STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	C 07/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/LEXI	**279 BRIAN CENTER DRIVE LEXINGTON, NC 27292**

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide incontinence care for an ambulatory resident (Resident #16) who remained in soiled clothing during a meal and walking about the facility. The findings included: Resident #16 was admitted to the facility on 12/23/13 with diagnoses including dementia, angina and deep vein thrombosis. The Minimum Data Set (MDS) dated 3/27/14 indicated Resident #16 had long and short term memory problems and impairment with daily decision making abilities. Behaviors were assessed as wandering with no refusals of care. The MDS indicated extensive assistance was required by staff for toileting and personal hygiene. Bowel and bladder assessment indicated he was always incontinent and was not on a toileting plan. The care plan dated 1/3/13 (initial) included a problem of requiring staff assistance for completion of activities of daily living. The stated goal included staff were to identify the resident ' s needs and to meet those needs. Observations on 7/7/14 beginning at 2:00 PM	F 241	F241 DIGNITY & RESPECT 1) Resident # 16 received appropriate incontinence care. Aide # 1, Aide # 3, Activity Director and the Administrative nurse have been in-serviced related to Dignity & Respect. 2) All residents have been audited related to dignity and respect. 3) A mandatory in-service has been conducted with all staff to ensure Resident's Dignity & Respect is maintained. Compliance Rounds will be conducted by the DON and or designee, daily X 2 weeks, weekly X 4, then monthly thereafter, to ensure ongoing compliance with Residents Dignity & Respect. Daily room Ambassador Rounds are conducted Mon-Fri by the Management Team related to Dignity & Respect. Audits will be documented utilizing the compliance rounds audit tool. 4) The QAPI Committee will monitor and evaluate for the effectiveness of the above plan to ensure ongoing compliance. "Preparation and/or execution of this plan of correction does not constitute	8/1/14

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

Electronically Signed | 07/31/2014

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F 241	Continued From page 1 revealed Resident #16 was lying in his bed on his left side. The right side of his pants, on the buttock area, was noted to have stool showing through to the outside of his pants. An odor of stool was observed in his room. Continuous observations revealed aide #1 went into Resident #16 ' s room and left after one minute and went to another room where she was observed straightening linens on an unoccupied bed. At 2:04 PM Resident #16 came out of his room to the hallway and began walking down the hall. Aide #3 stopped him and asked aide #1 to assist him. Aide #1 took him back to his room and left the hallway. Resident #16 came out of his room again, holding the back of his pants that was soiled and walked down the hallway, past the nurse ' s desk, into the dayroom where other residents were seated. Resident #16 walked from the day room, down the main hallway to the main dining room entrance. After standing at the dining room for a few seconds, Resident #16 walked back down the main hall toward the nurse ' s desk. A nurse asked Resident #16 to come to her and she took him down the hall to his room. Aide #1 came down the hall with a clean pair of sweatpants for the resident. Aide #1 gave the pants to the second shift aide. The second shift aide #5 obtained a towel and wash cloth. Resident #16 left his room for the third time and was stopped by the second shift aide #5 and returned to his room. The second shift aide #5 provided incontinence care for Resident #16 at 2:18 PM. Observations of the bottom bed sheet revealed a wet circle about 18 inches wide and long. Observations on 7/8/14 beginning at 7:58 AM revealed Resident #16 was brought to his room by the activity director. Resident #16 had an area	F 241	admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 241	Continued From page 2	F 241		

of wetness on the back of his pants. At 8:03 AM Resident #16 was observed coming out of his room, went to the day room across from the nurse ' s desk. He was wearing the same pants with noticeable wetness on the back. Resident #16 left the day room, and walked down the main hall to the dining room. At 8:04 AM he sat at a table in the main dining room. At 8:24 AM he received his breakfast tray by an administrative nurse.

Interview with the activity director on 7/8/14 at 8:01 revealed she was trying to find an aide for Resident #16. The resident had wet pants on and needed to be changed.

Interview with the administrative nurse at 8:24 AM revealed she was not aware the resident was wearing pants that were wet. Continued interview revealed she would not remove the resident from eating his breakfast to change his clothing and have incontinence care. She stated she would have someone change him when he was finished with breakfast.

Interview on 7/8/14 at 8:25 AM with the activity director revealed she could not find an aide earlier, but told a nurse that Resident #16 needed assistance. She did not know the name of the nurse she spoke to.

Observations on 7/8/14 at 8:34 AM revealed Resident #16 was assisted to his room and received incontinence care.

Interview on 7/9/14 at 11:15 AM with the director of nursing and corporate nurses revealed their expectation would be for the resident to receive incontinence care, not eat in soiled clothes or

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F 241	Continued From page 3 walk about wearing soiled clothes. The administrative nurse should have taken the resident from the dining room, obtained a new tray if necessary and not allow the resident to eat his meal wearing soiled clothing.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observations, the facility failed to update the care plan to reflect a documented need for a helix boot (pressure relieving boot) for the right foot for 1 of 22 residents (Resident #6). Findings included:	F 280	F280 RIGHT TO PARTICIPATE PLANNING CARE REVISE CP 1) Resident # 6 care plan has been revised to reflect the use of his Helix Boot (adaptive equipment).	8/1/14

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F 280	Continued From page 4 Resident #6 was admitted to the facility on 2/20/12 with diagnosis of dehydration, malaise and fatigue. Review of the (MDS) Minimum Data Set with assessment reference date of 6/13/14 indicated that Resident #6 was moderately impaired and required extensive assistance with Activity of Daily Living (ADLs) and was at risk for developing pressure ulcers. The care plan for pressure ulcers was implemented on 3/25/14 for actual stage 1 to right heel. A new intervention was implemented per physician's order on 5/27/14 for the resident to wear helix boot to the right foot, while up in the wheelchair and in bed, and may remove for care. The intervention was not added to Resident #6's care plan. An observation on 7/7/14 at 10:05 AM revealed resident #6 in bed on the left side with no Helix boot in place to right foot and at 11:30 AM positioned on right side with no Helix boot in place to right foot. At 2:00 PM the resident was in bed asleep and Helix boot was noted to be on the shelf. At 3:30 PM Resident #6 was in bed positioned on the right side with Helix boot noted to be on shelf. During an observation on 7/8/14 at 7:54 AM Resident #6 was noted to be in dining room for breakfast, up in wheelchair with tennis shoes on both feet. An interview with the treatment nurse on 7/8/14 at 9:20 AM revealed that Resident #6 should have the Helix boot on his right foot.	F 280	2) All residents were audited related to the Care Planning of any adaptive equipment. 3) A mandatory In-service was conducted related to care planning of adaptive equipment. Compliance Rounds will be conducted by the Unit Managers and/or designee, daily x 2 weeks, weekly x 4 weeks, then monthly thereafter, to ensure ongoing compliance with the residents current adaptive equipment/interventions. Audits will be documented utilizing the compliance rounds audit tool. 4) The QAPI Committee will monitor and evaluate for the effectiveness of the above plan to ensure ongoing compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 280	Continued From page 5 An interview with the Side B Unit Manager (UM) on 7/8/14 at 9:25 AM indicated that it is the responsibility of the nurses to make sure the boot is on Resident #6 ' s right foot. The intervention is on the treatment sheet for the nurses to apply the boot. The UM further indicated that the (RCS) Resident Care Sheets are for the nurse aide ' s (NA) to be aware of resident care needs and stated that when there is changes in plan of care it is discussed in morning meeting and added to the RCS sheets to inform the NA. An interview with NA #1 on 7/8/14 at 9:30 AM revealed that the care needs for the residents are communicated by the RCS sheets. An observation on 7/8/14 at 2:20 PM and 7/9/14 at 1:45 PM revealed Resident #6 in bed with no Helix boot in place to right foot and wearing socks on both feet.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to follow the physician ' s medication order when a controlled substance belonging to one resident was " borrowed " or used for administration to another resident on 3 occasions for 2 of 69 residents receiving controlled substances (Resident #25 and Resident #23).	F 281	F 281 SERVICES PROVIDED TO MEET PROFESSIONAL STANDARDS 1) Resident # 25, # 24, # 23, & resident # 20 medications have been received by the pharmacy for appropriate medication availability. A medication variance report was completed for resident #23 and #25. 2) All resident's medication records were	8/1/14

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F 281	Continued From page 6 The findings included: 1) Resident #25 was admitted to the facility on 2/10/10. A review of the resident ' s medical record revealed her medication orders included the following: 0.5 milligrams (mg) lorazepam (an antianxiety medication) given as 1/2 tablet (0.25 mg) every morning (ordered on 11/27/13); and 0.5 mg lorazepam given as 1 tablet every evening (ordered on 11/27/13). A review of Resident #25 ' s Controlled Medication Utilization Records revealed that on 6/6/14 at 5:00 AM, one-half of a 1 mg tablet of lorazepam dispensed for Resident #24 was " borrowed for (Resident #25). " A second notation was made on the Controlled Medication Utilization Records which indicated that on 6/7/14 at 5:00 AM, one-half of a 1 mg tablet of lorazepam dispensed for Resident #24 was again " borrowed for (Resident #25). " One-half of a 1 mg tablet of lorazepam equaled a 0.5 mg dose of the medication (versus the prescribed 0.25 mg dose to be given every morning). An interview was conducted with the Assistant Director of Nursing (ADON) and interim Director of Nursing (DON) on 7/9/14 at 10:10 AM. The interim DON reported that the facility had recently recognized concerns with the controlled substances in regards to record keeping and a delay in the re-ordering of the medications. A follow-up interview was conducted with the interim DON on 7/9/14 at 1:40 PM. Upon inquiry, the interim DON reported she had reviewed the records of the borrowed medications. She confirmed that there was a discrepancy between the dose of the medication prescribed and the dose of the medication borrowed and	F 281	audited related to the borrowing of controlled substances to ensure no other residents were affected. 3) A Mandatory In-service was conducted related to the borrowing of controlled substances/Narcotic reconciliation policy and procedure, medication shortage/unavailable medication policy and procedure. Compliance Rounds will be conducted by the DON and/or designee, daily x 2 weeks, weekly x 4 weeks, and then monthly thereafter, to ensure controlled substances are not being borrowed and the appropriate procedure for narcotic reconciliation is being followed. Audits will be documented utilizing the compliance rounds audit tool. 4) The QAPI Committee will monitor and evaluate for the effectiveness of the above plan to ensure ongoing compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 281	Continued From page 7 administered to the resident. A telephone interview was conducted with Nurse #4 on 7/9/14 at 2:23 PM. Nurse #4 was the 3rd shift nurse assigned to care for Resident #25 during the early morning hours of 6/6/14 and 6/7/14. Upon inquiry, the nurse indicated she did not recall the specific details of this incident. She was unable to provide any additional information in regards to the discrepancy between the dose of the medication prescribed and the dose of the medication borrowed and administered to the resident. 2) Resident #23 was admitted to the facility on 5/1/14. A review of the resident ' s medical record revealed his medication orders included the following: 10/325 milligrams (mg) hydrocodone/acetaminophen (a combination narcotic pain medication) given as 1 tablet by mouth every 6 hours as needed for pain (ordered on 5/1/14). A review of Resident #23 ' s Controlled Medication Utilization Records revealed that on 5/15/14 at 4:00 AM, two tablets of 5/325 mg hydrocodone/acetaminophen dispensed for Resident #20 were noted to have been used for Resident #23. Two tablets of 5/325 mg hydrocodone/acetaminophen equaled a dose of 10 mg hydrocodone and 650 mg acetaminophen (versus the prescribed 10 mg hydrocodone and 325 mg acetaminophen dose). An interview was conducted with the Assistant Director of Nursing (ADON) and interim Director of Nursing (DON) on 7/9/14 at 10:10 AM. The interim DON reported that the facility had recently recognized concerns with the controlled	F 281		

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F 281	Continued From page 8 substances in regards to record keeping and a delay in the re-ordering of the medications. A follow-up interview was conducted with the interim DON on 7/9/14 at 1:40 PM. Upon inquiry, the interim DON reported she had reviewed the records of the borrowed medication. She confirmed that there was a discrepancy between the dose of the medication prescribed and the dose of the medication borrowed and administered to the resident. A telephone interview was conducted with Nurse #5 on 7/9/14 at 2:15 PM. Nurse #5 was the 3rd shift nurse assigned to care for Resident #23 during the early morning hours of 5/15/14. During the interview, Nurse #5 recalled the situation and reported that the resident had run out of his medication. She was unable to provide any additional information in regards to the discrepancy between the dose of the medication prescribed and the dose of the medication borrowed and administered to the resident.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide incontinence care for an ambulatory resident (Resident #16) who remained in soiled clothing	F 312	F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 1) Resident # 16 received the	8/1/14

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F 312	Continued From page 9 during a meal and walking about the facility. The findings included: Resident #16 was admitted to the facility on 12/23/13 with diagnoses including dementia, angina and deep vein thrombosis. The Minimum Data Set (MDS) dated 3/27/14 indicated Resident #16 had long and short term memory problems and impairment with daily decision making abilities. Behaviors were assessed as wandering with no refusals of care. The MDS indicated extensive assistance was required by staff for toileting and personal hygiene. Bowel and bladder assessment indicated he was always incontinent and was not on a toileting plan. The care plan dated 1/3/13 (initial) included a problem of requiring staff assistance for completion of activities of daily living. The stated goal included staff were to identify the resident ' s needs and to meet those needs. Observations on 7/7/14 beginning at 2:00 PM revealed Resident #16 was lying in his bed on his left side. The right side of his pants, on the buttock area, was noted to have stool showing through to the outside of his pants. An odor of stool was observed in his room. Continuous observations revealed aide #1 went into Resident #16 ' s room and left after one minute and went to another room where she was observed straightening linens on an unoccupied bed. At 2:04 PM Resident #16 came out of his room to the hallway and began walking down the hall. Aide #3 stopped him and asked aide #1 to assist him. Aide #1 took him back to his room and left the hallway. Resident #16 came out of his room	F 312	appropriate incontinent care per the aide. 2) All residents were audited related to ADL Care to ensure appropriate care rendered. 3) A mandatory in-service has been conducted with all staff related to ADL care. Compliance Rounds will be conducted by the DON and/or designee, daily x 2 weeks, weekly x 4 weeks, then monthly thereafter, to ensure ongoing compliance with residents ADL Care. Daily Ambassador Rounds are conducted Mon-Fri by the Management Team related to providing of ADL Care. Audits will be documented utilizing the compliance rounds audit tool. 4) The QAPI Committee will monitor and evaluate for the effectiveness of the above plan to ensure ongoing compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 312	Continued From page 10	F 312		

again, holding the back of his pants that was soiled and walked down the hallway, past the nurse ' s desk, into the dayroom where other residents were seated. Resident #16 walked from the day room, down the main hallway to the main dining room entrance. After standing at the dining room for a few seconds, Resident #16 walked back down the main hall toward the nurse ' s desk. A nurse asked Resident #16 to come to her and she took him down the hall to his room. Aide #1 came down the hall with a clean pair of sweatpants for the resident. Aide #1 gave the pants to the second shift aide. The second shift aide #5 obtained a towel and wash cloth. Resident #16 left his room for the third time and was stopped by the second shift aide #5 and returned to his room. The second shift aide #5 provided incontinence care for Resident #16 at 2:18 PM. Observations of the bottom bed sheet revealed a wet circle about 18 inches wide and long.

Observations on 7/8/14 beginning at 7:58 AM revealed Resident #16 was brought to his room by the activity director. Resident #16 had an area of wetness on the back of his pants. At 8:03 AM Resident #16 was observed coming out of his room, went to the day room across from the nurse ' s desk. He was wearing the same pants with noticeable wetness on the back. Resident #16 left the day room, and walked down the main hall to the dining room. At 8:04 AM he sat at a table in the main dining room. At 8:24 AM he received his breakfast tray by an administrative nurse.

Interview with the activity director on 7/8/14 at 8:01 revealed she was trying to find an aide for Resident #16. The resident had wet pants on

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F 312	Continued From page 11 and needed to be changed. Interview with the administrative nurse at 8:24 AM revealed she was not aware the resident was wearing pants that were wet. Continued interview revealed she would not remove the resident from eating his breakfast to change his clothing and have incontinence care. She stated she would have someone change him when he was finished with breakfast. Interview on 7/8/14 at 8:25 AM with the activity director revealed she could not find an aide earlier, but told a nurse that Resident #16 needed assistance. She did not know the name of the nurse she spoke to. Observations on 7/8/14 at 8:34 AM revealed Resident #16 was assisted to his room and received incontinence care. Interview on 7/9/14 at 11:15 AM with the director of nursing and corporate nurses revealed their expectation would be for the resident to receive incontinence care, not eat in soiled clothes or walk about wearing soiled clothes. The administrative nurse should have taken the resident from the dining room, obtained a new tray if necessary and not allow the resident to eat his meal wearing soiled clothing.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		8/1/14

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F 314	Continued From page 12 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews the facility failed to provide physician ordered treatments to pressure ulcers (Residents # 2 and 18) and failed to provide a pressure reduction boot (Resident #6) for 3 of 6 sampled residents with pressure ulcers. The findings included: 1. Resident # 2 was admitted to the facility on 2/19/14 with diagnoses including pressure ulcers, diabetes and hypertension. The Minimum Data Set (MDS) dated 5/13/14 indicated the resident had no impairment in cognition, required extensive assistance for bed mobility, transfer, toileting, dressing and hygiene. The MDS indicated pressure ulcers were present. The care plan dated 2/19/14 included a problem of pressure ulcers "actual" with interventions including provide treatments as ordered. Record review revealed Resident #2 had three pressure ulcers that were a stage 3. Review of the most recent orders for June 2014 included instructions for wound care as follows: a. the posterior scrotum was to be cleansed with wound cleanser. Application of silver hydrogel and a dry dressing to be done daily. b. the right upper area was to be cleansed with	F 314	F 314 TREATMENT TO PREVENT/HEAL PRESSURE SORES 1) No adverse outcome was noted on resident # 2, # 18 or # 6. 2) All residents with adaptive equipment were audited to ensure compliance with physicians orders and all residents with wounds have been audited to ensure treatments rendered and documentation completed. 3) A mandatory in-service has been conducted with licensed nurses related to completing of treatments and application of adaptive equipment. Compliance Rounds will be conducted by the DON and/or designee, daily x 2 weeks, weekly x 4 weeks, then monthly thereafter to ensure ongoing compliance with completing residents treatments as ordered per the physician and the application of the adaptive equipment is followed per the physicians order. Audits will be documented utilizing the compliance rounds audit tool. 4) The QAPI Committee will monitor and evaluate for the effectiveness of the above plan to ensure ongoing compliance.	

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F 314	Continued From page 13 wound cleanser. Application of silver alginate and a dressing to be done daily. c. the right middle area was to be cleansed with wound cleanser. Application of silver hydrogel and a dressing to be done daily. Review of the treatment record for June revealed the dates of 6/1, 6/8, 6/11, 6/12, 6/24 and 6/26/14 were not initialed by nurses to indicate the treatments were provided. Review of the treatment record for July revealed the treatments were not initialed by the nurse to indicate the treatments were provided for 7/5/14. Interview with Resident #2 on 7/9/14 at 9:23 AM revealed his wound treatments were not always provided on weekends. The past weekend on Saturday (7/5/14) he did not have his dressings changed by the day or evening shift nurse. He stated he "kept asking, but no one knew who was supposed to do them." Evening shift told him day shift was supposed to do them. The day shift nurse did not know who was doing treatments. Continued interview revealed that (dressings not changed) happened frequently on the weekends. Interview on 7/9/14 at 11:15 AM with the Director of Nursing and corporate consulting nurses revealed it would be expected that nurses would do the wound treatments as ordered. Interview with Nurse #7 on 7/9/14 at 1:58 PM revealed she had worked the day shift on 7/5/14. Nurse #1 explained she was informed on orientation a nurse would be scheduled to do treatments on the weekends. She did not know who was working on that Saturday as the treatment nurse. She had not done any treatments that day due to her understanding a	F 314	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 314	Continued From page 14 treatment nurse would be doing them. Interview on 7/9/14 at 2:35 PM with the weekday treatment nurse revealed the floor nurses should know if a treatment nurse was working or not. The daily schedule had the nurse's name listed under "Treatment." If no one was doing treatments it would have been blank and the floor nurses would be expected to do the treatments. Interview with an administrative nurse on 7/9/14 at 2:40 PM revealed the treatment nurse scheduled for 7/5/14 was not able to work. The supervisor had been informed there would not be a treatment nurse and to have the floor nurses do the treatments. The nursing administration had begun scheduling treatment nurses on the weekends in the past couple of months.. The floor nurses had previously been responsible for doing the treatments on the weekends. The weekend treatment nurse was a recent change implemented to assist with wound care. 2. Resident #18 was admitted to the facility on 11/15/13 with diagnoses including fractured hip, multiple sclerosis and diabetes. The Minimum Data Set (MDS) dated 4/1/14 indicated Resident #18 had no impairment in cognition, required extensive assistance with bed mobility, transfers, dressing, toileting and hygiene. The care plan dated 4/7/14 included problems of extensive staff assistance was required for activities of daily living and potential for pressure ulcers, with updates on 6/13/14 for an actual pressure ulcer. Approaches indicated staff was to provide pressure ulcer treatments as ordered.	F 314		

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F 314	Continued From page 15 Review of the record revealed the date of onset of the pressure ulcer was 6/2/14. Physician orders for June revealed an order dated 6/2/14 to clean the left buttock with wound cleanser and apply Santyl and a dry dressing daily. A clarification order was written on 6/25/14 to add hydrogel after Santyl and a dry dressing. Review of the June treatment record revealed no nurse ' s initials were present for the dates of 6/28 or 6/29/14. Review of the July treatment record revealed no nurse ' s initials for the date of 7/5/14. Interview on 7/9/14 at 9:46 AM with Resident #18 revealed she did not have the dressing changed on 7/5/14 (Saturday) on either shift. Further interview revealed it had happened one time before, but she could not remember the exact date. She explained she had not had the wound very long. Interview on 7/9/14 at 11:15 AM with the Director of Nursing and corporate consulting nurses revealed it would be expected that nurses would do the wound treatments as ordered. Interview with Nurse #1 on 7/9/14 at 1:58 PM revealed she had worked the day shift on 7/5/14. Nurse #1 explained she was informed on orientation a nurse would be scheduled to do treatments on the weekends. She did not know who was working on that Saturday as the treatment nurse. She had not done any treatments that day due to her understanding a treatment nurse would be doing them. Interview on 7/9/14 at 2:35 PM with the weekday	F 314		

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F 314	Continued From page 16	F 314		

treatment nurse revealed the floor nurses should know if a treatment nurse was working or not. The daily schedule had the nurse's name listed under "Treatment." If no one was doing treatments it would have been blank and the floor nurses would be expected to do the treatments.

Interview with an administrative nurse on 7/9/14 at 2:40 PM revealed the treatment nurse scheduled for 7/5/14 was not able to work. The supervisor had been informed there would not be a treatment nurse and to have the floor nurses do the treatments. The nursing administration had begun scheduling treatment nurses on the weekends in the past couple of months.. The floor nurses had been responsible for doing the treatments on the weekends. The weekend treatment nurse was a recent change implemented to assist with wound care.

3. Resident #6 was admitted to the facility on 2/20/12 with diagnoses of dehydration, malaise and fatigue.

Review of the Minimum Data Set (MDS) with assessment reference date of 6/13/14 indicated that Resident #6's cognition was moderately impaired and required extensive assistance with Activity of Daily Living (ADLs) and was at risk for developing pressure ulcers.

The care plan for pressure ulcers was implemented on 3/25/14 for actual stage 1 to the right heel. A new intervention was implemented per physician's order on 5/27/14 for the resident to wear helix boot to the right foot, while up in the wheelchair and in bed, and may remove for care.

Review of the wound care specialist progress

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F 314	Continued From page 17 notes dated 6/25/14 indicated that Resident #6's right heel is stable with 100% skin sealed, apply skin prep once daily, and must be addressed with sponge boot. During an observation on 7/7/14 at 10:05 AM Resident #6 was in bed on the left side with no Helix boot in place to the right foot. At the 11:30 AM observation, the resident was positioned on the right side with no Helix boot in place to the right foot. At the 2:00 PM observation, the resident was in bed asleep and the Helix boot was noted to be on the shelf. At the 3:30 PM observation Resident #6 was in bed positioned on the right side with the Helix boot noted to be on the shelf. During an observation on 7/8/14 at 7:54 AM Resident #6 was noted to be in dining room for breakfast, up in the wheelchair with tennis shoes on both feet. An interview with the treatment nurse on 7/8/14 at 9:20 AM revealed that Resident #6 should have the Helix boot on his right foot. During an interview with the Side B Unit Manager (UM) on 7/8/14 at 9:25 AM indicated that it was the responsibility of the nurses to make sure the boot was on Resident #6 right foot, the intervention was on the treatment sheet for the nurses to apply the boot. An observation on 7/8/14 at 2:20 PM and 7/9/14 at 1:45 PM revealed Resident #6 in bed with no Helix boot in place to the right foot and wearing socks on both feet.	F 314		
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		8/1/14

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F 315 SS=D	Continued From page 18 RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to secure the indwelling catheter tubing for 2 of 4 sampled residents with catheters (Residents #1 and 4) and failed to complete incontinence care for 1 of 4 residents with recurrent urinary tract infections. (Resident #4). The findings included: 1. Resident #4 was admitted to the facility on 2/12/13 with diagnoses including intracerebral hemorrhage. The Minimum Data Set (MDS) dated 4/21/14 indicated Resident #4 was not interviewable, required extensive assistance for activities of daily living, was incontinent of bladder and bowels and a pressure ulcer was present on the sacrum. An indwelling urinary catheter was not indicated as being used during this assessment. The current care plan dated 2/3/14 included problems of incontinence related to diagnosis and "actual" urinary tract infection. The approaches included perineal care daily and as needed.	F 315	F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER 1) Resident #1 and #4 has been provided on 7/8/2014 with a leg strap to secure the catheter tubing. Aide #1 was in-serviced on appropriate catheter care on 7/8/2014. 2) All residents indwelling catheters were audited to ensure compliance with securing of the catheter tubing/appropriate catheter care. 3) A mandatory in-service has been conducted with the nursing staff related to appropriate care of residents with catheters and the securing of the catheter tubing. Compliance Rounds will be conducted daily x 2 weeks, then weekly x 4 weeks, then monthly thereafter by the DON and/or designee to ensure ongoing compliance with the securing of residents catheter tubing and providing proper	

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F 315	Continued From page 19 Review of lab work indicated Resident #4 had been treated with an antibiotic after a urinalysis reported results of an infection on 5/6/14. The lab work reported greater than 100,000 colonies of "enterococcus" which is a micro organism found in the stool. A physician's orders dated 5/27/14 included use of an indwelling urinary catheter due to a sacral pressure ulcer. The monthly physician's orders for June 2014 included the use of the urinary catheter with instructions to provide Foley catheter care every shift, anchor Foley catheter tubing to the leg and monitor placement every shift. Observations on 7/7/14 at 10:46 AM revealed no securing device was in place for the urinary catheter tubing. A second observation on 7/7/14 at 4:00 PM revealed no securing device was in place. Observations on 7/8/14 at 9:32 AM of catheter care and incontinence care revealed no securing device was in place. Observations of incontinence care and catheter care provided by aide #1 revealed the labia was not separated during perineal care, the catheter tubing was wiped with a towel from the farthest end away from the resident towards the perineal area. When Resident #4 was turned to the side, soft stool was noted on the buttocks. Aide #1 cleaned the perineal area from the front to back and used the same wash cloth. The resident was not checked for stool on the front perineal area between the labia nor at the insertion site of the catheter.	F 315	catheter care. Audits will be documented utilizing the compliance round audit tool. 4) The QAPI Committee will monitor and evaluate for the effectiveness of the above plan to ensure ongoing compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 315	Continued From page 20 Interview with aide #1 on 7/8/14 at 11:43 AM revealed she used a towel to wipe down the catheter tubing and did not use soap and water to clean the tubing. Aide #1 explained she did not separate the labia and wash the front perineal area because it was hard to get her (Resident #4) legs apart. Further interview revealed a securing device had not been in place for the catheter tubing. Aide #1 did not know why the resident did not have something to secure the catheter tubing and explained the resident was supposed to have one applied. She continued to explain she had " done what she could " and the nurse would need to get the strap/device to secure the tubing. Observations on 7/8/14 at 2:11 PM with medication aide #1 revealed a securing device that tapes to the leg had been applied to Resident #4 ' s leg. The catheter tubing was secured with the device. Interview with the Director of Nursing and corporate nurses on 7/9/14 at 11:15 AM revealed the incontinence care and catheter care had not been provided. They would expect staff to thoroughly cleanse the front perineal area, ensure no stool was present and clean the urinary catheter going four inches up the catheter. Soap and water should have been used to clean the urinary catheter tubing. 2. Resident #1 was admitted to the facility on 11/6/13 with diagnoses including Alzheimer's disease and benign prostate hypertrophy. The Minimum Data Set dated 4/18/14 indicated Resident #1 had impairment with short and long term memory, required extensive assistance by	F 315		

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F 315	Continued From page 21	F 315		

one staff for activities of daily living, had an indwelling urinary catheter and was always incontinent of bowel.

The updated care plan of 5/2/14 listed a problem that staff assistance was required for activities of daily living. Approaches included the resident ' s needs would be identified and met by the staff. The care plan included the use of an indwelling catheter. Approaches included for staff to secure the catheter, keep the bag below bladder level and observe the urine for color, odor, clarity and amount.

A telephone order dated 5/7/14 included instructions for care to the supra pubic catheter every shift, to anchor the tubing to the leg and check placement every shift.

Observations on 7/8/14 at 7:54 AM with nurse #2 revealed the tubing was not secured to the leg. Interview with nurse #2 at that time revealed she was not aware a supra pubic catheter was to be secured with a strap. She would inform the nurse for Resident #1 that a securing device was needed.

Observations on 7/8/14 at 2:09 PM with medication aide #1 revealed there was no device in place to secure the catheter tubing.

Observations on 7/9/14 at 10:00 AM with the treatment nurse revealed Resident #1 had a securing device in place for the catheter tubing. Interview with her at that time revealed the administrative nurses had checked all of the catheters for a securing device on the evening of 7/8/14. The nurses on the floor were to check for the securing devices, but she had assisted in

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F 315	Continued From page 22 checking the residents on 7/8/14. Interview on 7/9/14 at 11:15 AM with the director of nursing and corporate nurses revealed the catheter straps/securing devices were to be checked by the floor nurses. Residents with indwelling catheters should have the device in place. It was on the treatment record for the nurses' information.	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 3 medication errors out of 29 opportunities for 1 of 5 residents (Resident #20) observed during medication pass, resulting in a medication error rate of 10.3%. The findings included: A review of the facility ' s Policy entitled, " Medication Administration " dated August 2012 included the following statement: " Administer medications within 60 minutes of the scheduled time. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility. For example, if the medication is ordered for 8:00	F 332	F 332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE 1) Resident # 20 had no adverse outcome. The physician was notified for a medication adjustment due to the "out of compliance med administration." Nurse # 1 was in-serviced related to medication compliance on 7/08/2014. 2) All residents have been audited for medication administration compliance. 3) A mandatory in-service has been conducted with licensed nurses and CMA's related to Medication Administration/Prevention of Medication Errors. Compliance Rounds will be conducted by the DON and/or designee, daily x 2 weeks, weekly x 4 weeks, then monthly thereafter to ensure ongoing	8/1/14

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F 332	Continued From page 23 a.m., it must be given between 7:00 a.m. and 9:00 a.m. in order to be considered timely. " Resident #20 was re-admitted to the facility on 4/28/14 with cumulative diagnoses including hypertension (high blood pressure), tachycardia (rapid heart rate), atrial fibrillation (a specific type of irregular heartbeat), congestive heart failure, heart disease, history of seizure activity, and gastroesophageal reflux disease (GERD). On 7/8/14 at 12:02 PM, Nurse #1 was observed as she administered 9 medications to Resident #20. The medications given to the resident at that time included, in part: 500 milligrams (mg) levetiracetam (an antiseizure medication) given as one tablet by mouth; 30 mg diltiazem (a medication used to treat hypertension) given as one tablet by mouth; and 40 mg pantoprazole (a medication used to treat GERD) given as one tablet by mouth. A review of Resident #20 ' s physician medication orders revealed that 8 of the 9 medications given to Resident #20 at 12:02 PM were scheduled for administration at 7:00 AM. Three of those 8 medications were identified as having the potential to cause the resident discomfort and/or jeopardize the resident ' s health when given 5 hours after their scheduled administration time. The physician orders for these 3 medications were as follows: 1) 500 mg levetiracetam given as 1 tablet by mouth twice daily. The levetiracetam was scheduled for administration at 7:00 AM and 5:00 PM each day. According to LexiComp, a comprehensive online drug database, levetiracetam peaks in the bloodstream after about 1 hour and has a 6 - 8 hour half-life (the	F 332	compliance with medication administration. A Medication Pass Observation will be conducted 2 x weekly by the DON and/or designee. Audits will be documented utilizing the audit compliance tool. 4) The QAPI Committee will monitor and evaluate for the effectiveness of the above plan to ensure ongoing compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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time required for the serum concentration of a drug in the bloodstream to decline by 50 percent).
2) 30 mg diltiazem given as 1 tablet by mouth three times daily. The diltiazem was scheduled for administration at 7:00 AM, 11:00 AM and 4:00 PM each day. According to LexiComp, diltiazem ' s onset of action is 30-60 minutes after administration and the drug has a half-life of approximately 3-4.5 hours.
3) 40 mg pantoprazole given as one tablet by mouth once daily. The pantoprazole was scheduled for administration at 7:00 AM. According to LexiComp, pantoprazole is best taken before breakfast.

During an interview with Nurse #1 on 7/8/14 at 3:55 PM, the nurse confirmed that Resident #20 received 8 medications scheduled for 7:00 AM at 12:00 PM, along with one medication scheduled for 12:00 PM. Nurse #1 reported that after completing shift change at 6:00 AM, she went over to the other side of the facility (Hall B) to complete documentation from the previous day. The nurse noted that she did not return to her hallway until around 9:00 AM and therefore got started late on the 7:00 AM medication pass. Nurse #1 reported that Resident #20 was the last resident on the hallway to receive his medications scheduled for 7:00 AM. The nurse indicated that she told the resident ' s physician of the late medication administration and received a one-time order to delay Resident #20 ' s 3rd dose of diltiazem until later that evening.

An interview was conducted with the interim Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 7/9/14 at 10:10 AM. Upon inquiry, the interim DON stated that her expectation was for medications to be given

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F 332	Continued From page 25 within an acceptable time frame. She further indicated that an acceptable time frame was up to one hour before or one hour after the scheduled administration time for a medication. The interim DON also reported that she would have expected Nurse #1 to consult with her Unit Manager and/or DON to help ensure appropriate back up was provided so medications could have been administered to all residents within an appropriate time frame.	F 332		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews,	F 425	F 425 PHARMACEUTICAL ACCURATE	8/1/14

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F 425	Continued From page 26 pharmacy staff interviews and record review, the facility failed to follow established procedures for the ordering/re-ordering of narcotic medications to ensure that controlled substances (medications) belonging to one resident were not " borrowed " or used for administration to another resident for 4 of 69 residents receiving controlled substances (Resident #25, Resident #23, Resident #13, and Resident #12); and the facility failed to implement established procedures used to reconcile controlled medications for 4 of 4 medication carts (100, 200, 400/600, and 500/600 hall medication carts) and 1 of 1 emergency drug boxes. The findings included: 1) Resident #25 was admitted to the facility on 2/10/10. A review of the resident ' s medical record revealed her medication orders included the following: 0.5 milligrams (mg) lorazepam (an antianxiety medication) given as 1/2 tablet (0.25 mg) every morning (ordered on 11/27/13); and 0.5 mg lorazepam given as 1 tablet every evening (ordered on 11/27/13). A review of Resident #25 ' s Controlled Medication Utilization Records revealed that the last dose of the resident ' s 0.5 mg lorazepam (dispensed as 1/2 of a 0.5 mg tablet or a 0.25 mg dose) was used on 6/5/14. Further review of the Controlled Medication Utilization Records revealed that on 6/6/14 at 5:00 AM, one-half of a 1 mg tablet of lorazepam dispensed for Resident #24 was " borrowed for (Resident #25). " A second notation was made on the Controlled Medication Utilization Records which indicated that on 6/7/14 at 5:00 AM, one-half of a 1 mg tablet of lorazepam dispensed for Resident #24	F 425	PROCEDURES, RPH 1) Resident's # 25, # 23, # 13, or # 12 had no adverse outcome. 2) All residents□ medication administration records have been audited for borrowing of controlled substances and the accuracy of the controlled reconciliation records on the medication carts / emergency box for compliance. 3) A mandatory in-service has been conducted with all licensed nurses and CMA's related to the borrowing of controlled substances /Narcotic reconciliation, medication shortage/unavailable medication policy and procedure. Compliance Rounds will be conducted by the DON and/or designee daily x 2 weeks, weekly x 4 weeks, then monthly thereafter to ensure ongoing compliance with medication administration/Narcotic reconciliation. A medication Pass Observation will be conducted 2 x weekly by the DON and/or designee. Audits will be documented utilizing the compliance rounds audit tool. 4) The QAPI Committee will monitor and evaluate for the effectiveness of the above plan to ensure ongoing compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because	

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F 425	Continued From page 27 was again " borrowed for (Resident #25). " On 6/12/14, a refill of 0.5 mg lorazepam (dispensed as 1/2 of a 0.5 mg tablet or a 0.25 mg dose) was received from the pharmacy for Resident #25. An interview was conducted with the Assistant Director of Nursing (ADON) and interim Director of Nursing (DON) on 7/9/14 at 10:10 AM. The interim DON reported that the facility had recently recognized concerns with the controlled substances in regards to record keeping and a delay in the re-ordering of the medications. Part of the problem was identified as having difficulty in obtaining a hard copy script for a controlled substance during the off hours. The interim DON reported that the facility began to realize that the issues were not only related to the need for more staff education, but also may be partially attributed to the physician group providing care. The interim DON reported that a new Medical Director began caring for the residents approximately one week ago and described him as, " very responsive " to the residents ' and facility ' s needs. The interim DON stated that a new policy would be implemented to ensure that the supply of all residents ' medications, including narcotics, would be checked once a week and ordered/re-ordered from the pharmacy, if necessary. She noted that the nursing staff needed to be sure a medication was given to a resident as ordered and if there was a delay, the resident ' s physician needed to be notified. The interim DON stated, " It ' s never, ever acceptable to borrow narcotics " (from one resident to another). A telephone interview was conducted on 7/9/14 at	F 425	it is required by the provisions of federal and state law."	

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1:45 PM with the Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Pharmacy Manager reviewed the process of ordering or reordering controlled substances for residents. The Pharmacy Manager indicated that the pharmacy made a minimum of one scheduled delivery each day in the late evening, 7 days a week. She reported that controlled substances were sent out on the same schedule as other medications, but did require a hard copy of a script prior to being dispensed from the pharmacy. During a follow-up telephone interview on 7/9/14 at 2:08 PM, the Pharmacy Manager confirmed that a new order of 0.5 mg lorazepam (dispensed as 1/2 of a 0.5 mg tablet or a 0.25 mg dose) was received and dispensed from the pharmacy for Resident #25 on 6/11/14.

A telephone interview was conducted with Nurse #4 on 7/9/14 at 2:23 PM. Nurse #4 was the 3rd shift nurse assigned to care for Resident #25 during the early morning hours of 6/6/14 and 6/7/14. Upon inquiry, the nurse indicated she did not recall the specific details of this incident. However, Nurse #4 reported that a note had been posted which instructed the nursing staff not to hold any medications. She indicated that she would not have been able to obtain a hard copy of a prescription for the controlled medication at that time of day so opted to borrow a dose for Resident #25. Nurse #4 stated that she had been told not to borrow medications from one resident to another anymore but did not feel there was an alternative at the time. When asked what the facility ' s procedures were for reordering controlled medications, the nurse indicated that one time she called the on-call physician service, a hard script was called in or sent, and an

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emergency delivery was made from the pharmacy. Upon inquiry, the nurse reported she was unsure whether any follow-up was done or report given to the oncoming nurse in regards to the need to reorder Resident #25 ' s lorazepam.

2) Resident #23 was admitted to the facility on 5/1/14. A review of the resident ' s medical record revealed his medication orders included the following: 10/325 milligrams (mg) hydrocodone/acetaminophen (a combination narcotic pain medication) given as 1 tablet by mouth every 6 hours as needed for pain (ordered on 5/1/14).

A review of Resident #23 ' s Controlled Medication Utilization Records revealed that the last dose of the resident ' s 10/325 mg hydrocodone/acetaminophen was used on 5/11/14. Further review of the Controlled Medication Utilization Records revealed that on 5/15/14 at 4:00 AM, two tablets of 5/325 mg hydrocodone/acetaminophen dispensed for Resident #20 were noted to have been used for Resident #23.

On 5/27/14, a refill of 10/325 mg hydrocodone/acetaminophen was received from the pharmacy for Resident #23.

An interview was conducted with the Assistant Director of Nursing (ADON) and interim Director of Nursing (DON) on 7/9/14 at 10:10 AM. The interim DON reported that the facility had recently recognized concerns with the controlled substances in regards to record keeping and a delay in the re-ordering of the medications. Part of the problem was identified as having difficulty in obtaining a hard copy script for a controlled

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substance during the off hours. The interim DON reported that the facility began to realize that the issues were not only related to the need for more staff education, but also may be partially attributed to the physician group providing care. The interim DON reported that a new Medical Director began caring for the residents approximately one week ago and described him as, " very responsive " to the residents ' and facility ' s needs. The interim DON stated that a new policy would be implemented to ensure that the supply of all residents ' medications, including narcotics, would be checked once a week and ordered/re-ordered from the pharmacy, if necessary. She noted that the nursing staff needed to be sure a medication was given to a resident as ordered and if there was a delay, the resident ' s physician needed to be notified. The interim DON stated, " It ' s never, ever acceptable to borrow narcotics " (from one resident to another).

A telephone interview was conducted on 7/9/14 at 1:45 PM with the Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Pharmacy Manager reviewed the process of ordering or reordering controlled substances for residents. The Pharmacy Manager indicated that the pharmacy made a minimum of one scheduled delivery each day in the late evening, 7 days a week. She reported that controlled substances were sent out on the same schedule as other medications, but did require a hard copy of a script prior to being dispensed from the pharmacy. During a follow-up telephone interview on 7/9/14 at 2:08 PM, the Pharmacy Manager confirmed that a new order of 10/325 mg hydrocodone/acetaminophen was received and dispensed from the pharmacy for

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Resident #23 on 5/26/14.

A telephone interview was conducted with Nurse #5 on 7/9/14 at 2:15 PM. Nurse #5 was the 3rd shift nurse assigned to care for Resident #23 during the early morning hours of 5/15/14. During the interview, Nurse #5 recalled the situation and reported that the resident had run out of his medication. The nurse indicated that a note had been left for the Nurse Practitioner/Physician to renew the medication, and she had told the day shift nurse, unit coordinator and Director of Nursing (DON) of the situation. Nurse #5 stated, " They were going to call the pharmacy. "

3) Resident #13 was admitted to the facility on 3/26/14. A review of the resident ' s medical record revealed that on 5/19/14 at 11:15 AM, a verbal order was received as follows: " Roxinol (morphine sulfate) 0.25 mg (milligrams) one SL (under the tongue) / PO (by mouth) every 4 hours as needed. "

A review of the Controlled Medication Utilization Records for Resident #22 revealed that on 5/19/14 at 11:20 AM, a dose of " 0.25 " morphine sulfate (20 milligrams/milliliter solution) was noted as " used for (Resident #13). " A second notation was made on the Controlled Medication Utilization Records for Resident #22 which indicated that on 5/20/14 at 9:00 AM, a dose of " 0.25 " morphine sulfate (20 milligrams/milliliter solution) was again " used for (Resident #13). "

On 6/5/14, an order for morphine sulfate 20 mg/ml solution was filled by the pharmacy and received at the facility for Resident #13. The instructions included on the morphine sulfate dispensed for Resident #13 were as follows:

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Take 0.25 ml (5 mg) by mouth / sublingually every 4 hours as needed for pain or shortness of breath.

An interview was conducted with the Assistant Director of Nursing (ADON) and interim Director of Nursing (DON) on 7/9/14 at 10:10 AM. The interim DON reported that the facility had recently recognized concerns with the controlled substances in regards to record keeping and a delay in the re-ordering of the medications. Part of the problem was identified as having difficulty in obtaining a hard copy script for a controlled substance during the off hours. The interim DON reported that the facility began to realize that the issues were not only related to the need for more staff education, but also may be partially attributed to the physician group providing care. The interim DON reported that a new Medical Director began caring for the residents approximately one week ago and described him as, " very responsive " to the residents ' and facility ' s needs. The interim DON stated that a new policy would be implemented to ensure that the supply of all residents ' medications, including narcotics, would be checked once a week and re-ordered from the pharmacy, if necessary. She noted that the nursing staff needed to be sure a medication was given to a resident as ordered and if there was a delay, the resident ' s physician needed to be notified. The interim DON stated, " It ' s never, ever acceptable to borrow narcotics " (from one resident to another).

A telephone interview was conducted on 7/9/14 at 1:45 PM with the Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Pharmacy Manager reviewed the

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process of ordering or reordering controlled substances for residents. The Pharmacy Manager indicated that the pharmacy made a minimum of one scheduled delivery each day in the late evening, 7 days a week. She reported that controlled substances were sent out on the same schedule as other medications, but did require a hard copy of a script prior to being dispensed from the pharmacy. During a follow-up telephone interview on 7/9/14 at 2:08 PM, the Pharmacy Manager confirmed that an order for morphine sulfate 20 mg/ml was received and dispensed from the pharmacy for Resident #13 on 6/5/14.

A telephone interview was conducted with Nurse #6 on 7/9/14 at 3:30 PM. Nurse #6 stated that he had signed the Controlled Medication Utilization Record on 5/19/14 as an indication that he provided " approval " for borrowing the narcotic medication. Nurse #6 reported that he was the acting DON at the time. Upon inquiry, Nurse #6 reported that borrowing a narcotic medication from another resident was a " very rare thing. " He stated that the problems with the ordering/reordering of narcotics varied and sometimes included having difficulties in obtaining a hard copy of the script.

An interview was not conducted with the nurse assigned to care for Resident #13 on 5/20/14. No contact information was available for the nurse.

4) Resident #12 was admitted to the facility on 11/21/12. A review of the resident ' s medical record revealed her medication orders included the following: 5 milligrams (mg) oxycodone (a narcotic pain medication) given as 1 tablet by mouth every 6 hours as needed for moderate

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pain (ordered on 11/6/13). A review of the resident ' s April 2014, May 2014, and June 2014 Medication Administration Record (MAR) revealed that no oxycodone had been used for Resident #12.

A review of the Controlled Medication Utilization Records revealed that on 6/30/14 at 3:15 AM, one tablet of 5 mg oxycodone dispensed for Resident #21 was used for Resident #12.

Based on record review, Resident #12 did not have a supply of 5 mg oxycodone immediately available for use at the time of the on-site investigation (7/9/14).

An interview was conducted with the Assistant Director of Nursing (ADON) and interim Director of Nursing (DON) on 7/9/14 at 10:10 AM. The interim DON reported that the facility had recently recognized concerns with the controlled substances in regards to record keeping and a delay in the re-ordering of the medications. Part of the problem was identified as having difficulty in obtaining a hard copy script for a controlled substance during the off hours. The interim DON reported that the facility began to realize that the issues were not only related to the need for more staff education, but also may be partially attributed to the physician group providing care. The interim DON reported that a new Medical Director began caring for the residents approximately one week ago and described him as, " very responsive " to the residents ' and facility ' s needs. The interim DON stated that a new policy would be implemented to ensure that the supply of all residents ' medications, including narcotics, would be checked once a week and ordered/re-ordered from the pharmacy,

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if necessary. She noted that the nursing staff needed to be sure a medication was given to a resident as ordered and if there was a delay, the resident ' s physician needed to be notified. The interim DON stated, " It ' s never, ever acceptable to borrow narcotics " (from one resident to another).

A telephone interview was conducted on 7/9/14 at 1:45 PM with the Pharmacy Manager for the facility ' s contracted pharmacy. During this interview, the Pharmacy Manager reviewed the process of ordering or reordering controlled substances for residents. The Pharmacy Manager indicated that the pharmacy made a minimum of one scheduled delivery each day in the late evening, 7 days a week. She reported that controlled substances were sent out on the same schedule as other medications, but did require a hard copy of a script prior to being dispensed from the pharmacy. During a follow-up telephone interview on 7/9/14 at 2:08 PM, the Pharmacy Manager reported that there was no record of oxycodone 5 mg having been dispensed for Resident #12 within the last 3 months.

An interview was not conducted with the nurse assigned to care for Resident #12 on 6/30/14. No contact information was available for the nurse.

5) A review of the facility ' s policy entitled, " Controlled Substance Medications, " dated June 2013 included the following, in part:
" Policy: The facility must account for and properly dispose of all controlled substance medications in accordance with Federal and State laws and/or regulations.
Procedure:

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F 425	Continued From page 36 #2 of 6) An accurate inventory of controlled substance medications is maintained at all times. #3 of 6) Controlled substance medications are counted and reconciled at the beginning and end of each shift. " The facility utilized a standardized Controlled Drugs-Count Record for the reconciliation of controlled substance medications. The Controlled Drugs-Count Record specified that both the outgoing nurse and oncoming nurse for each shift needed to sign the record. A notation made at the top of the form read: " Signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the Controlled Drugs-Count Record. " On 7/8/14 at 6:00 AM, an observation was made of the shift change for 100 Hall between Nurse #4 (the outgoing 3rd shift nurse) and Nurse #1 (the oncoming 1st shift nurse). During the controlled substance reconciliation, Nurse #4 was observed to make corrections to the narcotic count for 5 medications administered during her shift. During the observation of this narcotic count, Nurse #1 stated to Nurse #4, " You have to sign them out as you go. " Nurse #4 replied, " I know, it ' s just hard. " Upon completion of the narcotic count, both nurses were observed as they signed off on the Controlled Drugs-Count Record. A telephone interview was conducted with Nurse #4 on 7/9/14 at 2:33 PM. During the interview, Nurse #4 stated that she normally tried to complete the documentation for the declining inventory narcotic sheets at the time each medication was given to a resident. However,	F 425		

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F 425	Continued From page 37 she indicated that the 3rd shift was very hectic at times and she was not always able to do so. A review of the Controlled Drugs-Count Records from June 2014 and July 2014 for each of the Medication (Med) Carts and the Emergency Drug Box revealed the following: For the 100 Hall Med Cart --- The Controlled Drugs-Count Record from June 2014 was signed (which indicated reconciliation of the narcotics) 108 out of the 180 times required for 90 shift changes during the month (one signature for the off-going nurse and one for the on-coming nurse); The Controlled Drugs-Count Record from July 2014 (7/1/14 - 7/6/14) was signed (which indicated reconciliation of the narcotics) 32 out of the 36 times required for 18 shift changes during the month (one signature for the off-going nurse and one for the on-coming nurse). For the 200 Hall Med Cart - The Controlled Drugs-Count Record from June 2014 was signed (which indicated reconciliation of the narcotics) 107 out of the 180 times required for 90 shift changes during the month (one signature for the off-going nurse and one for the on-coming nurse); The Controlled Drugs-Count Record from July 2014 (7/1/14 - 7/6/14) was signed (which indicated reconciliation of the narcotics) 24 out of the 36 times required for 18 shift changes during the month (one signature for the off-going nurse and one for the on-coming nurse). For the 400/600 Hall Med Cart - The Controlled Drugs-Count Record from June 2014 was signed (which indicated reconciliation of the narcotics) 128 out of the 180 times	F 425		

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F 425	Continued From page 38 required for 90 shift changes during the month (one signature for the off-going nurse and one for the on-coming nurse); The Controlled Drugs-Count Record from July 2014 (7/1/14 - 7/6/14) was signed (which indicated reconciliation of the narcotics) 32 out of the 36 times required for 18 shift changes during the month (one signature for the off-going nurse and one for the on-coming nurse). For the 500/600 Hall Med Cart - The Controlled Drugs-Count Record from June 2014 was signed (which indicated reconciliation of the narcotics) 118 out of the 180 times required for 90 shift changes during the month (one signature for the off-going nurse and one for the on-coming nurse); The Controlled Drugs-Count Record from July 2014 (7/1/14 - 7/6/14) was signed (which indicated reconciliation of the narcotics) 30 out of the 36 times required for 18 shift changes during the month (one signature for the off-going nurse and one for the on-coming nurse). For the Emergency Drug Box - The Controlled Drugs-Count Record from June 2014 was signed (which indicated reconciliation of the narcotics) 107 out of the 180 times required for 90 shift changes during the month (one signature for the off-going nurse and one for the on-coming nurse); The Controlled Drugs-Count Record from July 2014 (7/1/14 - 7/6/14) was signed (which indicated reconciliation of the narcotics) 13 out of the 36 times required for 18 shift changes during the month (one signature for the off-going nurse and one for the on-coming nurse). An interview was conducted with the Assistant	F 425		

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F 425	Continued From page 39 Director of Nursing (ADON) and interim Director of Nursing (DON) on 7/9/14 at 10:10 AM. The interim DON reported that the facility had recently recognized concerns with the controlled substances in regards to record keeping and had begun working to correct the issues. In regards to the controlled substance reconciliation done at shift change, the interim DON stated, " I want to see the name (of the resident) called, the drug called, the dose and the count. " She also indicated that if a nurse had not signed off on the narcotic count at shift change, it could not be assumed that the reconciliation was done. The interim DON stated, " What they were doing was substandard. " Upon inquiry, the interim DON stated her expectation was, " 100 percent compliance. I want the medication given and the reconciliation done. "	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		8/1/14

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F 431	Continued From page 40 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to securely store a controlled medication in 1 of 4 medication carts (200 Hall Cart); and failed to securely store insulin while doing blood sugar checks on 1 of 6 residence halls (500 Hall). The findings included: 1) A review of the facility ' s policy entitled, " Medication Cart Use, " dated June 2008 included the following statement: " During routine administration of medications, the cart may be kept in the doorway of the resident ' s room with: --drawers unlocked and facing inward, and within sight of the nurse --no medications are kept on top of the cart The cart must be clearly visible to the person administering medications, and all outward sides	F 431	F 431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 1) Resident # 28 or # 15 had no adverse outcome. 2) Nurse # 2 and #3 was in-serviced related to compliance of storage of biologicals for resident safety. 3) A mandatory in-service has been conducted with all licensed nurses and CMA's related to the facilities storage of medications/biologicals (syringes/lancets/insulin). Compliance Rounds will be conducted by the DON and/or designee daily x 2 weeks, weekly x 4 weeks, then monthly thereafter, to ensure ongoing compliance with the storage of the biologicals. A medication Pass Observation will be conducted 2 x weekly by the DON and/or designee.	

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F 431	Continued From page 41 must be inaccessible to persons passing by. " An observation of medication administration was conducted on 7/7/14 at 3:28 PM with Nurse #2. The nurse was observed as she prepared medications for administration to Resident #28. During this time, Nurse #2 placed a card containing 16 tablets of 0.25 milligrams (mg) alprazolam (a controlled medication frequently used for the treatment of anxiety) on top of the medication cart. At 3:40 PM, the nurse locked the medication cart, left the cart against the wall of the hallway (on one side of the resident ' s doorway), and entered Resident #28 ' s room. While the nurse was in the resident ' s room, 3 facility staff members passed by the medication cart. One ambulatory resident, Resident #15, was observed to be on the hallway ' s telephone (located one door down from the medication cart) while Nurse #2 was in Resident #28 ' s room and out of view of the medication cart. Nurse #2 exited Resident #28 ' s room and returned to the medication cart at 3:45 PM. An interview was conducted with Nurse #2 on 7/7/14 at 3:45 PM. Upon inquiry, Nurse #2 reported that she thought the alprazolam card was empty and had placed it with another card (which was empty) on top of the cart as a reminder to reorder the medication. The nurse stated that she should not have left the card containing medication on top of the cart and acknowledged the medication cart was out of her view while she was in the room at bedside with Resident #28. Following the interview, Nurse #2 secured the card of alprazolam in the locked compartment of the medication cart containing the controlled substances.	F 431	Audits will be documented utilizing the compliance rounds audit tool. 4) The QAPI Committee will monitor and evaluate for the effectiveness of the above plan to ensure ongoing compliance. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 431	Continued From page 42 During an interview with the interim DON (Director of Nursing) and Assistant Director of Nursing (ADON) on 7/9/14 at 10:10 AM, the DON indicated that her expectation would be for medications to be securely stored at all times. 2) A review of the facility ' s policy entitled, " Medication Cart Use, " dated June 2008 included the following statement: " During routine administration of medications, the cart may be kept in the doorway of the resident ' s room with: --drawers unlocked and facing inward, and within sight of the nurse --no medications are kept on top of the cart The cart must be clearly visible to the person administering medications, and all outward sides must be inaccessible to persons passing by. " An observation of medication administration was conducted on 7/8/14 at 7:21 AM with Nurse #3. Nurse #3 reported she was assigned to do the blood sugar checks for all residents on the hall and also assumed responsibility to administer insulin in accordance with the physician ' s orders. Nurse #3 indicated that a Medication Aide was assigned to administer all of the other medications to the residents on the hallway using the Medication Cart at that time. The nurse had supplies for blood sugar checks and insulin administration set on top of a rolling bedside tray table. The supplies included a basket of multiple insulin vials and insulin pens individually labeled for residents residing on that hallway. At 7:27 AM, Nurse #3 checked Resident #27 ' s blood sugar results and prepared an insulin injection for him. At 7:33 AM, the nurse went into the resident ' s room and closed the door to give the injection. The rolling bedside tray table was left in the	F 431		

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F 431	Continued From page 43 hallway with the basket of insulin medications sitting on top of it. Nurse #3 returned to the tray table at 7:35 AM. An interview was conducted with Nurse #3 on 7/8/14 at 2:14 PM. Nurse #3 reported that she had worked at the facility for about one year on a " PRN " or as needed basis. Upon inquiry, the nurse reported that she herself had a concern that items were left out and that, " anyone could have gotten to them. " However, she stated that at the time, she did not have access to a cart that could be locked. The nurse indicated that she had shared her concern with both the Assistant Director of Nursing (ADON) and interim Director of Nursing (DON) after completing the morning blood sugar checks. An interview was conducted with the interim DON (Director of Nursing) and Assistant Director of Nursing (ADON) on 7/9/14 at 10:10 AM. During the interview, the interim DON stated that the set-up used for blood sugar checks and insulin administration, " was not a system that should have been in place at all. " The interim DON reported that the hall did have a smaller locked medication cart that was intended to be used under such circumstances for blood sugar checks and insulin administration. The DON stated that use of this cart would have allowed for the insulin vials and insulin pens to have been locked up in between patients. The interim DON indicated that her expectation would be for medications to be securely stored at all times.	F 431		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive	F 463		8/1/14

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F 463	Continued From page 44 resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews, the facility failed to ensure a functioning call bell system for 14 of 86 call bell systems assessed for functioning (Rooms 405-A, 406-B, 408-B, 409-A, 411-A, 502-A, 505-A, 505-B, 506-A, 507-A, 507-B, 603-B, 608-A and 609-B). Findings included: During an interview with Resident #6 in room 405-A on 7/8/14 at 2:20PM he attempted to activate his call bell for assistance and it was noted not to be functioning. There were no lights noted in his room, outside his door and no audible signals when call bell system was activated. On 7/8/14 at 2:24PM the call bell system for Unit A and Unit B was assessed for functioning. There were 14 call bells discovered not to be functioning when tested as follows: 7/8/14 at 2:24PM Room 405-A had no visual or audible call bell function. 7/8/14 at 2:27PM Room 408-B had no visual or audible call bell function. 7/8/14 at 2:30PM Room 406-B had no visual or audible call bell function. 7/8/14 at 2:33PM Room 609-B had no visual or audible call bell function. 7/8/14 at 2:35PM Room 608-A had no visual or audible call bell function. 7/8/14 at 2:35PM Room 411-A had no visual or	F 463	F 463 RESIDENT CALL SYSTEM-ROOMS/TOILET/BATH 1) No adverse outcome was noted on resident # 6, and or residents in rooms 405A, 406B, 409A, 41A, 502A, 505A, 505B, 506A, 507A, 507B, 603B, 608A, and 609B. 2) All residents rooms, bathrooms, shower rooms were audited to ensure appropriate functioning of all call-bell systems. 3) A mandatory in-service has been conducted with all staff related to the facilities resident call system/ failure and preventative maintenance program policy. Compliance Rounds will be conducted by the DON and/or designee, daily x 2 weeks, weekly x 4 weeks, then monthly thereafter, to ensure ongoing compliance with the resident call system. All residents rooms call light switches identified to not be functioning appropriately have been replaced. Audits will be documented utilizing the compliance round audit tool. 4) The QAPI Committee will monitor and evaluate for the effectiveness of the above plan to ensure ongoing compliance. "Preparation and/or execution of this plan	

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F 463	Continued From page 45 audible call bell function. 7/8/14 at 2:37PM Room 409-A had no visual or audible call bell function. 7/8/14 at 2:39PM Room 507-A had no visual or audible call bell function. 7/8/14 at 2:41PM Room507-B had no visual or audible call bell function. 7/8/14 at 2:42PM Room 505-A and 505-B had no visual or audible call bell function. 7/8/14 at 2:43PM Room 506-A had no visual or audible call bell function. 7/8/14 at 2:46PM Room 502-A had no visual or audible call bell function. 7/8/14 at 2:50PM Room 603-B had no visual or audible call bell function. An interview with nurse aide (NA) #5 on 7/8/14 at 3:00PM revealed that she was not aware of any call bell ' s not functioning and if she found a call bell not functioning she would contact maintenance as soon as possible to have it repaired. During an interview with the maintenance director on 7/8/14 at 3:10PM revealed that the call system was checked last week and all call bells were functioning. He indicated that weekly checks are done to ensure that call bell systems are functioning. He further indicated that no staff have reported any call bells not functioning. The staff knows to call maintenance immediately for call bell repairs because maintenance staff considers call bell repairs a priority. During an interview with the administrator and maintenance director on 7/8/14 at 4:16PM indicated that their expectations were that all call bell systems were to be functioning and all call systems would be audited and corrected	F 463	of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 463	Continued From page 46 immediately. The action plan was implemented immediately on 7/8/14 and the identified rooms were corrected and an audit was completed on all rooms, bathrooms and shower rooms to verify properly functioning call bells.	F 463		