STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING ______ B. WING ______	C 10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON HEALTH AND REHABILITATION CENTER	**820 WELLINGTON AVENUE** **WILMINGTON, NC 28401**

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 10/23/14. Event ID# C2XJ11.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an interim care plan for 1 of 17 sampled residents (Resident #195). The findings included: Resident #195 was admitted to the facility on 10/14/14 and had diagnoses that included S/P	F 279	1. The initial interim care plan and Kardex for Resident #195 was completed on 10/22/14. 2. The Facility initiated transition to Electronic Medical Records on 10/01/2014. An audit was conducted by	11/13/14

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

Electronically Signed — 11/07/2014

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 279	Continued From page 1 (status post) Total Knee Replacement, Myocardial Infarction (Heart Attack) with Congestive Heart Failure after knee surgery and Diabetes. The Admission Nursing Assessment dated 10/14/14 revealed the resident was alert and oriented to person and place. The assessment revealed the resident was hard of hearing and had impaired eye sight with the ability to only see shadows. The assessment revealed the resident required assistance with eating, was incontinent and required extensive assistance with bed mobility and transfers. The Brief Interview for Mental Status dated 10/20/14 revealed the resident was moderately cognitively impaired. Review of the resident ' s medical record on 10/22/14 at 2:15 PM revealed a form titled Interim Plan of Care attached to the Nursing Admission Assessment form. The interim plan of care form had not been filled out. On 10/22/14 at 2:25 PM, MDS (Minimum Data Set) Nurse #1 stated in an interview that the nurse who did the admission nursing assessment was suppose to complete the interim care plan. An interview was conducted with NA (nursing assistant) #1 and NA #2 on 10/22/14 at 2:45 PM. The NAs stated they looked at the Resident Care Kardex for information on specific needs for a resident ' s care or they could ask the nurse. An observation of the book containing The Resident Care Kardex for the resident ' s on the unit where Resident #195 resided revealed there was not a Resident Care Kardex for Resident 195.	F 279	the MDS nurses on 10/22/14, to ensure documentation, including care plans were complete on all other Residents admitted from 10/01/14 to 10/22/14. 3. Education was conducted by the Staff Development Coordinator to licensed nurses 10/22/14 thru 10/25/14 regarding completion of admission documentation in Electronic Medical Records. Director of Nursing or Staff Development Coordinator will review admissions from the previous day Monday thru Friday to ensure Admission documentation is complete to include initial plan of care (Admissions on Saturday or Sunday will be reviewed within 72 hours)for the next 60 days. 4. The Director of Nursing will report the findings of admission reviews to the QAPI committee weekly times four weeks, then monthly times two months and action will be taken immediately if indicated, by the Director of Nursing.	

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F 279	Continued From page 2 The Director of Nursing (DON) stated in an interview on 10/22/14 at 3:15 PM that the facility was in the process of transferring to computerized charting and the documentation for admissions beginning on 10/01/14 should have been put in the computer. Review of computerized charting revealed no information was documented on the care plan for Resident #195. Nurse #1 stated in an interview on 10/23/14 at 2:21 PM that she did most of the resident ' s initial assessment but did not get back to finish the paperwork. The Nurse stated she reported to the next shift that Resident #195 was a new admission and that the paperwork had not been completed. The Nurse stated she thought she worked on another unit the next day and assumed the oncoming shift had finished the paperwork for Resident #195. The Nurse stated the nurses fill out the Resident Care Kardex but they had to wait for therapy to evaluate the resident to see how much assistance the resident required but was usually filled out within 24 hours of admission.	F 279		
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.	F 431		11/13/14

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F 431	Continued From page 3 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to remove expired medications from 1 of 1 central supply medication storage cabinet and 1 of 3 medication rooms. The findings included: 1. On 10/23/14 at 10:00 AM, an observation of the medication cart for residents on the 500 Hall was observed with Med (medication) Aide #1. A full bottle of One-Daily Multi Vitamins was observed on the cart that contained the expiration date of August 2014. The bottle was dated as	F 431	1. The expired medications were removed and returned to pharmacy for disposal on 10/23/14. 2. An audit was completed by the Nursing Management staff of all med carts, medication rooms, and central supply storage areas on 10/23/14. There were no other expired medications. 3. The Director of Nursing implemented a triple check system on 10/24/14 for all	

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F 431	Continued From page 4 opened on 10/23/14. The Med Aide stated earlier that morning she realized she did not have any multi vitamins on her cart and asked the ward clerk who was a Med Aide to get her a bottle of multi vitamins. Med Aide #1 stated she gave the medication to 2 residents on the 500 Hall that morning and stated she should have looked at the date on the bottle. The Director of Nursing (DON) stated in an interview on 10/23/14 at 11:14 AM that a nurse from their pharmacy came in once a month and checked all the medications in the facility. The DON stated someone from the pharmacy did a complete audit and checked all medications every 6 months and had just made a visit to the facility. The DON stated she did not know how this happened. On 10/23/14 at 12:47 PM an interview was conducted with the ward clerk and the staff member that worked in central supply. The Ward Clerk stated that morning Med Aide #1 asked her to get a bottle of Multi Vitamins without minerals or iron. The Ward Clerk stated she went to central supply and the staff member working there opened the cabinet where stock medications were stored. The Ward Clerk stated she picked up the first bottle of multi vitamins she saw and took the bottle back to the unit, opened the bottle, removed the cotton and labeled the bottle with the date it was opened. The Ward Clerk stated she did not check the expiration date on the bottle. 2. On 10/23/14 at 10:15 AM, an observation of the medication storage room on the 500/600 Halls was made with Med (Medication) Aide #1. There was one bottle of liquid Banophen on the	F 431	medications. Medication expiration dates will be checked initially with delivery manifests, by the Nurses for pharmacy delivered medications or the Central Supply Coordinator for over the counter medications. Second check will be done by the Nurse or Certified Medication Aide when the medication is stocked in the med cart. Third check of expiration dates will be conducted upon administration of medication. Medication Storage Audits will be conducted weekly by the Director of Nursing times four weeks and monthly times two months. Medication Storage Audits will be documented on the Omnicare Medication Storage Audit Tool. 4. The Director of Nursing will report the findings of the Medication Storage Audits to the QAPI committee weekly times four weeks and monthly times two months. Any negative findings will be addressed immediately and findings reported during QAPI meetings.	

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F 431	Continued From page 5 shelf in a bin with stock medications and contained an expiration date of January 2014. The bottle was almost full and handwritten on the bottle was the following: " Opened 9/25/14. " The Med Aide stated the bottle had been opened and should not be stored there. The Med Aide stated the medication had expired and she would dispose of it. On 10/23/14 at 11:14 AM the Director of Nursing (DON) stated in an interview that a nurse from their pharmacy checked all the medication carts and medication rooms once a month and another person from the pharmacy did an audit every 6 months and checked all medications. The DON stated an audit had just been done and she did not know how this happened.	F 431		