STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	08/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	**1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909**

(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 000	INITIAL COMMENTS The 2567 was amended on 9/2/2014 to correct the scope and severity of tag F364 from F to D.	F 000		
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 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 observation, staff interview and record review, the facility failed to implement measures to reduce pressure to heels for 1 or 4 residents (Resident #260) reviewed for pressure ulcers. The findings included: Resident #260 was admitted to the facility on 8/6/14. Diagnoses included status post surgical repair of a right hip fracture. The admission nursing assessment dated 8/6/14 revealed Resident #260 had a stage 1 pressure ulcer to his right heel. Wound Assessment Reports dated 8/6/14 revealed Resident #260 had a stage 1 pressure ulcer to his right heel, described as a reddened, non-blanchable, 10 centimeters (cm) by 10 cm	F 314	F 314 On 8/16/14, an alternating pressure relieving mattress was put on resident #260□s bed. On 8/16/14, an intervention of heel protector Boots to be put on the heels of resident #260 was put in the care guide. On 8/18/14, resident #260 had a nutrition assessment. The following supplements were added. Arginaid Extra 120 ML QID with med pass and one can of Ensure daily, given at lunch. On 8/29/14, an intervention of heels floated off pillows while in bed was added to the care guide.	9/13/14

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

Electronically Signed | 09/06/2014

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F 314	Continued From page 1 area; and an area of blanchable redness with bogginess to his left heel. The Treatment Administration Record (TAR) and Medication Administration Record (MAR) revealed Resident #260 was to wear padded boots (padded ankle high fabric boots to minimize pressure on heels and ankles) while in bed. The admission interim care plan dated 8/6/14 listed a need (problem) as skin integrity related to hip replacement. The goal included "absence of skin breakdown as evidenced by no redness/swelling, skin intact or breakdown with evidence of healing." Approaches included to position every 2 hours and as needed and implement pressure reducing devices as needed. The Care Guide, utilized by the nursing assistants, included the resident's shower schedule, need for assistance in getting out of bed and with activities of daily living. No instructions were provided regarding measures to reduce, minimize or eliminate pressure on his heels. Wound Assessment Reports dated 8/13/14 revealed Resident #260 had a stage 1 pressure ulcer to his right heel and blanchable redness to his left heel. No measurements were documented. The Reports indicated the physician was notified. The TAR revealed a new treatment was started on 8/13/14 for Mepilex (a foam dressing) 4 inch by 4 inch to the right heel every 7 days and as needed. The Wound Assessment Report dated 8/15/14	F 314	An in service for all nursing staff was conducted on pressure ulcer prevention. The pressure ulcer prevention in services will be conducted by the DON, ADON, and SDC nurse and will be completed by 9/13/2014. Each resident will have a Braden Scale Assessment completed by 9/10/2014. Appropriate interventions will be put in place depending on the outcome of the assessment. Each resident will have a skin check completed and a Braden Scale Assessment completed by a licensed nurse on a weekly basis. Licensed nursing staff completing the assessment will complete a Pressure Reduction Intervention Log form for each resident upon completion of the Braden Scale Assessment to ensure that appropriate interventions have been put in place. The Pressure Reduction Intervention form includes the weekly Braden Scores, previous and current interventions, and dates of implementation. The form also lists any pressure ulcers, and the date they were identified or resolved. MDS nurses will review the Pressure Reduction Intervention logs after being completed by licensed nursing staff and update the care plan and daily care guide for nurses and CNA□s. The Director of Nursing (DON), or Assistant Director of Nursing (ADON), and or the Staff Development Coordinator	

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F 314	Continued From page 2 revealed Resident #260 had a 2 cm by 2 cm area of blanchable redness on his right heel and right lateral foot. The physician was notified. The TAR revealed a new treatment was started on 8/15/14 for Allevyn (a foam dressing) to the right heel and right lateral foot every 3 days and as needed. Physician orders dated 8/15/14 included to float heels at all times when in bed. On 8/15/14 at 4:20 PM Resident #260 was observed with Nursing Assistant (NA) #1 in attendance. The resident was lying in bed with his heels resting directly on the mattress; he was not wearing padded boots nor were his heels floated. A dressing was intact to his right lateral foot. On 8/16/14 at 8:45 AM Resident #260 was observed with Nurse #1 in attendance. The resident was lying in bed with his heels resting directly on the mattress; he was not wearing padded boots nor were his heels floated. A dressing was intact to his right lateral foot. During an interview on 8/16/14 at 8:53 AM, NA #2, who was assigned to Resident #260, indicated she relied on the care guide information in the kiosk for instruction on what she needed to do for the resident. NA #2 then pulled up the resident's information in the kiosk but nothing was found regarding padded boots or floating heels. NA #2 also indicated that since the resident had padded boots in his room she had put them on the resident on prior days but he did not like them and would kick them off. During an interview on 8/16/14 at 11:10 AM, the	F 314	(SDC) Nurse will monitor the completed skin checks and Braden Scale Assessments by performing and completing five skin checks and Braden Scale Assessments per week for three months. These five weekly skin check and Braden Scale Assessment results will be compared to the most recent skin check and Braden Scale Assessments completed by licensed nursing staff. Monitoring results will be documented on the Weekly Skin Audit Tool form and presented to the QA committee and further monitoring will occur as directed by the QA Committee. The DON, or ADON, and or SDC Nurse will audit all completed Pressure Reduction Intervention Log forms for one month to ensure all pressure reducing interventions are in place. The DON, ADON, and or SDC will then audit ten completed Pressure Reduction Intervention Log forms per week for three months to ensure pressure reducing measures are in place. Results of the monitoring will be documented on the Pressure Area Monitoring Tool and presented to the QA Committee. Further monitoring will be determined by the recommendation of the QA Committee.	

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F 314	Continued From page 3 Assistant Director of Nursing (ADON) indicated the need for padded boots and floating heels should be in the care guides. She said the Minimum Data Set (MDS) nurse was responsible for updating the care guides which the nursing assistants accessed in the kiosks. The ADON also stated that a list of residents whose heels were being watched closely was posted at the 100-400 hall nursing station, but there was no list for the 500-800 halls, where Resident #260 resided, because there was a much higher turnover of residents. On 8/16/14 at 11:48 AM, Resident #260 was observed in bed with a pillow under his legs. The resident had slid down in the bed and his heels were resting directly on the mattress with no means of pressure relief. The Wound Nurse was present and put padded boots of both of the resident's feet. Resident #260 immediately began complaining that the boots were uncomfortable and began squirming out of them. The Wound Nurse then got assistance to reposition the resident in bed and float his heels. The Wound Nurse stated she would talk to the Director of Nursing (DON) and ADON about alternatives for the padded boots. During an interview on 8/16/14 at 12:23 PM, he DON indicated the facility sometimes used bulky dressings to the feet for resdient s who did not tolerate the padded boots. She added that floating heels may not be effective if the resident moved around in bed.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		9/12/14

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F 329	Continued From page 4 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, pharmacist and medical director interviews the facility gave a medication more frequently than was prescribed. The facility administered the medication routinely rather than prn (as needed). In addition, the facility administered the same medication every 4 hours during the day instead of the prescribed every 6 hours prn for the administration of Robaxin for 1 of 5 residents reviewed for unnecessary medications. (Resident #98) The findings included:	F 329	F329 The order for Robaxin 500mg PO QID for Resident #98 was corrected in the EMAR to Robaxin 500mg by mouth every 6 hours as needed for muscle spasms, which was on a physician□s order for Resident #98, dated 7/4/2014. This correction was made 8/14/14. The consultant pharmacist reviewed all resident□s medication regimes on dates	

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F 329	Continued From page 5 Resident #98 was readmitted to the facility on 7/02/14. The last Minimum Data Set (MDS) was dated on 07/30/2014 and indicated Resident #98 was cognitively intact. Active diagnosis included Spinal Stenosis and Chronic Pain. Resident #98 Functional Status was documented as extensive assistance. Review of a physician order dated 7/04/14 read "Robaxin 500 mg (milligrams) by mouth (po) every (q) 6 hours (h) as needed (prn), muscle spasms." Review of the Medication Administration Record (MAR) dated 7/04/14 through 8/15/14 read, "Robaxin 500 mg tablet (tab)." Review of the monthly physician orders for July and August read "7/04/14 Robaxin 500 mg tablet (tab) four times a day (qid)." Review of medication administration documentation on the MAR revealed that Robaxin was scheduled and signed as administered every 4 hours at 8:30 am, 12:30 pm, 4:30 pm and 8:30 pm to Resident #98 beginning 7/4/14 to present 8/15/14. On 8/14/14 at 11:50 am during an interview with the Physician/Medical Director he clarified the Physician Order dated 7/4/14 was written by himself and stated that it read "Robaxin 500 mg by mouth every 6 hours prn, muscle spasms." He indicated that he expected his orders to be transcribed correctly as written and that the nurse should call him to clarify any unclear or incomplete orders.	F 329	8/12/14, 8/13/14, 8/14/14, 8/15/14, 8/19/14 and 8/20 for errors or inconsistency. Any inconsistencies found were corrected. DON, ADON, SDC, and or a Licensed RN or LPN will audit all active orders received since 7/1/14 for accuracy by 9/10/14 The facility implemented a policy for all orders to be checked by a second licensed nurse. The policy states that after an order has been processed, a second nurse must review and verify that the order has been correctly entered into the Electronic Medication Record and then initail the order. All licensed nursing staff will be in serviced on this policy by 9/12/14. The in services will be conducted by the DON, ADON, and or the SDC nurse. DON, ADON, and or SDC will audit 10 orders per week for 12 weeks to ensure that orders were properly processed and that they were checked by a second nurse. Results will be documented on the Physician Order Review Audit Form. Auditing results will be reported to the QA Committee and further monitoring will occur as directed by the QA Committee	

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F 329	Continued From page 6 On 8/14/14 at 12 pm an interview with the Director of Nursing (DON) she stated that "Nurses transcribe medication orders and a pharmacist reviews the MAR once a month." The DON indicated that she expected orders should be transcribed according to physician orders, that unclear or incomplete physician orders should be clarified by the nurse with the physician and the MAR should be reviewed monthly by the pharmacist to identify and resolve any medication errors or problems and shared with the interdisciplinary team. The DON read the physician order for Resident #98 as "Robaxin 500 mg by mouth every 6 hours for muscle spasms." The DON stated, "Every 6 hours would be 6 am, 12 pm, 6 pm & 12 am." On 8/14/14 at 12:04 pm, an interview was conducted with the Pharmacist who stated that the physician order appeared to read, Robaxin 500 mg by mouth every 6 hours prn, muscle spasms. She indicated that the handwritten "prn" also looked like "for", if the nurse read it as for the order would have transcribed the physician order as Robaxin 500 mg by mouth every 6 hours for muscle spasms." She stated that "Yes, the Robaxin is scheduled on the MAR to be administered every 4 hours during the day instead of every six and should be prn instead of scheduled." The pharmacist stated that Robaxin was a Central Nervous System (CNS) Depressant. She indicated that common side effects of Robaxin would include signs and symptoms of sedation, lethargy, dry mouth and constipation with the main adverse effect of concern being lethargy.	F 329		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		9/10/14

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F 364	Continued From page 7 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on test tray observations and staff and resident interviews, the facility failed to provide food with palatability and an appetizing appearance for 2 of 3 residents (Resident #118 & #29) who reported food complaints. The findings included: 1. Resident # 29 was admitted to the facility on 5/29/14 with diagnoses including chronic airway obstruction, generalized anxiety disorder and Alzheimer dementia. Her current diet was regular food with chopped meats. An observation of resident # 29 on 8/12/14 at 9:30 AM revealed the resident sitting up in her wheelchair with a breakfast tray containing oatmeal, muffin, orange juice and coffee in front of her on the bedside tray table. An interview with resident # 29 on 8/12/14 at 10:05 AM revealed she did not like her morning oatmeal. The resident was observed to have a partial serving of oatmeal on her tray. She stated "oatmeal is lumpy and has no taste." The resident stated "I can ' t eat any more." Fifty percent of resident # 29's oatmeal was left on her breakfast tray.	F 364	F 364 On 9/10/2014, The Assistant Dietary Manager met with Resident # 29 and #118 and informed them of some changes that had been made in the preparation of food. This included informing Residents #29 and #118 that the dietary department was now using frozen vegetables and seasoning the vegetables differently. It also included informing the residents that the Dietary department was now using and preparing raw roast beef and whole cooked turkey breast as compared to pre cooked roast beef and sliced turkey. On 9/10/2014 Residents #29 and #118 were also informed of the Dietary Staff being in serviced on the appearance of the food. Both residents said that the food was better. On 9/3/14 Resident #29 and #118 were both interviewed by the Assistant Dietary Manager to ensure likes and dislikes were known. The Dietary Manager and or Assistant Dietary Manager will monitor resident #29 and resident #118'□s meals by	

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F 364	Continued From page 8 Observation of resident # 29 on 8/14/14 at 12:40 PM revealed the resident sitting up in her wheelchair with a tray containing chopped turkey-ham, steamed carrots, and green beans in front of her on the bedside tray table. An interview with resident # 29 on 8/14/14 at 1:15 PM revealed the resident did not like the taste of the chopped turkey-ham that was served on her lunch tray. The resident stated "it isn't very good." Observation of resident #29 on 8/15/14 at 12:55 PM revealed the resident sitting up in her wheelchair with a tray containing ground chicken, mashed potatoes, broccoli and a roll in front of her on the bedside table. An interview with resident # 29 on 8/15/14 at 1:35 PM revealed the resident did not like the taste of the ground chicken that was served on her lunch tray. The resident stated "I can't eat much of this, it tastes bad." Observation was made that resident # 29 had 50% of her food left on her lunch tray. During a test tray evaluation of a regular meal tray on 8/14/14 at 1:15 PM the food items on the tray were tasted with the Dietary Director. The pieces of potato in the mixed vegetables had a dark discolored appearance with browning on the outer edges. The lima beans in the mixed vegetables were dark colored and wrinkled in appearance. The roast beef had the appearance of being a processed, precooked meat that was thinly sliced and dark brownish-black. The Dietary Director, during an interview on 8/14/14 at 1:15 PM, stated that the mixed vegetables were overcooked and the meat tasted	F 364	interviewing residents two times a week during a meal for meal palatability and meal appearance for one month. This will include a minimum of two breakfast, two lunch, and two dinner interviews. Results of the monitoring will be documented on a Resident Meal Satisfaction Tool form and results reported to the QA Committee and further monitoring will occur as directed by the QA Committee On 8/18/14 the Dietary Department started purchasing frozen vegetables as compared to canned which the dietary department was previously purchasing. Vegetables are now being prepared or cooked in a steamer. On 8/18/14 the Dietary Department started purchasing Fresh Round Roast Beef as compared to precooked sliced roast beef that the dietary department was previously purchasing. An in service for all Dietary staff was conducted by the Dietary Manager and Assitant Dietary Manager on preparing food that maintains palatability and an appetizing appearance. This in servicing was completed by 9/10/2014. All Department Heads were in serviced on the appetizing appearance of food, food pallatability and the use of the monitoring tool. This in service was conducted and completed by the Administrator on	

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F 364	Continued From page 9 too salty and processed. She also stated the food items did not taste good. She added that the roast beef was purchased already cooked or processed and would taste better if it was cooked from raw. In addition the Dietary Director stated the food items did not look appetizing. She reported that most of the vegetables were canned items and the meats were processed meats. She added that if the foods were not canned or processed that they would look more appetizing. She also felt that if the food items were not overcooked they would look more appetizing 2. Resident # 118 was readmitted to the facility on 2/24/12 with diagnoses including Parkinson's disease and muscle weakness. His current diet was a no added salt, mechanical soft with pureed meats diet. An interview with resident #118 on 8/12/14 at 11:00 AM revealed that some of the food did not look appetizing or taste good. He added the food had no seasoning. During a test tray evaluation of a regular meal tray on 8/14/14 at 1:15 PM the food items on the tray were tasted with the Dietary Director. The pieces of potato in the mixed vegetables had a dark discolored appearance with browning on the outer edges. The lima beans in the mixed vegetables were dark colored and wrinkled in appearance. The roast beef had the appearance of being a processed, precooked meat that was thinly sliced and dark brownish-black. The Dietary Director, during an interview on 8/14/14 at 1:15 PM, stated that the mixed vegetables were overcooked and the meat tasted	F 364	9/9/2014. A minimum of 10 inteviewable resident□s meal trays will be monitored weekly for 3 months by the Dietary Manager, Assistant Dietary Manager, and or Department Heads to ensure Residents meals are palatable and appetizing in appearance. This will be determined by the input from the residents interviewed and documented on the Resident Meal Satisfaction Tool. The ten monitored meals per week will include a minimum of two breakfasts, two lunches and two dinners. Results of the monitoring will be reported to the QA Committee and further monitoring will occur as directed by the QA Committee. The Dietary Manager, Assistant Manager, and or Department Heads will monitor the quality of meals once daily for a month and then three meals a week for two months. This will be done by tasting and critiquing the appetizing appearance of the meal. Results of the monitoring will be documented on the Quality of Meal Tool form. Results will be reported to the QA Committee and further monitoring will occur as directed by the QA Committee.	

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F 364	Continued From page 10 too salty and processed. She also stated the food items did not taste good. She added that the roast beef was purchased already cooked or processed and would taste better if it was cooked from raw. In addition the Dietary Director stated the food items did not look appetizing. She reported that most of the vegetables were canned items and the meats were processed meats. She added that if the foods were not canned or processed that they would look more appetizing. She also felt that if the food items were not overcooked they would look more appetizing.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to use a barrier between bare hands and ready-to-eat food by staff members who picked up bread with their bare hands during 2 of 2 observed meals. The findings included: 1. A dining observation was conducted on 8/11/14 at 12:10 PM in the main dining room. NA #3 was observed to place a tray on the dining table for a resident. She then assisted the resident with	F 371	F 371 All staff will be in-serviced on the proper procedure in the handling of Resident food. This includes educating all staff that while handling food a barrier must be between an employees hands and a Residents food by the use of gloves, and or utensils. This will be completed by 9/13/2014. The inservice will be	9/13/14

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F 371	Continued From page 11 putting butter on her biscuit. NA #3 picked the biscuit up with her bare hands, pulled it in half, placed the top down and applied butter with a knife to the bottom portion. She then picked up the bottom portion of the biscuit with her bare hands, put the top and bottom biscuit halves together and placed them on the resident's plate. During an interview with NA #3 on 8/11/14 at 12: 20 PM she stated, "We are expected to assist the resident with applying condiments to their food. If a resident wants butter on their biscuit I open the biscuit with my hands to put the butter on it." NA #3 indicated that the facility had never taught her not to touch the food with her bare hands. NA #3 stated "We are expected to sanitize or wash our hands with soap and water prior to beginning to serve food." The Director of Nursing (DON) was interviewed on 8/15/14 at 1:00 PM. The DON stated that she expected staff to wash their hands with soap and water prior to tray delivery and to sanitize their hands between residents. She expected staff to stop serving food and wash their hands after touching a resident or any soiled item. The DON said that if their hands were washed with soap and water it was alright for staff to handle resident food with their bare hands. 2. On 8/11/14 at 12:05 PM, the meal service in the fine dining room for the Sycamore Unit was observed. Unit Secretary #1 was in attendance. He was observed to wash his hands prior to passing meal trays. While setting up the residents' trays, Unit Secretary #1 was observed to remove bread from the waxed paper bag with his bare hands for 4 of the 7 residents in the dining room. Per the request of a resident to	F 371	conducted by the DON, ADON, SDC nurse, Dietary Manager and or the Administrator. This procedure will also be incorporated into the Orientation material for new hires. Gloves and hand sanitizer will be provided in all dining areas for staff to wear and use. The Central Supplies Clerk, and or Housekeeping staff will ensure gloves are adequately stocked in dining areas. Monitoring will be done by the Administrator and or Department Heads. The Administrator and or Department heads will monitor one meal a day for one month. The total monitored meals for the month will include at least seven breakfast, seven lunch, and seven dinner services. The Administrator and or Department heads will then monitor three meal services a week for two months. These three meal services will include one breakfast, one lunch, and one dinner service per week. Monitoring will be recorded on the Meal Observation Tool form. Monitoring results will be reported to the QA Committee by the Administrator and further monitoring will occur as directed by the QA committee.	

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F 371	Continued From page 12 remove the crust from the bread, Unit Secretary #1 did so with his bare hands. During an interview on 8/11/14 at 12:15 PM, Unit Secretary #1 indicated he had been taught to wash his hands before handling the trays. He added that some residents have told him in the past they did not want him touching their food while wearing gloves. The Director of Nursing (DON) was interviewed on 8/15/14 at 1:00 PM. The DON stated that she expected staff to wash their hands with soap and water prior to tray delivery and to sanitize their hands between residents. She expected staff to stop serving food and wash their hands after touching a resident or any soiled item. The DON said that if their hands were washed with soap and water it was alright for staff to handle resident food with their bare hands. 3. During a dining observation on 8/12/14 at 5:23PM NA #4 was observed in the Cypress Dining Room. She placed butter on a piece of bread for a resident by holding the bread in her bare hand and spreading the butter with a knife. An interview was conducted with NA #4 as she walked away from that table. She stated she used hand sanitizer prior to the tray delivery and between serving residents. She reported she felt she only needed to wash her hands with soap and water if the resident had placed the utensil in their mouth. She reported she felt it was acceptable to touch the bread with her bare hand if she had washed her hands with soap and water. When questioned if she would allow someone to hold bread she was going to eat with their bare hand she felt that was not acceptable.	F 371		

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F 371	Continued From page 13 The Director of Nursing (DON) was interviewed on 8/15/14 at 1:00 PM. The DON stated that she expected staff to wash their hands with soap and water prior to tray delivery and to sanitize their hands between residents. She expected staff to stop serving food and wash their hands after touching a resident or any soiled item. The DON said that if their hands were washed with soap and water it was alright for staff to handle resident food with their bare hands.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, pharmacist and Attending Physician interviews, the facility pharmacist failed to identify a medication discrepancy for 1 of 5 residents reviewed for unnecessary medications. Resident #98. The findings included: Resident #98 last Minimum Data Set (MDS) was dated on 07/30/14 and indicated Resident #98	F 428	F 428 The order for Robaxin 500mg PO QID for Resident #98 was corrected in the EMAR to Robaxin 500mg by mouth every 6 hours as needed for muscle spasms, which was on a physician□s order for Resident #98, dated 7/4/2014. This correction was made 8/14/14	9/10/14

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F 428	Continued From page 14 was cognitively intact. Active diagnosis included Spinal Stenosis, Difficulty in Walking, Muscle Weakness and Chronic Pain. Resident #98 Functional Status was documented as extensive assistance. Review of a physician order (PO) dated 7/04/14 read "Robaxin 500 mg po (by mouth) q (every) 6 h (hours), prn (as needed), muscle spasms." Times of administration were not written on the PO. Review of the Medication Administration Record (MAR) dated 7/04/14 through 8/15/14 read, "Robaxin 500mg tablet (tab)." Review of the monthly Physician Orders for July and August read "7/04/14 Robaxin 500mg tab (tablet) qid (four times a day)." Review of medication administration documentation on the MAR revealed that Robaxin was scheduled and administered at 8:30 am, 12:30 pm, 4:30 pm and 8:30 pm to Resident #98 beginning 7/4/14 to present 8/15/14. Review of the facility document "Medication Regimen Review" (MRR) dated 7/21/14 and authored by the pharmacist read "Initial review. Allergies: Codeine, Oxycodone with APAP (acetaminophen)." No irregularities were documented on the MRR. On 8/14/14 at 11:50 am during an interview with the Attending Physician he clarified the PO dated 7/4/14 was written by himself and stated that it read "Robaxin 500 mg by mouth every 6 hours prn, muscle spasms." He indicated that he expected his orders to be transcribed correctly as	F 428	Consultant pharmacist was in-serviced on the importance of evaluation of accurate order transcription by nursing staff and pharmacist□s responsibility to notify facility staff if any irregularities are found during medication regimen review. This in service was completed on 9/5/2014 and conducted by the facility's contracted Pharmacy's Regional Clinnical Manager. DON, ADON, SDC, and or a Licensed RN or LPN will audit all active orders received since 7/1/14 for accuracy by 9/10/14. A member of the contracted pharmacy management team will conduct a 20% audit of the charts reviewed by the consultant pharmacist during the regularly scheduled medication regimen review. This audit will be conducted monthly for a three month period. The audit will focus on evaluating if all new active orders have been transcribed accurately by nursing staff with the 20% random sample. Documentation of the audits will be provided to the facility and then reported to the QA Committee. The QA Committee will determine the need and or frequency of future audits	

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F 428	Continued From page 15 written and that the nurse should call him to clarify any unclear or incomplete orders. On 8/14/14 at 12 pm an interview was conducted with the Director of Nursing (DON). She stated that "nurses transcribe medication orders and a pharmacist reviews the MAR once a month." The DON indicated that she expected orders should be transcribed according to physician orders, that unclear or incomplete PO's should be clarified by the nurse with the physician. The MAR should be reviewed monthly by the pharmacist to identify and resolve any medication errors or problems and shared with the interdisciplinary team. The DON read the PO for Resident #98 as "Robaxin 500 mg by mouth every 6 hours prn for muscle spasms." The DON stated, "Every 6 hours would be 6 am, 12 pm, 6 pm & 12 am." On 8/14/14 at 12:04 pm, an interview was conducted with the Pharmacist who indicated that her knowledge of Resident #98 included that she had chronic and severe pain that was hard to control. She stated that Resident #98 physician order "appeared to read, Robaxin 500 mg by mouth every 6 hours prn, muscle spasms." She indicated that the handwritten "prn" also looked like "for", "if the nurse read it as "for" the nurse would have transcribed the PO as Robaxin 500mg by mouth every 6 hours for muscle spasms." She stated that "Yes, the Robaxin is scheduled on the MAR to be administered every 4 hours during the day instead of every six and should be prn instead of scheduled. I reviewed her chart 7/21/14 and I always look at physician orders and compare them to the MAR, I did not catch that, I certainly wish I would have."	F 428		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		9/12/14

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F 431 SS=D	Continued From page 16 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 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 observation, staff interview and record	F 431	F431	

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F 431	Continued From page 17 review, the facility failed to discard expired medications from 1 of 6 medication carts (700 hall cart), and failed to lock the medication cart when unattended for 2 of 6 medication carts (600 hall cart and 500/800 hall cart). The findings included: 1. On 8/14/14 at 11:05 AM, the 700 hall medication cart was checked with Nurse #2. One bottle of Banophen tablets with an expiration date of 2/14 and one bottle of Mytab tablets with an expiration date of 6/14 were in the stock medication drawer. Nurse #2 indicated she would check about what to do with the expired medications. During an interview on 8/14/14 at 12:47 PM, the Director of Nursing stated expired meds should be returned to the pharmacy and not stored at the facility. 2. An undated facility policy entitled "Medication Storage" read in part, "D. The medication cart shall be locked at all times, when not under the direct physical supervision of a licensed nurse." On 8/14/14 at 12:02 PM, Nurse #3was observed standing in front of the 600 hall medication cart, parked next to room 610. The cart was unlocked. A resident was sitting on his walker seat next to the medication cart, talking with the nurse. A dietary staff member was observed to hand the nurse a lunch tray. The nurse took the tray and walked into room 614, leaving the cart unlocked and unattended by staff. The nurse returned to the cart within 2 minutes. The nurse told the resident who was sitting next to the cart that his lunch would be here soon; the resident walked	F 431	DON and or ADON audited all 6 medication carts and 2 medication storage rooms in the facility to ensure that all expired medications have been removed from the carts and discarded appropriately. All licensed nursing staff will be in serviced on monitoring and removing any expired medications from the medication carts and the medication storage rooms and returning the expired medications to pharmacy by 9/12/14. The DON, ADON, and or SDC nurse will conduct the in service. DON and ADON will monitor all 6 medication carts and 2 medication storage rooms weekly for 1 month and then monthly for 2 months. Results will be recorded on the Expired Drug Audit form. The monitoring results will be reported to the QA Committee and further monitoring will occur as directed by the QA Committee. All licensed nursing staff will be in serviced on the locking of medication carts by 9/12/2014. The in service will be conducted by the DON, ADON, and or SDC nurse. The consulting pharmacist will conduct a monthly audit on all 6 medication carts for three months to monitor if medication carts are locked while unattended. Results will be reported to the DON. The DON will report the results to the QA	

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F 431	Continued From page 18 away. Family members then approached Nurse #3, and 2 other nurses joined in the conversation with the family. At 12:05 PM all left the medication cart to enter room 610. The cart remained unlocked, unattended by staff and was not visible from inside room 610. Nurse #3 returned to the cart at 12:08 PM and was interviewed. She said that the medication cart should be locked when not attended. The nurse indicated she got distracted when the dietary staff handed her the tray. On 8/15/14 at 10:30 am in an Interview with the Assistant Director of Nursing (ADON) she stated, "I would expect that when the medication nurse walks into a resident's room, he/she would ensure that the medication cart is locked." 3. An undated facility policy entitled "Medication Storage" read in part, "D. The medication cart shall be locked at all times, when not under the direct physical supervision of a licensed nurse." On 8/15/14 at 9:30AM a medication cart was located outside room 608. Nurse #5 was inside the room providing eye drops to the resident who was seated in a wheel chair at the end of the bed closest to the window. Her back was to the door way of the room. She was not able to see the medication cart from inside the resident's room. The medication cart was observed to be unlocked and unattended by staff. An interview was conducted with Nurse #5 at 9:33AM when she returned to the unlocked medication cart. Nurse #5 stated she was not aware the cart was unlocked and that she was just inside the resident's room.	F 431	Committee and further monitoring will occur as directed by the QA Committee. DON, ADON and or SDC will monitor a medication pass 3 times weekly for one month and then weekly for 2 months at random times to ensure medication carts are locked when unattended. The first months monitoring will include the monitoring of each of the 6 medication carts at least twice. Results will be documented on the Medication Administration Audit form. Results will be reported to the QA Committee and further monitoring will occur as directed by the QA Committee.	

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F 431	Continued From page 19 On 8/15/14 at 10:30 am in an Interview with the Assistant Director of Nursing (ADON) she stated, "I would expect that when the medication nurse walks into a resident's room, he/she would ensure that the medication cart is locked." 4. An undated facility policy entitled "Medication Storage" read in part, "D. The medication cart shall be locked at all times, when not under the direct physical supervision of a licensed nurse." On 8/15/14 at 9:57 am, an observation revealed that the 800 Hall Medication Cart in the 800 hallway was unlocked. The medication cart was unattended. Nurse #4 was in a resident's room; the medication cart was out of the nurse's line of sight. At 9:58 am Nurse #4 came out of the room and back to the medication cart. On 8/15/14 at 9:58 am, in an interview with Nurse #4 she stated, "Yes I know it is unlocked, I was just right there in the room." On 8/15/14 at 10:30 am in an interview with the Assistant Director of Nursing (ADON) she stated, "I would expect that when the medication nurse walks into a resident's room, he/she would ensure that the medication cart is locked."	F 431		