

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345054</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/10/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOODHAVEN NURS &amp; ALZHEIMER'S C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1150 PINE RUN DRIVE</b> <b>LUMBERTON, NC 28358</b>		
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F 160 SS=B	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on financial record reviews and staff interviews, the facility failed to convey expired resident's personal funds to the executor of the estate or probate jurisdiction administering the resident's estate for 2 of 5 resident fund accounts reviewed. (Resident #135 and Resident #24).</p> <p>The findings included:</p> <p>1. Resident #135 expired on 7/18/14 and a check for \$52.00 was forwarded to a family member on 8/7/14.</p> <p>During an interview on 10/9/14 at 11:30 AM, the Business Office Manager revealed that when a resident expired the check was usually forwarded to the Clerk of Court.</p> <p>During an interview on 10/10/14 at 1:56 PM, the Director of Nursing explained that the Business Office Manager usually forwarded the check to the Clerk of Court, but the family members were close. She concluded if the Business Office Manager was not certain who to forward the expired resident's funds, the check should be forwarded to the Clerk of Court.</p>	F 160	<p>1. Although the funds didn't go through the clerk of court, The funds did go to the appropriate family members. No one was directly affected by this deficiency.</p> <p>2. All other accounts have been checked and all other funds have been sent through the clerk of court.</p> <p>3. The Business office staff has been educated on the appropriate conveyance of personal funds upon death of a Resident.</p> <p>4. This has been added to the Facility's quality assurance program to be monitored monthly by the Performance Improvement nurse.</p> <p>5. The corrective action date is October 31, 2014.</p>	10/31/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/31/2014

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

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F 160	Continued From page 1  2. Resident #24 expired on 9/5/14 and a check for \$341.29 was forwarded to a family member on 9/8/14.  During an interview on 10/9/14 at 11:30 AM, the Business Office Manager revealed that a family member wanted the money to be used for funeral home expenses. She reported that usually the money was sent to the Clerk of Court.  During an interview on 10/10/14 at 1:56 PM, the Director of Nursing explained that the Business Office Manager usually forwarded the check to the Clerk of Court, but the family members were close. She concluded if the Business Office Manager was not certain who to forward the expired resident's funds, the check should be forwarded to the Clerk of Court.	F 160			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to utilize the least restrictive device for residents who had medical symptoms that were being treated for 3 of 3 dependent residents (Resident # 156, # 207, # 200) who were observed in restraints. The findings included:	F 221	1. It has always been the goal of the nursing staff at Woodhaven to keep our Residents safe and treat them with dignity and respect. The Posey beds were being used to prevent fall and injury. It was not our intention to use them for any other reasons. The posey beds have been discontinued and the staff are working	11/3/14	

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F 221	<p>Continued From page 2</p> <p>1. Resident # 156 was admitted to the facility on 9/5/14 and readmitted on 10/7/14 with diagnosis that included osteoarthritis, osteoporosis, left femur fracture.</p> <p>The most recent Minimum Data Set (MDS) dated 9/7/14 coded the resident as having short term and long term memory problems and moderately impaired decision making skills. Behaviors were coded as rejection of care. She required extensive assist of two person physical assist to total dependence on staff for transfers and bed mobility. The resident coded for physical restraints as other, used daily.</p> <p>Review of the Care Area Assessment Summary triggered in the area of falls related to the resident had a fall at home and was at high risk for falls.</p> <p>Review of the Restraint Assessment Form dated 10/8/14 documented less restrictive measures used in the past included bed/chair alarm, merry walker, floor-bed alarm and moving bed to nurses desk. Recommendations for the geri tent included release every 2 hours &amp; as needed 10 minutes for toileting, assist diet and range of motion.</p> <p>Resident # 156 was observed on 10/8/14 at 3:36 PM up in her wheel chair with a personal body alarm (PBA) attached watching television with other residents.</p> <p>During an interview on 10/8/14 at 5:19 PM nursing assistant # 4 stated that there was not a zipper or any way to get out from the inside of the geriatric tent.</p> <p>On 10/9/14 at 8:20 AM resident # 156 was</p>	F 221	<p>hard to prevent falls and injuries of these Residents.</p> <p>2. There are no other posey beds being used. All other restraints have been assessed to ensure the least restrictive method is being used and there is a medical reason for the restraint.</p> <p>3. The staff will not be able to get an order for any type of restraint unless the Director of Nursing is notified and there is a medical reason for it. It will also need to be the least restrictive.</p> <p>4. This will be added to the Facility Quality Assurance Program to be monitored monthly by the Performance Improvement Nurse. The Facility will also assess restraints during our BEST team meeting (Behavioral evaluation and strategic team)to assess reduction if feasible.</p> <p>5. Completion date for this deficiency is 11-3-14.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 221	<p>Continued From page 3</p> <p>observed in her closed geriatric tent yelling out. Staff were observed to open the tent and attempt to administer medications for agitation.</p> <p>During an observation on 10/10/14 at 8:26 AM the resident was observed in her closed geriatric tent calling out " Nurse, nurse. "</p> <p>During an interview with Nurse # 3 on 10/9/14 at 4:28 PM she stated that when at home the resident was used to getting up on her own, had fallen at home, broke her hip and now was in the geriatric bed to keep from falling. The nurse stated that the facility had tried PBA and bed alarms but the resident could take it off and refused any offer of activities.</p> <p>2. Resident # 207 was admitted to the facility on 9/16/14 with diagnosis that included seizure disorder, anoxic brain injury, bipolar affective disorder and psychotic agitation.</p> <p>The Admission Minimum Data Set dated 9/29/14 coded the resident as moderately impaired for cognition, having verbal behaviors directed towards others. He required limited assistance with one person physical assistance for bed mobility and transfers. The resident coded for physical restraints as other, used daily.</p> <p>Review of the Care Area Assessment Summary triggered in the area of physical restraints related to he uses a geritent while in bed for safety daily. Review of the Restraint Assessment Form dated 9/16/14 documented less restrictive measures used in the past included personal body alarm (PBA) which the resident can remove and lap buddy.</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>Review of the Care Plan dated 10/6/14 listed interventions for physical restraint use as lap buddy to prevent Falls/injury, monitor/document/report PRN any changes regarding effectiveness of restraint, less restrictive device, offer resident toileting, hydration, nutrition and range of motion every 2 hours. Allow resident to walk 10 minutes every 2 hours.</p> <p>An observation was made of Resident # 207 on 10/10/14 at 12:05 PM. The resident was in his closed geriatric tent hollering out. Staff were observed entering the room, and talked to the resident. After staff turned the television on the resident stopped hollering and staff left the room.</p> <p>During an interview with the Nurse # 4 on 10/10/14 at 12:10 PM she stated that the resident had unzipped his geriatric bed and could get out, but seldom tried. She stated that the resident had been educated on how to use the call light but he just hollered out when ever he wanted care.</p> <p>3. Resident # 200 was admitted to the facility on 9/6/14 and was readmitted on 10/2/14 with diagnosis that included syncope, dementia and seizures.</p> <p>The Discharge Return Anticipated Minimum Data Set (MDS) dated 9/30/14 coded the resident as severely impaired cognitively, having verbal behaviors directed towards others. She required extensive assistance of two person physical assist for bed mobility and limited assistance of one person physical assist for transfers, dressing, toilet use and personal hygiene. The resident</p>	F 221			

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F 221	Continued From page 5 coded for Physical Restraints as other, used less than daily.  During the initial tour on 10/7/14 at 10:00 AM Resident # 200 was observed. The resident was reading in her geriatric tent with the tent flap open and folded back over the top of the geriatric tent. Resident # 200 stated that she would like to get out of this " dumb " bed and did not know why she had to be inside it.  During an interview with the Director of Nursing on 10/10/14 at 11:07 AM she stated that the resident had a posey bed while in the hospital and her Medical Doctor had continued the order at the facility.	F 221			
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 reviews and staff interviews the facility failed to preserve dignity for 3 of 3 dependent residents (Resident # 156, # 207, # 200) who were observed in a geriatric tent. The findings included:  1. Resident # 156 was admitted to the facility on 9/5/14 and readmitted on 10/7/14 with diagnosis that included osteoarthritis, osteoporosis, left femur fracture.	F 241	1. It has always been the goal of the nursing staff at Woodhaven to keep our Residents safe and treat them with dignity and respect. The Posey beds were being used to prevent fall and injury.It was not our intention to use them for any other reasons. The posey beds have been discontinued and the staff are working hard to prevent falls and injuries of these Residents. 2. There are no other posey beds being	11/3/14	

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F 241	<p>Continued From page 6</p> <p>The most recent Minimum Data Set (MDS) dated 9/7/14 coded the resident as having short term and long term memory problems and moderately impaired decision making skills. Behaviors were coded as rejection of care. She required extensive assist of two person physical assist to total dependence on staff for transfers and bed mobility. The resident coded for physical restraints as other, used daily.</p> <p>During an interview on 10/8/14 at 5:19 PM nursing assistant # 4 stated that there was not a zipper or any way to get out from the inside of the geriatric tent.</p> <p>10/9/14 at 8:20 AM resident # 156 was observed in her closed geriatric tent yelling out. Staff were observed to open the tent and attempt to administer medications for agitation.</p> <p>During an observation on 10/10/14 at 8:26 AM the resident was observed in her closed geriatric tent calling out " Nurse, nurse. "</p> <p>2. Resident # 207 was admitted to the facility on 9/16/14 with diagnosis that included seizure disorder, anoxic brain injury, bipolar affective disorder and psychotic agitation.</p> <p>The Admission Minimum Data Set dated 9/29/14 coded the resident as moderately impaired for cognition, having verbal behaviors directed towards others. He required limited assistance with one person physical assistance for bed mobility and transfers. The resident coded for physical restraints as other, used daily.</p> <p>An observation was made of Resident # 207 on</p>	F 241	<p>used. All other restraints have been assessed to ensure the least restrictive method is being used and there is a medical reason for the restraint.</p> <p>3. The staff will not be able to get an order for any type of restraint unless the Director of Nursing is notified and there is a medical reason for it. It will also need to be the least restrictive.</p> <p>4. This will be added to the Facility Quality Assurance Program to be monitored monthly by the Performance Improvement Nurse. The Facility will also assess restraints during our BEST team meeting (Behavioral evaluation and strategic team)to assess reduction if feasible.</p> <p>5. Completion date for this deficiency is 11-3-14.</p>		

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F 241	Continued From page 7 10/10/14 at 12:05 PM. The resident was in his closed geriatric tent hollering out. Staff were observed entering the room, talked to the resident turned on the television and left the room.  3. Resident # 200 was admitted to the facility on 9/6/14 and was readmitted on 10/2/14 with diagnosis that included syncope, dementia and seizures.  The Discharge Return Anticipated Minimum Data Set (MDS) dated 9/30/14 coded the resident as severely impaired cognitively, having verbal behaviors directed towards others. She required extensive assistance of two person physical assist for bed mobility and limited assistance of one person physical assist for transfers, dressing, toilet use and personal hygiene. The resident coded for Physical Restraints as other, used less than daily.  During the initial tour on 10/7/14 at 10:00 AM Resident # 200 was observed. The resident was reading in her geriatric tent with the tent flap open and folded back over the top of the geriatric tent. Resident # 200 stated that she would like to get out of this " dumb " bed and did not know why she had to be inside it.  During an interview with the Director of Nursing on 10/10/14 at 11:07 AM she stated that the resident had a posey bed while in the hospital and her Medical Doctor had continued the order at the facility.	F 241			
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically	F 272		11/7/14	

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F 272	<p>Continued From page 8</p> <p>a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:            Identification and demographic information;            Customary routine;            Cognitive patterns;            Communication;            Vision;            Mood and behavior patterns;            Psychosocial well-being;            Physical functioning and structural problems;            Continence;            Disease diagnosis and health conditions;            Dental and nutritional status;            Skin conditions;            Activity pursuit;            Medications;            Special treatments and procedures;            Discharge potential;            Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and            Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 272			

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F 272	<p>Continued From page 9</p> <p>Based on observations, record review and resident and staff interviews the facility failed to comprehensively assess a hand contracture for 2 of 3 residents reviewed for range of motion. (Resident #46 and Resident #25). The facility also failed to comprehensively assess residents receiving antipsychotic medications for behaviors for 2 of 3 residents reviewed receiving antipsychotic medications with behaviors. (Resident #123 and Resident #65).</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>Resident #123 was originally admitted to the facility on 6/24/14 with diagnoses including Dementia, Depression and Insomnia. Review of the Care Area Assessment Summary (CAAs) dated 1/19/14, under Behavioral Symptoms read, "See CAA for Cognitive Loss/Dementia." The Cognitive Loss/Dementia section of the CAAs read in part, "Resident had one episode of verbal behavior directed toward others during look back period." Under care plan considerations, read, "Will Behavioral Symptoms -Functional Status be addressed in the care plan? Yes." Review of the Care Area Assessment Summary (CAA) for Psychotropic, under, " Nature of the problem/condition " read in part, " Potential for adverse side effects of psychotropic medication. Resident currently takes temazepam (to treat insomnia) citalopram (to treat depression) risperidone (used to treat insomnia and dementia for Resident #123) and lorazepam (to treat anxiety). Diagnosis: dementia, depression and insomnia. "</li> </ol> <p>Review of Resident #123's Care Plan, updated 7/15/14, revealed that Resident #123 was not Care Planned for behaviors.</p>	F 272	<ol style="list-style-type: none"> <li>The care plans have been corrected to reflect the behaviors and the contractures with the appropriate interventions.</li> <li>All care plans have been reviewed for contractures and behaviors and have been updated as needed.</li> <li>All Residents have been screened by the Rehab Dept. and interventions have been put into place as needed. The Rehab dept. will continue to screen all Residents quarterly for contractures.</li> <li>This will be added to the facility Quality Assurance program to be monitored monthly by the Performance Improvement Nurse. All psychotropic drugs will be monitored for behaviors on the care plans and care plans will be monitored for ROM and contractures.</li> <li>Completion date for this deficiency is November 7, 2014.</li> </ol>		

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F 272	Continued From page 10  According to the most recent Minimum Data Set (MDS) dated 7/15/14, in the area of behavior, Resident #123 was coded for "verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). These behaviors were noted to have occurred 1 to 3 days. The MDS also coded wandering as a behavior, which occurred 1 to 3 days. Resident #123 was coded as receiving antipsychotic medication.  Review of October, 2014, Medication Administration Record (MAR) revealed Resident #123 received Risperidone 0.25mgs. twice daily for Dementia and Insomnia.  Review of a Pharmacy note dated 1/2/14, read, in part, "Best team notes- patient on 0.25 mgs. Risperidone twice daily- main issues noted are sleep issues, occasional hitting mentioned in meeting. May consider decrease attempt again in near future. Also discussed possible trial of Melatonin if sleep issues persist."  Review of a Pharmacy note dated 3/26/14, read, "Best team - Discussed patient today. Still with behavior issues so no changes recommended."  Review of a Pharmacy note dated 7/29/14, read "Best team note: patient rambles and resists care-on current Risperidone dose since 3/31/14- Care easier to provide per nursing. No changes recommended."  During an interview on 10/10/14 at 10:49 AM, Staff Nurse #3 revealed that Resident #123's behaviors were documented in nurse's notes and behavior notes. Staff Nurse #3 stated that if	F 272			

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NAME OF PROVIDER OR SUPPLIER  <b>WOODHAVEN NURS &amp; ALZHEIMER'S C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1150 PINE RUN DRIVE</b> <b>LUMBERTON, NC 28358</b>		
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F 272	<p>Continued From page 11</p> <p>Resident #123 became more agitated she was brought to the Nurse's station at night.</p> <p>During an interview on 10/10/14 at 12:51 PM, the Minimum Data Set (MDS) Nurse #2 stated that Resident #123's bed was pulled up to the nurse's station at night and Resident #123 was constantly up and down and in and out of other resident's rooms. The MDS Nurse #2 was not able to explain why Resident #123 was not Care Planned for behaviors.</p> <p>During an interview on 10/10/14 at 2:06 PM, the Director of Nursing (DON) revealed that resident's behavior and medication were reviewed in monthly meetings. She stated staff that worked directly with the residents were involved in the meetings. The DON said anyone that exhibited behaviors should be Care Planned with interventions. She stated that they tried every intervention they had to control behaviors as much as possible. She reported that Resident #123 would not eat nor take her medications. She further revealed that Resident #123 fought with staff and could not carry on a sensible conversation without her current medication.</p> <p>2. Resident #65 was originally admitted to the facility on 2/20/12 with diagnoses including Alzheimer ' s Dementia, Hallucinations and Aggressiveness. Review of the Care Area Assessment Summary (CAA) dated 2/9/14, under Behavioral Symptoms read, "See CAA for Cognitive Loss/Dementia." The Cognitive Loss/Dementia section of the CAAs read in part, "Resident has a history of Alzheimer ' s Dementia and hallucinations. She is currently on Risperdal (used for Alzheimer ' s Disease and Hallucinations for Resident #65), Remeron</p>	F 272			

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F 272	<p>Continued From page 12 (Depression), and Namenda (Alzheimer ' s Disease). She had one episode of yelling at another resident during the look back period but was easily redirected. " Under care plan considerations, "Will Behavioral Symptoms -Functional Status be addressed in the care plan? Yes." According to the CAAs, Resident #65 received antipsychotic medication due to diagnoses of Alzheimer ' s Disease and Hallucinations.</p> <p>According to the most recent Annual Minimum Data Set (MDS) dated 2/9/14, in the area of behavior, Resident #65 was coded for "verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). These behaviors were noted to have occurred 1 to 3 days. The MDS also coded wandering as a behavior, which occurred 1 to 3 days. Resident #65 was coded as receiving antipsychotic medication.</p> <p>Review of Resident #65's Care Plan updated 8/6/14 revealed that she was not Care Planned for behaviors.</p> <p>Review of October, 2014, Medication Administration Record (MAR) revealed Resident #65 received Risperidone 0.25mgs. twice daily for Alzheimer's Disease and Hallucinations.</p> <p>During an interview on 10/10/2014 at 11:49 AM Staff Nurse #6 revealed that when Resident #65 was admitted to the facility she exhibited behavior of hitting other residents, refusing to eating, fighting staff and cursing at other residents. In regard to behaviors that were being tracked, Staff Nurse #6 explained that Resident #65's behavior was better in that the resident was not cursing</p>	F 272			

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F 272	<p>Continued From page 13</p> <p>and yelling at other residents and was not going after other residents. Staff Nurse #6 reported that staff chart Resident #65's behaviors every shift and monitor for any other symptoms. She revealed that staff intervene and redirect Resident #65 when she exhibited behaviors.</p> <p>During an interview on 10/10/14 11:53 AM, Nursing Assistant (NA# 5) revealed that in reference to Resident #65's behavior's, she might get a little feisty, such as saying shut up, stop talking or move out of the way if someone got in her personal space, but she had not seen Resident #65 being aggressive to staff or residents. NA#5 stated that she had not heard Resident #65 curse at others and she did not resist care.</p> <p>During an observation on 10/10/2014 at 12:04 PM, Resident #65 was in the dining room eating her meal during lunchtime. She sat looking at her food and would eat a couple of bites of food and sat back in her chair and looked around.</p> <p>During an interview on 10/10/2014 at 12:32 PM, MDS Nurse #2 revealed that Resident #65 would sit in the day room area with staff. She stated that Resident #65 would holler at staff and residents and tell them to shut up. In reference to Care Planning, MDS Nurse #2 reported that staff on the unit would let them know about resident ' s behaviors and medication. She revealed that the Pharmacist was made aware of resident ' s behaviors and Nursing Assistants would document resident ' s behaviors in the computer. MDS Nurse #2 revealed that Resident #65 got loud at times, and hollered at other residents. She stated that Resident #65 currently received Risperidone (Alzheimer ' s Disease and</p>	F 272			

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F 272	<p>Continued From page 14</p> <p>Hallucinations) and Remeron (depression) and she had one episode of yelling at others and the intervention was to redirect her. MDS Nurse #2 reported that they usually discussed what needed to be done during monthly meetings. She did not explain why a care plan was not completed for Resident #65.</p> <p>During an interview on 10/10/14 at 2:06 PM, the Director of Nursing (DON) revealed that resident's behavior and medication were reviewed in monthly meetings. She stated staff that worked directly with residents were involved in the meetings. The DON said anyone that exhibited behaviors should be Care Planned with interventions. She stated that they tried every intervention they had to control behaviors as much as possible.</p> <p>3. Resident #46 was admitted to the facility on 3/11/14 and had diagnoses including CVA (Cerebrovascular Accident).</p> <p>An Occupational Therapy Note dated 3/17/14 read: " Hand hygiene to L (left), gentle stretch/ROM (range of motion) to LUE (left upper extremity) in preparation of wearing splint for contracture. "</p> <p>The Care Area Assessment (CAA) dated 3/18/14 for Activities of Daily Living (ADLs) revealed the resident had left sided weakness from a prior CVA (Stroke). There was no information in the CAA summaries regarding the resident ' s left</p>	F 272			

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F 272	<p>Continued From page 15 hand contracture.</p> <p>The resident ' s Care Plan for ADLs dated 4/3/14 revealed the resident had ADL self-care performance deficit related to left sided weakness/paralysis of left arm from a prior stroke. The Care Plan revealed the resident had no short term memory problems and was independent in decision making. There was no information on the Care Plan regarding the care for the resident's left hand contracture.</p> <p>A Quarterly Minimum Data Set (MDS) Assessment dated 6/8/14 revealed the resident had impairment of the upper extremity on one side. There were no changes made to the Care Plan following this assessment.</p> <p>A Quarterly MDS Assessment dated 9/6/14 revealed the resident was cognitively intact. The MDS revealed the resident had impairment of the upper extremity on one side. There were no changes made to the Care Plan regarding the hand contracture after this assessment.</p> <p>During an interview with Resident #46 on 10/7/14 at 3:55 PM, the resident ' s left hand was observed to be balled up in a fist. The resident stated his hand had been like that for a long time. The Resident stated he did not wear a splint on his left hand.</p> <p>In an interview with Resident #46 on 10/10/14 at 9:32 AM the Resident was observed to take his right hand and slightly move his left index and ring fingers and stated his fingers were sore. The resident was unable to extend the fingers on his left hand. The Resident stated he had not had a splint for his left hand since admission to the</p>	F 272			

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F 272	<p>Continued From page 16 facility. The Resident stated he had a splint for his left hand at home and did not know what happened to it.</p> <p>An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 10/10/14 at 1:07 PM. MDS Nurse #1 stated the nurse that did the assessments for Resident #46 no longer worked at the facility. MDS Nurse #2 stated she did not remember the nurse who did the assessments saying anything about the resident having a contracture.</p> <p>The Director of Nursing stated in an interview on 10/10/14 at 2:28 PM that she would expect a hand contracture to be assessed and care planned for a hand roll.</p> <p>4. Resident #25 was originally admitted to the facility on 8/21/12 and had diagnoses that included Severe Dementia and Cerebrovascular Accident (Stroke).</p> <p>The most recent Minimum Data Set (MDS) Assessment (Annual) dated 8/13/14 revealed the resident had short and long term memory loss and was severely cognitively impaired. The MDS revealed the resident had impairment of the upper extremity on one side. The MDS revealed the resident was totally dependent on staff for all activities of daily living.</p> <p>The Care Area Assessment (CAA) for Cognitive Status dated 8/13/14 revealed the resident was rarely/never understood nor did he understand others and was non-verbal. There was no information in the Care Area Assessments regarding the resident ' s hand contracture.</p>	F 272			

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F 272	Continued From page 17 The resident ' s Care Plan dated 8/15/14 revealed no information regarding the resident ' s had contracture.  On 10/8/14 at 9:51 AM, Resident #25 was observed lying in bed. The resident's right hand was balled up in a fist. There was not a hand roll or a splint for the resident ' s hand.  On 10/10/14 at 11:07 AM Resident #25 was observed lying in bed with a washcloth hand roll in the right hand. NA (Nursing Assistant) #3 entered the room during the observation and stated she was assigned to the resident ' s care that day. The NA stated the resident was supposed to have a washcloth in his right hand all the time but would use his left hand to work the washcloth out of the other hand. The NA stated the resident had been using the hand roll for a long time but could not remember how long. The NA stated she was trained that if a resident had a hand contracture they needed a hand roll.  MDS Nurse #2 stated in an interview the MDS Nurse that did the resident ' s last annual assessment no longer worked at the facility. The MDS Nurse stated she usually care planned contractures whether a hand roll or a splint was to be used. The MDS Nurse stated she was not aware that Resident #25 had a hand contracture.  On 10/10/14 at 2:28 PM the Director of Nursing stated she would expect a hand contracture to be assessed and care planned.	F 272			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment	F 279		11/7/14	

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F 279	<p>Continued From page 18 to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to care plan behaviors for 2 of 3 residents reviewed for behaviors (Resident #123 and #65). The facility also failed to care plan contractures for 2 of 3 residents reviewed for range of motion (Resident #46 and #25) and failed to care plan a pressure ulcer for 1 of 1 sampled resident with a pressure ulcer (Resident #85).</p> <p>The findings included:</p> <p>1. Resident #123 was originally admitted to the facility on 6/24/14 with diagnoses including Dementia, Depression and Insomnia. Review of the Care Area Assessment Summary (CAAs)</p>	F 279	<p>1.The care plans have been corrected to reflect the behaviors, contractures, and pressure ulcers with the appropriate interventions.</p> <p>2. All care plans have been reviewed for contractures, behaviors, and pressure ulcers and have been updated as needed.</p> <p>3. All Residents have been screened by the Rehab Dept. and interventions have been put into place as needed. The Rehab dept. will continue to screen all Residents quarterly for contractures.</p> <p>4. This will be added to the facility Quality Assurance program to be monitored monthly by the Performance Improvement Nurse. All psychotropic drugs will be</p>		

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F 279	<p>Continued From page 19</p> <p>dated 1/19/14, under Behavioral Symptoms read, "See CAA for Cognitive Loss/Dementia." The Cognitive Loss/Dementia section of the CAAs read in part, "Resident had one episode of verbal behavior directed toward others during look back period." Under care plan considerations, read, "Will Behavioral Symptoms -Functional Status be addressed in the care plan? Yes." Review of the Care Area Assessment Summary (CAA) for Psychotropic, under, " Nature of the problem/condition " read in part, " Potential for adverse side effects of psychotropic medication. Resident currently takes temazepam (to treat insomnia) citalopram (to treat depression) risperidone (used to treat insomnia and dementia for Resident #123) and lorazepam (to treat anxiety). Diagnosis: dementia, depression and insomnia. "</p> <p>Review of Resident #123 Care Plan, updated 7/15/14, revealed that Resident #123 was not Care Planned for behaviors.</p> <p>According to the most recent Minimum Data Set (MDS) dated 7/15/14, in the area of behavior, Resident #123 was coded for "verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). These behaviors were noted to have occurred 1 to 3 days. The MDS also coded wandering as a behavior, which occurred 1 to 3 days. Resident #123 was coded as receiving antipsychotic medication.</p> <p>Review of October, 2014, Medication Administration Record revealed Resident #123 received Risperidone 0.25mgs. twice daily for Dementia and Insomnia.</p>	F 279	<p>monitored for behaviors on the care plans and care plans will be monitored for ROM, contractures, and pressure ulcers.</p> <p>5. Completion date for this deficiency is November 7, 2014.</p>		

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F 279	<p>Continued From page 20</p> <p>During an interview on 10/10/14 at 10:49 AM, Staff Nurse #3 revealed that Resident #123's behaviors were documented in nurse's notes and behavior notes. Staff Nurse #3 stated that if Resident #123 became more agitated she was brought to the Nurse's station at night.</p> <p>During an interview on 10/10/14 at 12:51 PM, the Minimum Data Set (MDS) Nurse #2 stated that Resident #123's bed was pulled up to the nurse's station at night and Resident #123 was constantly up and down and in and out of other resident's rooms. The MDS Nurse #2 was not able to explain why Resident #123 was not Care Planned for behaviors.</p> <p>During an interview on 10/10/14 at 2:06 PM, the Director of Nursing (DON) revealed that resident's behavior and medication were reviewed in monthly meetings. She stated staff that worked directly with the residents were involved in the meetings. The DON said anyone that exhibited behaviors should be Care Planned with interventions. She stated that they tried every intervention they had to control behaviors as much as possible. She reported that Resident #123 would not eat nor take her medications. She further revealed that Resident #123 fought with staff and could not carry on a sensible conversation without her current medication.</p> <p>2. Resident #65 was originally admitted to the facility on 2/20/12 with diagnoses including Alzheimer ' s Dementia, Hallucinations and Aggressiveness. Review of the Care Area Assessment Summary (CAA) dated 2/9/14, under Behavioral Symptoms read, "See CAA for Cognitive Loss/Dementia." The Cognitive Loss/Dementia section of the CAAs read in part,</p>	F 279			

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NAME OF PROVIDER OR SUPPLIER  <b>WOODHAVEN NURS &amp; ALZHEIMER'S C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1150 PINE RUN DRIVE</b> <b>LUMBERTON, NC 28358</b>		
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F 279	<p>Continued From page 21</p> <p>"Resident has a history of Alzheimer ' s Dementia and hallucinations. She is currently on Risperdal (used for Alzheimer ' s Disease and Hallucinations for Resident #65), Remeron (Depression), and Namenda (Alzheimer ' s Disease). She had one episode of yelling at another resident during the look back period but was easily redirected. " Under care plan considerations, "Will Behavioral Symptoms -Functional Status be addressed in the care plan? Yes." According to the CAAs, Resident #65 received antipsychotic medication due to diagnoses of Alzheimer ' s Disease and Hallucinations.</p> <p>According to the most recent Annual Minimum Data Set (MDS) dated 2/9/14, in the area of behavior, Resident #65 was coded for "verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). These behaviors were noted to have occurred 1 to 3 days. The MDS also coded wandering as a behavior, which occurred 1 to 3 days. Resident #65 was coded as receiving antipsychotic medication.</p> <p>Review of Resident #65's Care Plan updated 8/6/14 revealed that she was not Care Planned for behaviors.</p> <p>Review of October, 2014, Medication Administration Record (MAR) revealed Resident #65 received Risperidone 0.25mgs. twice daily for Alzheimer ' s Disease and Hallucinations.</p> <p>During an interview on 10/10/2014 at 11:49 AM Staff Nurse #6 revealed that when Resident #65 was admitted to the facility she exhibited behavior of hitting other residents, refusing to eating,</p>	F 279			

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F 279	<p>Continued From page 22</p> <p>fighting staff and cursing at other residents. In regard to behaviors that were being tracked, Staff Nurse #6 explained that Resident #65 ' s behavior was better in that the resident was not cursing and yelling at other residents and was not going after other residents. Staff Nurse #6 reported that staff chart Resident #65 ' s behaviors every shift and monitor for any other symptoms. She revealed that staff intervene and redirect Resident #65 when she exhibited behaviors.</p> <p>During an interview on 10/10/14 11:53 AM, Nursing Assistant (NA# 5) revealed that in reference to Resident #65's behaviors, she might get a little feisty, such as saying shut up, stop talking or move out of the way if someone got in her personal space, but she had not seen Resident #65 being aggressive to staff or residents. NA#5 stated that she had not heard Resident #65 curse at others and she did not resist care.</p> <p>During an observation on 10/10/2014 at 12:04 PM, Resident #65 was in the dining room during eating lunch. She had to be encouraged to eat because she sat looking at her food and would eat a couple of bites of food and sat back in her chair and looked around.</p> <p>During an interview on 10/10/2014 at 12:32 PM, MDS Nurse #2 revealed that Resident #65 would sit in the day room area with staff. She stated that Resident #65 would holler at staff and residents and tell them to shut up. In reference to Care Planning, MDS Nurse #2 reported that staff on the unit would let them know about resident ' s behaviors and medication. She revealed that the Pharmacist was made aware of resident ' s behaviors and Nursing Assistants would</p>	F 279			

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F 279	<p>Continued From page 23</p> <p>document resident ' s behaviors in the computer. MDS Nurse #2 revealed that Resident #65 got loud at times, and hollered at other residents. She stated that Resident #65 currently received Risperidone (Alzheimer's Disease and Hallucinations) and Remeron (depression) and she had one episode of yelling at others and the intervention was to redirect her. MDS Nurse #2 reported that they usually discussed what needed to be done during monthly meetings. She did not explain why a care plan was not completed for Resident #65.</p> <p>During an interview on 10/10/14 at 2:06 PM, the Director of Nursing (DON) revealed that resident's behavior and medication were reviewed in monthly meetings. She stated staff that worked directly with residents were involved in the meetings. The DON said anyone that exhibited behaviors should be Care Planned with interventions. She stated that they tried every intervention they had to control behaviors as much as possible.</p> <p>3. Resident #46 was admitted to the facility on 3/11/14 and had diagnoses including CVA (Cerebrovascular Accident).</p> <p>An Occupational Therapy Note dated 3/17/14 read: " Hand hygiene to L (left), gentle stretch/ROM (range of motion) to LUE (left upper extremity) in preparation of wearing splint for contracture. "</p> <p>The Care Area Assessment (CAA) dated 3/18/14</p>	F 279			

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F 279	<p>Continued From page 24 for Activities of Daily Living (ADLs) revealed the resident had left sided weakness from a prior CVA (Stroke). There was no information in the CAAs regarding the resident ' s left hand contracture.</p> <p>The resident ' s Care Plan for ADLs dated 4/3/14 revealed the resident had ADL self-care performance deficit related to left sided weakness/paralysis of left arm from a prior stroke. The Care Plan revealed the resident had no short term memory problems and was independent in decision making. There was no information on the Care Plan regarding a contracture of the resident ' s left hand or of a hand roll or splint for the contracted hand.</p> <p>A Quarterly Minimum Data Set (MDS) Assessment dated 6/8/14 revealed the resident had impairment of the upper extremity on one side. There were no changes made to the Care Plan following this assessment.</p> <p>A Quarterly MDS Assessment dated 9/6/14 revealed the resident was cognitively intact. The MDS revealed the resident had impairment of the upper extremity on one side. There were no changes made to the Care Plan regarding a contracture after this quarterly assessment.</p> <p>During an interview with Resident #46 on 10/7/14 at 3:55 PM, the resident ' s left hand was observed to be balled up in a fist. The resident stated his hand had been like that for a long time. There was not a hand roll or a splint for the resident ' s hand contracture.</p> <p>In an interview with Resident #46 on 10/10/14 at 9:32 AM the Resident was observed to take his</p>	F 279			

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F 279	<p>Continued From page 25</p> <p>right hand and slightly move his left index and ring fingers and stated his fingers were sore. The resident was unable to extend the fingers on his left hand. There was not a hand roll or a splint for the resident ' s hand contracture.</p> <p>An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 10/10/14 at 1:07 PM. MDS Nurse #1 stated the nurse that did the admission assessment for Resident #46 no longer worked at the facility. MDS Nurse #2 stated she did not remember the nurse who did the assessment saying anything about the resident having a contracture.</p> <p>The Director of Nursing stated in an interview on 10/10/14 at 2:28 PM that she would expect a hand contracture to be care planned for a hand roll.</p> <p>4. Resident #25 was originally admitted to the facility on 8/21/12 and re-admitted to the facility on 9/16/13. The resident had diagnoses that included Severe Dementia and Cerebrovascular Accident (Stroke).</p> <p>The most recent Minimum Data Set (MDS) Assessment dated 8/13/14 revealed the resident had short and long term memory and was severely cognitively impaired. The MDS revealed the resident had impairment of the upper extremity on one side. The MDS revealed the resident was totally dependent on staff for all activities of daily living.</p> <p>The Care Area Assessment (CAA) for Cognitive Status dated 8/13/14 revealed the resident was rarely/never understood nor did he understand and was non-verbal. There was no information in</p>	F 279			

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F 279	<p>Continued From page 26</p> <p>the Care Area Assessments regarding the resident ' s hand contracture.</p> <p>The resident ' s Care Plan dated 8/15/14 revealed no information regarding the resident ' s contracture or a hand roll or splint for the contracted hand.</p> <p>On 10/8/14 at 9:51 AM, Resident #25 was observed lying in bed. The resident ' s right hand was balled up in a fist. There was not a hand roll or a splint for the resident ' s hand.</p> <p>On 10/10/14 at 11:07 AM Resident #25 was observed lying in bed with a washcloth hand roll in the right hand. NA (Nursing Assistant) #3 entered the room during the observation and stated she was assigned to the resident ' s care that day. The NA stated the resident was supposed to have a washcloth in his right hand all the time but would use his left hand to work the washcloth out of the other hand. The NA stated the resident had been using the hand roll for a long time but could not remember how long. The NA stated she was trained that if a resident had a hand contracture they needed a hand roll in their hand.</p> <p>MDS Nurse #2 stated in an interview on 10/10/14 at 1:05 PM the MDS Nurse that did the resident ' s last annual assessment no longer worked at the facility. The MDS Nurse stated she usually care planned contractures whether a hand roll or a splint was to be used. The MDS Nurse stated she was not aware that Resident #25 had a hand contracture.</p> <p>On 10/10/14 at 2:28 PM the Director of Nursing stated she would expect a hand contracture to be</p>	F 279			

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F 279	<p>Continued From page 27 care planned.</p> <p>5. Resident # 85 as originally admitted to the facility on 7/30/14 with diagnoses that included Diabetes and Cerebrovascular Accident (Stroke).</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated 8/6/14 revealed the resident was moderately cognitively impaired. The MDS revealed the resident was totally dependent on staff for bed mobility and was continent of bowel and bladder. The MDS revealed the resident was at risk of developing pressure ulcers but did not have pressure ulcers on admission to the facility.</p> <p>The Care Area Assessment (CAA) Summary dated 8/12/14 revealed a decision to care plan pressure ulcers.</p> <p>The resident ' s Care Plan for Activities of Daily Living (ADL) dated 8/12/2014 revealed the resident was at risk for skin breakdown related to bed immobility.</p> <p>The resident was discharged to the hospital on 8/24/2014 and re-admitted to the facility on 8/28/14. The Admission Nursing Assessment dated 8/28/2014 revealed the resident had three unstageable pressure ulcers. The nursing assessment revealed a scabbed area on the right toe that was noted as an unstageable pressure ulcer. There was an area on the left small toe and the right heel that was noted as an unstageable pressure ulcer. An unstageable</p>	F 279			

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F 279	<p>Continued From page 28</p> <p>pressure ulcer is an ulcer with the wound bed covered by tissue that prevents the underlying depth from being observed.</p> <p>The resident was discharged to the hospital on 9/9/14 and readmitted to the facility on 9/16/2014. The Admission Nursing Assessment dated 9/16/14 revealed the resident had an unstageable pressure ulcer on the right toe and right heel. There was documentation of a missing toe nail on the left toe with no pressure ulcer noted.</p> <p>The resident ' s Care Plan initiated 8/12/14 was not updated to reflect the development or care for the new pressure ulcers.</p> <p>On 10/09/2014 at 10:49 AM wound care was observed for resident # 85. A large pressure ulcer was noted on the right heel and an ulcer on the right great toe. Both ulcers were covered with escar (black tissue).</p> <p>On 10/9/14 at 11:08 AM, Nurse #3 was observed to review the resident ' s current care plan and stated that pressure ulcers were not care planned for the resident.</p> <p>MDS Nurse #1 stated in an interview on 10/9/14 at 10:50 AM the resident should have been care planned for pressure ulcers. The MDS Nurse stated she depended on the floor nurses to notify her of new concerns so the care plan could be updated.</p> <p>MDS Nurse #1 stated in an interview on 10/9/2014 at 10:50 AM that the resident should have been care planned for pressure ulcers. The MDS Nurse stated that if the resident had new problems the nurses were supposed to let the</p>	F 279			

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F 279	Continued From page 29 MDS Nurse know so that the care plan could be updated. The MDS Nurse stated she was not aware the resident had pressure ulcers and did not update the care plan.	F 279			
F 312 SS=D	The Director of Nursing (DON) stated in an interview on 10/10/2014 at 3:35 PM that the pressure ulcers should have been care planned. 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 observation, record review and staff interviews the facility failed to ensure staff thoroughly cleaned a resident during incontinence care for 1 of 2 residents observed to receive incontinence care (Resident #63). The findings included:  Resident #63 was re-admitted to the facility on 2/25/14 and had diagnoses that included End Stage Dementia and Recurrent Urinary Tract Infections.  The resident ' s Care Plan dated 5/13/14 revealed the resident was incontinent of bowel and bladder and required total assist of 2 persons for toileting.  The Care Area Assessment (CAA) for Cognitive Loss/Dementia dated 5/26/14 revealed the	F 312	1. The Nursing Assistant was educated on Pericare immediately. 2. All Nursing assistants are in the process of being inerviced on peri-care. 3. The Staff will be educated on peri-care quarterly by the nurse educator. 4. This will be added to the Quality Assurance program to be monitored monthly to ensure pericare is being given accurately. 5. Completion date for this deficiency is November 7, 2014.	11/7/14	

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F 312	<p>Continued From page 30</p> <p>resident ' s memory could not be assessed and the resident was severely cognitively impaired. The CAA for Urinary Incontinence revealed the resident was always incontinent and was totally dependent on staff for toileting.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 8/12/14 revealed the resident required total assistance of 2 persons for toileting and was always incontinent of bowel and bladder.</p> <p>On 10/09/14 at 9:15 AM NA (Nursing Assistant) #1 and NA #2 were observed to provide incontinence care for Resident #63. Prior to being transferred to the bed for care, the resident had been reclined in a geri-chair with both knees bent with her feet in the chair. Upon removal of the resident ' s incontinent brief, the brief was observed to be wet in the front and back without stool present. NA #1 used a wet wash cloth with no-rinse soap to clean the resident ' s perineal area from front to back and dried the area. The 2 NAs assisted the resident to roll over and placed a clean incontinent brief under the resident and rolled her over onto her back and proceeded to tape the brief in place. NA #1 was asked if she cleaned the resident ' s buttocks and stated she did not because she saw the resident was just wet in the front but would wash the resident ' s buttocks. The 2 NAs proceeded to remove the incontinent brief and turned the resident over onto her side and NA #1 washed the resident ' s buttocks and peri-rectal area with a wet wash cloth with no rinse soap. The NA dried the area and applied the clean incontinent brief.</p> <p>An interview was conducted with the Director of Nursing (DON) and the Unit Manager on 10/09/14 at 9:51 AM. The DON stated the NA should have</p>	F 312			

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F 312	Continued From page 31 washed the resident ' s buttocks. The Unit Manager stated she would in-service the staff now because she did not want resident ' s to not be washed all the way.	F 312			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews the facility failed to provide a hand roll or splint for a contracture for 1 of 3 residents reviewed for contractures (Resident #46).  Resident #46 was admitted to the facility on 3/11/14 and had diagnoses including CVA (Cerebrovascular Accident).  The Care Area Assessment (CAA) dated 3/18/14 for Activities of Daily Living (ADLs) revealed the resident had left sided weakness from a prior CVA (Stroke). The CAA summaries contained no information regarding a hand contracture.  The resident ' s Care Plan for ADLs dated 4/3/14 revealed the resident had ADL self-care performance deficit related to left sided weakness/paralysis of left arm and left leg from a	F 318	1. The Resident is being seen by Occupational therapy. The hand splint has been ordered. A hand roll is currently being used. 2. All Residents have been screened by Occupational Therapy for contractures. 3. Residents will be screened quarterly by the Rehab team for contractures and treated as needed. 4. This has been added to the Quality Assurance Program for the PI nurse to monitor Residents quarterly for contractures and interventions. 5. The completion date for this deficiency is November 7, 2014.	11/7/14	

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F 318	<p>Continued From page 32</p> <p>prior stroke. The Care Plan revealed the resident had no short term memory problems and was independent in decision making. There was no information on the Care Plan regarding a contracture of the resident ' s hand or of a hand roll or splint for the contracture.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 9/6/14 revealed the resident was cognitively intact. The MDS revealed the resident had impairment of the upper extremity on one side.</p> <p>Review of Occupational Therapy (OT) Notes revealed the resident was seen by OT from 3/13/14 through 4/4/14 for 5 days a week for therapy for a left hand contracture. A therapy note dated 4/4/14 by Occupational Therapy Assistant (OTA) #1 revealed hand care was provided with range of motion, gentle stretch and double rolled wash cloth in preparation of resting splint. The note revealed a trial of a hand splint from home but the splint was inappropriate for the resident ' s thumb. There were no additional therapy notes regarding a splint for the resident ' s hand contracture after 4/4/14.</p> <p>During an interview with Resident #46 on 10/7/14 at 3:55 PM, the resident ' s left hand was observed to be balled up in a fist. The resident did not have a hand roll or a splint on the contracted hand. The resident stated his hand had been like that for a long time. The Resident stated he did not wear a splint on his left hand.</p> <p>In an interview with Resident #46 on 10/10/14 at 9:32 AM the Resident was observed to take his right hand and slightly move his left index and middle fingers and stated his fingers were sore</p>	F 318			

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F 318	Continued From page 33 and was unable to extend the fingers on his left hand. The resident did not have a hand roll or a splint for the contracted hand. The Resident stated he had not had a splint for his left hand since admission to the facility. The Resident stated he had a splint for his left hand at home and did not know what happened to it.  On 10/10/14 at 9:35 AM OTA (Occupational Therapy Assistant) #1 stated in an interview that she trialed a splint to the resident ' s left hand that he brought from home but the splint was not appropriate because it did not fit. The OTA stated it would be the Occupational Therapist ' s call regarding obtaining a new splint for the resident.  The Rehab Director stated in an interview on 10/10/14 at 10:09 AM that according to the documentation on 3/17/14, the hand contracture was noted and prepped in preparation for a splint because the splint he brought from home did not meet his needs. The Rehab Director stated another hand splint should have been ordered and they dropped the ball. The Rehab Director stated she was not sure what happened but apparently the OTA did not carry over the washcloth hand roll to nursing and the OTA should have notified the Occupational Therapist that the splint did not fit and the therapist would have evaluated the resident for the splint.	F 318			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids;	F 328		11/7/14	

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F 328	<p>Continued From page 34</p> <p>Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to follow physician orders for gastric tube flushes for 1 of 1 sampled resident reviewed for hydration by gastric feeding tube (Resident #63). The findings included:</p> <p>Resident #63 was re-admitted to the facility on 2/25/14 and had diagnoses of Dysphagia (difficulty swallowing) with PEG (Percutaneous Endoscopic Gastric) Tube and End Stage Dementia.</p> <p>The resident ' s Care Plan dated 5/13/14 revealed the resident received water flushes at 25mls per hour continuously. The Care Plan revealed the resident was at risk for dehydration. The interventions included the following: " Administer tube feedings as ordered and water flushes @ 25mls/hr continuously. RD (Registered Dietician) to evaluate and make diet change recommendations PRN (as needed). "</p> <p>The Care Area Assessment (CAA) dated 5/26/14 revealed that Resident #1 could not be assessed for memory and decision making was severely impaired. The CAA for Nutritional Status revealed the resident received water flushes at 25mls per hour continuously.</p>	F 328	<ol style="list-style-type: none"> <li>1. Upon further evaluation of the chart, the flush order was not transcribed correctly by nursing. The order has been corrected. The Resident has been evaluated by the dietician.</li> <li>2. All other tube feeding orders have been checked. No other deficient areas have been identified.</li> <li>3. The nurses are being educated on the proper technique of transcribing orders. The Dietician will have a front sheet of everyone that is admitted to the facility in her box in the front office so she will see all Residents being admitted.</li> <li>4. This will be added to the facility Quality Assurance Program to be monitored monthly by the PI nurse.</li> <li>5. Completion date for this deficiency is November 7, 2014.</li> </ol>		

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F 328	<p>Continued From page 35</p> <p>Review of the most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 8/12/14 revealed the resident was severely cognitively impaired and was totally dependent on staff for eating. The MDS revealed the resident had a feeding tube and received 51% or more calories through the feeding tube and received 501 mls/day or more of fluids through a feeding tube. This assessment was also coded as a discharge assessment and the resident was discharged to the hospital on 8/12/14.</p> <p>Review of the physician ' s admission orders dated 8/27/14 upon return from the hospital revealed an order for water flushes by gastric tube at 40mls/hour.</p> <p>There was an order on the physician ' s order sheet written by Speech Language Pathologist (SLP) #2 dated 8/29/14 for water flushes per feeding tube at 25mls/hour.</p> <p>A note by Dietary Aid #1 dated 9/18/14 revealed the resident had been readmitted after a hospital stay on 8/27/14 and noted pleasure feedings and the rate of the tube feeding formula. The note did not address the water flushes. Review of the medical record revealed no assessments by the dietician since readmission to the facility on 8/27/14.</p> <p>Review of the Medication Administration Record (MAR) for October 2014 revealed the resident was to receive water flushes at 40mls/hour.</p> <p>On 10/09/14 at 9:11 AM Resident #1 was observed sitting in a geri-chair in a common area near the nurse ' s station. The resident ' s mouth and tongue were observed to be moist. The</p>	F 328			

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F 328	<p>Continued From page 36</p> <p>resident ' s tube feeding formula and water flushes were on a pump that was preset to the rates the fluids were to be infused through the resident ' s feeding tube. The water flush was preset to 25mls/hour.</p> <p>On 10/09/14 at 10:40 AM Nurse #1 was observed to review the resident ' s MAR and stated the resident was to receive 40mls per hour of water flushes. The nurse was observed to go to the resident and check the tube feeding pump and stated the water flush was set at 25mls/hour.</p> <p>On 10/09/14 at 1:54 PM SLP #1 stated in an interview that the Speech Language Pathologist did not determine the amount of tube feeding flushes received by a resident. The SLP stated when a SLP made a change in the texture of a resident ' s diet or added pleasure feedings, the facility required them to write an order for the change plus the resident ' s current diet. SLP #1 stated the SLP that wrote the order on 8/29/14 wrote an incorrect order. SLP #1 stated there were no other written physician ' s orders to change the tube feeding flushes from 40mls/hour to 25mls/hour.</p> <p>On 10/09/14 at 2:32 PM an interview was conducted with SLP #2 who wrote the order for tube feeding flushes at 25mls/hour on 8/29/14. The SLP stated he was asked to see the resident for a bedside swallowing evaluation and made a change in the resident ' s pleasure feedings. The SLP stated he asked one of the nurses about the resident ' s tube feeding orders and was told to take the information from the chart on the desk and was told this was her order from before she went out to the hospital.</p>	F 328			

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F 328	<p>Continued From page 37</p> <p>On 10/09/14 at 2:50 PM the Dietary Manager stated in an interview that the Dietician usually saw residents within 5 days after admission or re-admission and during each quarterly assessment. The Dietary Manager stated the resident was in the hospital in August 2014 when the quarterly assessment was completed.</p> <p>The Dietician stated in an interview on 10/09/14 at 3:05 PM if a resident was not out of the facility more than 14 days she did not necessarily do another assessment unless she received a dietary consult. The Dietician stated the resident was out of the facility for 15 days and she should have seen the resident after she was re-admitted. The Dietician stated the resident ' s name must not have been on her list of residents to see.</p> <p>MDS Nurse #2 stated in an interview on 10/09/14 at 3:43 PM that each department head, including dietary received a copy of a resident ' s face sheet upon re-admission to the facility and the Dietician got her list of residents to see from the Dietary Manager. The MDS Nurse stated the Dietician usually came weekly on Thursdays.</p> <p>Review of the physician ' s orders revealed an order dated 10/09/14 at 9:00 PM to change the resident ' s tube feeding water flushes to 40mls/hour via pump.</p> <p>On 10/10/14 at 12:55 PM Resident # 63 was observed sitting in a geri-chair in the common area near the nurse ' s station. The feeding tube pump was observed to be preset to infuse 40mls of water flush per hour.</p> <p>The Director of Nursing stated in an interview on 10/10/14 at 2:29 PM that from now on the nurse</p>	F 328			

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F 328	Continued From page 38 would be writing the therapy recommended diet orders after clarifying the orders with the physician.	F 328			
F 329 SS=D	<b>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b>  Each resident's drug regimen must be free from 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 observations, record reviews and staff interviews, the facility failed to ensure a resident drug regimen was free from unnecessary medication by administering an antipsychotic	F 329	1.Tapering has been started on the two listed Residents for eventual discontinuation of the Medication if appropriate.	11/7/14	

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F 329	<p>Continued From page 39</p> <p>medication without an appropriate indication of use for 2 of 3 residents reviewed for unnecessary medication. (Resident #123 and Resident #65).</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>Resident #123 was originally admitted to the facility on 6/24/14 with diagnoses including Dementia, Depression and Insomnia. Review of the Care Area Assessment Summary (CAAs) dated 1/19/14, under Behavioral Symptoms read, "See CAA for Cognitive Loss/Dementia." The Cognitive Loss/Dementia section of the CAAs read in part, "Resident had one episode of verbal behavior directed toward others during look back period." Under care plan considerations, read, "Will Behavioral Symptoms -Functional Status be addressed in the care plan? Yes." Review of the Care Area Assessment Summary (CAA) for Psychotropic, under, " Nature of the problem/condition " read in part, " Potential for adverse side effects of psychotropic medication. Resident currently takes temazepam (to treat insomnia) citalopram (to treat depression) risperidone (used to treat insomnia and dementia for Resident #123) and lorazepam (to treat anxiety). Diagnosis: dementia, depression and insomnia. "</li> </ol> <p>Review of Resident #123's Care Plan, updated 7/15/14, revealed that Resident #123 was not Care Planned for behaviors.</p> <p>According to the most recent Minimum Data Set (MDS) dated 7/15/14, in the area of behavior, Resident #123 was coded for "verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). These behaviors were noted to have</p>	F 329	<ol style="list-style-type: none"> <li>All other Residents on Psychotropics have been evaluated to ensure there is no unnecessary drug usage.</li> <li>We have developed a form that includes all the components required for antipsychotic use that will be used on all Residents receiving them. The Director of Nursing has to be notified of all orders to ensure that there is appropriate medical necessity for the medication.</li> <li>This has been added to the facility Quality Assurance Program for all Antipsychotic medications to be reviewed monthly to ensure there is an appropriate reason for the drug use and there is a benefit outweighs risk note from the physician. The black box warning has been added to the consent forms.</li> <li>The completion date for this deficiency is November 7, 2014.</li> </ol>		

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F 329	<p>Continued From page 40 occurred 1 to 3 days. The MDS also coded wandering as a behavior, which occurred 1 to 3 days. Resident #123 was coded as receiving antipsychotic medication.</p> <p>Review of October, 2014, Medication Administration Record (MAR) revealed Resident #123 received Risperidone 0.25mgs. twice daily for Dementia and Insomnia.</p> <p>Monograph for Risperdal (Risperidone) Excerpted from LexiComp's Geriatric Dosage Handbook, 17th edition</p> <p>Pharmacologic Category: Antipsychotic Agent</p> <p>Use: Treatment of schizophrenia, treatment of acute mania or mixed episodes associated with bipolar disorder; treatment of irritability/aggression associated with autistic disorder</p> <p>Warnings Precautions U.S. Boxed Warning this is the highest warning type issued from the FDA) [ in bold print] Elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death compared to placebo. [regular print]Most deaths appeared to be either cardiovascular (e.g. heart failure, sudden death) or infectious (e.g. pneumonia) in nature, In addition, an increased incidence of cerebrovascular effects (e.g. transient ischemic attack, cerebrovascular accidents) has been reported in studies of placebo controlled trials of risperidone in elderly patients with dementia related psychosis. ***Risperidone is not approved for the treatment of dementia-related psychosis.***</p>	F 329			

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F 329	Continued From page 41  Review of a Pharmacy note dated 1/2/14, read, in part, "Best team notes- patient on 0.25 mgs. Risperidone twice daily- main issues noted are sleep issues, occasional hitting mentioned in meeting. May consider decrease attempt again in near future. Also discussed possible trial of Melatonin if sleep issues persist."  Review of a Pharmacy note dated 3/26/14, read, "Best team - Discussed patient today. Still with behavior issues so no changes recommended."  Review of a Pharmacy note dated 7/29/14, read "Best team note: patient rambles and resists care-on current Risperidone dose since 3/31/14- Care easier to provide per nursing. No changes recommended."  During an interview on 10/09/2014 at 3:56 PM, the Consultant Pharmacist stated that Resident #123 was receiving Risperidone because she was not sleeping. She stated that they changed her sleep medication and found that her agitation might be due to lack of sleep. The Pharmacist revealed that Resident #123 had been on the same dosage of Risperidone 0.25 mgs. since March, 2013. She revealed that Resident #123 was reviewed every month in meetings to discuss her medication and behavior. The Pharmacist revealed that they had been changing Resident #123's pain and sleep medication. She stated that Resident #123 was combative and that they met quarterly to talk about residents on antipsychotic medication. The Pharmacist reported that Resident #123 was tried on sleep medication, Melatonin and the medication was not working. The Pharmacist stated that Resident #123's inability to sleep was causing her to be agitated	F 329			

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F 329	<p>Continued From page 42</p> <p>during hands on care. She revealed that Resident #123 had a diagnosis of Dementia and agitation was being tracked as a behavior. She revealed that Resident #123 was combative and agitated during hands on care. She stated that she did not believe Resident #123 yelled out. The Pharmacist stated that they met quarterly to talk about what was in the best interest of Resident #123.</p> <p>During an interview on 10/10/14 at 10:49 AM, Staff Nurse #3 revealed that Resident #123's behaviors were documented in nurse's notes and behavior notes. Staff Nurse #3 stated that if Resident #123 became more agitated she was brought to the Nurse's station at night.</p> <p>During an interview on 10/10/14 at 12:51 PM, the Minimum Data Set (MDS) Nurse #2 stated that Resident #123's bed was pulled up to the nurse's station at night and Resident #123 was constantly up and down and in and out of other resident's rooms. The MDS Nurse #2 was not able to explain why Resident #123 was not Care Planned for behaviors.</p> <p>During an interview on 10/10/14 2:16 PM, the Medical Doctor for Resident #123 revealed that agitation was more of a reason for Resident #123 receiving the antipsychotic medication, Risperidone. He explained that Resident #123 stayed up during the night and when she was awake, she was agitated during the day. He revealed that Resident #123 refused medications and refused bathing. The Medical Doctor stated that he routinely looked at residents that received antipsychotic medications and he tried to taper their medication to the lowest dose. He revealed that Resident #123 was on the lowest dose of Risperidone. The Medical Doctor reported that</p>	F 329			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345054</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/10/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOODHAVEN NURS &amp; ALZHEIMER'S C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1150 PINE RUN DRIVE</b> <b>LUMBERTON, NC 28358</b>		
(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 329	<p>Continued From page 43</p> <p>the Nurses would tell him if the benefits outweighed the risk of the resident receiving the medication. He stated that they discussed the benefits versus risks of Risperidone and if appropriate he would continue the medication.</p> <p>During an interview on 10/10/14 at 2:06 PM, the Director of Nursing (DON) revealed that resident's behavior and medication were reviewed in monthly meetings. She stated staff that worked directly with the residents were involved in the meetings. The DON said anyone that exhibited behaviors should be Care Planned with interventions. She stated that they tried every intervention they had to control behaviors as much as possible. She reported that Resident #123 would not eat nor take her medications. She further revealed that Resident #123 fought with staff and could not carry on a sensible conversation without her current medication.</p> <p>2. Resident #65 was originally admitted to the facility on 2/20/12 with diagnoses including Alzheimer ' s Dementia, Hallucinations and Aggressiveness. Review of the Care Area Assessment Summary (CAA) dated 2/9/14, under Behavioral Symptoms read, "See CAA for Cognitive Loss/Dementia." The Cognitive Loss/Dementia section of the CAAs read in part, "Resident has a history of Alzheimer ' s Dementia and hallucinations. She is currently on Risperdal (used for Alzheimer ' s Disease and Hallucinations for Resident #65), Remeron (Depression), and Namenda (Alzheimer ' s Disease). She had one episode of yelling at another resident during the look back period but was easily redirected. " Under care plan considerations, "Will Behavioral Symptoms -Functional Status be addressed in the care plan?"</p>	F 329			

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F 329	<p>Continued From page 44</p> <p>Yes." According to the CAAs, Resident #65 received antipsychotic medication due to diagnoses of Alzheimer's Disease and Hallucinations.</p> <p>According to the most recent Annual Minimum Data Set (MDS) dated 2/9/14, in the area of behavior, Resident #65 was coded for "verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). These behaviors were noted to have occurred 1 to 3 days. The MDS also coded wandering as a behavior, which occurred 1 to 3 days. Resident #65 was coded as receiving antipsychotic medication.</p> <p>Review of Resident #65's Care Plan updated 8/6/14 revealed that she was not Care Planned for behaviors.</p> <p>Review of October, 2014, Medication Administration Record (MAR) revealed Resident #65 received Risperidone 0.25mgs. twice daily for Alzheimer ' s Disease and Hallucinations.</p> <p>Monograph for Risperdal (Risperidone) Excerpted from LexiComp's Geriatric Dosage Handbook, 17th edition</p> <p>Pharmacologic Category: Antipsychotic Agent</p> <p>Use: Treatment of schizophrenia, treatment of acute mania or mixed episodes associated with bipolar disorder; treatment of irritability/aggression associated with autistic disorder</p> <p>Warnings Precautions U.S. Boxed Warning this is the highest warning type issued from the FDA) [</p>	F 329			

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F 329	<p>Continued From page 45 in bold print] Elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death compared to placebo. [regular print]Most deaths appeared to be either cardiovascular (e.g. heart failure, sudden death) or infectious (e.g. pneumonia) in nature. In addition, an increased incidence of cerebrovascular effects (e.g. transient ischemic attack, cerebrovascular accidents) has been reported in studies of placebo controlled trials of risperidone in elderly patients with dementia related psychosis. ***Risperidone is not approved for the treatment of dementia-related psychosis.***</p> <p>During an interview on 10/10/2014 at 11:49 AM Staff Nurse #6 revealed that when Resident #65 was admitted to the facility she exhibited behavior of hitting other residents, refusing to eating, fighting staff and cursing at other residents. In regard to behaviors that were being tracked, Staff Nurse #6 explained that Resident #65 ' s behavior was better in that the resident was not cursing and yelling at other residents and was not going after other residents. Staff Nurse #6 reported that staff chart Resident #65 ' s behaviors every shift and monitor for any other symptoms. She revealed that staff intervene and redirect Resident #65 when she exhibited behaviors.</p> <p>During an interview on 10/10/14 11:53 AM, Nursing Assistant (NA# 5) revealed that in reference to Resident #65's behaviors, she might get a little feisty, such as saying shut up, stop talking or move out of the way if someone got in her personal space, but she had not seen Resident #65 being aggressive to staff or residents. NA#5 stated that she had not heard</p>	F 329			

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F 329	<p>Continued From page 46</p> <p>Resident #65 curse at others and she did not resist care.</p> <p>During an observation on 10/10/2014 at 12:04 PM, Resident #65 was in the dining room eating her meal during lunchtime. She sat looking at her food and would eat a couple of bites of food and sat back in her chair and looked around.</p> <p>During an interview on 10/10/2014 at 12:32 PM, MDS Nurse #2 revealed that Resident #65 would sit in the day room area with staff. She stated that Resident #65 would holler at staff and residents and tell them to shut up. In reference to Care Planning, MDS Nurse #2 reported that staff on the unit would let them know about resident's behaviors and medication. She revealed that the Pharmacist was made aware of resident's behaviors and Nursing Assistants would document resident ' s behaviors in the computer. MDS Nurse #2 revealed that Resident #65 got loud at times, and hollered at other residents. She stated that Resident #65 currently received Risperidone (Alzheimer ' s Disease and Hallucinations) and Remeron (depression) and she had one episode of yelling at others and the intervention was to redirect her. MDS Nurse #2 reported that they usually discussed what needed to be done during monthly meetings.</p> <p>During an interview on 10/10/14 at 12:41 PM, the Consultant Pharmacist stated that Resident #65 was aggressive, refused care and was combative toward other residents. She stated she did not know if risk/benefits of Resident #65's medication had been noted by the doctor.</p> <p>During an interview on 10/10/14 at 2:14 PM, the facility Medical Doctor revealed that Resident #65</p>	F 329			

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F 329	Continued From page 47 was receiving antipsychotic medication for agitation and at one point in time the resident needed to be on medication to keep her under control. The Medical Doctor revealed that he might have been an oversight of him not writing a risk/benefit note for Resident #65 receiving antipsychotic medication. He explained that the Nurses reminded him about making the notation and he would note it in the chart. He further stated that if there was no diagnosis for the medication, the nurses would inform him and he would put one in the chart.  Review of Medical Doctor's notes from February, 2014 to current revealed that there were no risk/benefits notes entered for Resident #65 in the Physician progress note section of the chart.  During an interview on 10/10/14 at 2:06 PM, the Director of Nursing (DON) revealed that resident's behavior and medication were reviewed in monthly meetings. She stated staff that worked directly with residents were involved in the meetings. The DON said anyone that exhibited behaviors should be Care Planned with interventions. She stated that they tried every intervention they had to control behaviors as much as possible.	F 329			
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	F 371		10/31/14	

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F 371	Continued From page 48  This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to prepare foods under sanitary conditions, by failing to effectively degrease and clean the range hood, failed to clean 1 of 2 ice machines in the kitchen and failed to remove expired milk from 2 of 4 nourishment refrigerators. The findings included:  The facility policy dated Revised: 5/2012 Subject: Hood and Filter Cleaning Read as follows: Purpose: To provide correct cleaning instruction for hoods and filters.  Policy: The hood system sides and filters are to be cleaned twice a month or more frequently if necessary. Supplies: detergent solution, Rinse Dry, Stainless Self Cleaner. Clean around all areas of the hood with a solution of detergent and hot water. Lightly clean around the sprinkler and fire retardant discharge nozzle areas. Clean outside areas of hood with stainless steel cleaner.  1. During the initial kitchen tour with the Certified Dietary Manager (CDM) on 10/7/14 at 8:44 AM the hood exhaust system was observed. The hood drip ledge was observed with a piece of clear tape or cellophane 3 inches wide and blowing upwards. The inside of the hood was observed with a light film of grease coating the	F 371	1. No Resident has been affected by the deficiency. 2. No Resident had the potential to be affected by this deficiency. Breakfast had just been cooked when grease was noted on the hoods. The hoods are usually cleaned once a day. The white matter noted on the outside lid and the corners of the ice machine was dried glue from a previous maintenance service. The staff is educated on checking the date on anything that they give the Residents from the refrigerator. The glue has been removed by the maintenance department. The clear cellophane noted on the very top inside corners of the hood was protective covering from the manufacturer and has been removed. 3. The dietary staff will begin cleaning the hood after each meal. The ice machines will be cleaned daily. This all will be documented on a daily checklist. 4. This has been added to the Facility quality assurance program. The checklist will be monitored monthly for accuracy. 5. Completion date for this deficiency is 10/31/14.		

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F 371	<p>Continued From page 49 inner walls of the hood.</p> <p>A second observation of the kitchen on 10/9/14 at 9:14 AM revealed inside the hood a light film of grease that coated the inner walls of the hood. A large pot of soup was observed simmering on the single oven stove directly below the hood system walls.</p> <p>During an interview with the CDM on 10/9/14 at 9:33 AM she stated that staff should wipe down the hood area once a week or more as needed.</p> <p>2. During the initial kitchen tour with the Certified Dietary Manager (CDM) on 10/7/14 at 8:45 AM the ice machine near the dietary office was observed. The ice machine door was observed with dried liquid and the inside edge of the ice machine had a dried white build up in the 4 corner edges of the frame.</p> <p>A second observation of the ice machine on 10/9/14 at 9:26 AM revealed the ice machine door with dried liquid and the inside edge of the ice machine with a dried white build up in the 4 corner edges of the frame.</p> <p>During an interview with the CDM on 10/9/14 at 9:35 AM she stated that the ice machine should have been wiped down.</p> <p>The undated facility policy Dating Procedures read as follows: These are only guidelines to follow, if you have any questions ask myself or your supervisor. You must remember the below standard operating procedures: All open items must be dated. All open refrigerated items must include a open date and discard date according to the item.</p>	F 371			

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F 371	Continued From page 50 All refrigeration must maintain 41 degrees or less. Any refrigeration not maintaining the correct temperature must be reported to your supervisor. It is everyone ' s responsibility to check all items for dates and discard any items at or past their discard date.  3. On 10/8/14 at 9:03 AM the 1100 hall refrigerator was observed. 5 cartons of whole milk were observed on the shelf with expiration dates of 10/6/14.  In an interview with the 1100 hall unit Nurse # 5 on 10/8/14 at 9:11 AM she stated that the night nurse checks the temperature every night and on Fridays staff check the dates and throw out any expired foods.  In an interview with the CDM on 10/8/14 at 9:44 AM she stated that dietary staff were responsible for stocking the milk but nursing assistants were responsible to check for expired items.  On 10/8/14 at 9:15 AM the 1200 hall refrigerator was observed. One carton of fat free milk was observed on the shelf ready for use with an expiration date of 10/5/14.  During an interview with the 1200 hall Nurse # 3 on 10/8/14 at 9:23 AM she stated that every shift staff did daily temperature checks and should check the dates on foods every day.	F 371			
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.	F 372		10/31/14	

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F 372	<p>Continued From page 51</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the dumpster was fully functioning and the area surrounding the dumpster was free of spillage.</p> <p>The findings included:</p> <p>During the initial kitchen tour on 10/7/14 with the Certified Dietary manager (CDM) at 9:00 AM the dumpster was observed leaking liquid onto the dumpster roller and pooling onto the ground in front of the dumpster. The front end of the dumpster was observed leaking on the left side</p> <p>During a second observation of the dumpster area on 10/8/14 at 8:06 AM the dumpster was observed leaking liquid onto the dumpster roller and ground that flowed two and a half feet wide that stopped at the curb in front of the dumpster.</p> <p>Observation of the dumpster on 10/9/14 with the CDM at 9:30 AM revealed the dumpster was in the same condition.</p> <p>In an interview with the CDM on 10/9/14 at 9:34 AM she stated that the housekeeping department is in charge of the dumpster and that the dumpster company came one or two times a week to empty the dumpster.</p> <p>During an interview with the Environmental Services Manager on 10/9/14 at 10:07 AM he stated that he had called the dumpster company to service the dumpster on Tuesday and instead the company had emptied the trash. He stated that he would call the dumpster company again</p>	F 372	<ol style="list-style-type: none"> <li>1. No Residents were effected by this deficiency.</li> <li>2. NO Resident had the potential to be affected by this deficiency. According to the Waste company, no wastes were leaking from the dumpster, only hydraulic fluid.</li> <li>3. This has been added to the dietary checklist for the kitchen staff to check the dumpster daily.</li> <li>4. This has been added to the Quality improvement program. The completion of the dietary check off sheets will be monititered monthly for 100% accuracy.</li> <li>5. Completion date for this deficiency is 10/31/14.</li> </ol>		

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F 372	Continued From page 52 and tell them to replace the dumpster.	F 372			
F 428 SS=D	<p>In an interview with the Director of Nursing on 10/10/14 at 9:15 AM she stated that she did not know the dumpster was leaking. If she had known she would have someone there that day to fix or replace the dumpster.</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews and pharmacist interview, the facility Consultant Pharmacist failed to request an appropriate diagnosis for use of an antipsychotic medication for 2 of 3 residents reviewed receiving antipsychotic medication. (Resident #123 and Resident #65).</p> <p>The findings included:</p> <p>1. Resident #123 was originally admitted to the facility on 6/24/14 with diagnoses including Dementia, Depression and Insomnia. Review of the Care Area Assessment Summary (CAAs)</p>	F 428	<p>1.Tapering has been started on the two listed Residents for eventual discontinuation of the Medication if appropriate.</p> <p>2. All other Residents on Psychotropics have been evaluated to ensure there is no unnecessary drug usage.</p> <p>3. We have developed a form that includes all the components required for antipsychotic use that will be used on all Residents receiving them. The Director of Nursing has to be notified of all orders to ensure that there is appropriate medical necessity for the medication. The</p>	11/7/14	

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F 428	<p>Continued From page 53</p> <p>dated 1/19/14, under Behavioral Symptoms read, "See CAA for Cognitive Loss/Dementia." The Cognitive Loss/Dementia section of the CAAs read in part, "Resident had one episode of verbal behavior directed toward others during look back period." Under care plan considerations, read, "Will Behavioral Symptoms -Functional Status be addressed in the care plan? Yes." Review of the Care Area Assessment Summary (CAA) for Psychotropic, under, " Nature of the problem/condition " read in part, " Potential for adverse side effects of psychotropic medication. Resident currently takes temazepam (to treat insomnia) citalopram (to treat depression) risperidone (used to treat insomnia and dementia for Resident #123) and lorazepam (to treat anxiety). Diagnosis: dementia, depression and insomnia. "</p> <p>Review of Resident #123's Care Plan, updated 7/15/14, revealed that Resident #123 was not Care Planned for behaviors.</p> <p>According to the most recent Minimum Data Set (MDS) dated 7/15/14, in the area of behavior, Resident #123 was coded for "verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). These behaviors were noted to have occurred 1 to 3 days. The MDS also coded wandering as a behavior, which occurred 1 to 3 days. Resident #123 was coded as receiving antipsychotic medication.</p> <p>Review of October, 2014, Medication Administration Record (MAR) revealed Resident #123 received Risperidone 0.25mgs. twice daily for Dementia and Insomnia.</p>	F 428	<p>pharmacy monthly reviews of the drug regimens will be reviewed in the monthly BEST meetings. The drug reviews are given to the DON/MD monthly as soon as they are done. They will be reviewed as soon as they are received to ensure that any irregularities are corrected.</p> <p>4. This has been added to the facility Quality Assurance Program for all Antipsychotic medications to be reviewed monthly to ensure there is an appropriate reason for the drug use and there is a benefit outweighs risk note from the physician. The black box warning has been added to the consent forms.</p> <p>5. The completion date for this deficiency is November 7, 2014.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>WOODHAVEN NURS &amp; ALZHEIMER'S C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1150 PINE RUN DRIVE</b> <b>LUMBERTON, NC 28358</b>		
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F 428	<p>Continued From page 54</p> <p>Monograph for Risperdal (Risperidone) Excerpted from LexiComp's Geriatric Dosage Handbook, 17th edition</p> <p>Pharmacologic Category: Antipsychotic Agent</p> <p>Use: Treatment of schizophrenia, treatment of acute mania or mixed episodes associated with bipolar disorder; treatment of irritability/aggression associated with autistic disorder</p> <p>Warnings Precautions U.S. Boxed Warning this is the highest warning type issued from the FDA) [ in bold print] Elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death compared to placebo. [regular print]Most deaths appeared to be either cardiovascular (e.g. heart failure, sudden death) or infectious (e.g. pneumonia) in nature, In addition, an increased incidence of cerebrovascular effects (e.g. transient ischemic attack, cerebrovascular accidents) has been reported in studies of placebo controlled trials of risperidone in elderly patients with dementia related psychosis. ***Risperidone is not approved for the treatment of dementia-related psychosis.***</p> <p>Review of a Pharmacy note dated 1/2/14, read, in part, "Best team notes- patient on 0.25 mgs. Risperidone twice daily- main issues noted are sleep issues, occasional hitting mentioned in meeting. May consider decrease attempt again in near future. Also discussed possible trial of Melatonin if sleep issues persist."</p> <p>Review of a Pharmacy note dated 3/26/14, read,</p>	F 428			

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F 428	<p>Continued From page 55</p> <p>"Best team - Discussed patient today. Still with behavior issues so no changes recommended."</p> <p>Review of a Pharmacy note dated 7/29/14, read "Best team note: patient rambles and resists care-on current Risperidone dose since 3/31/14- Care easier to provide per nursing. No changes recommended."</p> <p>During an interview on 10/09/2014 at 3:56 PM, the Consultant Pharmacist stated that Resident #123 was receiving Risperidone because she was not sleeping. She stated that they changed her sleep medication and found that her agitation might be due to lack of sleep. The Pharmacist revealed that Resident #123 had been on the same dosage of Risperidone 0.25 mgs. since March, 2013. She revealed that Resident #123 was reviewed every month in meetings to discuss her medication and behavior. The Pharmacist revealed that they had been changing Resident #123's pain and sleep medication. She stated that Resident #123 was combative and that they met quarterly to talk about residents on antipsychotic medication. The Pharmacist reported that Resident #123 was tried on sleep medication, Melatonin and the medication was not working. The Pharmacist stated that Resident #123's inability to sleep was causing her to be agitated during hands on care. She revealed that Resident #123 had a diagnosis of Dementia and agitation was being tracked as a behavior. She revealed that Resident #123 was combative and agitated during hands on care. She stated that she did not believe Resident #123 yelled out. The Pharmacist stated that they met quarterly to talk about what was in the best interest of Resident #123.</p> <p>During an interview on 10/10/14 at 10:49 AM,</p>	F 428			

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F 428	<p>Continued From page 56</p> <p>Staff Nurse #3 revealed that Resident #123's behaviors were documented in nurse's notes and behavior notes. Staff Nurse #3 stated that if Resident #123 became more agitated she was brought to the Nurse's station at night.</p> <p>During an interview on 10/10/14 at 12:51 PM, the Minimum Data Set (MDS) Nurse #2 stated that Resident #123's bed was pulled up to the nurse's station at night and Resident #123 was constantly up and down and in and out of other resident's rooms. The MDS Nurse #2 was not able to explain why Resident #123 was not Care Planned for behaviors.</p> <p>During an interview on 10/10/14 2:16 PM, the Medical Doctor for Resident #123 revealed that agitation was more of a reason for Resident #123 receiving the antipsychotic medication, Risperidone. He explained that Resident #123 stayed up during the night and when she was awake, she was agitated during the day. He revealed that Resident #123 refused medications and refused bathing. The Medical Doctor stated that he routinely looked at residents that received antipsychotic medications and he tried to taper their medication to the lowest dose. He revealed that Resident #123 was on the lowest dose of Risperidone. The Medical Doctor reported that the Nurses would tell him if the benefits outweighed the risk of the resident receiving the medication. He stated that they discussed the benefits versus risks of Risperidone and if appropriate he would continue the medication.</p> <p>During an interview on 10/10/14 at 2:06 PM, the Director of Nursing (DON) revealed that resident's behavior and medication were reviewed in monthly meetings. She stated staff</p>	F 428			

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F 428	<p>Continued From page 57</p> <p>that worked directly with the residents were involved in the meetings. The DON said anyone that exhibited behaviors should be Care Planned with interventions. She stated that they tried every intervention they had to control behaviors as much as possible. She reported that Resident #123 would not eat nor take her medications. She further revealed that Resident #123 fought with staff and could not carry on a sensible conversation without her current medication.</p> <p>2. Resident #65 was originally admitted to the facility on 2/20/12 with diagnoses including Alzheimer's Dementia, Hallucinations and Aggressiveness. Review of the Care Area Assessment Summary (CAA) dated 2/9/14, under Behavioral Symptoms read, "See CAA for Cognitive Loss/Dementia." The Cognitive Loss/Dementia section of the CAAs read in part, "Resident has a history of Alzheimer's Dementia and hallucinations. She is currently on Risperdal (used for Alzheimer's Disease and Hallucinations for Resident #65), Remeron (Depression), and Namenda (Alzheimer's Disease). She had one episode of yelling at another resident during the look back period but was easily redirected. " Under care plan considerations, "Will Behavioral Symptoms -Functional Status be addressed in the care plan? Yes." According to the CAAs, Resident #65 received antipsychotic medication due to diagnoses of Alzheimer ' s Disease and Hallucinations.</p> <p>According to the most recent Annual Minimum Data Set (MDS) dated 2/9/14, in the area of behavior, Resident #65 was coded for "verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). These behaviors were noted to</p>	F 428			

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F 428	<p>Continued From page 58</p> <p>have occurred 1 to 3 days. The MDS also coded wandering as a behavior, which occurred 1 to 3 days. Resident #65 was coded as receiving antipsychotic medication.</p> <p>Review of Resident #65's Care Plan updated 8/6/14 revealed that she was not Care Planned for behaviors.</p> <p>Review of October, 2014, Medication Administration Record (MAR) revealed Resident #65 received Risperidone 0.25mgs. twice daily for Alzheimer's Disease and Hallucinations.</p> <p>Monograph for Risperdal (Risperidone) Excerpted from LexiComp's Geriatric Dosage Handbook, 17th edition</p> <p>Pharmacologic Category: Antipsychotic Agent</p> <p>Use: Treatment of schizophrenia, treatment of acute mania or mixed episodes associated with bipolar disorder; treatment of irritability/aggression associated with autistic disorder</p> <p>Warnings Precautions U.S. Boxed Warning this is the highest warning type issued from the FDA) [ in bold print] Elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death compared to placebo. [regular print]Most deaths appeared to be either cardiovascular (e.g. heart failure, sudden death) or infectious (e.g. pneumonia) in nature, In addition, an increased incidence of cerebrovascular effects (e.g. transient ischemic attack, cerebrovascular accidents) has been reported in studies of placebo controlled trials of</p>	F 428			

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F 428	<p>Continued From page 59</p> <p>risperidone in elderly patients with dementia related psychosis. ***Risperidone is not approved for the treatment of dementia-related psychosis.***</p> <p>During an interview on 10/10/2014 at 11:49 AM Staff Nurse #6 revealed that when Resident #65 was admitted to the facility she exhibited behavior of hitting other residents, refusing to eat, fighting staff and cursing at other residents. In regard to behaviors that were being tracked, Staff Nurse #6 explained that Resident #65's behavior was better in that the resident was not cursing and yelling at other residents and was not going after other residents. Staff Nurse #6 reported that staff chart Resident #65's behaviors every shift and monitor for any other symptoms. She revealed that staff intervene and redirect Resident #65 when she exhibited behaviors.</p> <p>During an interview on 10/10/14 11:53 AM, Nursing Assistant (NA# 5) revealed that in reference to Resident #65's behaviors, she might get a little feisty, such as saying shut up, stop talking or move out of the way if someone got in her personal space, but she had not seen Resident #65 being aggressive to staff or residents. NA#5 stated that she had not heard Resident #65 curse at others and she did not resist care.</p> <p>During an observation on 10/10/2014 at 12:04 PM, Resident #65 was in the dining room eating her meal during lunch. She sat looking at her food and would eat a couple of bites of food and sat back in her chair and looked around.</p> <p>During an interview on 10/10/2014 at 12:32 PM, MDS Nurse #2 revealed that Resident #65 would</p>	F 428			

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F 428	<p>Continued From page 60</p> <p>sit in the day room area with staff. She stated that Resident #65 would holler at staff and residents and tell them to shut up. In reference to Care Planning, MDS Nurse #2 reported that staff on the unit would let them know about resident's behaviors and medication. She revealed that the Pharmacist was made aware of resident's behaviors and Nursing Assistants would document resident's behaviors in the computer. MDS Nurse #2 revealed that Resident #65 got loud at times, and hollered at other residents. She stated that Resident #65 currently received Risperidone (Alzheimer's Disease and Hallucinations) and Remeron (depression) and she had one episode of yelling at others and the intervention was to redirect her. MDS Nurse #2 reported that they usually discussed what needed to be done during monthly meetings.</p> <p>During an interview on 10/10/14 at 12:41 PM, the Consultant Pharmacist stated that Resident #65 was aggressive, refused care and was combative toward other residents. She stated she did not know if risk/benefits of Resident #65's medication had been noted by the doctor.</p> <p>During an interview on 10/10/14 at 2:14 PM, the facility Medical Doctor revealed that Resident #65 was receiving antipsychotic medication for agitation and at one point in time the resident needed to be on medication to keep her under control. The Medical Doctor revealed that not writing a risk/benefit note for Resident #65 receiving antipsychotic medication was an oversight. He explained that the Nurses reminded him about making the notation and he would note it in the chart. He further stated that if there was no diagnosis for the medication, the nurses would inform him and he would put one in the chart.</p>	F 428			

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F 428	Continued From page 61  Review of Medical Doctor's notes from February, 2014 to current revealed that there were no risk/benefits notes entered for Resident #65 in the Physician progress note section of the chart.  During an interview on 10/10/14 at 2:06 PM, the Director of Nursing (DON) revealed that resident's behavior and medication were reviewed in monthly meetings. She stated staff that worked directly with residents were involved in the meetings. The DON said anyone that exhibited behaviors should be Care Planned with interventions. She stated that they tried every intervention they had to control behaviors as much as possible.	F 428			
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 facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		10/31/14	

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F 431	<p>Continued From page 62 controls, and permit only authorized personnel to have access to the keys.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to lock 1 of 11 medication carts located in the facility when the cart was left unattended on hall 1116-1124 in the ICF Unit.</p> <p>The findings included:</p> <p>Facility's Cart Management policy for medications states " All carts will be locked when not in direct eyesight of the nurse."</p> <p>Observation of the medication cart identified as cart 1116-1124 on ICF unit on 10/10/2014 at 9:16 AM revealed the medication cart was unlocked and unattended while Nurse #1 was giving medication to a resident. The nurse was not in direct view of the cart during this time. The lock on the right side of the cart was in an unlocked position and medication drawers could be opened. There were no residents in hallway at the time.</p>	F 431	<ol style="list-style-type: none"> <li>1. No Residents were affected by this deficiency.</li> <li>2. All Residents had the potential to be affected by an unattended unlocked medication cart.</li> <li>3. The nurses have been educated on not leaving unlocked carts unattended.</li> <li>4. This has been added to the facility Quality Assurance program to be monitored weekly times 4 weeks then monthly if 100% compliance is achieved.</li> <li>5. Completion date for this deficiency is 10/31/14.</li> </ol>		

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F 431	<p>Continued From page 63</p> <p>Interview with Nurse #1 on 10/10/2014 at 9:17 AM revealed the nurse assigned to medication cart 1116-1124 stated she was aware that the medication cart was to be locked when she was not in direct eyesight of the cart. The Nurse stated she could not see the cart from the room she was just in. The Nurse stated she should have locked the cart or have been in direct eyesight of the cart if she was giving medicine to a resident in their room.</p> <p>An interview on 10/10/2014 at 9:49 AM with the facility's Director of Nursing (DON) revealed that the facility had a policy on locking the medication carts. The DON stated the medication carts should be locked when the nurses step away and all the nurses were aware of the policy.</p>	F 431			