

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/22/2015
NAME OF PROVIDER OR SUPPLIER CLEMMONS NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012		
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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administer diabetic medications as ordered by the physician for one of three residents (resident #3) reviewed for unnecessary medications and failed to monitor blood glucose as ordered by the physician for 1 of 3 residents (resident #3) reviewed for unnecessary medications. The findings included:</p> <p>Example 1) Resident #3 was admitted to the facility on 9/9/14 with multiple diagnoses including diabetes mellitus, dementia, dysphagia and history of a fracture of the vertebrae.</p> <p>A review of the Minimum Data Set dated 9/16/14 revealed the resident was assessed being moderately impaired for cognitive skills for daily decision making. The review also revealed the resident was assessed with receiving insulin injections.</p> <p>A review of the Physician ' s Orders revealed an order dated 9/13/14 at 11:20 PM which stated " Start sliding scale for blood sugars greater than 300. "</p>	F 309	<p>" Resident # 3 discharged from the facility on 9/21/14. The deficient practice was not discovered until after discharge.</p> <p>" All residents receiving prescription medications have the potential to be affected by the practice.</p> <p>" A 100% audit of all residents MARs for administration of diabetic medications, SSI, and completion of accuchecks was completed by the ADONs on 1/27/15. Results of the audit revealed omissions on multiple residents MARs. On 1/28/15 in-servicing began for full time, part time and PRN nurses on omissions on the MAR by the DON. In-servicing included that on 2/2/2015, a verification sheet would be placed in the front of each narcotic book for nurses to sign verifying that he/she has followed the physician orders according to the MAR, including accuchecks and SSI. Any order not followed, the nurse will sign, circle, and give an explanation on the back of the MAR as to why the order was not followed per facility policy. In-servicing will continue thru 2/28/2015 for all licensed nurses.</p>	2/28/15	

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

TITLE

(X6) DATE

Electronically Signed

02/06/2015

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 309	Continued From page 1 A review of the Medication Administration Record (MAR) dated 9/9/14 to 9/30/14 was conducted. The review revealed an undated medication order which read "Novolin R subcutaneous (SQ) with sliding scale: 301 - 350 6 units, 351 - 400 8 units, 401 - 450 10 units, 451 - 500 12 units." The order required documentation of the blood sugar, the amount of insulin administered and the site the insulin was administered at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. The review revealed blood sugars, the amount of insulin administered and the site the insulin was administered was not documented on 9/14/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. The review revealed blood sugars, the amount of insulin administered and the site the insulin was administered was not documented on 9/15/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. The review revealed blood sugars, the amount of insulin administered and the site the insulin was administered was not documented on 9/16/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. The review revealed blood sugars, the amount of insulin administered and the site the insulin was administered was not documented on 9/17/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. The review revealed blood sugars, the amount of insulin administered and the site the insulin was administered was not documented on 9/18/14 at 6:30 AM. An interview was conducted with the Physician 's Assistant (PA) on 1/22/15 at 10:06 AM. The PA stated the nursing staff was expected to begin administration of new medication orders at the next scheduled medication administration as ordered by the physician.	F 309	" In-servicing to licensed nurses began on 2/3/2015 instructing any nurse working 11-7 to pull all pink copy of physicians orders placed in the unit box, check that the orders have been transcribed correctly on to the MAR and to place their initials on the top corner of the order once transcription was verified. ADONs will collect the pink copies daily Monday <input type="checkbox"/> Friday and verify that a nurse has initialed the pink copy. " ADONs will audit verification sheet and MAR twice weekly for 4 weeks, weekly for 4 weeks, and monthly for 3 months for correct transcription and compliance with medication administration. " Compliance will be monitored by the Director of Nursing. Audit tools will be collected and reviewed weekly from the ADONs by the DON and reported to the QA committee for three months.		

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F 309	<p>Continued From page 2</p> <p>An interview was conducted with Administrative Staff #1 on 1/22/15 at 12:38 PM. She stated the nursing staff was expected to fax all new medication orders to the pharmacy. Once a new medication was received from the pharmacy, the nursing staff was expected to administer the new medication at the next scheduled medication administration as ordered by the physician. Administrative Staff #1 stated she reviewed the resident ' s medical record and was unable to find documentation that Novolin R was administered on the above referenced dates and times as ordered by the physician. Administrative Staff #1 did not offer an explanation why Novolin R was not administered on the above referenced dates and times as ordered by the physician.</p> <p>Example 2) Resident #3 was admitted to the facility on 9/9/14 with multiple diagnoses including diabetes mellitus, dementia, dysphagia and history of a fracture of the vertebrae.</p> <p>A review of the Minimum Data Set dated 9/16/14 revealed the resident was assessed as being moderately impaired for cognitive skills for daily decision making. The review also revealed the resident was assessed as receiving insulin injections.</p> <p>A review of the Physician ' s Orders revealed an order dated 9/15/14 which stated " Lantus 3 units subcutaneous (SQ) every morning. "</p> <p>A review of the MAR dated 9-9-14 to 9-30-14 revealed an order dated 9/15/14 which stated " Lantus SQ 3 units every morning. " The insulin was scheduled to be administered at 8:00 AM. The review revealed Lantus SQ 3 units was not</p>	F 309			

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F 309	<p>Continued From page 3</p> <p>administered on 9/20/14 at 8:00 AM and 9/21/14 at 8:00 AM.</p> <p>An interview was conducted with Administrative Staff #1 on 1/22/15 at 12:38 PM. She stated the nursing staff was expected to administer medications as ordered by the physician. Administrative Staff #1 stated she reviewed the resident ' s medical record and was unable to find documentation that Lantus 3 units SQ was administered on 9/20/14 at 8:00 AM and on 9/21/14 at 8:00 AM as ordered by the physician. Administrative Staff #1 did not offer an explanation why Lantus 3 units SQ was not administered on 9/20/14 at 8:00 AM and on 9/21/14 at 8:00 AM as ordered by the physician.</p> <p>Example 3) Resident #3 was admitted to the facility on 9/9/14 with multiple diagnoses including diabetes mellitus, dementia, dysphagia and history of a fracture of the vertebrae.</p> <p>A review of the Minimum Data Set dated 9/16/14 revealed the resident was assessed being moderately impaired for cognitive skills for daily decision making.</p> <p>A review of the Physician ' s Orders revealed an order dated 9/15/14 which stated " Metformin 750 milligrams (mg) by mouth (po) every morning (qam) at 9:00 AM. "</p> <p>A review of the MAR dated 9-9-14 to 9-30-14 revealed the order dated 9/15/14 which stated " Metformin 750 milligrams po qam at 9:00 AM " was not transcribed onto the MAR. Metformin 750 mg was not administered on 9/16/14 at 9:00 AM, 9/17/14 at 9:00 AM, 9/18/14 at 9:00 AM, 9/19/14</p>	F 309			

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F 309	<p>Continued From page 4 at 9:00 AM, 9/20/14 at 9:00 AM and on 9/21/14 at 9:00 AM.</p> <p>An interview was conducted with the Physician ' s Assistant (PA) on 1/22/15 at 10:06 AM. The PA stated the nursing staff was expected to begin administration of new medication orders at the next scheduled medication administration as ordered by the physician.</p> <p>An interview was conducted with Administrative Staff #1 on 1/22/15 at 12:38 PM. She stated the nursing staff was expected to transcribe new medication orders to the MAR. She stated the nursing staff was expected to fax all new medication orders to the pharmacy. Once a new medication was received from the pharmacy, the nursing staff was expected to administer the new medication at the next scheduled medication administration as ordered by the physician. Administrative Staff #1 stated she reviewed the resident ' s medical record and was unable to find documentation that Metformin 750 mg po qam was administered on the above referenced dates and times as ordered by the physician. Administrative Staff #1 did not offer an explanation why Metformin 750 mg po qam was not administered on the above referenced dates and times as ordered by the physician.</p> <p>Example 4) Resident #3 was admitted to the facility on 9/9/14 with multiple diagnoses including diabetes mellitus, dementia, dysphagia and history of a fracture of the vertebrae.</p> <p>A review of the Minimum Data Set dated 9/16/14 revealed the resident was assessed being moderately impaired for cognitive skills for daily</p>	F 309			

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F 309	<p>Continued From page 5 decision making.</p> <p>A review of the Physician ' s Orders revealed an order dated 9/15/14 which stated " Metformin 250 milligrams (mg) by mouth (po) every evening (qpm) at 5:00 PM. "</p> <p>A review of the MAR dated 9-9-14 to 9-30-14 revealed the order dated 9/15/14 which stated " Metformin 250 milligrams po qpm at 5:00 PM " was not transcribed onto the MAR. Metformin 750 mg was not administered on 9/16/14 at 5:00 PM, 9/17/14 at 5:00 PM, 9/18/14 at 5:00 PM, 9/19/14 at 5:00 PM, and on 9/20/14 at 5:00 PM.</p> <p>An interview was conducted with the Physician ' s Assistant (PA) on 1/22/15 at 10:06 AM. The PA stated the nursing staff was expected to begin administration of new medication orders at the next scheduled medication administration as ordered by the physician.</p> <p>An interview was conducted with Administrative Staff #1 on 1/22/15 at 12:38 PM. She stated the nursing staff was expected to transcribe new medication orders to the MAR. She stated the nursing staff was expected to fax all new medication orders to the pharmacy. When a new medication was received from the pharmacy, the nursing staff was expected to administer the new medication at the next scheduled medication administration as ordered by the physician. Administrative Staff #1 stated she reviewed the resident ' s medical record and was unable to find documentation that Metformin 250 mg po qpm was administered on the above referenced dates and times as ordered by the physician. Administrative Staff #1 did not offer an explanation why Metformin 250 mg po qpm was</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>not administered on the above referenced dates and times as ordered by the physician.</p> <p>Example 5) Resident #3 was admitted to the facility on 9/9/14 with multiple diagnoses including diabetes mellitus, dementia, dysphagia and history of a fracture of the vertebrae.</p> <p>A review of the Minimum Data Set dated 9/16/14 revealed the resident was assessed being moderately impaired for cognitive skills for daily decision making.</p> <p>A review of the Physician ' s Orders revealed an order dated 9/9/14 which stated " Accuchecks before meals (AC) and at bedtime (HS) at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM.</p> <p>A review of the MAR dated 9/9/14 to 9/30/14 was conducted. The review revealed accuchecks were not performed on 9/9/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. Accuchecks were not performed on 9/10/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. Accuchecks were not performed on 9/11/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. Accuchecks were not performed on 9/12/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. Accuchecks were not performed on 9/13/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. Accuchecks were not performed on 9/14/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. Accuchecks were not performed on 9/15/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. Accuchecks were not performed on 9/16/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. Accuchecks were not performed on 9/17/14 at 6:30 AM, 11:30 AM, 4:30 PM and at 8:00 PM. The review also revealed</p>	F 309			

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F 309	Continued From page 7 accuchecks were not performed on 9/18/14 at 6:30 AM. An interview was conducted with Administrative Staff #1 on 1/22/15 at 12:38 PM. She stated the nursing staff was expected to begin checking blood sugars as ordered by the physician. Administrative Staff #1 stated she reviewed the resident ' s medical record and was unable to find documentation that blood sugars were obtained on the above mentioned dates and times. She did not offer an explanation why the blood sugars were not obtained on the above mentioned dates and times.	F 309			
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		2/28/15	

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F 322	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to check placement of gastrostomy tube (GT) by the insertion of air into the GT with a syringe and listening to the stomach with a stethoscope for gurgling sounds prior to medication administration for one of one resident (resident #4) observed receiving medications via GT. The findings included:</p> <p>A review of the Policy and Procedures for Medication Administration through Enteral Tubes dated 2007 was conducted. The policy stated the nurse was expected to verify tube placement with the insertion of a small amount of air into the tube with a syringe and listening to the stomach with a stethoscope for gurgling sounds before medication administration.</p> <p>Resident #4 was admitted to the facility on 6/30/14.</p> <p>A review of the Physician ' s Orders revealed an order dated 12/1/14 which stated " Lorazepam 0.5 milligram, take 1 tablet per tube three times a day. " The review revealed an order dated 12/1/14 which stated " Lyrica 50 milligram capsule, take 1 capsule per tube three times a day. "</p> <p>Nurse #2 was observed administering medication to resident #4 via a GT on 1/21/15 at 12:12 PM. Nurse #2 failed to verify tube placement with the insertion of a small amount of air into the tube with a syringe and listening to the stomach with a stethoscope for gurgling sounds before medication administration.</p>	F 322	<p>" A physician order was obtained to verify placement of Gtube prior to medication administration via auscultation for resident #4.</p> <p>" All residents receiving medication administration via Gtube has the potential to be affected by the practice.</p> <p>" A 100% audit of the MAR for the residents receiving medications via Gtubes was completed by the DON on 1/27/2015. Audit revealed no written orders to check placement of Gtube had been written.</p> <p>" Corrective action: All residents receiving medications via Gtube will have orders written according to Pharmacy Nursing policy and procedure to check for placement via auscultation prior to medication administration.</p> <p>" All licensed nurses, full time, part time, and PRN, will be in-serviced on verifying Gtube placement via auscultation by 2/27/2015. In-servicing will be completed by ADONs and the DON.</p> <p>" Skills check-off will be completed by all full time, part time and PRN licensed nurses by 2/27/2015. All newly hired nurses will be checked off for compliance by the Unit Managers.</p> <p>" DON will monitor auditing tool weekly thru 2/27/2015, then monthly for three months and report to the QA Committee.</p>		

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F 322	Continued From page 9 An interview was conducted with Nurse #2 on 1/21/15 at 12:26 PM. Nurse #2 stated the nursing staff was not expected to verify tube placement with the insertion of a small amount of air into the tube with a syringe and listening to the stomach with a stethoscope for gurgling sounds before medication administration. An interview with Administrative Staff #1 was conducted on 1/21/15 at 12:41 PM. She stated the nursing staff was expected to verify tube placement with the insertion of a small amount of air into the tube with a syringe and listening to the stomach with a stethoscope for gurgling sounds before medication administration.	F 322			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain a medication error rate of 5% or below by not flushing the gastrostomy tube (GT) with water before medication administration and between medications for one of one resident (resident #4) observed receiving medications via GT. The facility failed to administer the correct units of insulin as ordered by the physician for one of three residents (resident #9) observed receiving insulin injections. There were 3 errors of 25 opportunities for error resulting in a 12% error	F 332	A 100% audit of the MAR for the resident #4 was completed by the DON on 1/27/2015. Audit revealed no written orders to administer medication via Pharmacy Nursing policy and procedure were written. A physicians order was obtained for Resident #4 to administer medication via Gtube per Pharmacy Nursing Policy and Procedure which orders to Flush with 60mlsof water prior to medication administration, give each medication with 5ml of water separately,	2/28/15	

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F 332	<p>Continued From page 10 rate. The findings included:</p> <p>Example 1) A review of the Policy and Procedures for Medication Administration through Enteral Tubes dated 2007 was conducted. The policy stated the nurse was expected to flush the tube with at least 15 milliliters of water prior to medication administration.</p> <p>Resident #4 was admitted to the facility on 6/30/14.</p> <p>A review of the Physician ' s Orders revealed an order dated 12/1/14 which stated " Lorazepam 0.5 milligram, take 1 tablet per tube three times a day. " The review revealed an order dated 12/1/14 which stated " Lyrica 50 milligram capsule, take 1 capsule per tube three times a day. "</p> <p>Nurse #2 was observed administering medication to resident #4 via a GT on 1/21/15 at 12:12 PM. Nurse #2 failed to flush the GT with water prior to medication administration.</p> <p>An interview was conducted with Nurse #2 on 1/21/15 at 12:26 PM. Nurse #2 stated the nursing staff was expected to flush the GT with 60 milliliters of water before medication administration. She stated she forgot to flush the GT with 60 milliliters of water before medication administration.</p> <p>An interview was conducted with Administrative Staff #1 on 1/21/15 at 12:41 PM. She stated the nursing staff was expected to flush the GT with 60 milliliters of water before medication administration.</p>	F 332	<p>and flush with 5mls of water after each medication is given, and flush with 60mls of water after completing medication administration. Medication administration for Resident #4 will be observed on all 3 shifts to ensure all nursing staff is administering medication per Pharmacy Policy and Procedure. Observations will be completed by the Pharmacy Consultant, the Director of Nursing and the Assistant Directors of Nursing no later than February 28, 2015.</p> <p>All residents receiving medication via Gtube have the potential to be affected by the practice.</p> <p>Upon admission, a Physician order will be obtained for any resident receiving medication via Gtube per Pharmacy Nursing policy and procedure to Flush with 60mls of water prior to medication administration, give each medication with 5ml of water separately, and flush with 5mls of water after each medication is given, and flush with 60mls of water after completing medication administration.</p> <p>All licensed nurses, full time, part time, and PRN, will be in-serviced on medication administration via Gtube by 2/28/2015. In-servicing will be completed by Pharmacy Consultant, ADONs and the DON.</p> <p>Medication Administration Skills check-off will be completed by all current full time, part time and PRN licensed nurses by 2/28/2015 and will be completed by</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/22/2015
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F 332	<p>Continued From page 11</p> <p>Example 2) A review of the Policy and Procedures for Medication Administration through Enteral Tubes dated 2007 was conducted. The policy stated the enteral tubing was to be flushed with at least 5 milliliters of water between medication administrations.</p> <p>Resident #4 was admitted to the facility on 6/30/14.</p> <p>A review of the Physician ' s Orders revealed an order dated 12/1/14 which stated " Lorazepam 0.5 milligram, take 1 tablet per tube three times a day. " The review revealed an order dated 12/1/14 which stated " Lyrica 50 milligram capsule, take 1 capsule per tube three times a day. "</p> <p>Nurse #2 was observed administering medication to resident #4 via a GT on 1/21/15 at 12:12 PM. Nurse #2 failed to flush the GT with water between medication administrations.</p> <p>An interview was conducted with Nurse #2 on 1/21/15 at 12:26 PM. Nurse #2 stated the nursing staff was not expected to flush a GT with 5 milliliters of water between medication administrations.</p> <p>An interview was conducted with Administrative Staff #1 on 1/21/15 at 12:41 PM. She stated the nursing staff was expected to flush a GT with 5 milliliters of water between medication administrations.</p> <p>Example 3) Resident #9 was admitted to the facility on</p>	F 332	<p>Pharmacy Consultant, DON, and ADONs. Upon hire all Nurses will receive a Medication Administration Skills Check-off.</p> <p>DON will monitor auditing tool weekly thru 2/28/2015, then monthly for three months and report to the QA Committee for three months.</p> <p>Resident # 9 MAR was reviewed by ADON on 1/23/2015, and verified that proper dose of Insulin is being given." Insulin administration to Resident #9 was observed by ADON on 1/23/2015 and in her observation, the correct dosage was administered. Resident #9 has expired.</p> <p>All residents receiving insulin have the potential to be affected by the practice.</p> <p>A 100% audit of all residents receiving insulin was completed by ADONs on 1/28/15. Audit revealed correct doses have been given.</p> <p>All nursing staff, full time, part time, and PRN nurses will be in-serviced on proper Medication Administration which will include insulin administration and the five rights. In-servicing will be completed by 2/28/2015 and will be done by the DON and ADONs.</p> <p>Proficiency will be documented on a skills check off sheet. All current nurses will complete skills check off sheet by 2/28/2015. Proficiency will be completed by the DON and ADONs. Upon hire all</p>		

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F 332	<p>Continued From page 12 4/5/2011 with multiple diagnoses including diabetes mellitus.</p> <p>A review of the Physician ' s Orders revealed an order dated 12/22/14 which stated " Levemir 100 units per milliliter inject 15 units subcutaneous every morning. "</p> <p>Nurse #1 was observed to administer 13 units of Levemir subcutaneous to resident #9 on 1/22/15 at 7:50 AM.</p> <p>An interview was conducted with Nurse #1 on 1/22/15 at 8:25 AM. She stated she looked at the medication administration record prior to drawing up the insulin and believed the order stated to administer 13 units of Levemir. Nurse #1 stated she normally administers 15 units of Levemir to resident #9 daily.</p> <p>An interview was conducted with Administrative Staff #2 on 1/22/15. She stated the nursing staff was expected to verify the dose of insulin to be given by reviewing the medication administration record prior to administering to the residents.</p>	F 332	<p>Nurses will receive a Medication Administration Skills Check-off which will include insulin administration.</p> <p>ADONs will continue randomly observe insulin administration to two residents per week times 4 weeks and then bi-weekly times one month.</p> <p>Director of Nursing will monitor audit tools weekly for compliance thru 2/28/2015, then monthly for three months. This will be reported to and monitored by the QA committee for three months.</p>		