up because he was alert and oriented. SW and nursing assisted him with transportation to the address he provided. She stated no referral for social services or adult protective services was made following Resident #13's discharge. On 07/03/13 at 5:24 PM, The Director of Nursing (DON) stated she too offered Resident #13 home health care because she was concerned he needed more teaching related to his dressing changes and hand hygiene during the dressing changes. She stated she feared he would get them infected or get sepsis. She described him as being noncompliant with care and cited the example of dressing changes in that he did not use gloves or wash his hands. She stated when she asked him if he had a primary care physician he cussed her. Resident #13 knew the address and phone number where he was going and recited it several times consistently. She also stated she was not sure if it was a legitimate address.	F 250		

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F 250	Continued From page 4 On 07/03/13 at 5:58 PM the Administrator also stated he was concerned that Resident #13 left the facility because he was not accepting the care the Administrator felt he needed.	F 250		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews and record review the facility failed to assess if advance directives had been executed for a resident with a legal guardian for 1 of 6 sampled residents with legal guardians (Resident #3). Immediate jeopardy began on 06/23/13 when the facility discharged Resident #3 to the Emergency Department as FULL CODE. The interim administrator was notified of the immediate jeopardy on 07/02/13 at 12:15 PM. Immediate jeopardy was removed on 07/03/13 at 4:45 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.	F 309	F309 1. Resident #3 No longer resides at facility. 2. An audit of residents with legal guardians was completed by Social Service Department on 7/3/13. All legal guardians have been notified regarding code status by Social Services. 3. Admissions, Social Services and DON received In-service education provided by the Regional Clinical Director regarding process of communication, advance directives and placing accurate information in residents medical records. Completed on 7/2/13 Admissions Director will notify the Admissions Coordinator that a new admission is being admitted with a legal guardian to determine if an Advance Directive has been executed. The Admissions Coordinator will also notify the Legal Guardian that the facility will need documentation of the Resident's Advance Directive within 10 days of admission to the facility.	7/30/13

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F 309	Continued From page 5 The findings included: A document issued by the North Carolina Superior Court dated 05/14/10 was sent via facsimile to the facility on 06/11/13 titled "Letters of Appointment Guardian of the Person" identified that Resident #3 was declared an "incompetent person" and placed in the custody, care and control of Gaston County Department of Social Services (DSS) but that the Guardian has no authority to receive, manage or administer property, estate or business affairs of the ward. On 02/11/13 Gaston County DSS in accordance with Resident #3's physicians ordered that Resident #3 be "DO NOT RESUSCITATE" (DNR). On 02/15/13 a DNR order was signed by a physician (golden rod form) and indicated that it had no expiration. Review of the medical record revealed this information was not in the medical record. Resident #3 was admitted to the facility on 05/24/13 with diagnoses that included pneumonia, chronic obstructive pulmonary disease (COPD), dementia and others. A document titled "ADVANCE DIRECTIVES/MEDICAL TREATMENT DECISIONS ACKNOWLEDGEMENT OF RECEIPT" dated 05/24/13 signed by Resident #3 and Nurse #1 specified Resident #3 was FULL CODE. In addition, admission paperwork including "Consent to Treat" form was signed by Resident #3 in the presence of Nurse #1. The "Nursing Admission Assessment" dated 05/24/13 completed by Nurse #1 specified the resident was alert and oriented to person only.	F 309	The Admissions Coordinator will document the Advance Directive for the new admission on the facility's Advance Directive form used for communication to nursing. This form will be filed in the medical record as part of the admission paperwork. If the Admissions Coordinator is unable to determine the new admission's advance directive then the resident will not be admitted to the facility until the information is obtained. The Admissions Coordinator will document on the communication form that a resident is being admitted with a legal guardian. The form will be given to the Social Service Director and the Director of Nursing. After 10 days of admission to the facility, the Social Service Director will review the medical record to ensure that the documented advanced directives has been provided by the legal guardian. The Social Service Director will notify the Administrator if after 10 days the facility does not have the advance directive documentation.	

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F 309	Continued From page 6 Resident #3's hospital discharge summary and FL-2 were reviewed and revealed no advance directives were identified and no primary contact information was specified. Resident #3's "Admission Orders" dated 05/24/13 completed by Nurse #1 and signed by the physician on 05/27/13 indicated the resident's code status was "resuscitate." The physician's progress note dated 05/27/13 specified Resident #3 was unable to provide history due to dementia. The physician documented the resident's "judgment and insight was impaired." The physician's assessment of the resident specified the resident was unable to communicate effectively because of memory impairment. Resident #3's "Face Sheet" dated 05/29/13 specified he had a legal guardian and no advanced directives. The "Face Sheet" identified Gaston County DSS as the legal guardian and provided contact information. The admission Minimum Data Set (MDS) dated 05/31/13 specified the resident had severely impaired cognitive skills. On 07/01/13 at 4:15 PM the Admissions Director was interviewed and reported that she was responsible for making bed offers and notifying the Admissions Coordinator of the new admissions to the facility. She stated that she also relayed "pertinent" information about the new admission such as if they had a legal guardian. She added that this information was	F 309	All admissions will be audited by the DON for two (2) weeks to ensure Legal Guardians were properly identified. Completed on 7/17/13. The Regional Clinical Director will audit 15 charts in a quarter to ensure that Legal Guardians were properly identified. Admission Director will provide Social Services and DON/Designee with In-House Communication Form for all new admissions with Legal Guardians at time of admission. All new admission Advance Directives will be reviewed by DON/Designee within (72) hours of admission for two (2) months. 4. Weekly ad hoc QAPI meeting for four (4) weeks. SS/designee will report results of audit to Quality Assurance Performance Committee for three (3) additional months or until substantial compliance has been achieved and maintained as determined by the QAPI Committee.	

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F 309	Continued From page 7 communicated via telephone conversation or email. The Admissions Director explained that the Admissions Coordinator was responsible for completing the admission paperwork within 24 hours of the resident being admitted to the facility. During the interview, the Admissions Director explained that she had been working with DSS and Resident #3's Assisted Living Facility (ALF) since 02/2013 to try to admit him to the facility because the resident appeared to require skilled care and had experienced 8 hospitalizations in 2013. She stated that she knew Resident #3 had a legal guardian and added that the majority of residents the facility received from the ALF where Resident #3 resided had legal guardians. She reported that prior to Resident #3 being discharged from the hospital on 05/24/13 the legal guardian had to sign hospital paperwork for discharge to a skilled nursing facility. She added that she notified the Admissions Coordinator that Resident #3 would be admitted to the facility on 05/24/13 late in the evening and that he had a legal guardian. She also stated that it would have been the Resident's legal guardian who was responsible for completing the admission paperwork and determining the resident's advance directives. On 07/01/13 at 11:45 AM the Admissions Coordinator was interviewed and explained the process for admitting a resident and determining advance directives. She stated that the process for admitting a resident was that she completed the admission packet (consisting of advance directives, consent to treat and various other consent forms required by the facility) if the resident was admitted during her business hours.	F 309		

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F 309	Continued From page 8 She added that after her business hours and on weekends the admitting nurse was responsible for completing the admission packet. The Admissions Coordinator stated that she would notify the admitting nurse that a new admission would be entering the facility. She reported that she tried to share pertinent details about a new resident with the admitting nurse. She indicated that before a resident was admitted the facility had basic knowledge of the resident that included diagnoses, reason for hospitalization and basic medical history. She stated that in most cases residents' advance directives were specified on the information received from the hospital but it was the responsibility of the individual admitting the resident to verify advance directives at the time of admission to the facility. She stated she couldn't recall if she had known that Resident #3 had a legal guardian but confirmed that she did not report to the admitting nurse that Resident #3 had a legal guardian. She also stated that she didn't know that a resident with a legal guardian was not able to give consent and make determinations about advance directives. The Admissions Coordinator reported that if a resident was not alert and oriented then the family or responsible party was contacted and asked to come to the facility to sign the admission packet paperwork. She stated that she had not contacted Resident #3's legal guardian to request that they sign the admission paperwork. She stated that she was trained that if residents appeared to comprehend the forms then they were able to sign them including signing the advance directives sheet. On 07/01/13 at 2:45 PM Nurse #1 was interviewed on the telephone and reported that	F 309		

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F 309	Continued From page 9 she was trained that if an admission came after the Admissions Coordinator's business hours then it was the admitting nurse's responsibility for completing the admission packet/paperwork that included determining the resident's advance directives. She added that she was trained that if the resident being admitted seemed to comprehend the forms then he was capable of signing the consent to treat form and declaring advance directives. She added that if no advance directives were able to be determined then the resident was considered full code until the family or responsible party could be reached. She stated that a resident with a legal guardian would not be able to sign consent forms or make health care decisions such as advance directives. Nurse #1 reported that she admitted Resident #3 on 05/24/13 in the evening. She stated she was unaware the Resident had a legal guardian. She added that she allowed the resident to participate in the admission process by signing the consent to treat form and determining his advance directives because "he seemed to understand what she was saying." She stated that she documented his expressed advance directives on the "ADVANCE DIRECTIVES/MEDICAL TREATMENT DECISIONS ACKNOWLEDGEMENT OF RECEIPT" form and filed it in his medical record. Review of the form specified Resident #3 was FULL CODE. During the interview, the "Nursing Admission Assessment" form dated 05/24/13 was reviewed with Nurse #1; she reported that she had completed the form and felt that Resident #3 was "with it enough" to answer the questions. She added that in most cases for residents with confusion they were allowed to sign the advance directives form and "consent to treat" until the	F 309		

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F 309	Continued From page 10 family or responsible party was present to review the forms with the Social Service Director to verify accuracy. Nurse #1 reported that she reviewed paperwork form the hospital to aid in admitting Resident #3 which included his discharge summary and FL-2. On 07/01/13 at 3:00 PM the Social Services Director (SSD) was interviewed and reported that the facility held "72 hour post admission care conferences" with residents and their responsible parties. She stated that the Admissions Coordinator was responsible for scheduling the care conference and that she was responsible for coordinating the conference. She explained that during the conference she reviewed advance directives with the resident and/or responsible party depending on the resident's cognition. She stated that legal guardians would be invited and expected to participate for the resident and the information would be documented in the medical record. The SSD reported that she met with Resident #3 and attempted to conduct the care conference. She stated that when she attempted to speak with Resident #3 she felt he was not able to make health care decisions and she ended the conference. Resident #3's medical record was reviewed with the SSD and revealed that she had no documentation of the care conference or attempts made to contact Resident #3's legal guardian. She confirmed that contact was not made to notify the legal guardian of the care conference. The SSD stated that it was her usual practice to review the medical record to ensure that advance directives were in place. She added that she assumed the FULL CODE status was correct because in her experience most residents with legal guardians were FULL	F 309		

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CODE. She stated that Resident #3's legal guardian should have been contacted to determine his code status and that the resident should not have been allowed to make decisions for his care. She stated that she recalled being notified by the Admissions Coordinator that the Resident had a legal guardian but the FL-2 did not specify who the legal guardian was.

On 07/01/13 at 1:40 PM the Director of Nursing (DON) was interviewed and reported that the Admissions Coordinator reviewed advance directives and if she was not availble then it was the admitting nurse's responsibility to review and document a new admission's advance directives in the medical record. She reported that for residents with legal gaurdians the paperwork has to be completed by the legal guardian. She added that in most cases residents with legal guardians are FULL CODE. The DON also explained that in several cases the facility wasn't aware a resident had a legal guardian until the day after admission and in cases like that she would expect the admission paperwork to be redone by the legal guardian. She stated that in the case of Resident #3 it was assumed he was FULL CODE and that no one followed up with his legal guardian to verify his advance directives.

On 07/01/13 at 11:15 AM and 3:50 PM Resident #3's legal guardian was interviewed. She reported that she had been assigned guardianship over Resident #3 in 04/2013. She explained that the Resident had "paperwork" including a MOST form, golden rod stating he was DNR and the papers signed by the Superior Court appointing Resident #3 a ward of DSS that was kept with the resident. She added that the

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BRIAN CTR HEALTH & REHAB/GASTO	969 COX RD GASTONIA, NC 28054

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F 309	Continued From page 12 ALF where Resident #3 had been living had the papers and was responsible for sending the paperwork with the resident in the event he was discharged. The legal guardian added that the resident was admitted to the facility on 05/24/13 late in the evening and she visited him in the facility on 05/28/13. She stated that she did not have Resident #3's court issued paperwork because the process was that the paperwork should have accompanied the resident from the hospital to the facility. She added that she was never contacted by the facility requesting the court issued paperwork. During her visit to the facility on 05/28/13 she met with the nurse assigned to care for Resident #3 and his therapists. She left her business card with the nurse and asked that it be filed in the resident's medical record and that she was to be notified for care related concerns regarding Resident #3. She stated that she inquired about the skilled services the resident was receiving in the facility and was given copies of therapist notes. The legal guardian did not review Resident #3's medical record or discuss advance directives with the facility during this visit. She added that she never discussed Resident #3's advance directives with the facility. On 06/11/13 the legal guardian faxed the facility's Social Service Director the court appointed letter stating that Resident #3 was a ward of DSS. She stated she did this because the resident's Medicare benefits were ending and she was asked by the facility to sign the "Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)" form. The faxed communication did not include advance directives. The legal guardian provided fax confirmation	F 309		

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F 309	Continued From page 13 dated 06/11/13 addressed to the Social Service Director confirming the facility was notified that Resident #3 had a legal guardian. On 07/03/13 at 11:50 AM the Social Service Director was interviewed and confirmed that she had received facsimile communication from Resident #3's legal guardian but had already known that the resident had a legal guardian. She explained that she did not review advance directives with the legal guardian because she assumed his advance directives were correct. She added that she had always known wards of the State to "usually be FULL CODE." On 07/02/13 at 9:40 AM the physician was interviewed and reported that if Resident #3 had a legal guardian then Resident #3 should not have been allowed to execute advance directives or give consent to treat. He stated that he was unaware Resident #3 had a legal guardian. He was also unaware the resident had a previous DNR. Further review of Resident #3's medical record revealed that on 06/23/13 at 4:30 PM he was noted to have a change in condition and was sent to the Emergency Department with instructions that the Resident was FULL CODE. On 07/01/13 at 3:45 PM Nurse #2 was interviewed and reported that she was assigned to care for Resident #3 on 06/23/13. She recalled the evening Resident #3 was sent to the Emergency Department and explained that when discharging a resident to the hospital the nurse was responsible for making photocopies of information that was to be sent with the resident	F 309		

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F 309	Continued From page 14 that included: advance directives, face sheet, Medication Administration Record (MAR), and recent labs. She reported that on 06/23/13 she assessed the resident and determined that his condition had changed and he was having difficulty breathing. She stated she checked Resident #3's medical record and saw he was FULL CODE and called 911. She explained that Resident #3's "ADVANCE DIRECTIVES/MEDICAL TREATMENT DECISIONS ACKNOWLEDGEMENT OF RECEIPT" specified he was FULL CODE and a copy of the form was made and sent with the resident to the Emergency Department. Hospital records for Resident #3 revealed a document titled "Emergency Department Report" dated 06/23/13 specified that the resident presented to the Emergency Department in critical illness and in respiratory distress, was FULL CODE and required immediate intubation (a means to preserve breathing capacity to support life). A second document titled "Discharge Summary" dated 07/02/13 read in part Resident #3, "presented to the emergency room with severe shortness of breath and was diagnosed with septic shock and pneumonia with respiratory failure. He had to be intubated. Later it was found out that Resident #3 had wished not to be intubated and was DNR and order was reinstated. Resident #3 was extubated after optimization (withdrawal of sedatives). He continued to deteriorate as he was terminal and irreversible. Resident #3 died on 07/02/13 at 2:50 PM." The interim administrator was notified of the immediate jeopardy on 07/02/13 at 12:15 PM.	F 309		

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F 309	Continued From page 15 The facility provided a credible allegation of compliance on 07/03/13 at 4:45 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy: Resident #3 was discharged to the hospital on 06/23/13 as a full code. On 07/02/13 the facility was notified by Resident #3's legal guardian that his advance directives specified DO NOT RESUCITATE (DNR). Resident #3 died in the hospital on 07/02/13. No residents with legal guardians will be admitted until in-servicing on the new system is completed by 07/03/13. All residents currently residing in the facility with legal guardians were reviewed to determine that Advance Directives were accurate. The audit was completed on 07/02/13 by the Social Service Director. Advance directives are current and accurate as of 07/03/13. During the admission process, the facility's Admission Director will be responsible for determining if a new admission has a legal guardian. The Admissions Director will notify the Admissions Coordinator that a new admission is being admitted with a legal guardian. The Admissions Coordinator will be responsible for contacting the legal guardian to determine if an advance directive has been executed. The Admissions Coordinator will also notify the legal guardian that the facility will need documentation of the resident's advance directives within 10 days of admission to the facility. The Admissions Coordinator will document the advance directive for the new admission on the facility's "Advance Directives form" used for communication to nursing a resident's code status. This form will be filed in the medical record as part of the	F 309		

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F 309	Continued From page 16 admission paperwork. If the Admissions Coordinator is unable to determine the new admission's advance directive then the resident will not be admitted to the facility until the information is obtained. The Admissions Coordinator will document on the communication form that a resident is being admitted with a legal guardian. The form will be given to the Social Service Director and Director of Nursing. After 10 days of admission to the facility, the Social Service Director will review the medical record to ensure that the documented advance directives has been provided by the legal guardian. It will be the responsibility of the Social Service Director to notify the Administrator if after 10 days the facility does not have the advance directive documentation. The Director of Nursing was educated on 07/02/13 by the Regional Clinical Director regarding receiving the communication form from the Admission Coordinator with the information that there is a legal guardian in place and the advance directives form for a new admission to ensure that advance directives with current and accurate information is placed in the resident's medical record. The Social Service Director was educated on 07/02/13 by the Regional Clinical Director regarding receiving a communication form from the Admissions Coordinator indicating that a new admission has a legal guardian in place and the legal guardian will provide the documentation of the advance directives within 10 days. If not received within the 10 days, the Social Service Director will contact the Legal Guardian to ensure compliance and notify the Administrator that the written documentation has not been received.	F 309		

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F 309	Continued From page 17 The Admissions Director and Admissions Coordinator (who will be back-up in the case of Admissions Director absence) were educated by the Regional Clinical Director on 07/02/13 regarding the identification of a Legal Guardian and contacting the Legal Guardian to obtain current Advance Directive and to inform the Legal Guardian to provide the documentation to the facility with 10 days of admission. All admissions will be audited by Director of Nursing for a period of 2 weeks to ensure that Legal Guardians were properly identified. The Regional Clinical Director will audit 15 charts in a quarter to ensure that Legal Guardians were properly identified. An ad hoc Quality Assessment Performance Improvement (QAPI) meeting was held 07/02/13 regarding the above process. A weekly ad hoc QAPI meeting will be held for a period of 1 month then monthly for 2 additional months to determine that substantial compliance has been achieved and maintained. The Immediate Jeopardy was lifted on 07/03/13 at 4:45 PM when the facility provided credible evidence that residents with legal guardians had correct advance directives in place. The facility contacted each legal guardian and verified the residents' advance directives with them. In addition, staff members involved with admitting new residents and assessing advance directives were interviewed to ensure they were aware of the facility's new system.	F 309		
F 333	483.25(m)(2) RESIDENTS FREE OF	F 333		

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F 333 SS=D	Continued From page 18 SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to administer the correct dose of long acting Insulin for 1 of 3 residents reviewed for Insulin monitoring. (Resident #1) The findings include: Resident #1 was admitted to the facility on 02/28/13. The admission Minimum Data Set (MDS) dated 03/07/13 coded Resident #1's Brief Interview of Mental Status (BIMS) score as 15. Resident #1's diagnoses included Insulin dependent Diabetes Mellitus, anxiety and chronic spinal stenosis. A review of the current medication orders dated 03/13/13 included: · Lantus 100 unit/1ml (milliliter) Vial - Inject 27 units SQ (subcutaneously) at bedtime - Dx (diagnosis): DM (Diabetes Mellitus) A review of the nursing note at 12:00 midnight on 06/10/13 documented an error in Lantus administration and also the medication error report dated 06/11/13 revealed that Nurse #2 had made an error and had injected 100 units (1 ML) of Lantus Insulin rather than 27 units to Resident #1 by mistake. The nursing note of 06/10/13 documented that Resident #1's Finger Stick Blood Sugar (FSBS) was 315 mg/dl (milligram per deciliter) at 10:30 PM on 06/10/13 and further	F 333	1. Upon identification of error, Nurse #2 immediately notified MD/NP. Resident #1 was sent to the ER for observation and returned the following day. No adverse effects were noted to the resident 1:1 education provided to Nurse #2 on Medication Administration and Five Rights of Medication Administration. This education was completed on 6/11/13 Nurse #2 was placed with RN for three (3) days of additional orientation and observation. Medication Pass observation for Nurse #2 completed weekly for four (4) weeks. Completed on 7/10/13 2. Residents with the potential to be affected have been identified through audit of Physician orders for current residents receiving Insulin completed by DON/Designee on 6/28/13	7/30/13

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F 333	Continued From page 19 noted that she notified the Nurse Practitioner (NP) immediately regarding the error and the NP ordered to send Resident #1 to ER (Emergency Room) for monitoring and observation. Further review of the medical record revealed that Resident #1 returned to the facility on 06/12/13 approximately at 1:15 PM. Continued review of the Medication Administration Record (MAR) for the month of June 2013 revealed that all previous medications were resumed for Resident #1 without any changes. A review of the hospital discharge summary revealed that Resident #1 was admitted due to accidental overdose of long acting Insulin and his sugar was monitored every hour. The discharge note laboratory results reviewed noted that the lowest sugar level of 70 mg/dl (milligram per deciliter) reached on 06/12/13 at 00:19 and another level 75 mg/dl on 06/11/13 at 11:58 AM. He was monitored appropriately without any incidents of hypoglycemia and was discharged on 06/12/13 when sugar was stable with the same dose (27 units at bedtime) of Lantus Insulin. Resident #1 was observed and interviewed on 07/01/13 at 3:48 PM. Resident #1 was aware that he was overdosed with Lantus Insulin on 06/10/13 with 100 units of Lantus than his usual dose of 27 units. Resident #1 stated that Nurse #1 told him that she made an error in reading the Insulin order and admitted her mistake and called the doctor to send him to the hospital. Resident #1 stated that at that time he was "very nervous and anxious, felt funny and pained all over the body." The interview revealed he was transported immediately to the hospital and the	F 333	3. All licensed staff was in-serviced on Medication Administration Education completed 6/14/13 Staff Development Coordinator will observe random Medication Observations of licensed staff Three (3) times a week for four (4) weeks, then two (2) times a week for four (4) weeks, then two (2) times a month for one (1) additional month. Consultant Pharmacy will complete random Medication Pass Observation of licensed staff during routine monthly visits. 4. Don/Designee will report results of Audit to Quality Assurance Performance Committee for a period of three (3) months or until substantial compliance has been achieved and maintained as determined by the QAPI Committee	

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F 333	Continued From page 20 hospital checked his sugar often and sent him back to the facility the next day. Nurse #2 was interviewed on 07/01/13 at 3:25 PM. Nurse #2 stated that she was not familiar with the residents medication doses and wrongly read the order of Lantus Insulin in the MAR: "Lantus 100 units/ml" and administered 100 units without reading the correct order of 27 units to be given. As soon she realized that this was an error she called the Nurse Practitioner for further orders and also informed the Director of Nursing (DON). Nurse #2 stated that she made an honest mistake and learnt her lesson. The DON was interviewed on 7/1/13 at 4:30 PM. The DON stated Nurse #2 contacted her immediately after the wrong Insulin dose administration and Nurse #2 was reeducated and was trained 1:1 in reading Insulin orders and was in-serviced on medication administration. A medication error report was documented including the reeducation of the Nurse #2.	F 333		