

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/06/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIHEALTH POST-ACUTE CARE-HIGH POINT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3830 N MAIN STREET HIGH POINT, NC 27265</b>		
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F 000	INITIAL COMMENTS	F 000			
F 159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of</p>	F 159		3/11/15	

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

TITLE

(X6) DATE

Electronically Signed

03/02/2015

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 159	<p>Continued From page 1</p> <p>resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, record review and staff interview, the facility failed to notify 3 of 58 sampled residents (Resident #11 #35 and, #65) and/or representative of resident trust funds exceeding the SSI (supplemental security income) resource limit of \$2,000.</p> <p>The findings included:</p> <p>Review of the Resident Trust Policy dated September 2009; read in part: under #7 the center shall notify each resident that receives Medicaid benefits when the amount in the resident ' s account reaches \$1,800.00. The resident could only have \$2,000.00 in personal funds in order to stay eligible for Medicaid.</p> <p>1 .Resident#11 was admitted to the facility on 8/2/13, review of trust fund account was</p>	F 159	<p>This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.</p> <p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>Residents #11, #35 and #65 have completed a list of each of their needs</p>		

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F 159	<p>Continued From page 2</p> <p>conducted on 2/5/14 at 4:00PM. The trust account revealed a balance of \$3,436.25. There was no documentation presented to indicate that Resident#11 and/or representative had been notified the account balance had exceeded the Medicaid resource limit of \$2,000.</p> <p>During an interview on 2/5/15 at 4:10PM, the cooperation consultant and administrator indicated the previous business office manager was removed from the position and further investigation would be conducted into the resident ' s trust accounts was in process for notification to residents and responsible person.</p> <p>During an interview on 2/6/15 at 8:17AM, administrative staff #3 and administrator indicated the financial counselor was responsible for ensuring that residents on Medicaid were notified when their monies were approaching the Medicaid limits of \$2,000. Administrative Staff #3 stated it was the responsibility of the financial counselor, SW and administrator to ensure the resident ' s money was spent down when the account balances approached or exceeded the designated amount.</p> <p>During an interview on 2/6/14 at 3:35PMAM, the social worker (SW) indicated the financial counselor was responsible for ensuring resident accounts did not exceed the Medicaid limits. The financial counselor would then inform SW of when monies needed to be spent for the resident. In addition, the SW did not have direct contact with the notification process of informing the resident and/or representative of the residents account balances approaching or exceeding the resource limits.</p>	F 159	<p>and the Social worker and/or Activities will go shopping for the residents to bring their accounts below \$2,000.00. Regional Financial Manager (RFM) or Counselor will also be verifying Resident #65's liability.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Regional Financial Manager reviewed all resident accounts to ensure accounts are current and below Supplemental Security Income (SSI) resource limit on 2/27/15. No other Residents were identified as being over the SSI resource limit.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>As of 2/25/14 a part-time financial counselor will monitor accounts and handle resident accounts until a full time financial counselor is hired. She was trained by the Regional Financial Counselor on 2/25/14.</p> <p>The facility has recruited a full time financial counselor with a hire date of 3/17/14 and upon hire will be trained by the regional financial counselor.</p> <p>A member of the Regional Financial team will also be in the facility three days week to handle resident accounts as well.</p>		

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F 159	<p>Continued From page 3</p> <p>2. Resident #35 was admitted to the facility on 8/1/05, review of trust fund account was conducted on 2/5/14 at 4:00PM. The trust account revealed a balance of \$2,458.46. There was no documentation presented to indicate that Resident#35 and/or representative had been notified the account balance had exceeded the Medicaid resource limit of \$2,000.</p> <p>During an interview on 2/5/15 at 4:10PM, the cooperation consultant and administrator indicated the previous business office manager was removed from the position and further investigation would be conducted into the resident ' s trust accounts was in process for notification to residents and responsible person.</p> <p>During an interview on 2/6/15 at 8:17AM, administrative staff #3 and administrator indicated the financial counselor was responsible for ensuring that residents on Medicaid were notified when their monies were approaching the Medicaid limits of \$2,000. Administrative Staff #3 stated it was the responsibility of the financial counselor, SW and administrator to ensure the resident ' s money was spent down when the account balances approached or exceeded the designated amount.</p> <p>During an interview on 2/6/14 at 3:35PMAM, the social worker (SW) indicated the financial counselor was responsible for ensuring resident accounts did not exceed the Medicaid limits. The financial counselor would then inform SW of when monies needed to be spent for the resident. In addition, the SW did not have direct contact with the notification process of informing the resident and/or representative of the residents account balances approaching or exceeding the resource limits.</p>	F 159	<p>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p> <p>Monitoring of the balance of the Resident accounts will occur weekly for four weeks by the Region Financial Counselor (RFC) then monthly for three months. Results of the monitoring with have tracking and trending will be given to the Administrator by the Region Financial Counselor (RFC) who will report these results to the Quality Assurance Committee for recommendations of improvement and or changes as needed to ensure compliance.</p>		

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F 159	<p>Continued From page 4</p> <p>3. Resident #65 was admitted to the facility on 8/29/14, review of trust fund account was conducted on 2/5/14 at 4:00PM. The trust account revealed a balance of \$2,166.11. There was no documentation presented to indicate that Resident#65 and/or representative had been notified the account balance had exceeded the Medicaid resource limit of \$2,000.</p> <p>During an interview on 2/5/15 at 4:10PM, the cooperation consultant and administrator indicated the previous business office manager was removed from the position and further investigation would be conducted into the resident ' s trust accounts was in process for notification to residents and responsible person.</p> <p>During an interview on 2/6/15 at 8:17AM, administrative staff #3 and administrator indicated the financial counselor was responsible for ensuring that residents on Medicaid were notified when their monies were approaching the Medicaid limits of \$2,000. Administrative Staff #3 stated it was the responsibility of the financial counselor, SW and administrator to ensure the resident ' s money was spent down when the account balances approached or exceeded the designated amount.</p> <p>During an interview on 2/6/14 at 3:35PMAM, the social worker (SW) indicated the financial counselor was responsible for ensuring resident accounts did not exceed the Medicaid limits. The financial counselor would then inform SW of when monies needed to be spent for the resident. In addition, the SW did not have direct contact with the notification process of informing the resident and/or representative of the residents</p>	F 159			

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F 159	Continued From page 5	F 159			
F 224 SS=J	<p>account balances approaching or exceeding the resource limits.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff, family, nurse practitioners and physician interviews, and record review, the facility failed to provide care and treatment to a resident who had a mental health diagnoses and had refused medications for medical conditions, mental health conditions and pressure ulcers. The facility did not actively pursue options to address the mental health issue and allowed the resident to continue to refuse medications and care/treatment of the pressure ulcers when his decision making was impaired for 1 of 4 sampled residents with pressure ulcers (Resident #3). The immediate jeopardy (IJ) started on 7/7/14 and was removed on 2/6/15 at 6:00PM when the facility provided an acceptable allegation of compliance. The facility remains out of compliance at a scope and severity of D, an isolated deficiency that constitutes no actual harm with potential for more than minimal harm due to on-going in-service training of staff and allowing time for the facility to implement the changes</p>	F 224	<p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>Resident #3 was involuntary committed and sent to Novant Health Forsyth Medical Center. The attending physician and the psych services was calling the hospital to give report and history of the resident. The facility sent to the hospital with EMS copies of the attending physician progress notes, wound care notes, medication administration records and psych notes.</p> <p>Upon return the guardianship will continued to be pursued. Guardianship paper was filed at the magistrate office on Feb 4, 2015.</p> <p>How will you identify other residents</p>	3/11/15	

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F 224	<p>Continued From page 6 through the Quality Assurance program. The findings included Resident #3 was admitted to the facility on 12/17/12. The diagnoses included schizophrenia, depressive disorder, esophageal reflux, anemia, diabetes, psychosis, mood instability, colostomy, adult failure to thrive, paraplegia and pressures ulcers stage III (left and right calf) and stage IV on bilateral buttocks.</p> <p>Review of the Medication Administration Record (MAR) from January 2014 to February 2015, revealed Resident #3 had medication orders for Levimir injections for diabetes that had started on 12/18/12 (not documented as given January 2014 - February 2015) and a Risperdal injection for schizophrenia was started on 1/7/14 and the last time it was documented it was given was 5/15/14 because the resident was refusing the medication.</p> <p>On 6/24/14, the consultant pharmacist informed the physician that Resident #3 continued to refuse medications from January 2014 - June 2014. The pharmacist suggested discontinuation of the following medications due to the resident's continued refusal of medications. Depakote used for seizures; aspirin; multivitamins with minerals; Senna, chlorophyll, Arginaid orange (a supplement for chronic wound healing), calcium D, iron medications and routine labs. The pharmacist recommended changing: Effexor to Prozac for depression; Baclofen to valium for spasticity. The physician agreed and signed off on the recommendations on 7/7/14. There was no documentation that showed the resident had been educated about the negative consequences of the discontinuation of the medications and treatment.</p>	F 224	<p>having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents are at risk</p> <p>Residents with a BIMS score higher then 9 (per the RAI manual) on the last completed MDS were interviewed by the Social Services/Licensed Nurses on 2/5/15 in regards to neglect issues identified will be reported to the Director of Health Services and/or the Administrator for further interventions.</p> <p>For resident with BIMs scores 9 and below compliance rounds are completed daily by assigned staff, including by not limited to Department heads, week-end nursing supervisor, week-end manager on duty, and administrative staff, compliance rounds are reviewed by the Administrator and the Administrator in Training. Items on the compliance rounds that are reviewed are the following items but not limited Resident care items (nails, dressing, and clean dried and toileted, odors, hydration) that have the potential to identify possible neglect.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>On 2/5/15 education for all staff began on the Abuse and neglect including dignity, education was completed by the Clinical Competency Coordinator. Any staff</p>		

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F 224	<p>Continued From page 7</p> <p>Pro-Stat liquid protein supplement was ordered on 7/20/14, but was not given due to resident refusal.</p> <p>The quarterly Minimum Data (MDS) dated 8/7/14 indicated the basic mental status interview indicated Resident #3 was moderately cognitively impaired. Resident #3 required total assistance with all activities of daily living excepting feeding. The pressure ulcer was documented as Stage III on left and right calves and Stage IV buttocks. The resident was coded as refusing treatment on the MDS. There was still no documentation that the resident had been counseled or educated as to the consequences of the refusal of medication or the treatment of the pressure ulcers.</p> <p>Review of the physician's progress note dated 9/29/14, revealed stage IV pressure ulcer, mood agitated, orientation confused and noncompliance with care and treatment. There was no change in treatment. There was no indication that the condition of the wound had been observed or assessed for treatment by the physician. There was no documentation that the physician had made any changes to the treatment of the pressure ulcers or to changes to the resident's medication. The 11/3/14 physician notes repeated the evaluation of the 9/29/14, with no inclusion of wound condition or treatment. There was no indication that the physician had explored any alternative treatment for the mental health diagnoses or the pressure ulcers.</p> <p>The annual MDS dated 11/6/14, indicated the resident would not participate in the assessment. The cognition care area assessment on 11/6/14 indicated Resident #3 was moderately impaired</p>	F 224	<p>member not receiving the in-service, due to PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work. Upon hire staff will be trained in abuse and neglect including dignity prior to working assigned shifts orientation will be completed by the Clinical Competency Coordinator.</p> <p>Education on compliance rounds, including signs of neglect and dignity, was completed on 2/6/15 for assigned staff on responsibilities, items to review and items that need to be reported to the Director of Health Services and/or the Administrator for immediate corrective action. Education was completed by Administrator in Training and Administrator.</p> <p>Compliance rounds will be completed daily by assigned team members including but not limited to department managers and staff from each department. Administrator will track and trend the results from the compliance and will present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>Social Worker/Week-end Licensed Nurse/ Week-end Manager on Duty will interview 7 residents per week in regards to neglect any identified issues with be handled immediately by the person completing the</p>		



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F 224	<p>Continued From page 8</p> <p>with poor decision-making, behaviors come and go, changes in severity. Resident #3 made his own daily care decision but made poor decisions. Admitted with huge pressure ulcers and history of noncompliance with care. The urinary care area assessment included Resident #3 had a urostomy and colostomy and required total care with activities of daily living due to multiple wounds some severe. Nutrition was unassessed due to weight refusals and refusal of supplements that promote wound healing and labs. Pressure ulcer care assessment included multiple wounds, some severe, that covered the entire buttocks, stage IV and stage III on right and left calves.</p> <p>The care plan dated 11/6/14 identified problem as: 1. noncompliance (refusal of medications, lab work, activities of daily living, weights, wound care, turn and repositioning and adherence to diet). The goal included compliance with nursing staff at least once a day. The approaches included involve Resident #3 in planning ways to comply, help resident set goals for compliance, psychiatric referral as needed. 2. Chronic pressure ulcers, impaired cognition and required assistance with activities of daily living. The goal included resident would have no pressure ulcers, wounds would decrease in size and heal through next review. The approaches included monitor for incontinence episodes, keep clean and dry as much as possible, provide ostomy care every shift, weekly skin assessments, turn and reposition, pressure reduce ion mattress and cushion. 3. Behaviors included refusal of care, verbally and physically abusive at times and refusal of medications. The goal included resident would cause no harm to self or others through next review. The approaches included psychiatric services as needed, explain procedures before</p>	F 224	<p>interview. The interviews will be completed weekly x 4 weeks, then twice a month x 1, and then monthly x 3 months or until compliance is sustained.</p> <p>Social worker will track and trend the results from the interviews and corrected action if needs and will present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p> <p>Quality Assurance Performance Improvement Committee met on Feb 5, 2015 to discuss F 224 citation at the IJ level during current survey. Team discussed Credible Allegation submitted to progress of audit tools and education.</p> <p>Compliance rounds will be completed daily by assigned team members including but not limited to department managers and staff from each department. Administrator will track and trend the results from the compliance and will present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance</p>		

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F 224	<p>Continued From page 9 attempting them, give the resident alternatives to express feelings and provide reassurance.</p> <p>On 11/17/14 the physician's progress note had no change in the assessment or indication of wound condition or treatment changes. There was no documentation presented that Resident #3 had been referred to a wound care center or any other mental health center.</p> <p>Review of psychiatric progress notes from 12/2/14 and 1/21/15, revealed history of depression, mood instability, psychosis, noncompliance with care, medications and treatment. Recommendations was to continue current treatment plan. Monitor for changes in mood or behaviors.</p> <p>Review of wound documentation note dated 12/3/14, revealed that right and left calf stage III pressure ulcer was meeting the care plan goals as evidence by no change to measurements. Review of the wound treatment on 12/13/14 and 12/30/14 showed no changes to the pressure ulcers on the calves. The nurse indicated Resident #3 was given an update of wound status, there was no documentation of what information of the wound was provided.</p> <p>Review of the wound documentation noted dated 12/16/14, revealed a decline noted to stage IV sacral wound. Bone visible and palpable in wound bed. Resident continued to be noncompliant and refused care and treatment of the pressure ulcers. There was no intervention by the facility documented. The nurse practitioner was notified and there were no new orders. The nurse indicated Resident #3 was given an update of wound status, there was no documentation of</p>	F 224	<p>is sustained.</p> <p>Social worker will track and trend the results from the interviews and corrected action if needs and will present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p>		

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/06/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIHEALTH POST-ACUTE CARE-HIGH POINT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3830 N MAIN STREET HIGH POINT, NC 27265</b>		
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F 224	<p>Continued From page 10 what information of the wound was provided.</p> <p>A wound documentation noted dated 12/29/14, revealed that resident was covered in bowel movement, no colostomy bag on stoma, stool all over resident ' s hands, blanket, radio, bed and bed control, stool puddle on resident's left side, saturating the dressing. The resident was eating crackers with stool on his hands. The room had foul odor. The resident demanded that nurse only replace the colostomy bag. The nurse talked the resident into dressing changes, noted no changes to wounds appearance and wrote, "Continue with current intervention. There was no documentation indicating resident's noncompliance or new interventions done by the facility. The nurse indicated Resident #3 was given an update of wound status, there was no documentation of what information of the wound was provided.</p> <p>Review of wound documentation note dated 1/6/15 revealed, left calf decline due to refusals area measures 13cm x 5cmw (centimeter wide) x 0.5cm depth. Mixed tissues to wound bed. Resident #3 had no interest in wound care, morning care or colostomy care. Continue with interventions as resident allows. There was no documentation that the facility tried or attempted other interventions to educate the resident as to the continued refusal of care, nor was there documentation that the resident was being referred for behavioral interventions for continued refusal to take his medications or have consistent treatment for his pressure ulcers.</p> <p>The 1/9/15 comprehensive metabolic panel (CMP) including a complete blood count (CBC) documented the following lab results were below normal limits: albumin less than 2.0(3.5-5.2) low,</p>	F 224			

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F 224	<p>Continued From page 11</p> <p>calcium 7.4(8.4-10.5) low, creatinine 0.30(0.50-1.35) low. Other labs were either at normal limits or near normal including glucose 66, sodium 134, potassium 3.5, and chloride 103. The complete blood count (CBC) test was not performed.</p> <p>Review of lab dated 1/14/15, revealed completed blood count (CBC), comprehensive metabolic panel (CMP): red blood count= 3.50(4.22-5.81) low, platelet 758(150-400) high, creatinine 0.32(0.50-1.35) low, calcium 7.3(8.4-10.5) low, albumin less than 2.0(3.5-5.2) low, hematocrit 21.3( 39.0-52.0) low, hemoglobin 5.4(13.0-17) low: resident refused blood transfusion.</p> <p>Review of wound documentation noted dated 1/14/15 revealed pressure to the bilateral buttock. It measured 43x33x0. The wound had tunneling and undermining present. The wound bed had granulation and non-granulation slough tissue with extremely heavy, serosanguineous, purulent, odorous drainage. "The wound continued to get worse. Resident often refused to have treatment done. Resident currently is not taking any meds and refuses to be treated for anything that could potentially help with healing. ...Self: resident does nothing to help himself. He continues to lie in feces and urine for days at a time refusing any type of care. Often cussing and being mean to staff. Wound rapidly declining and spreading to middle of back. Will continue to treatment as resident would allow."</p> <p>During an interview on 2/4/15 at 3:30PM, the physician discussed the most recent labs dated 1/14/15 in reference to the low hemoglobin of 5.4 which would make a person unresponsive. He further stated that he hoped with the low</p>	F 224			

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F 224	<p>Continued From page 12</p> <p>hemoglobin Resident #3 would deteriorate so that he would become unresponsive and then his care needs would be taken care of the proper way. Review of pressure wound conditions:</p> <p>Right Calf 12/02/14            11.5x2.1x0 cm 02/02/15            42 x7x 0.5 cm</p> <p>Left Calf 12/02/14            4.5x2x0.1 cm 01/14/15            19x7x0.5 cm</p> <p>BILATERAL BUTTOCKS 12/02/14            42x27x0 cm 02/02/15            50x53x0 cm</p> <p>During an interview on 2/4/15 at 9:55AM, the social worker (SW) indicated she had met with the family on 1/16/15 to discuss Resident #3's refusals for activities of daily care and medications. She indicated that she contacted the psychiatric services for an evaluation to determine Resident #3's mental status and since the resident had the right to refuse, the facility could not make the resident accept care or medication. She had no response of why the resident was not assessed for involuntary commitment due to behaviors and the need for aggressive wound care. She indicated that she attempted to obtain guardianship status from a family member who indicated that she had guardianship papers. The SW further stated the first step was to obtain the psychiatric evaluation to determine the what next approach would be since no one could get the resident to accept medication or treatment. She did not know what else to do since the magistrate told her unless he was a danger to self or others he would not be declared incompetent and had the right to make poor healthcare decisions. The SW noted dated 1/16/15 included a</p>	F 224			

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F 224	Continued From page 13 discussion was held with the resident's family. The family indicated their main concerns were the poor care of the resident's wound and the cleanliness of Resident #3 and why had the facility not provided proper care for a person who was unable to make informed decisions about his care. The SW note also specified that the guardianship paperwork was filed on 2/5/15. Review of the psychiatric consultant on 1/21/15 the assessment did not include any attempt to try another antidepressant drug. There was also no indication that the resident had been referred for any other mental health services nor were there any documentation that showed the resident was provided education or information for the negative impact of refusal of medications or treatment. During an interview on 2/5/15 at 10:59AM, psychiatric nurse practitioner (PNP) indicated that she had been following Resident #3's mental health care for the past year. She stated that she felt Resident #3 was not a danger to himself or others and was alert and oriented enough to answer questions regarding his basic care needs. She indicated that he had not exhibited any psychotic events that would indicate he needed inpatient treatment. The PNP further stated that Resident #3 would not have been accepted on a psychiatric unit due to his history of noncompliance and refusal of medication and condition of the wound. In addition, several attempts to medicate Resident #3 on psychotropic medications from June 2014 to most recent 1/21/15 were unsuccessful. Resident #3 did not meet the criteria for inpatient treatment due to his ability to answer basic health care questions correctly and was not actively a danger to himself. The PNP stated Resident #3 had the right to refuse care/treatment and medications. In her opinion Resident #3 was in no danger to	F 224			

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F 224	<p>Continued From page 14</p> <p>himself. Resident #3's evaluations on 12/2/14 and 1/21/15 were confirmed by the PNP that Resident #3 had impaired cognition, anxious mood, poor concentration, poor short and long term memory, poor insight and judgment. In addition, the PNP indicated the physician would be the person to make the final decision regarding the extent of care/treatment needed for the pressure ulcer and the need for involuntary commitment. The PNP further stated she felt the extent of services and medication attempts had been made for Resident #3 and since Resident #3 had not met the criteria for placement based on her evaluation he was alert/oriented enough to refuse care. When asked whether Resident #3 had cognition and decision making skills to understand the need for extensive care and treatment for his pressure ulcer, the response was the physician would have to make the decision on healthcare. She only evaluated his ability to refuse care and treatment or medications at which time the recommendation was to start Zyprexa on 1/21/15.</p> <p>During an initial tour on 2/2/15 at 9:30AM, Resident #3 was lying in bed with the covers over his head. There was strong urine/fecal/body odor in room. The colostomy bag was full. Resident #3 indicated that he did not want anyone to bother him and he was not going to take any medications because he didn't want to. He added that he was not getting out of bed and wanted to stay in room all day.</p> <p>During an observation on 2/4/15 at 8:30 AM, the surveyor was in the room and attempted to speak with resident who had a strong, foul odor on his person and in the room. He was verbally abusive (swearing, cursing and refusing care) toward anyone who entered the room. Resident #3 had a</p>	F 224			

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F 224	<p>Continued From page 15</p> <p>urostomy and colostomy. A large decubitus on the sacrum area that was exposed once the bedroom door was opened. The area had black tissue around the edges and raw tissue surrounding the base of the buttocks. The odor was very strong and foul. The director of nursing was asked to enter the room to assist Resident #3. She attempted to ask Resident #3 what he needed. She exited the room and asked for nursing assistant care from NA#2. Resident #3 refused care from NA#2. The nursing assistant indicated he refused care and he had the right per nursing to refuse care and Resident #3 would be offered care again later.</p> <p>The wound documentation note dated 2/2/15, resident allowed dressing to be changed for first time on 1/25/15 noted decline with increase in measurement. Stage IV pressure ulcer to bilateral buttocks measured 50x53x0 due to slough in wound bed. Mixed tissues noted in wound bed. 10% slough 10% purple ischemic tissue 0% non-granulation 60% granulation heavy serosanguineous drainage. Resident #3 refuses meds double meats ordered to promote wound healing resident continues to refused ostomy care, turn and reposition , meds wound care. Re-educated on importance of compliance in relation to wound healing resident refused to acknowledge this nurse. Continue with interventions as resident allows. Resident updated on decline. Stage III to left calf was unstageable due to 50% slough coverage and 50% non-granulation area had declined and measurements 21 cml x 7cm x 0 cm depth. Resident updated on decline to wound. Resident continued to be noncompliant and refused dressing changes. The interventions was to continue with treatment as resident allows.</p>	F 224			



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F 224	Continued From page 16  During an interview on 2/4/15 at 8:42AM, Nurse#1 indicated the resident had a bath two days ago when his dressing for pressure ulcer to sacral area was cleaned. He indicated that the resident was verbally abusive and refused all care and medications. Nurse#1 indicated that when the resident would refuse care and treatment, attempts would be made to reoffer but if he refused he was not provided the care or treatment until he accepted.  During an interview on 2/4/15 at 8:58AM, Nurse #6 indicated that the resident had the right to refuse care and when he did not want his wounds checked or changed she did not force him. She indicated that Resident #3 was combative with all treatment and care in addition to refusals of medications. She added that she provided wound care when Resident #3 would allow. She did her measurements and basic treatment as ordered. She added that Resident #3 would have bowel movements in the wound site and she would clean the area the best she could. Resident #3 refused supplements that would promote wound healing. Nurse #9 indicated the wound care center would not accept the resident due to noncompliance. She added that the physicians and nurse practitioner were aware of the condition of the wound and had not ordered any new or aggressive treatment. The current wound treatment was for maintenance of the wound. Resident #3 refused and had a right to refuse therefore nothing else would be done until Resident #3 allowed staff to provide care. Nurse#9 confirmed the wounds continued to get worse and there was a strong odor present in the wound of dying tissues.	F 224			

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F 224	Continued From page 17  During an interview on 2/4/15 at 9:05AM, the DON, indicated Resident #3 continued to refuse all medications, labs, treatment and care, so she reported the concern to the social worker in an attempt to get guardianship. She added that she and the social worker had a discussion with the local magistrate on 1/16/15 in an attempt to declare incompetency or guardianship. The DON reported a conversation on 1/16/15 was also held with the family member who indicated that she had guardianship papers. The relative refused to discuss change of guardianship and hung up. When asked about involuntary commitment, the response was the magistrate stated unless the resident was declared incompetent and was a danger to self and others he had a right to refuse care and treatment even though he was making poor decisions regarding his overall care. The DON indicated the resident would only allow basic care needs to be met. The DON stated that Resident #3 was seen by psychiatric services on 1/21/15 and the recommendation was to start the Zyprexa.  During an interview on 2/4/15 at 9:30AM, the NP indicated that she did the referral to psychiatric services for evaluation due to Resident #3's refusal of all medications, labs and care. She indicated a discussion had been held with the treatment team and the primary physicians regarding involuntary commitment for further evaluation and aggressive wound care treatment, but since Resident #3 was able to answer the questions appropriately through the psychiatric evaluation there was nothing more that could be done since he could not be declared incompetent based on his current mental status and ability to answer questions appropriately about his care.	F 224			

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F 224	<p>Continued From page 18</p> <p>She confirmed that the wounds continued to decline and Resident #3 was literally rotting from the inside/out. In addition, with the refusal of labs and care there was nothing much more could be done unless Resident #3 allowed for proper care to be performed. The NP added that she had seen the wound a few times but the primary physicians was overseeing the orders and treatments with the nursing staff.</p> <p>During an interview on 2/4/15 at 11:25AM to 12:09PM, the family member indicated that she felt Resident #3 was unable to make decisions on his own about his care and medical condition. She indicated the facility was responsible for ensuring that he received his medication and proper care to his wound. She indicated that the resident did have periods of confusion at time and felt it was the facility's responsibility to ensure the resident's wounds were properly cleaned and cared for and not getting worse. The family member indicated if Resident #3's mental status was taken care of he would accept the proper care. She believed that psychiatric services did not assess Resident #3's mental needs thoroughly. The family indicated if Resident #3 didn't have any medication in his system to take care of his mental issues, he would not be mentally stable to make decisions about his general health care. The family indicated the facility staff continued to call and say Resident #3 was refusing all care, treatments and medications. Part of the problem was his mental problems and until that was taken care of the wound would not be taken care of properly or healed. The family indicated Resident #3 had real body odors because staff had not been bathing Resident #3 regularly.</p>	F 224			

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F 224	<p>Continued From page 19</p> <p>During an interview on 2/4/15 at 2:15PM, NA #2 indicated that Resident #3 had been verbally and physically aggressive toward staff when care was attempted to be provided. Resident #3 would curse and tell staff to get the hell out of the room, would refuse to have colostomy bag changed, baths etc. He tells staff when he wants these things done. The last bath was on 2/2/15. NA#2 indicated that on occasion there would be fluid oozing from the wound to the buttocks and they would have a very bad odor. "We were by told by nursing if the resident refused just to come back and try later." NA#2 indicated that he may go several days before he would let staff bathe him or do any kind of care. "We don't know what else to do for him our hands are tied." NA#3 indicated Resident #3 ate well and in the past few months the behaviors have gotten worse and the resident wanted to stay in room more with covers over his head and the odors from the wounds have been worst. She added that he would allow her on occasion to bathe him but it was on his terms. The wound on the buttocks/calf area had gotten worse. "We do what we can when we are allowed by the resident."</p> <p>During a follow-up interview on 2/4/15 at 2:30PM, Nurse#6 indicated that the wound doctor did not make regular rounds with her when she did wound care. She added that she had made the NP and physician 's aware of the resident's refusal of care and the increased size of the wounds, refusal of supplements, care and treatment. Resident #3 had been referred to wound care center and the wound care center refused to treat resident due to noncompliance. She further stated that she had been documenting the changes and the increase in the</p>	F 224			

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F 224	<p>Continued From page 20</p> <p>wound size, but there had been no real or different changes to the treatment. Resident #3 received santyl, an absorbent dressing for maintenance of the wound. Resident #3 was not on any medications. She reported that she had discussed with the team last week about the conditions of the wounds on the buttocks and legs and no final decision had been made. She added that she was uncertain of when the physician directly looked at the wound. She indicated Nurse#9 would look and check after her treatments.</p> <p>During an interview on 2/4/15 at 3:30PM, the physician indicated that he felt Resident #3 was alert and oriented enough to make decisions about his care even though in his medical opinion the decisions were poor and contraindicated to the care he really needed for the wound and anemia. The physician indicated that the pressure wounds had worsened and essentially were decaying/rotting and the resident needed intensive medical treatment. Resident #3 continued refusals of all treatment, care, labs, hospitalizations impacted on the quality of care he would receive. The physician indicated that he discussed all the risk and health factors with Resident #3 and Resident #3 demonstrated understanding of his decisions not to have proper care. The physician also stated that since Resident #3 indicated that the pressure ulcer didn't bother him he could not force treatment on the resident because he had the right to refuse. The physician also indicated that during the past two weeks staff had made him aware of the mental status changes in Resident #3.</p> <p>Resident #3 was referred for psychiatric</p>	F 224			

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NAME OF PROVIDER OR SUPPLIER  <b>UNIHEALTH POST-ACUTE CARE-HIGH POINT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3830 N MAIN STREET HIGH POINT, NC 27265</b>		
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F 224	<p>Continued From page 21</p> <p>evaluation. The physician indicated that he accepted that Resident #3 made poor/bad decision after he had explained all the risks factors associated with poor and lack of care. The physician indicated that nursing staff had reported the condition of the pressure ulcer had worsened, but he had not directly looked at the wound himself in about 3 months. "I can give recommendations for care and treatment and Resident #3 would refuse. I had been discussing blood transfusion with Resident #3 and he refused treatment.</p> <p>The physician indicated that medications were stopped because of the resident's refusal. If Resident #3 refused medication, then it doesn't make sense to keep asking. If Resident #3 refused for a month it made sense to stop medications all together. If Resident #3 refused wound care then there was nothing he could do about if resident continued to refuse. " The physician indicated the team talked about involuntary committing Resident #3 a while back, but the magistrate stated that if the resident was alert and oriented he could not be involuntarily commented because he had the right to refuse care and make bad decisions about his care. The physician also stated that if the resident was committed involuntarily they would get him medically stable (wounds) and they would send him back and after a month. Resident #3 would return to the behaviors of refusals. The physician was asked his expectation of the time frame of wound care treatment when stool was observed in the wound to prevent infections. The response was for staff to provide care/treatment to the area immediately, but if Resident #3 was going to continue to refuse care, staff would wait until resident became compliant as to when an how</p>	F 224			

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F 224	<p>Continued From page 22</p> <p>long the stool would remain in wound. He further stated he had no recommendation for the wound care treatment. The most recent labs dated 1/14/15 were discussed and in reference to the low hemoglobin of 5.4 which would make a person unresponsive. Based on what he saw today (2/4/15) during the visit with Resident #3 this was his normal behavior. Resident #3 answered all the questions appropriately to basic concern of pain, where he was hurting. Resident #3 did not answer in an aggressive manner, or with anger, if you try to do things he refused and would hit staff. The physician indicated the resident reported he was fine as long as he ate, slept and smoked cigarettes. He further stated he felt the resident would not change his opinion care. Psychiatry was attempting to restart Zyprexa to see what would happen. The physician did not feel that the Zyprexa medication would change the condition. He added that he was leaving the behavioral and mental status evaluation to the specialty of psychiatric services. All he can do was encourage the resident.</p> <p>During an observation on 2/5/15 at 7:25 AM, in Resident #3's room Nurse#6 noted a strong urine odor. Resident #3 pulled down the blanket from his head, and prior to hearing any questions, stated " I do not know anything." The nurse asked the resident if she can check his wounds, help him to clean his body or reposition in bed. His answers on all questions were " No." Resident #3 was asked when the last time he had a bed bath was and he said "I do not know." Do you have any wounds? The response was " No, I do not " Do you need some help to go to the bathroom? The response was " No, I go myself " When did you eat last time? The response was "I do not know." Do you receive any medications?</p>	F 224			

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F 224	Continued From page 23 Resident #3 response was " I do not know " Do you feel comfortable in bed? Response was "I do not know." Would you like to get out of bed? Resident #3 response was "I do not know. " At this point Nurse#6 asked Resident #6 when he would like to have a next wound check, the answer was "I do not know. " During an interview on 2/5/15 at 11:30AM, NA#6 indicated that several attempts to care for Resident #3 on different shifts were made but resident would refuse care. Nursing told the nursing assistants when Resident #3 refused just to document because it and it was his right to refuse. NA#6 indicated that Resident #3 was verbally abusive and not always pleasant and would get agitated and would say leave him alone. Care was not provided when Resident #3 refused. During an interview on 2/6/15 at 8:15AM, administrative staff #3 and administrator were present. Administrative staff #3 indicated when a resident refused medications, care and treatment, which an individual had the right to refuse medication and care, staff should provide education and documentation to support the understanding of what type of care and treatment a resident was refusing. If there was concerns or questions about their ability to understand the care/treatment, psychiatric services should become involved. Nursing should be able to assess and determine when refusal of care occurs whether a resident was able to understand the critical care needs and risk factors associated with delayed or lack of care and the impact on their lives,. The physician and RP (responsible person) should become involved in the decision making process about the overall care to be provided. The SW should be involved in working with family and resident in making referrals when	F 224			



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F 224	<p>Continued From page 24</p> <p>necessary to other outside services. Administrative staff #3 indicated the expectation included the wound care nurse informing the treatment nurse supervisor, administrator and the physician of the decline in condition of the pressure ulcer. The physician would observe the pressure ulcer and make treatment recommendations and changes when there was no change or improvement of the pressure ulcer.</p> <p>The facility was notified on 2/5/15 at 8:25AM of the immediate jeopardy. The facility provided a credible allegation on 2/6/15 as follows: The credible allegation documented the following: What corrective action will be accomplished for those residents having potential to be affected by the same deficient practice? Resident # 3 was involuntary committed and sent to Medical Center. The attending physician and the psych services was calling the hospital to give report and history of the resident. The facility sent to the resident to the hospital with EMS and copies of the attending physician progress notes, wound care notes, medication administration records and psych notes. Upon return the guardianship will continued to be pursued. Guardianship paper was filed at the magistrate office on Feb 4, 2015. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place:</p> <ul style="list-style-type: none"> <li>· All residents are at risk</li> <li>· Residents with a BIMS score higher then 9 (per the RAI manual) on the last completed MDS were interviewed by the Social Services/Licensed Nurses on 2/5/15 in regards to neglect issues identified will be reported to the Director of Health</li> </ul>	F 224			

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F 224	<p>Continued From page 25</p> <p>Services and/or the Administrator for further interventions.</p> <p>For resident with BIMs scores 9 and below compliance rounds are completed daily by assigned staff, including by not limited to Department heads, week-end nursing supervisor, week-end manager on duty, and administrative staff, compliance rounds are reviewed by the Administrator and the Administrator in Training. Items on the compliance rounds that are reviewed are the following items but not limited Resident care items (nails, dressing, and clean dried and toileted, odors, hydration) that have the potential to identify possible neglect.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <ul style="list-style-type: none"> <li>On 2/5/15 education for all staff began on the Abuse and neglect including dignity education completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</li> </ul> <p>Compliance rounds will be completed daily by assigned team members including but not limited department managers and staff from each department. Education with staff was completed on 2/6/15 on responsibilities, items to review and items that need to be reported to the Director of health Services and/or the Administrator for immediate corrective action. Education was completed by Administrator in Training and Administration.</p> <p>On 2/6/14 at 3:30PM, staff were interviewed on the expectation of the reporting process, documentation and notification to nursing, social work, physician and administrative staff of residents that refuse care, treatment and</p>	F 224			

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F 224	Continued From page 26 medications. The daily rounds and 24 hour report, skin assessments forms were reviewed. Staff were able to describe the expectations for resident refusal of care, treatment and medications as they had received an in-service on 2/5/15 and 2/6/15. The administrative staff were able to describe the expectation for implementing care and treatment for residents that had 2 consecutive refusals of care, treatment and medications. The social worker indicated the expectation for referrals to outside agencies for additional services.	F 224			
F 241 SS=J	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, staff and family interviews and record reviews, the facility failed to provide personal hygiene for a residents who had a mental health diagnoses and was moderately cognitively impaired who had body odors for 1 of 3 sampled residents that needed assistance with personal hygiene (Resident #3). Immediate Jeopardy (IJ) began on 2/2/15 due to foul odors. The facility remains out of compliance at a scope and severity of D; isolated deficiency that constitutes no actual harm with potential for more than minimal harm; due to on-going in-service training of staff and allowing time for the facility to implement the changes through the Quality Assurance program.	F 241	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?  Resident # 3 was involuntary committed and sent to Novant Health Forsyth Medical Center. The attending physician and the psych services was calling the hospital to give report and history of the resident. The facility sent to the hospital with EMS copies of the attending physician progress notes, wound care notes, medication administration records and psych notes.	3/11/15	

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F 241	<p>Continued From page 27</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on 12/17/12. The diagnoses included schizophrenia, depressive disorder, esophageal reflux, anemia, diabetes, psychosis, mood instability, colostomy, adult failure to thrive, paraplegia and pressures ulcers stage III (left and right calf) and stage IV on bilateral buttocks. The annual Minimum Data Set (MDS) dated 11/6/14, indicated resident would not participate in the assessment. The quarterly MDS dated 8/7/14 indicated the basic mental status interview was coded as moderately cognitively impaired. Resident #3 required total assistance with all activities of living except feeding.</p> <p>During an initial tour on 2/2/15 at 9:30AM, Resident #3 was lying in bed with covers over his head. There was strong urine/fecal/body odor in room. The colostomy bag was full. Resident #3 indicated that he did not want anyone to bother him and he was not going to take any medications because he didn ' t want to. He added that he was not getting out of bed and wanted to stay in room all day.</p> <p>During an observation on 2/4/15 at 8:30 AM, the surveyor was in room and attempted to speak with resident who had a strong, foul odor on his person and in the room. He was verbally abusive (swearing, cursing and refusing care) toward anyone who entered the room. Resident#3 had a urostomy and colostomy. A large decubitus on the sacrum area was exposed once the bedroom door was opened. The area had black tissue around the edges and raw tissue surrounding the base of the buttocks. The odor was very strong and foul. The director of nursing was asked to</p>	F 241	<p>Upon return the guardianship will continued to be pursued. Guardianship paper was filed at the magistrate office on Feb 4, 2015.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected</p> <p>Residents with a BIMS score higher than 9 (per the RAI manual) recorded on the last completed MDS were interviewed by the Social Services/licensed nurses on 2/5/15 in regards to Dignity any resident with dignity issues identified will be reported to the Director of Health Services and/or the Administrator for further interventions.</p> <p>For resident with BIMs scores 9 and below compliance rounds are completed daily by assigned staff, including by not limited to Department heads, week-end nursing supervisor, week-end manager on duty, and administrative staff, compliance rounds are reviewed by the Administrator and the Administrator in Training. Items on the compliance rounds that are reviewed are the following items but not limited Resident care items (nails, dressing, and clean dried and toileted, odor, hydration) that have the potential to identify possible neglect. What measures will be put in place or</p>		

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F 241	<p>Continued From page 28</p> <p>enter the room to assist Resident #3. She attempted to ask Resident #3 what he needed. She exited the room and asked for nursing assistant care from NA#2. Resident #3 refused care from NA#2. The nursing assistant indicated he refused care and he had the right per nursing to refuse care and Resident #3 would be offered care again later.</p> <p>During an interview on 2/4/15 at 8:42AM, Nurse#1 indicated the resident had a bath two days ago when his dressing for pressure ulcer to sacral area was cleaned. He indicated that the resident was verbally abusive and refused all care and medications. Nurse#1 indicated that when the resident would refuse care and treatment, attempts would be made to reoffer but if he refused he was not provided the care or treatment until he accepted.</p> <p>During an interview on 2/4/15 at 11:25AM to 12:09PM, the family member indicated that she felt Resident #3 was unable to make decisions on his own about his care and medical condition. She indicated the facility was responsible for ensuring that he received his medication and proper care to his wound. She indicated that the resident did have periods of confusion at time and the family felt it was the facility ' s responsibility to ensure the resident ' s wounds were properly cleaned and cared for and not getting worse. The family member indicated if Resident#3 ' s mental status was taken care of he would accept the proper care. She believed that psychiatric services did not assess Resident#3 ' s mental needs thoroughly. The family indicated if Rresident#3 didn ' t have any medication in his system to take care of his mental issues, he</p>	F 241	<p>what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>On 2/5/15 education for all staff began on the Abuse and neglect including dignity, education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due to PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work. Upon hire staff will be trained in abuse and neglect including dignity prior to working assigned shifts orientation will be completed by the Clinical Competency Coordinator.</p> <p>Education on compliance rounds, including signs of neglect and dignity, was completed on 2/6/15 for assigned staff on responsibilities, items to review and items that need to be reported to the Director of Health Services and/or the Administrator for immediate corrective action. Education was completed by Administrator in Training and Administrator.</p> <p>Compliance rounds will be completed daily by assigned team members including but not limited to department managers and staff from each department. Administrator will track and trend the results from the compliance and will present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change</p>		

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F 241	<p>Continued From page 29</p> <p>would not be mentally stable to make decisions about his general health care. The family stated the facility staff continued to call and say Resident#3 was refusing all care and treatments and medications. The family indicated part of the problem was his mental problems and until that was taken care of the wound would not be taken care of properly or healed. The family stated Resident #3 had real body odors because staff had not been bathing Resident#3 regularly.</p> <p>During an observation on 2/4/15 at 12:50 PM, Nurse#6 and physician attempted to see the wound of Resident #3 in his room. There was a strong urine and feces odor in the room. The resident was covered by blanket over his head and answered all the questions as " I do not want anything, I am fine for now. " The nurse and physician asked the resident several times to observe his wound, provide care and treatment and to take his medication. The resident ' s voice became stronger in tone as he refused. At this point the nurse and physician left the resident ' s room.</p> <p>During an interview on 2/4/15 at 2:15PM, NA #2 indicated that Resident#3 had been verbally and physically aggressive toward staff when care was attempted to be provided. Resident#3 would curse and tell staff to get the hell out of the room, would refuse to have colostomy bag changed, baths etc. He tells staff when he wants these things done. The last bath was on 2/2/15. NA#2 indicated that on occasion there would be fluid oozing from the wound to the buttocks and they would have a very bad odor. " We were by told by nursing if the resident refused just to come back and try later. " NA#2 indicated that he may go several days before he would let staff bathe him or do any kind of care. " We don ' t know</p>	F 241	<p>bi-monthly x 6 month or until compliance is sustained.</p> <p>Social Worker/Week-end Licensed Nurse/ Week-end Manager on Duty will interview 7 residents per week in regards to dignity any identified issues with be handled immediately by the person completing the interview. The interviews will be completed weekly x 4 weeks, then twice a month x 1, and then monthly x 3 months or until compliance is sustained.</p> <p>Social worker will track and trend the results from the interviews and corrected action if needs and will present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p> <p>Quality Assurance Performance Improvement Committee met on Feb 5, 2015 to discuss F 241 citation at the IJ level during current survey. Team discussed Credible Allegation submitted to progress of audit tools and education.</p> <p>Compliance rounds will be completed daily by assigned team members including but not limited to department</p>		

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F 241	<p>Continued From page 30</p> <p>what else to do for him our hands are tied. " NA#3 indicated Resident#3 ate well and in the past few months the behaviors have gotten worse and the resident wanted to stay in room more with covers over his head and the odors from the wounds had been worst. She added that he would allow her on occasion to bathe him but it was on his terms. The wound on the buttocks/calf area had gotten worse. " We do what we can when we are allowed by the resident. "</p> <p>During an observation on 2/5/15 at 7:25 AM, Resident #3 ' s room Nurse#6 noted a strong urine odor. Resident#3 pulled down the blanket from his head, and prior to hearing any questions, stated " I do not know anything. " The nurse asked the resident if she can check his wounds, help him to clean his body or reposition in bed. His answers on all questions were " No. " Resident #3 was asked when was the last time he had a bed bath and he said " I do not know. " Do you have any wounds? The response was " No, I do not " Do you need some help to go to the bathroom? The response was " No, I go myself " When did you eat last time? The response was " I do not know " . Do you receive any medications? Resident#3 response was " I do not know " Do you feel comfortable in bed? Response was " I do not know. " Would you like to get out of bed? Resident #3 response was " I do not know. " At this point Nurse#6 asked Resident #6 when he would like to have a next wound check, the answer was " I do not know. " During an interview on 2/5/15 at 11:30AM, NA#6 indicated that several attempts to care for Resident#3 on different shifts were made but resident would refuse care. Nursing told the nursing assistants when Resident#3 refused just to document because it was his right to refuse.</p>	F 241	<p>managers and staff from each department. Administrator will track and trend the results from the compliance and will present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>Social worker will track and trend the results from the interviews and corrected action if needs and will present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained</p>		

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F 241	<p>Continued From page 31</p> <p>NA#6 indicated that Resident#3 was verbally abusive and not always pleasant and would get agitated and would say leave him alone. Care was not provided when Resident#3 refused. During an interview on 2/5/15 at 11:30AM, NA#6 indicated that several attempts to care for Resident#3 on different shifts were made but the resident would refuse care. Nursing told the nursing assistants when Resident#3 refused just to document because it was his right to refuse. NA#6 indicated that Resident#3 was verbally abusive and not always pleasant and would get agitated and would say leave him alone. Care was not provided when Resident#3 refused. During an interview on 2/6/15 at 8:15AM, administrative staff #3 acknowledged Resident #3 had not been assessed or referred to alternative care and treated in a dignified manner with his overall care/treatment, mental status and pressure ulcer care.</p> <p>The facility was notified on 2/5/15 at 8:25AM of the immediate jeopardy. The facility provided a credible allegation on 2/6/15 as follows: The credible allegation documented the following: What corrective action will be accomplished for those residents having potential to be affected by the same deficient practice? · Resident # 1 was involuntary committed and sent to a Medical Center. The attending physician and the psych services was calling the hospital to give report and history of the resident. The facility sent to the resident to the hospital with EMS and copies of the attending physician progress notes, wound care notes, medication administration records and psych notes. Upon return the guardianship will continued to be pursued. Guardianship paper was filed at the magistrate office on Feb 4, 2015.</p>	F 241			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	<p>Continued From page 32</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place:</p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected</li> <li>· Residents with a BIMS score higher than 9 (per the RAI manual) recorded on the last completed MDS were interviewed by the Social Services/licensed nurses on 2/5/15 in regards to Dignity any resident with dignity issues identified will be reported to the Director of Health Services and/or the Administrator for further interventions. For resident with BIMs scores 9 and below compliance rounds are completed daily by assigned staff, including by not limited to Department heads, week-end nursing supervisor, week-end manager on duty, and administrative staff, compliance rounds are reviewed by the Administrator and the Administrator in Training. Items on the compliance rounds that are reviewed are the following items but not limited Resident care items (nails, dressing, and clean dried and toileted, odor, hydration) that have the potential to identify possible neglect. <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <ul style="list-style-type: none"> <li>· On 2/5/15 education for all staff began on the Abuse and neglect including dignity education completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</li> </ul> <p>On 2/6/14 at 3:30PM, staff were interviewed on the expectation of the reporting process, documentation and notification to nursing, social work, physician and administrative staff of</p> </li></ul>	F 241			

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F 241	Continued From page 33 residents that refuse care, treatment and medications. The daily rounds and 24 hour report, skin assessments forms were reviewed. Staff were able to describe the expectations for resident refusal of care, treatment and medications as they had received an in-service on 2/5/15 and 2/6/15. The administrative staff were able to describe the expectation for implementing care and treatment for residents that had 2 consecutive refusals of care, treatment and medications. The social worker indicated the expectation for referrals to other outside agencies.	F 241			
F 250 SS=J	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff and family interviews and record review the facility failed to identify and recognize when a resident continued to refuse medications and other mental health interventions over a period of time that impacted on his ability to make informed decisions about his personal care and treatment of a pressure ulcer for 1 of 4 sampled residents (Resident #3). Immediate Jeopardy (IJ) began on 6/24/14 when Resident #3 's medications were discontinued. The IJ was removed on 2/6/15 at 6:00PM when the facility provided an acceptable allegation of	F 250	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?  Resident # 3 was involuntary committed and sent to Novant Health Forsyth Medical Center. The attending physician and the psych services was calling the hospital to give report and history of the resident. The facility sent to the hospital with EMS copies of the attending physician progress notes, wound care	3/11/15	

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F 250	<p>Continued From page 34</p> <p>compliance. The facility remained out of compliance at a scope and severity of D; isolated deficiency that constitutes no actual harm with potential for more than minimal harm; due to on-going in-service training of staff and allowing time for the facility to implement the changes through the Quality Assurance program.</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on 12/17/12. The diagnoses included schizophrenia, depressive disorder, esophageal reflux, anemia, diabetes, psychosis, mood instability, colostomy, adult failure to thrive, paraplegia and pressures ulcers stage III and IV. The annual Minimum Data Set (MDS) dated 11/6/14, indicated resident would not participate in the assessment. The quarterly MDS dated 8/7/14 indicated the basic mental status interview was coded as moderately cognitively impaired. Resident #3 required total assistance with all activities of living except feeding.</p> <p>Review of the resident ' s care plan dated 11/6/14, identified problem as 1.the refusal of medications, labs, blood transfusions, treatments and hospitalizations. The goal included Resident #3 would maintain blood levels in acceptable range. The approaches included obtain and monitor labs as ordered, explain the consequences of refusals of treatment and care, involve family with encouraging treatment/medications/labs, re-approach with refusals of care and treatment. 2. Noncompliance (refusal of medications, lab work, activities of daily living care, weights, wound care, turn and repositioning and adherence to diet). The goal included compliance with nursing staff at least</p>	F 250	<p>notes, medication administration records and psych notes.</p> <p>Upon return the guardianship will continued to be pursued. Guardianship paper was filed at the magistrate office on Feb 4, 2015.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All resident have the potential to being affected</p> <p>Skin Integrity Nurses has reviewed 100% of residents with wounds to ensure wounds are staged and documented appropriately, treatment is being delivered as ordered, and care plans are individualizes. Treatment records were also reviewed for the month of January and February for refusals of treatments. Any residents identified with refusals of 2 consecutive treatments care plans were reviewed and updated for behaviors and need for mental health services.</p> <p>Licensed Nurse, Unit Managers are reviewing the Medication Administration Records, for the months of January to current date, for refusal of medications. Any residents identified with more than 2 consecutive doses of a vital medication, including but not limited to cardiac medications, anticoagulants, psych medications, anti-seizure medications, and anti-diabetic medication, are withheld</p>		

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F 250	<p>Continued From page 35</p> <p>once a day. The approaches included involve Resident #3 in planning ways to comply, help resident set goals for compliance, psychiatric referral as needed. 3. Behaviors included refusal of care, verbally and physically abusive at times and refusal of medications. The goal included resident would cause no harm to self or others through next review. The approaches included psychiatric services as needed, explain procedures before attempting them, give the resident alternatives to express feelings and provide reassurance.</p> <p>Review of pressure wound conditions revealed the resident ' s wounds worsened from 12/02/14 to 02/02/15:</p> <table border="0"> <tr> <td>Right Calf</td> <td></td> </tr> <tr> <td>12/2/14</td> <td>11.5x2.1x0cm</td> </tr> <tr> <td>2/2/15</td> <td>42 x7x 0.5 cm</td> </tr> <tr> <td>Left Calf</td> <td></td> </tr> <tr> <td>12/02/14</td> <td>4.5x2x0.1 cm</td> </tr> <tr> <td>1/14/15</td> <td>19x7x0.5 cm</td> </tr> </table> <p><b>BILATERAL BUTTOCKS</b></p> <table border="0"> <tr> <td>12/2/14</td> <td>42x27x0 cm</td> </tr> <tr> <td>2/2/15</td> <td>50x53x0 cm</td> </tr> </table> <p>During an initial tour on 2/2/15 at 9:30AM, Resident #3 was lying in bed with covers over his head. There was strong urine/fecal/body odor in room. The colostomy bag was full. Resident #3 indicated that he did not want anyone to bother him and he was not going to take any medications because he didn ' t want to. He added that he was not getting out of bed and wanted to stay in room all day.</p> <p>During an observation on 2/4/15 at 8:30 AM, the surveyor was in room and attempted to speak with resident who had a strong, foul odor on his</p>	Right Calf		12/2/14	11.5x2.1x0cm	2/2/15	42 x7x 0.5 cm	Left Calf		12/02/14	4.5x2x0.1 cm	1/14/15	19x7x0.5 cm	12/2/14	42x27x0 cm	2/2/15	50x53x0 cm	F 250	<p>or refused the physician will be notified. Care plan will be reviewed and updated for behavior and mental health services as needed.</p> <p>Activity of Daily Living (ADL) documents were reviewed by the Director of Health Services for any refusal of care. Noted refusal of care for more than 2 consecutive instances will be addressed with a care plan review and update, education of resident, responsible party notification, physician notification and mental health services as indicated.</p> <p>The Social worker and Director of Health Services reviewed the last 30 days of 24 hours reports to identify resident with behaviors. Current 24 hours report address behaviors.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>Residents that are currently refusing care and services will be reviewed by the Interdisciplinary Team, including but not limited to the attending physician, social worker, Director of Health Services, responsible party and resident in question, to determine the plan of care including but not limited to treatment alternatives, engaging the ombudsman, Adult protective services, psych services referrals and applying for guardianship. Cognition status will be reviewed during this meeting to determine how the facility will proceed with referral and treatment</p>	
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F 250	<p>Continued From page 36</p> <p>person and in the room. He was verbally abusive (swearing, cursing and refusing care) toward anyone who entered the room. Resident#3 had an urosotmy and colostomy. The resident had a large decubitus on the sacrum area. The area had black tissue around the edges and raw tissue surrounding the base of the buttocks. The odor was very strong and foul. The director of nursing was asked to enter the room to assist Resident #3. She attempted to ask Resident #3 what he needed. She exited the room and asked for nursing assistant from NA#2. Resident #3 refused care from NA#2. The nursing assistant indicated he refused care and he had the right per nursing to refuse care and Resident #3 would be offered care again later.</p> <p>Review of the Medication Administration Record (MAR) January 2014 through February 2015, Resident #3 had not taken any psychiatric medications.</p> <p>On 6/24/14, the consultant pharmacist informed the physician that Resident #3 continued to refuse medications from January 2014-February 2015. The pharmacist suggested discontinuation of the following medications due to the resident ' s continued refusal of medications. Depakote used for seizures; aspirin; multivitamins with minerals; senna, chlorophyll, Arginaid orange (a supplement for chronic wound healing), calcium D, iron medications and routine labs. The pharmacist recommended changing: Effexor to Prozac for depression; baclofen to valium for spasticity. The physician agreed and signed off on the recommendations on 7/7/14. There was no documentation that showed the resident had been educated about the negative consequences of the discontinuation of the medications and</p>	F 250	<p>alternatives.</p> <p>The Social Worker with track and trend the residents with refusal of care and treatments there were discussed with the Interdisciplinary Team and present the findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>On 2/5/15 education for nursing staff, including licensed and non-licensed staff, and therapy on what to do of a resident refuses care and treatments, including but not limited to bathing, dressing, peri-care, turning and reposition, eating, medications, wound treatments, outside appointments and procedures including labs and x-rays. Licensed staff are to document in the medical record and on the 24 hour report. Non-Licensed staff and therapy are to report refusal of care to the charge nurse, unit manager, Director of Health Services to ensure proper interventions were implemented, education was completed by the Clinical Competency Coordinator/Unit Manager/Director of Health Services. Any staff member not receiving the in-service, due to PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>Education began on 2/5/15 with licensed nurses on the use of the 24 hour report with recording of behaviors including but not limited refusal of care and treatments.</p>		

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F 250	<p>Continued From page 37 treatment.</p> <p>Pro-Stat liquid protein supplement was ordered on 7/20/14, but was not given due to resident refusal.</p> <p>Review of psychiatric progress notes from 12/2/14 and 1/21/15, revealed history of depression, mood instability, psychosis, noncompliance with care/medications/treatment. On 12/2/14 evaluation Resident #3 thoughts were difficult to assess however no grossly abnormal content, poor historian, mood anxious, no psychiatric medications, cognition impaired, poor concentration, short and long term memory poor, insight/judgment poor. On 1/21/15 evaluation assessment no change recommendation to attempt to try Zyprexa. There was no indication that Resident#3 had been referred to any other mental health service center.</p> <p>During an interview on 2/4/15 at 9:55AM, the social worker (SW) indicated she had met with the family on 1/16/15 to discuss Resident#3 's refusals for activities of daily care and medications. She indicated that she contacted the psychiatric services for an evaluation to determine Resident#3 's mental status and since the resident had the right to refuse, the facility could not make the resident accept care or medication. She had no response of why the resident was not assessed for involuntary commitment due to behaviors and the need for aggressive wound care. She indicated that she attempted to obtain guardianship status from a family member who indicated that she had guardianship papers. The SW further stated the first step was to obtain the psychiatric</p>	F 250	<p>Education was completed by the Clinical Competency coordinator/Unit Manager/Director of Health Services staff member not receiving the in-service, due to PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>The 24 hour reports will be reviewed daily by the Director of Health Services, and/or Licensed Nurse Manager for behaviors including but not limited to refusal of care and treatment. The Director of Health Service will track and trend any noted behaviors and present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p> <p>Quality Assurance Performance Improvement Committee met on Feb 5, 2015 to discuss F 250 citation at the IJ level during current survey. Team discussed Credible Allegation submitted to progress of audit tools and education.</p> <p>The Social Worker will track and trend the residents with refusal of care and treatments there were discussed with the Interdisciplinary Team and present the</p>		

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F 250	Continued From page 38 evaluation to determine the next approach would be since no one could get the resident to accept medication or treatment. She did not know what else to do since the magistrate told her unless he was a danger to self or others he would not be declared incompetent and had the right to make poor healthcare decisions. The SW noted dated 1/16/15 included a discussion with the family. The family ' s main concerns were the poor care of the wound and the cleanliness of Resident#3 and why had the facility not provided proper care for a person who was unable to make informed decisions about his care. The SW note also specified that the guardianship paperwork was filed on 2/5/15. During an interview on 2/4/15 at 11:25AM to 12:09PM, the family member indicated that she felt Resident #3 was unable to make decisions on his own about his care and medical condition. She indicated the facility was responsible for ensuring that he received his medication and proper care to his wound. She indicated that the resident did have periods of confusion at time and felt it was the facility ' s responsibility to ensure the resident ' s wounds were properly cleaned and cared for and not getting worse. The family member indicated if Resident#3 ' s mental status was taken care of he would accept the proper care. She believed that psychiatric services did not assess Resident#3 ' s mental needs thoroughly. The family indicated if Resident #3 didn ' t have any medication in his system to take care of his mental issues, he would not be mentally stable to make decisions about his general health care. The family indicated the facility staff continued to call and say Resident#3 was refusing all care and treatments and medications. Part of the problem was his mental problems and until that was taken care of the	F 250	findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.  The 24 hour reports will be reviewed daily by the Director of Health Services, and/or Licensed Nurse Manager for behaviors including but not limited to refusal of care and treatment. The Director of Health Service will track and trend any noted behaviors and present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.		

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F 250	<p>Continued From page 39</p> <p>wound would not be taken care of properly or healed. Resident #3 had real body odors because staff had not been bathing Resident#3 regularly.</p> <p>During an interview on 2/4/15 at 3:30PM, the physician indicated that he felt Resident #3 was alert and oriented enough to make decisions about his care even though in his medical opinion the decisions were poor and contraindicated to the care he really needed for the wound and anemia. The physician indicated that the resident 's pressure wounds had worsened and essentially were decaying/rotting and the resident needed intensive medical treatment. Resident #3 continued refusals of all treatment, care, labs, hospitalizations impact on the quality of care he would receive. The physician indicated that he discussed all the risk and health factors with Resident #3 and he demonstrated understanding of his decision not to have proper care. The physician also indicated that during the past two weeks staff had been made aware of mental status changes in Resident #3.</p> <p>Resident#3 was referred for psychiatric evaluation. The physician indicated that he accepted that Resident #3 made poor/bad decisions after he had explained all the risks factors associated with poor/lack of care. " If Resident#3 refused medication doesn ' t make sense to keep asking, if Resident #3 refused for a month it made sense to stop medications all together. If Resident#3 refused wound care nothing he could do about if the resident continued to refuse. " The physician indicated the team talked about involuntary committing Resident #3 a while back, but the magistrate stated that if resident was alert and oriented he could not be involuntarily commented because</p>	F 250			



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F 250	<p>Continued From page 40</p> <p>had the right to refuse care and make bad decisions about his care. The physician also stated that if the resident was committed involuntarily they would get him medically stable (wounds) and they would send him back and after a month. Resident #3 would return to the behaviors of refusals. Based on what he saw today (2/4/15) during the visit with Resident #3 this was his normal behavior. Resident #3 answered all the questions appropriately to basic concern of pain, where he was hurting. Resident #3 did not answer in an aggressive manner, or with anger, if you try to do things he refused and would hit staff. The physician indicated the resident reported he was fine as long as he ate, slept and smoked cigarettes. The physician stated he felt the resident would not change his opinion care. Psychiatry was attempting to restart Zyprexa to see what would happen. The physician did not feel that the Zyprexa medication would change the condition. He added that he was leaving the behavioral and mental status evaluation and assessment to the specialty of psychiatric services. All he can do was encourage the resident.</p> <p>During an interview on 2/5/15 at 10:59AM, psychiatric nurse practitioner (PNP) indicated that she had been following Resident#3 's mental health care for the past year. She stated that she felt Resident#3 was not a danger to himself or others and alert and oriented enough to answer questions regarding his basic care needs. She indicated that he had not exhibited any psychotic events that would indicate he needed inpatient treatment. The PNP further stated that Resident#3 would not have been accepted on a psychiatric unit due to his history of noncompliance and refusals of medications and</p>	F 250			

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F 250	<p>Continued From page 41</p> <p>condition of the wounds. In addition, several attempts to medicate Resident#3 on psychotropic medications from June 2014 to most recent 1/21/15 had been unsuccessful. Resident#3 did not meet the criteria for inpatient treatment due to his ability to answer basic health care questions correctly and was not actively a danger to himself. Resident#3 had the right to refuse care/treatment and medications. In her opinion Resident #3 was in no danger to himself.</p> <p>Resident#3 ' s evaluations on 12/2/14 and 1/21/15 were confirmed by the PNP that Resident#3 had impaired cognition, anxious mood, poor concentration, poor short and long term memory, poor insight and judgment. In addition, the PNP stated the physician would be the person to make the final decision regarding the extent of care/treatment needed for the pressure ulcer and the need for involuntary commitment. The PNP further stated she felt the extent of services and medication attempts had been made for Resident #3 and Resident#3 had not met the criteria for placement based on her evaluation he was alert/oriented enough to refuse care. When asked whether Resident#3 had cognition and decision making skills to understand the need for extensive care and treatment for his pressure ulcer, the response was the physician would have to make the decision on healthcare she only evaluated his ability to refuse care and treatment or medications at which time the recommendation was to Zyprexa on 1/21/15.</p> <p>During an interview on 2/6/15 at 8:15AM, administrative staff #3 indicated the SW social worker should be involved in working with family and resident in making referrals when necessary to other outside services.</p>	F 250			

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F 250	Continued From page 42  The facility was notified on 2/5/15 at 8:25AM of the immediate jeopardy. The facility provided a credible allegation on 2/6/15 as follows: The credible allegation documented the following:  What corrective action will be accomplished for the resident found to have been affected by the deficient practice? Resident # 3 was involuntary committed and sent to a Medical Center. The attending physician and the psych services was calling the hospital to give report and history of the resident. The facility sent to the resident to the hospital with EMS and copies of the attending physician progress notes, wound care notes, medication administration records and psych notes. Upon return the guardianship will continued to be pursued. Guardianship paperwork was filed at the magistrate office on Feb 4, 2015.  How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place: All resident have the potential to being affected Skin Integrity Nurses has reviewed 100% of residents with wounds to ensure wounds are staged and documented appropriately, treatment is being delivered as ordered, and care plans are individualizes. Treatment records were also reviewed for the month of January and February for refusals of treatments. Any residents identified with refusals of 2 consecutive treatments care plans were reviewed and updated for behaviors and need for mental health services. Residents that are currently refusing care and services will be reviewed by the Interdisciplinary Team, including but not limited to the attending	F 250			

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F 250	Continued From page 43 physician, social worker, Director of Health Services, responsible party and resident in question, to determine the plan of care including but not limited to treatment alternatives, engaging the ombudsman, Adult protective services, psych services referrals and applying for guardianship. Cognition status will be reviewed during this meeting to determine how the facility will proceed with referral and treatment alternatives. Education began on 2/5/15 with licensed nurses on the use of the 24 hour report with recording of behaviors including but not limited refusal of care and treatments. Education was completed by the Clinical Competency coordinator/Unit Manager/Director of Health Services staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work. Resident council meeting will be conducted on 2/6/15 by the Social worker, and activities director to review resident ' s rights to refuse care and services. On 2/5/15 education for nursing staff, including licensed and non-licensed staff, and therapy on what to do of a resident refuses care and treatments, including but not limited to bathing, dressing, peri-care, turning and reposition, eating, medications, wound treatments, outside appointments and procedures including labs and x-rays, staff are to document in the medical record and report refusal of care to the charge nurse, unit manager, Director of Health Services to ensure proper interventions were implemented, education was completed by the Clinical Competency Coordinator/Unit Manager/Director of Health Services. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and	F 250			

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F 250	<p>Continued From page 44</p> <p>will be educated prior to return to work. Licensed Nurse, Unit Managers are reviewing the Medication Administration Records, for the months of January to current date, for refusal of medications. Any residents identified with more than 2 consecutive doses of a vital medication, including but not limited to cardiac medications, anticoagulants, psych medications, anti-seizure medications, and anti-diabetic medication, are withheld or refused the physician will be notified. Care plan will be reviewed and updated for behavior and mental health services as needed. Activity of Daily Living (ADL) documents were reviewed by the Director of Health Services for any refusal of care. Noted refusal of care for more than 2 instances will be addressed with a care plan review and update, education of resident, responsible party notification, physician notification and mental health services as indicated.</p> <p>The Social worker and Director of Health Services reviewed the last 30 days of 24 hours reports to identify resident with behaviors. Current 24 hours report address behaviors. What measures will be in place or what systemic changes will be made to ensure the deficient practice will not reoccur?</p> <p>Residents that currently refusing care and services will be reviewed by the interdisciplinary Team, including but not limited to the attending physician, social worker, director of Health Services, responsible party and resident in question, to determine the plan of care including but not limited to treatment alternatives, engaging the ombudsman, Adult protective service, psych services referrals and applying for guardianship. Cognition status will be reviewed during this meeting to determine how the facility will proceed with referral and treatment alternatives.</p>	F 250			

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F 250	<p>Continued From page 45</p> <p>Education began on 2/5/15 with licensed nurses on the use of the 24 hour report with recording of behaviors including but not limited to refusal of care and treatments and medications. Education was completed by the Clinical Competency coordinator/Unit Manager/Director of Health Service. Staff members not receiving the in-service, due to PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>Resident council meeting will be conducted on 2/6/15 by the Social Worker and activities director to review resident ' s rights to refuse care and services.</p> <p>On 2/5/15 education for nursing staff, including licensed and unlicensed staff, and therapy on what to do if a resident refuses care and treatments, including but not limited to bathing, dressing, peri-care, turning and reposition, eating, medications, wound treatments, outside appointments and procedures including labs and x-rays, staff are to document in the medical record and report refusal of care to the charge nurse, unit manager, Director of Health Services to ensure proper interventions were implemented, education was completed by the Clinical Competency Coordinator/Unit Manager/Director of Health Services. Any staff member not receiving the in-services due to PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>On 2/6/14 at 3:30PM, staff were interviewed on the expectation of the reporting process, documentation and notification to nursing, social work, physician and administrative staff of residents that refuse care, treatment and medications. The daily rounds and 24 hour report, skin assessments forms were reviewed. Staff were able to describe the expectations for</p>	F 250			

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F 250	Continued From page 46 resident refusal of care, treatment and medications as they had received an in-service on 2/5/15 and 2/6/15. The administrative staff were able to describe the expectation for implementing care and treatment for residents that had 2 consecutive refusals of care, treatment and medications. The social worker indicated the expectation for referrals to outside agencies for additional services.	F 250			
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to eliminate odors of urine and feces on the two of the three hallways for 3 of 3 sampled residents that had concerns with odors in the facility (Resident #103, #15, Resident #10). The findings included:  During the initial tour on 2/2/15 at 9:20 AM, on 100 and 200 halls, a strong lingering smell of urine was noticed in the entire 100 and 200 hallways and the dining area.  On 2/4/15 at 5:00 AM, during the observation, there was a strong lingering odor of urine and faces, which was noticed in entire 100 and 200 hallways and the dining area. On 2/4/15 at 5:00 AM, during the interview,	F 252	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?  Resident <input type="checkbox"/> s # 103 and #15 were interviewed by assigned team members, including but not limited to department managers and staff from each department on compliance rounds to report odors and have any issues reported to the Administrator. The room across from Resident #15 was deep cleaned on 2/5/15.  Resident #10 not addressed in the 2567 and not identified on the Sample Resident	3/11/15	

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F 252	<p>Continued From page 47</p> <p>resident #103, who resided on 100 hall, stated that she consistently noticed a " bad urine smell " the end of 100 hall. This unpleasant odor was bothering her a lot because she constantly smelled it. The resident could recall that she talked about it with activity manager and other nurses. She did not know what facility was planning to do to fix it.</p> <p>On 2/4/15 at 5:05 AM, during the interview, resident #15, who resided on 100 hall, stated that urine and feces were smelled consistent, regardless of time of day. The resident had to keep the door to their room closed because of the unpleasant odor that came from the room across the hall. Resident #15 added that his friends refused to visit him because of the bad smell in the facility.</p> <p>On 2/4/15 at 5:00 AM, during an interview, nurse #10, who worked on 200 hall, stated that since the facility implemented new system to clean rooms of the residents, the situation with bad odor on 100 and 200 halls was in the process of being improved. However, she indicated there was a constantly noticeable smell of urine and feces on 100 and 200 halls.</p> <p>On 2/4/15 at 5:10 AM, during an interview, nurse #4, who worked on 100 hall, indicated that the reason for the bad smell on 100 and 200 hallways was from the carpet, he was not sure. He was aware of the new cleaning system for resident ' s rooms, which decreased the smell of urine. He indicated that the smell still persisted.</p> <p>During an interview on 2/4/15 at 5:30 AM, aide #4 indicated the new cleaning system helped, and the smell of urine and feces was less but still existed and was still unpleasant.</p> <p>During an interview on 2/4/15 at 5:40 AM, aide #9 worked on 200 hall, indicated that there was always a bad smell on 100 and 200 halls. He was</p>	F 252	<p>List.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All Residents have the potential to be affected by odors in the facility. All interview able Residents have been interviewed for their perception of the odors in the facility by use of the compliance rounds.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>Clinical Competency Coordinator (CCC) and Environmental Director, began in-service on March 3, 2015, in-service 100% nursing and environmental department that all linen and trash barrels will be located in soiled utility room, no linen or trash barrels will be located on hallways.</p> <p>Compliance rounds will be completed daily by assigned team members including but not limited department managers and staff from each department. Education with staff was completed on 2/6/15 on responsibilities, items to review and items that need to be reported to the Director of health Services and/or the Administrator for immediate corrective action. Education was completed by Administrator in Training</p>		



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F 252	Continued From page 48 aware of new residents ' rooms cleaning system that facility implemented during the last month in attempt to eliminate an unpleasant odor on 100 and 200 halls. During an interview on 2/4/15 at 6:10 AM, the maintenance director, stated that he was aware of the smell of feces and urine in the building. In the last month, facility stripped and redone the floors in order to eliminate the source of this smell. The facility implemented new system to utilize residents ' trash into big trash can inside of the utility room, in attempt to remove it from the hall. The maintenance director indicated he saw some improvement in regards to the situation of unpleasant odor in the building. During an interview on 2/05/15 at 2:20PM, the administrator indicated that he was not aware of odors in the hallways. He had not smelled strong odors of urine and feces. The interim administrator indicated that she had no ability to smell and relied on reports of other staff members.	F 252	and Administrator.  On March 5, 2015 Lennox will service the ventilation system on the 200 and 300 hall.  On Feb 13, 2015 Architect Kurmaskie Associates visited the facility to review the existing environmental conditions of the 100 hall, specific to the HVAC system. As a result, a mechanical design will be proposed that will introduce conditioned outside "Fresh Air" ventilation and will be exhausted at a similar rate of exchange.  How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.  Monitoring of the effectiveness of the education and changes of monitoring for odors, cleaning of common areas and linen disposition will occur by use of daily compliance rounds by the Department Managers and Licensed nurses Monday thru Friday. Week end Manager on duty and week end licensed nurses will do the compliance rounds on Saturday and Sunday. If any areas are found not to be in compliance the Department Manager or Licensed Nurse will be responsible for initiating corrective action. All compliance rounds will be turned into the Administrator.  The monitoring will occur daily for four (4)		

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F 252	Continued From page 49	F 252	<p>weeks, then weekly for four (4) weeks and then monthly for three (3) months or until compliance is continuous.</p> <p>Results of the monitoring for tracking and trending will be done by the Administrator and reported to the monthly Quality Assurance and Performance Improvement (QAPI) Committee for recommendations and suggestions for changes for continued improvement.</p> <p>The results of the monitoring, of the compliance rounds, with tracking and trending will be reported to the Quality Assurance and Performance Improvement Committee by the Administrator for suggestion and recommendations for change.</p>		
F 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to clean the wheelchairs for 3 (Resident # 15, #12 &amp; # 38) of 3 sampled residents observed. Findings including:</p> <p>1. Resident #15 was admitted to the facility on 11/7/14. The quarterly Minimum Data Set (MDS) assessment dated 1/16/15 indicated that</p>	F 253	<p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>Residents # 15, #12 and #38 wheel chairs were cleaned on 2/6/15</p> <p>How will you identify other residents</p>	3/11/15	

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F 253	<p>Continued From page 50</p> <p>Resident #15 was cognitively intact.</p> <p>On 2/3/15 at 2:30 PM, 2/4/15 at 10:30 AM and 2/5/15 at 11:35 AM, the electric wheelchair of Resident #15 was observed. The wheelchair was observed to be dirty with dust and debris all over it.</p> <p>On 2/5/15 at 11:35 AM, Resident # 15 was interviewed. He stated that since he was admitted to the facility his wheelchair had never been cleaned.</p> <p>On 2/5/15 at 12:05 PM, Nurse # 1 was interviewed. Nurse #1 stated that the night shift nursing assistants were responsible for cleaning the wheelchairs at night. Nurse #1 acknowledged that some wheelchairs needed to be cleaned including the wheelchair of Resident #15.</p> <p>On 2/5/15 at 12:10 PM, administrative staff #1 was interviewed. She stated that the nursing assistants at night were responsible for cleaning the wheelchairs. She added that the schedule for cleaning the wheelchair was on the daily NA (nurse aide) assignment sheet.</p> <p>The daily NA (nursing assistant) assignment sheets were reviewed. The sheets included the daily wheelchair cleaning schedule. The sheets were reviewed and had no initials to indicate that the wheelchair had been cleaned.</p> <p>On 2/6/15 at 6:45 AM, NA (nursing assistant) #1 was interviewed. She stated that she worked third shift and stated that wheelchairs were supposed to be cleaned by the third shift NA but it was not always done.</p>	F 253	<p>having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents in transportation devices have the potential to be affected</p> <p>100% audit was completed by the Maintenance Director of transportation devices to determine if any were in need repairs and was completed on 2/18/15.</p> <p>Housekeeping Supervisor and housekeeping staff cleaned 100% of the transportation devices starting on 2/9/15 and completed on the 2/19/15.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>Transportation devices will be deep cleaned weekly on assigned units by the housekeeping department. A schedule will be developed by the Administrator and followed by the Housekeeping Supervisor.</p> <p>Transportation devices will be observed daily by assigned team members, including but not limited to department managers and staff from each department on compliance rounds for any maintenance issues and cleanliness and report to the Housekeeping and Maintenance supervisor for cleaning and repairs as needed.</p> <p>The Administrator will educated the</p>		

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F 253	Continued From page 51  2. Resident #12 was admitted to the facility on 4/27/14. The quarterly MDS assessment dated 11/11/14 indicated that Resident #12 was cognitively impaired.  On 2/3/15 at 2:30 PM, 2/4/15 at 10:30 AM and 2/5/15 at 11:35 AM, the wheelchair of Resident #12 was observed to be dirty. The seat and the frames were observed with thick layers of dried food particles and dust.  On 2/5/15 at 12:05 PM, Nurse # 1 was interviewed. Nurse #1 stated that the night shift nursing assistants were responsible for cleaning the wheelchairs at night. Nurse #1 acknowledged that some wheelchairs needed to be cleaned including the wheelchair of Resident #12.  On 2/5/15 at 12:10 PM, administrative staff #1 was interviewed. She stated that the nursing assistants at night were responsible for cleaning the wheelchairs. She added that the schedule for cleaning the wheelchair was on the daily NA assignment sheet.  The daily NA (nursing assistant) assignment sheets were reviewed. The sheets included the daily wheelchair cleaning schedule. The sheets were reviewed and had no initials to indicate that the wheelchair had been cleaned.  On 2/6/15 at 6:45 AM, NA (nursing assistant) #1 was interviewed. She stated that she worked thirds shift and stated that wheelchairs were supposed to be cleaned by the third shift NA but it	F 253	maintenance and housekeeping supervisors on responsibly for cleaning and making needed reports of transportation devices.  How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.  The Administrator will monitor the deep clean schedule and maintenance issues weekly x 6 months. The results of the monitoring with tracking and trending by the Administrator will be reported to the Quality Assurance and Performance Improvement Committee by the Administrator for suggestions and recommendations for change.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 253	<p>Continued From page 52 was not always done.</p> <p>3. Resident #38 was admitted to the facility on 7/17/13. The quarterly MDS assessment dated 1/14/15 indicated that Resident #38 was cognitively impaired.</p> <p>On 2/3/15 at 2:30 PM, 2/4/15 at 10:30 AM and 2/5/15 at 11:35 AM, the wheelchair of Resident #38 was observed to be dirty. The seat and the frames were observed to have debris and dust.</p> <p>On 2/5/15 at 12:05 PM, Nurse # 5 was interviewed. Nurse #5 stated that the night shift nursing assistants were responsible for cleaning the wheelchairs at night. Nurse #5 acknowledged that the wheelchair of Resident #38 needed to be cleaned.</p> <p>On 2/5/15 at 12:10 PM, administrative staff #1 was interviewed. She stated that the nursing assistants at night were responsible for cleaning the wheelchairs. She added that the schedule for cleaning the wheelchair was on the daily NA assignment sheet.</p> <p>The daily NA (nursing assistant) assignment sheets were reviewed. The sheets included the daily wheelchair cleaning schedule. The sheets were reviewed and had no initials to indicate that the wheelchair had been cleaned.</p> <p>On 2/6/15 at 6:45 AM, NA (nursing assistant) #1 was interviewed. She stated that she worked thirds shift and stated that wheelchairs were</p>	F 253			

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F 253	Continued From page 53	F 253			
F 274 SS=D	<p>supposed to be cleaned by the third shift NA but it was not always done.</p> <p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a significant change in status assessment for 1 (Resident #82) of 3 sampled residents reviewed with a decline in activity of daily living (ADL). Finding included:  Resident #82 was originally admitted to the facility on 10/23/13 with multiple diagnoses including alzheimer's disease and hypertension.</p> <p>The Minimum Data Set assessments were reviewed. The annual MDS assessment dated 10/8/14 indicated that Resident # 82 needed limited assistance with bed mobility and transfer, had no falls since admission/prior assessment,</p>	F 274	<p>Corrective action will be accomplished for the resident found to have been affected by the deficient practice:</p> <p>Resident # 82 no longer resides in the facility.</p> <p>Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:</p> <p>On March 2, 2015 Interdisciplinary Team began to validate accuracy of assessments by utilizing Reimbursement Utilization Group Analysis, quick print, real</p>	3/11/15	

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F 274	<p>Continued From page 54</p> <p>weight 169 pounds (lbs), had no weight loss and had no pressure ulcer. The quarterly MDS assessment dated 1/8/15 indicated that Resident #82 needed extensive assist with bed mobility and transfer, had a fall since admission/prior assessment, weight 142 lbs. and had a weight loss.</p> <p>On 2/2/15 at 2:48 PM, Nurse #5 was interviewed. She stated that Resident #82 had a stage II pressure ulcer on the sacrum.</p> <p>On 1/13/15, there was a doctor' order to clean stage II pressure ulcer on the sacrum with normal saline and apply hydrocolloid dressing.</p> <p>On 2/5/15 at 3:35 PM, Nurse #8 was interviewed. Nurse #8 stated that she was the MDS coordinator. She added that she didn't think that the decline in bed mobility and transfer, the significant weight loss, the falls and the development of pressure ulcer would warrant a significant change in status assessment.</p>	F 274	<p>time Data Integrity Analysis from Point Right and review of chart in morning meeting to discuss MDS prior to submission.</p> <p>On February 27, 2015 a Senior Nurse Consultant educated the Interdisciplinary Team, : Case Mix Director, Social Worker, Dietary Manager, Activities Director, Skin Integrity Coordinator, Clinical Competency Coordinator, Nurse Managers on conducting MDS accuracy reviews utilizing the utilizing Reimbursement Utilization Group Analysis, quick print, real time Data Integrity Analysis from Point Right and review of chart.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not occur:</p> <p>The Case Mix Director has completed Automated Information System (AIS) course "OBRA assessments 3.4, Significant change" in status assessment. The Interdisciplinary Team to include Social Worker, Dietary Manager, Activities Director, Skin Integrity Coordinator, Clinical Competency Coordinator, Nurse Managers and Director of Health Services to complete monthly scheduled AIS training.</p> <p>The Interdisciplinary team that includes: Case Mix Director, Social Worker, Dietary Manager, Activities Director, Skin Integrity Coordinator, Clinical Competency Coordinator, Nurse Managers and Director of Health Services complete the</p>		

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F 274	Continued From page 55	F 274	MDS accuracy audit tool for each assessment weekly x 4 weeks and monthly x 4 months.  Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained:  The Case Mix Director / Director of Health Services will present the trending of the MDS accuracy audit tool to the Quality Assurance Performance Improvement Committee, for review and revision, monthly for three months or until a pattern of compliance is obtained.		
F 279 SS=J	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	F 279		3/11/15	



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F 279	<p>Continued From page 56</p> <p>§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 staff interview and record review, the facility failed to review and revise the care plan when they realized goals were not being met and approaches to care needed to be changed for Resident #3 whose mental health condition affected his ability to make informed decisions about his care for 1 of 3 sampled residents. Immediate Jeopardy (IJ) began on 11/6/14. The IJ was removed on 2/6/15 at 6:00PM when the facility provided a acceptable allegation of complaince. The facility remains out of compliance at a scope and severity of D, an isolated deficiency that constitutes no actual harm with potential for more than minimal harm due to on-going in-service training of staff and allowing time for the facility to implement the changes through the Quality Assurance program. The findings included: Resident #3 was admitted to the facility on 12/17/12. The diagnoses included schizophrenia, depressive disorder, esophageal reflux, anemia, diabetes, psychosis, mood instability, colostomy, adult failure to thrive, paraplegia and pressure ulcers stage III and IV.</p> <p>The annual Minimum Data Set (MDS) dated 11/6/14, indicated resident would not participate in the assessment. MDS indicated that Resident #3 's moderately impaired with poor decision making skills that required cues and supervision for care and treatment. Resident #3 's mood was not assessed and the behaviors included rejection of care when he required extensive and</p>	F 279	<p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>Resident # 3 was involuntary committed and sent to Novant Health Forsyth Medical Center. The facility sent to the hospital with EMS copies of the attending physician progress notes, wound care notes, medication administration records and psych notes.</p> <p>Upon return the guardianship will continued to be pursued. Guardianship paper was filed at the magistrate office on Feb 4, 2015.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Skin Integrity Nurses has reviewed 100% of residents with wounds to ensure wounds are staged and documented appropriately, treatment is being delivered as ordered and care plans are individualizes. The Director of Health Services has validated the audit completed by the Skin Integrity Nurses.</p> <p>Licensed nurses completed 100% body</p>		

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F 279	Continued From page 57 total assistance. Stage III and Stage IV pressure ulcer conditions were not assessed for measurement of the wound at the time of assessment and how they would be treated. The use of psychotropic medications for his mental health condition was not assessed. Noncompliance of care and treatment, medication and labs was not assessed or how to address the concern. Review of care plan dated 11/6/14, identified problem as 1. The anemia and refusal of medications, labs, blood transfusions, treatments and hospitalizations. The goal included Resident #3 would maintain blood levels in acceptable range. The approaches included obtain and monitor labs as ordered, monitor for adequate bowel movement, explain the consequences of refusals of treatment and care, involve family with encouraging treatment/medications/labs, re-approach with refusals of care and treatment. 2. Noncompliance (refusal of medications, lab work, activities of daily living care, weights, wound care, turn and repositioning and adherence to diet). The goal included compliance with nursing staff at least once a day. The approaches included involve Resident #3 in planning ways to comply, help resident set goals for compliance, psychiatric referral as needed. 3. Chronic pressure ulcers, impaired cognition and required assistance with activities of daily living. The goal included resident would have no pressure ulcers, wounds would decrease in size and heal through next review. The approaches included monitor for incontinence episodes, keep clean and dry as much as possible, provide ostomy care every shift, weekly skin assessments, turn and reposition, pressure reduce ion mattress and cushion. 4. Behaviors included refusal of care, verbally and physically	F 279	audit on 2/5/15 for all residents, the Director of Health Services is reviewing the body audits as they are completed to ensure that all skin areas have been identified and are being treated, including care plan updates, responsible party and physician notification.  Licensed Nurse, Unit Managers are reviewing the Medication Administration Records for refusal of medications. Any residents identified with more than 2 consecutive doses of a vital medication, including but not limited to cardiac medications, anticoagulants, anti-seizure medications, psych medications and anti-diabetic medication, are withheld or refused the physician will be notified. Care plan will be reviewed and updated for behavior and mental health services as needed.  Activity of Daily Living (ADL) documents were reviewed by the Director of Health Services for any refusal of care. Noted refusal of care for more than 2 instances will be addressed with a care plan review and update, education of resident, responsible party notification, physician notification and mental health services as indicated. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?  On 2/5/15 the interdisciplinary team including but not limited to the Case Mix Director, Director of Nursing, Activities,		

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F 279	<p>Continued From page 58</p> <p>abusive at times and refusal of medications. The goal included resident would cause no harm to self or others through next review. The approaches included psychiatric services as needed, explain procedures before attempting them, give the resident alternatives to express feelings and provide reassurance.</p> <p>During an interview on 2/4/15 at 4:24PM, Nurse #8 indicated that Resident #3 's care plan did not address what was expected to occur when refusals of care, treatment, medication occurred. Nurse #8 confirmed the implementation of the care plan had not been effective for Resident #3. During an interview on 2/4/15 at 4:45PM, the Director of Nurses indicated the care plan should include measurable outcomes, goals and interventions that would improve the concerns. Staff were expected to document resident decline so that changes could be noted and updates made to the care plan.</p> <p>The facility was notified on 2/5/15 at 8:25AM of the immediate jeopardy. The facility provided a credible allegation on 2/6/15 as follows: The credible allegation documented the following: What corrective action will be accomplished for those residents having potential to be affected by the same deficient practice?</p> <ul style="list-style-type: none"> <li>Resident #3 was involuntarily committed and sent to a Medical Center. The facility sent to the resident to the hospital with EMS and copies of the attending physician progress notes, wound care notes, medication administration records and psych notes.</li> </ul> <p>Upon return the guardianship will continued to be pursued. Guardianship paper was filed at the magistrate office on Feb 4, 2015.</p> <p>How will you identify other residents having the potential to be affected by the same deficient</p>	F 279	<p>Social Worker, and the Skin Integrity Coordinator, were educated on care plan being individualized for each resident, education was completed by corporate consulting staff. Any staff member not receiving the in-service, due to PRN status, out on Family Medical Leave (FMLA) and/or currently on vacation or sick time will be removed from the schedule and will be educated prior to return to work.</p> <p>Interdisciplinary team including but not limited to Director of Health Services, Activities, Social worker, dietary, wound nurse and Case Mix Director will review the care plans from the previous week to ensure care plans are individualized and updated. The Case Mix Director will track and trend identified issues including but not limited to refusals, personal requests, and/or behaviors and present the findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>Residents that are currently refusing care and services will be reviewed by the Interdisciplinary Team, including but not limited to the attending physician, social worker, Director of Health Services, responsible party and resident in question, to determine the plan of care including but not limited to treatment alternatives, engaging the ombudsman, Adult protective services, psych services referrals and applying for guardianship.</p>		

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F 279	<p>Continued From page 59</p> <p>practice and what corrective action will take place:</p> <p>Skin Integrity Nurses has reviewed 100% of residents with wounds to ensure wounds are staged and documented appropriately, treatment is being delivered as ordered and care plans are individualizes. The Director of Health Services has validated the audit completed by the Skin Integrity Nurses.</p> <ul style="list-style-type: none"> <li>Licensed nurses are completing 100% body audit on all residents 2/5/15 the Director of Health Services is reviewing the body audits as they are completed to ensure that all skin areas have been identified and are being treated, including care plan updates, responsible party and physician notification.</li> <li>Licensed Nurse, Unit Managers are reviewing the Medication Administration Records for refusal of medications. Any residents identified with more than 2 consecutive doses of a vital medication, including but not limited to cardiac medications, anticoagulants, anti-seizure medications, psych medications and anti-diabetic medication, are withheld or refused the physician will be notified. Care plan will be reviewed and updated for behavior and mental health services as needed.</li> </ul> <p>Activity of Daily Living (ADL) documents were reviewed by the Director of Health Services for any refusal of care. Noted refusal of care for more than 2 instances will be addressed with a care plan review and update, education of resident, responsible party notification, physician notification and mental health services as indicated.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <ul style="list-style-type: none"> <li>On 2/5/15 the interdisciplinary team including</li> </ul>	F 279	<p>Cognition status will be reviewed during this meeting to determine how the facility will proceed with referral and treatment alternatives.</p> <p>The Social Worker will track and trend the residents with refusal of care and treatments there were discussed with the Interdisciplinary Team and present the findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>On 2/5/15 education for nursing staff, including licensed and non-licensed staff, and therapy on what to do of a resident refuses care and treatments, including but not limited to bathing, dressing, peri-care, turning and reposition, eating, medications, wound treatments, outside appointments and procedures including labs and x-rays. Licensed staff are to document in the medical record and on the 24 hour report. Non-Licensed staff and therapy are to report refusal of care to the charge nurse, unit manager, Director of Health Services to ensure proper interventions were implemented, education was completed by the Clinical Competency Coordinator/Unit Manager/Director of Health Services. Any staff member not receiving the in-service, due to PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>The 24 hour reports will be reviewed daily</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>UNIHEALTH POST-ACUTE CARE-HIGH POINT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3830 N MAIN STREET HIGH POINT, NC 27265</b>		
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F 279	<p>Continued From page 60</p> <p>but not limited to the Case Mix Director, Director of Nursing, Activities, Social Worker, and the Skin Integrity Coordinator, were educated on care plan being individualized for each resident, education was completed by corporate consulting staff. Any staff member not receiving the in-service, due to part time status, out on Family Medical Leave (FMLA) or currently on vacation or sick time will be removed from the schedule and will be educated prior to return to work.</p> <ul style="list-style-type: none"> <li>On 2/5/15 education for nursing staff, including licensed and non-licensed staff, and therapy on what to do of a resident refuses care and treatments, including but not limited to bathing, dressing, peri-care, turning and reposition, eating, medications, wound treatments, outside appoints and procedures including labs and x-rays, staff are to document in the medical record and report refusal of care to the charge nurse, unit manager, Director of Health Services to ensure proper interventions were implemented, education was completed by the Clinical Competency Coordinator/Unit Manager/Director of Health Services. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</li> <li>Residents that are currently refusing care and services will be reviewed by the Interdisciplinary Team, including but not limited to the attending physician, social worker, Director of Health Services, responsible party and resident in question, to determine the plan of care plan including but not limited to treatment alternatives, engaging the ombudsman, Adult protective services, psych services referrals and applying for guardianship. Cognition status will be reviewed during this meeting to determine how</li> </ul>	F 279	<p>by the Director of Health Services, and/or Licensed Nurse Manager for behaviors including but not limited to refusal of care and treatment to ensure care plan have been updated and individualized. The Director of Health Service will track and trend any noted behaviors and present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p> <p>Quality Assurance Performance Improvement Committee met on Feb 5, 2015 to discuss F 279 citation at the IJ level during current survey. Team discussed Credible Allegation submitted to progress of audit tools and education.</p> <p>The Case Mix Director will track and trend reviewed care plan for identified issues including but not limited to refusals, personal requests, and/or behaviors and present the findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p>		

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F 279	Continued From page 61 the facility will proceed with referral and treatment alternatives. On 2/6/14 at 3:30PM, staff were interviewed on the expectation of the reporting process, documentation and notification to nursing, social work, physician and administrative staff of residents that refuse care, treatment and medications. The daily rounds and 24 hour report, skin assessments forms were reviewed. Staff were able to describe the expectations for resident refusal of care, treatment and medications as they had received an in-service on 2/5/15 and 2/6/15. The administrative staff were able to describe the expectation for implementing care and treatment for residents that had 2 consecutive refusals of care, treatment and medications. The social worker indicated the expectation for referrals to outside agencies for additional services.	F 279	The 24 hour reports will be reviewed daily by the Director of Health Services, and/or Licensed Nurse Manager for behaviors including but not limited to refusal of care and treatment to ensure care plan have been updated and individualized. The Director of Health Service will track and trend any noted behaviors and present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  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.  This REQUIREMENT is not met as evidenced by: Based on observations, staff, family nurse practitioners and physician interviews, the facility failed to assess and implement mental health treatment which resulted in failure to provide wound care and personal care for 1 of 3 sampled	F 309	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?	3/11/15	

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F 309	<p>Continued From page 62</p> <p>residents (Resident #3). The facility further failed to administer arginaid (a protein supplement) and pro-stat (a protein supplement) as ordered and failed to provide cushion in wheelchair to promote wound healing (Resident #24).</p> <p>Immediate Jeopardy (IJ) began on 1/6/15 for Resident # 3 when the wounds to the bilateral calves declined. The IJ was removed on 2/6/15 at 6:00PM when the facility provided an acceptable allegation of compliance. The facility remains out of compliance at a scope and severity of D, isolated deficiency that constitutes no actual harm with potential for more than minimal harm, for example # 2, Resident # 24, and due to on-going in-service training of staff and allowing time for the facility to implement the changes through the Quality Assurance program.</p> <p>The findings included:</p> <p>1. Resident #3 was admitted to the facility on 12/17/12. The diagnoses included schizophrenia, depressive disorder, esophageal reflux, anemia, diabetes, psychosis, mood instability, colostomy, adult failure to thrive, paraplegia and pressures ulcers stage III and IV. The annual Minimum Data Set (MDS) dated 11/6/14, indicated resident would not participate in the assessment and no staff was assessment conducted. The quarterly MDS dated 8/7/14 indicated the basic mental status interview was moderately cognitively impaired. Resident #3 required total assistance with all activities of living except feeding.</p> <p>Review of previous medication history on 6/24/15 the consultant pharmacist 's communication to physician documented Resident #3 continued to refuse medications that were being sent weekly</p>	F 309	<p>Resident # 3 was involuntary committed and sent to Novant Health Forsyth Medical Center. The facility sent to the hospital with EMS copies of the attending physician progress notes, wound care notes, medication administration records and psych notes.</p> <p>Upon return the guardianship will continued to be pursued. Guardianship paper was filed at the magistrate office on Feb 4, 2015.</p> <p>Resident # 24 Prostat 30 and arginaid were placed on the medication administration record and given as ordered.</p> <p>Resident # 24 wheel chair cushion was obtained.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Skin Integrity Nurses has reviewed 100% of residents with wounds to ensure wounds are staged and documented appropriately, treatment is being delivered as ordered and care plans are individualizes. The Director of Health Services has validated the audit completed by the Skin Integrity Nurses.</p> <p>Licensed nurses completed 100% body audit on 2/5/15 for all residents the Director of Health Services is reviewing the body audits as they are completed to</p>		

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F 309	<p>Continued From page 63</p> <p>by pharmacy and therefore being charged to resident, yet was being wasted. Resident #3 also received a couple of floor stock items that he refused. Consider discontinuing the following medications at this time. Depakote 500mg (milligrams) every morning and 625mg every night; the levels were &lt;1.0, Effexor 150mg every day and change to Prozac 90 milligrams weekly for depression, aspirin 325 mg every day, multivitamins with minerals, baclofen 10mg milligrams-start valium 2mg every 12 hours as needed for spasticity, senna every day, chlorophyll 3mg twice a day, arginaid orange supplement 1 packet mixed with water twice a day, calcium D, iron 325 milligram twice a day (refuse transfusion and medication and routine labs). Physician agreed and signed off on 7/7/14. Resident #3 was also on Risperdal injection 37.5mg every 14 days for schizophrenia started on 1/7/14 and last given 5/15/14, levimir injection 5 units subcutaneous at bedtime for diabetes started on 12/18/12 not given due to resident refusal, pro-stat supplement 30milliliters three times a day start 7/20/14 not given due to refusals.</p> <p>Review of the monthly medication administration record( MAR) for December 2014 to February 2015 revealed an order for hydrocerin cream after bathing, pat skin dry, apply to face, torso and legs once daily for skin. There was no documentation on the MAR to address the wounds to the calf areas. Review of the Treatment Administration Record(TAR) for February 2015 revealed to clean stage III to left and right calf with normal saline apply hydrogel gauze cover with dry dressing change two times per week. There was no documentation on the TAR to indicate the treatment was completed.</p>	F 309	<p>ensure that all skin areas have been identified and are being treated, including care plan updates, responsible party and physician notification.</p> <p>Licensed Nurse, Unit Managers are reviewing the Medication Administration Records for refusal of medications. Any residents identified with more than 2 consecutive doses of a vital medication, including but not limited to cardiac medications, anticoagulants, anti-seizure medications, psych medications and anti-diabetic medication, are withheld or refused the physician will be notified. Care plan will be reviewed and updated for behavior and mental health services as needed.</p> <p>Activity of Daily Living (ADL) documents were reviewed by the Director of Health Services for any refusal of care. Noted refusal of care for more than 2 instances will be addressed with a care plan review and update, education of resident, responsible party notification, physician notification and mental health services as indicated.</p> <p>Skin integrity nurse audited 100% of wheel chairs to ensure cushions are in wheel chair. Wheel Chair cushions were ordered on Feb 9, 2015.</p> <p>Skin integrity coordinator completed an audit of all residents with wounds to ensure medications ordered for wound healing are current on the medication administration records.</p>		



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F 309	<p>Continued From page 64</p> <p>Review of the pressure wound conditions revealed the resident ' s wounds worsened from 12/2/14-2/2/15.</p> <p>Right Calf 12/2/14            11.5x2.1x0cm 2/2/15            42 x7x 0.5 cm</p> <p>Left Calf 12/02/14            4.5x2x0.1 cm 1/14/14            19x7x0.5 cm</p> <p>Review of wound documentation note dated 12/3/14, revealed the right calf/left calf stage III was meeting the care plan goals as evidenced by no change to measurements. Resident #3 updated on current status. On 12/9/14, right calf Stage III meeting current care plan goals resident updated on status and continue current treatment. On 12/13/14 and 12/30/14 documentation unchanged.</p> <p>Review of wound documentation note dated 12/29/14, Nurse #6 documented " resident covered in BM (bowel movement) no colostomy bag on stoma. Stool all over resident hands, blankets radio, bed and bed control. Stool puddle on resident left side. Saturating dressing, resident eating crackers with stool on hands room with foul odor, resident then demands only colostomy bag be replaced This nurse talks resident into dressing changes also no changes to wounds appearance, continue with current interventions. "</p> <p>Review of wound documentation note dated on 1/6/15, left calf decline due to refusals area measures 13cml x 5cmw (centimeter wide) x 0.5cm depth. Mixed tissues to wound bed.</p>	F 309	<p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>On 2/5/15 education for nursing staff, including licensed and non-licensed staff, and therapy on what to do if a resident refuses care and treatments, including but not limited to bathing, dressing, peri-care, turning and reposition, eating, medications, wound treatments, outside appointments and procedures including labs and x-rays. Licensed staff are to document in the medical record and on the 24 hour report. Non-Licensed staff and therapy are to report refusal of care to the charge nurse, unit manager, Director of Health Services to ensure proper interventions were implemented, education was completed by the Clinical Competency Coordinator/Unit Manager/Director of Health Services. Any staff member not receiving the in-service, due to PRN status and/or out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>The 24 hour reports will be reviewed daily by the Director of Health Services, and/or Licensed Nurse Manager for behaviors including but not limited to refusal of care and treatment. The Director of Health Service will track and trend any noted behaviors and present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance</p>		

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F 309	<p>Continued From page 65</p> <p>Resident #3 had no interest in wound care, morning care or colostomy care. Continue with interventions as resident allows.</p> <p>The 1/9/15 comprehensive metabolic panel CMP) including a complete blood count (CBC) documented the following lab results were below normal limits: albumin less than 2.0(3.5-5.2) low, calcium 7.4(8.4-10.5) low, creatinine 0.30(0.50-1.35) low. Other labs were either at normal limits or near normal including glucose 66, sodium 134, potassium 3.5, and chloride 103. The complete blood count (CBC) test was not performed.</p> <p>Review of lab dated 1/14/15, revealed completed blood count (CBC), comprehensive metabolic panel (CMP): red blood count= 3.50(4.22-5.81) low, platelet 758(150-400) high, creatinine 0.32(0.50-1.35) low, calcium 7.3(8.4-10.5) low, albumin less than 2.0(3.5-5.2) low, hematocrit 21.3( 39.0-52.0) low, hemoglobin 5.4(13.0-17) low: resident refused blood transfusion.</p> <p>Review of the wound documentation on 2/2/15, left calf was unstageable due to 50% slough coverage 50% non-granulation area has declined and measures 21cm x 7cm x 0 in depth. Resident #3 was updated on the decline to wound. Resident #3 continued to be noncompliant and refused to allow dressing change. Nurse wrote to continue interventions as resident would allow. The right calf stage III shows no change to measurements; the area measures 42 cm x 7cm x0.5 cm and Resident #3 refused dressing changes since 1/25/15. The resident was updated on current wound status. There was no documentation of what information was provided to Resident #3 on the status of the wound.</p>	F 309	<p>is sustained.</p> <p>On 2/5/15 educated for Licensed Nurses staff began on Policy and Procedure medication general guidelines referring to notification of physician of 2 consecutive doses of a vital medication including but not limited to cardiac medications, anticoagulants, anti-seizure medications, psych medications, psych medications, and anti-diabetic medication, are withheld or refused the physician will be notified, education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due to PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>On 2/5/15 education began with the Skin Integrity Nurses and the license nurses on reporting to the Director of Health Services and/or Administrator if a resident has refused wound care for more than 2 consecutive treatments. The Physician will also be notified of refusal of 2 consecutive treatments. Education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due PRN status and/or out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>The Director of Health Services will review the weekly wound report for refusal, attending physician notification and new interventions to ensure appropriate follow</p>		

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F 309	<p>Continued From page 66</p> <p>During an interview on 2/4/15 at 8:58AM, Nurse #6 indicated that the resident had the right to refuse care and when he did not want his wounds checked or changed, she did not force him. She indicated that Resident #3 was combative with all treatments and care in addition to refusals of mediations. She added that she provided wound care when Resident #3 would allow. She did her measurements and basic treatment as ordered. The resident refused supplements that would promote wound healing. Nurse #9 indicated that wound care center would not accept the resident due to noncompliance. She added that the physician and nurse practitioner were made aware of the condition of the wounds and had not ordered any new or aggressive treatments. The current wound treatments were for maintenance of the wound. Resident refused and he had the right to refuse care, therefore nothing else would be done, until Resident #3 allowed staff to provide care.</p> <p>During a follow-up interview on 2/4/15 at 2:30PM, Nurse#6 indicated that the wound doctor did not make regular rounds with her when she did wound care. She added that she had made the NP and physician 's aware of the resident's refusal of care and the increased size of the wounds, refusal of supplements, care and treatment. Resident#3 had been referred to wound care center and the wound care center refused to treat resident due to noncompliance. She further stated that she had been documenting the changes and the increase in the wound size, but there had been no real or different changes to the treatment. Resident#3 received santyl, an absorbent dressing for</p>	F 309	<p>up completed weekly x 6 months or until compliance is sustained. The results of the monitoring with tracking and trending will be reported to the Quality Assurance and Performance Improvement Committee by the Director of Health Services for suggestion and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>Residents that are currently refusing care and services will be reviewed by the Interdisciplinary Team, including but not limited to the attending physician, social worker, Director of Health Services, responsible party and resident in question, to determine the plan of care including but not limited to treatment alternatives, engaging the ombudsman, Adult protective services, psych services referrals and applying for guardianship. Cognition status will be reviewed during this meeting to determine how the facility will proceed with referral and treatment alternatives. The Social Worker with track and trend the residents with refusal of care and treatments there were discussed with the Interdisciplinary Team and present the findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>Education was started on 2/28/15 by the Clinical Competency coordinator with licensed nursing staff on physician order</p>		

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F 309	<p>Continued From page 67</p> <p>maintenance of the wound. Resident#3 was not on any medications. She reported that she had discussed with the team last week about the conditions of the wounds on the buttocks and legs and no final decision had been made. She added that she was uncertain of when the physician directly looked at the wound. She indicated Nurse#9 would look and check after her treatments.</p> <p>During an interview on 2/4/15 at 3:30PM, the physician indicated that he felt Resident #3 was alert and oriented enough to make decisions about his care even though in his medical opinion the decisions were poor and contraindicated to the care he really needed for the wound and anemia. The physician indicated that the resident 's pressure wounds had worsened and essentially were decaying/rotting and the resident needed intensive medical treatment. Resident #3 's continued refusals of all treatment, care, labs, hospitalizations, impacted the quality of care he would receive. The physician indicated that he discussed all the risk and health factors with Resident #3 and he demonstrated understanding of his decisions not to have proper care. The physician also indicated that during the past two weeks staff had made him aware of mental status changes in Resident #3.</p> <p>Resident#3 was referred for psychiatric evaluation. The physician indicated that he accepted that Resident #3 made poor/bad decisions after he had explained all the risks factors associated with poor/lack of care. " If Resident#3 refused medications it doesn ' t make sense to keep asking, if Resident #3 refused for a month it made sense to stop medications all together. If Resident#3 refused wound care</p>	F 309	<p>regarding order transcription. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>All new medication orders will be discussed in morning clinical meeting by the Director of Health Services (DHS) or Clinical Competency Coordinator (CCC) Monday thru Friday and by Licensed Nursing Management on Saturday and Sunday to ensure proper transcription daily for four weeks. The monitoring will continue weekly for four weeks and then monthly for two months or until compliance is sustained.</p> <p>The Director of Health Services will track and trend results of the monitoring of medications orders and will report the findings to the Quality Assurance and Performance Improvement Committee bi-monthly x 6 months or until compliance is sustained.</p> <p>Education was begun on 2/28/15 by the clinical competency coordinator for licensed and non-licensed nursing staff of what to do if cushion is not in wheel chair, and where to obtain a cushion from. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>Education on compliance rounds, including but not limited to signs of neglect, dignity, odors and wheel chair</p>		

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F 309	<p>Continued From page 68</p> <p>nothing he could do about if the resident continued to refuse." The physician indicated the team talked about involuntarily committing Resident #3 a while back, but the magistrate stated that if the resident was alert and oriented he could not be involuntarily committed because had the right to refuse care and make bad decisions about his care. The physician also stated that if the resident was committed involuntarily they would get him medically stable (wounds) and they would send him back and after a month. Resident #3 would return to the behaviors of refusals. Based on what he saw today (2/4/15) during the visit with Resident #3 this was his normal behavior. Resident #3 answered all the questions appropriately to basic concern of pain, where he was hurting. Resident #3 did not answer in an aggressive manner, or with anger, if you try to do things he refused and would hit staff. The physician indicated the resident reported he was fine as long as he ate, slept and smoked cigarettes. The physician stated he felt the resident would not change his opinion about care. Psychiatry was attempting to restart Zyprexa to see what would happen. The physician did not feel that the Zyprexa medication would change the condition. He added that he was leaving the behavioral and mental status evaluation and assessment to the specialty of psychiatric services. All he can do was encourage the resident.</p> <p>Resident #3 was sent to the hospital on the critical care unit on 2/5/15. The hospital records revealed he received 2 units of red blood cells, normal saline 1500 milliliters, 1 gram of vancomycin, pro-stat protein supplement 60ml per day, Zyprexa 2.5mg orally at bedtime in the emergency room. Review of hospital labs done</p>	F 309	<p>cushions, was completed on 2/6/15 for assigned staff on responsibilities, items to review and items that need to be reported to the Director of Health Services and/or the Administrator for immediate corrective action. Education was completed by Administrator in Training and Administrator</p> <p>Compliance rounds will be completed daily by assigned team members including but not limited to department managers and staff from each department. Administrator will track and trend the results from the compliance and will present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p> <p>Quality Assurance Performance Improvement Committee met on Feb 5, 2015 to discuss F 2309 citation at the IJ level during current survey. Team discussed Credible Allegation submitted to progress of audit tools and education.</p> <p>The 24 hour reports will be reviewed daily by the Director of Health Services, and/or</p>		

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F 309	<p>Continued From page 69</p> <p>on 2/5/15 revealed the CMP results albumin 1.8(3.5-5.5) low, calcium 7.4(8.7-10.2) low, creatinine 0.30(0.76-1.27) low, sodium 135(136-146) low, potassium 3.6(3.7-5.4) low, hemoglobin 5.2((13.0-17.0) low. The lab values revealed a decline in health general condition. Review of the hospital records under the skin assessment documented Resident #3 had multiple unstageable wounds to bilateral calves. Foul purulent drainage noted from all wounds, odorous and copious drainage. The hospital records did not stage the calf wounds.</p> <p>The facility was notified on 2/5/15 at 8:25AM of the immediate jeopardy. The facility provided an acceptable credible allegation on 2/6/15 as follows: The credible allegation documented the following: What corrective action will be accomplished for those residents having potential to be affected by the same deficient practice? How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place: Skin Integrity Nurses has reviewed 100% of residents with wounds to ensure wounds are staged and documented appropriately, treatment is being delivered as ordered and care plans are individualizes. The Director of Health Services has validated the audit completed by the Skin Integrity Nurses. Licensed nurses are completing 100% body audit on all residents 2/5/15 the Director of Health Services is reviewing the body audits as they are completed to ensure that all skin areas have been identified and are being treated, including care plan updates, responsible party and physician</p>	F 309	<p>Licensed Nurse Manager for behaviors including but not limited to refusal of care and treatment. The Director of Health Service will track and trend any noted behaviors and present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>Administrator will track and trend the results from the compliance and will present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>The Director of Health Services will track and trend results of the monitoring of medications orders and will report the findings to the Quality Assurance and Performance Improvement Committee bi-monthly x 6 months or until compliance is sustained.</p> <p>The Social Worker with track and trend the residents with refusal of care and treatments there were discussed with the Interdisciplinary Team and present the findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained</p>		

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F 309	Continued From page 70 notification. Licensed Nurse, Unit Managers are reviewing the Medication Administration Records for refusal of medications. Any residents identified with more than 2 consecutive doses of a vital medication, including but not limited to cardiac medications, anticoagulants, anti-seizure medications, psych medications and anti-diabetic medication, are withheld or refused the physician will be notified. Care plan will be reviewed and updated for behavior and mental health services as needed. Activity of Daily Living (ADL) documents were reviewed by the Director of Health Services for any refusal of care. Noted refusal of care for more than 2 instances will be addressed with a care plan review and update, education of resident, responsible party notification, physician notification and mental health services as indicated. · What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? On 2/5/15 education for nursing staff and therapy on what to do of a resident refuses care, and who to report refusal of care to, education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work. · On 2/5/15 educated for Licensed Nurses staff began on Policy and Procedure medication general guidelines referring to notification of physician of 2 consecutive doses of a vital medication including but not limited to cardiac medications, anticoagulants, anti-seizure medications, psych medications, psych medications, and anti-diabetic medication, are withheld or refused the physician will be notified,	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 71</p> <p>education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <ul style="list-style-type: none"> <li>On 2/5/15 education was begun with the Skin Integrity Nurses and the license nurses on reporting to the Director of Health Services and/or Administrator if a resident has refused wound care for more than 2 consecutive treatments. The Physician will also be notified of refusal of 2 consecutive treatments. Education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</li> <li>On 2/5/15 education for nursing staff, including licensed and non-licensed staff, and therapy on what to do of a resident refuses care and treatments, including but not limited to bathing, dressing, peri-care, turning and reposition, eating, medications, wound treatments, outside appointments and procedures including labs and x-rays, staff are to document in the medical record and report refusal of care to the charge nurse, unit manager, Director of Health Services to ensure proper interventions were implemented, education was completed by the Clinical Competency Coordinator/Unit Manager/Director of Health Services. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</li> <li>Resident council meeting will be conducted on 2/6/15 by the Social worker, and activities director to review resident 's rights to refuse care and services.</li> </ul>	F 309			



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F 309	<p>Continued From page 72</p> <ul style="list-style-type: none"> <li>Residents that are currently refusing care and services will be reviewed by the Interdisciplinary Team, including but not limited to the attending physician, social worker, Director of Health Services, responsible party and resident in question, to determine the plan of care including but not limited to treatment alternatives, engaging the ombudsman, Adult protective services, psych services referrals and applying for guardianship. Cognition status will be reviewed during this meeting to determine how the facility will proceed with referral and treatment alternatives. Completion date 2/6/15.</li> </ul> <p>On 2/6/14 at 3:30PM, staff were interviewed on the expectation of the reporting process, documentation and notification to nursing, social work, physician and administrative staff of residents that refuse care, treatment and medications. The daily rounds and 24 hour report, skin assessments forms were reviewed. Staff were able to describe the expectations for resident refusal of care, treatment and medications as they had received an in-service on 2/5/15 and 2/6/15. The administrative staff were able to describe the expectation for implementing care and treatment for residents that had 2 consecutive refusals of care, treatment and medications. The social worker indicated the expectation for referrals to outside agencies for additional services.</p> <p>2a. Resident #24 was admitted to the facility on 1/15/14 with multiple diagnoses including congestive heart failure and diabetes mellitus. The annual Minimum Data Set (MDS) assessment dated 1/9/15 indicated that Resident #24 was cognitively intact and had a burn.</p>	F 309			

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F 309	<p>Continued From page 73</p> <p>The care plan dated 12/18/14 was reviewed. One of the care plan problem was burns to right thigh. The goal was " will heal wound in 90 days. " The approaches included pressure reduction mattress in chair and provide dietary supplement to promote wound healing.</p> <p>The doctor's orders were reviewed. On 12/18/14, there was an order for prostat 30 milliliter (ml) twice a day. On 1/29/15, there was an order for arginaid orange one packet mix with water daily to promote wound healing.</p> <p>Review of the laboratory reports revealed that the prealbumin level for Resident #24 on 1/14/15 was 12 (low) and on 2/4/15, the prealbumin level was 10.7 (low). The reference/normal range was 17-34.</p> <p>The documentation of wound observation and assessment form was reviewed. The wound assessment dated 2/2/15 indicated that Resident #24 had a full thickness burn on the right thigh, status post skin graft, measuring 45 by 15 centimeter (cm).</p> <p>The February, 2015 Medication Administration Records (MARs) were reviewed. Prostat and arginaid were not transcribed to the MARs and therefore were not administered to Resident #24.</p> <p>On 2/4/15 at 9:30 AM, Nurse # 5 was interviewed. She acknowledged that prostat and arginaid were not transcribed to the February, 2015 MARs and therefore were not administered to Resident #24.</p>	F 309			

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F 309	<p>Continued From page 74</p> <p>On 2/4/15 at 3:05 PM, administrative staff members #1 &amp; #2 were interviewed. They acknowledged that prostat and arginaid were not transcribed to the February, 2015 MARs and therefore were not administered</p> <p>On 2/5/15 at 10:30 AM, Resident #24 was observed during the dressing change. The burn area was on the right side of the leg from the ankle to the upper part of the knee. The area had a skin graft. Nurse #6 cleaned the burn area with normal saline and xeroform dressing was applied, covered with an ABD pad and secured with kerlix.</p> <p>2b. Resident #24 was admitted to the facility on 1/15/14 with multiple diagnoses including congestive heart failure and diabetes mellitus. The annual Minimum Data Set (MDS) assessment dated 1/9/15 indicated that Resident #24 was cognitively intact and had a burn.</p> <p>The care plan dated 12/18 was reviewed. One of the care plan problem was burns to right thigh. The goal was " will heal wound in 90 days. " The approaches included pressure reduction mattress in chair and provide dietary supplement to promote wound healing.</p> <p>The doctor's orders were reviewed. On 1/27/15, there was a doctor's order for a cushion to wheelchair for pressure relief.</p> <p>The documentation of wound observation and assessment form was reviewed. The wound assessment dated 2/2/15 indicated that Resident #24 had a full thickness burn on the right thigh, status post skin graft, measuring 45 by 15 centimeter (cm).</p>	F 309			

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F 309	Continued From page 75  On 2/4/15 at 10:30 AM and 2/5/15 at 10:05 AM, Resident #24 was observed up in wheelchair. The wheelchair was observed to have no cushion.  On 2//515 at 10:30 AM, Resident #24 was observed during the dressing change. The burn area was on the right side of the leg from the ankle to the upper part of the knee. The area had a skin graft. Nurse #6 cleaned the burn area with normal saline and xeroform dressing was applied, covered with an ABD pad and secured with kerlix.  On 2/5/15 at 10:50 AM, Nurse # 5 was interviewed. Nurse #5 stated that Resident #24 should have a cushion in her wheelchair. Nurse #5 had observed the wheelchair of Resident #24 and acknowledged that there was no cushion. She added that she would order a new cushion for Resident #24.	F 309			
F 314 SS=J	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by:	F 314		3/11/15	

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F 314	<p>Continued From page 76</p> <p>Based on observations, staff and physician interviews and record reviews, the facility failed to reassess and provide treatment for pressures ulcers that had increased in size and severity since December 2014 for Resident #3. Resident had stop taking his psychotropic medication for his mental health diagnoses since June 2014 and the facility did not identify his inability to make decisions about his wound care for 1 of 4 sampled residents with pressure ulcers. Immediate Jeopardy (IJ) began on 12/9/14 when the wound observation note indicated no change in measurements of the pressure ulcers to the buttocks and the care plan goals were being met. The IJ was removed on 2/6/15 at 6:00PM when the facility provided an acceptable allegation of compliance. The facility remained out of compliance at a scope and severity of D; isolated deficiency that constitutes no actual harm with potential for more than minimal harm; due to on-going in-service training of staff and allowing time for the facility to implement the changes through the Quality Assurance program.</p> <p>The findings included: Resident #3 was admitted to the facility on 12/17/12. The diagnoses included schizophrenia, depressive disorder, esophageal reflux, anemia, diabetes, psychosis, mood instability, colostomy, adult failure to thrive, paraplegia and pressures ulcers stage III and IV. The annual Minimum Data Set (MDS) dated 11/6/14, indicated resident would not participate in the assessment and no staff was assessment conducted. The quarterly MDS dated 8/7/14 indicated the basic mental status interview was moderately cognitively impaired. Resident #3 required total assistance with all activities of living except feeding.</p>	F 314	<p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>Resident # 3 was involuntary committed and sent to Novant Health Forsyth Medical Center. The attending physician and the psych services was calling the hospital to give report and history of the resident. The facility sent to the hospital with EMS copies of the attending physician progress notes, wound care notes, medication administration records and psych notes.</p> <p>Upon return the guardianship will continued to be pursued. Guardianship paper was filed at the magistrate office on Feb 4, 2015.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Skin Integrity Nurses has reviewed 100% of residents with wounds to ensure wounds are staged and documented appropriately and treatment is being delivered as ordered. Any residents with document refusal of skin treatments the physician will be immediately notified. The resident's responsible party will also be notified of any refusal of skin treatments. The Director of Health Services has validated the audit completed by the Skin Integrity Nurses. Results from current wound review</p>		

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F 314	<p>Continued From page 77</p> <p>Review of the physician ' s progress note dated 9/29/14, revealed stage IV pressure ulcer, mood agitated, orientation confused and noncompliance with care and treatment. There was no change in treatment. There was no indication that the condition of the wound had been observed or assessed for treatment by the physician. There was no documentation that the physician had made any changes to the treatment of the pressure ulcers or to changes to the resident ' s medication. The 11/3/14 physician notes repeated the evaluation of the 9/29/14, with no inclusion of wound condition or treatment. There was no indication that the physician had explored any alternative treatment for the mental health diagnoses or the pressure ulcers.</p> <p>Review of care plan dated 11/6/14, identified problem as 1. noncompliance (refusal of medications, lab work, activities of daily living care, weights, wound care, turn and repositioning and adherence to diet). The goal included compliance with nursing staff at least once a day. The approaches included involve Resident #3 in planning ways to comply, help resident set goals for compliance, psychiatric referral as needed. 2. Chronic pressure ulcers, impaired cognition and required assistance with activities of daily living. The goal included resident would have no pressure ulcers, wounds would decrease in size and heal through next review. The approaches included monitor for incontinence episodes, keep clean and dry as much as possible, provide ostomy care every shift, weekly skin assessments, turn and reposition, pressure reduction mattress and cushion.</p>	F 314	<p>revealed two (2) residents had refused care. The Physician was notified and dressing orders were changed. Documentation is current for all Residents receiving skin care.</p> <p>Licensed nurses completed 100% body audit on 2/5/15 for all residents, the Director of Health Services is reviewing the body audits as they are completed to ensure that all skin areas have been identified and are being treated, including care plan updates, responsible party and physician notification.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>On 2/5/15 education was begun with the Skin Integrity Nurses and the license nurses on reporting to the Director of Health Services and/or Administrator if a resident has refused wound care for more than 2 consecutive treatments. The Physician will also be notified of refusal of 2 consecutive treatments. Education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due to PRN status and/or out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>The Director of Health Services will review the weekly wound report for refusal,</p>		

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F 314	<p>Continued From page 78</p> <p>Review of the monthly medication administration record (MAR) for December 2014 to February 2015 revealed an order for hydrocerin cream after bathing, pat skin dry, apply to face, torso and legs once daily for skin. There was no documentation on the MAR to address the pressure ulcers to the buttocks area. Review of the Treatment Administration Record(TAR) for February, 2015 revealed to clean stage IV to bilateral buttocks with normal saline apply ointment to wound, cover with dry dressing and change once daily. There was no documentation on the TAR to indicate the treatment was completed.</p> <p>Review of the pressure wound conditions revealed the resident ' s wounds worsened from 12/2/14-2/2/15.</p> <p><b>BILATERAL BUTTOCKS</b> 12/2/14            42x27x 0 cm 2/2/15             50x53x 0 cm</p> <p>Review of the wound observation note dated 12/3/14, revealed stage IV pressure to bilateral buttocks. The care plan goals was meeting goals was evidenced by no change in measurements. The resident was updated and continue with current interventions. There was no documentations of the information the resident was provided about the wound.</p> <p>Review of wound observation note dated 12/9/14 for the stage IV bilateral buttocks indicated no change in measurements and care plan goals were being met. Continue with current interventions.</p>	F 314	<p>attending physician notification and new interventions to ensure appropriate follow up completed weekly x 6 months or until compliance is sustained. The results of the monitoring with tracking and trending will be reported to the Quality Assurance and Performance Improvement Committee by the Director of Health Services for suggestion and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>On 2/5/15 Skin Integrity Coordinator and Skin Integrity Nurse were educated on reporting to medical staff any changes in pressure ulcers resulting in wound declines, and refusal of treatments. In cases where the wound has declined nurse will request an out wound care specialist as indicated. If the medical staff does not offer and interventions with wound declines the nurses will report to the Director of Health Care Services and/or Administrator for further interventions. Education was provided by the Clinical Corporate staff</p> <p>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p> <p>Quality Assurance Performance Improvement Committee met on Feb 5, 2015 to discuss F 314 citation at the IJ level during current survey. Team discussed Credible Allegation submitted</p>		

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F 314	<p>Continued From page 79</p> <p>Nursing note dated 12/16/14 decline noted to stage IV sacral wound bone visible and palpable in wound bed. Residents none compliance continued. NP notified with no new orders.</p> <p>A wound documentation on 12/23/14 revealed that there was heavy drainage due to leakage of urostomy and colostomy. Resident noncompliant with dressing changes.</p> <p>A wound documentation noted dated 12/29/14, revealed that resident was covered in bowel movement, no colostomy bag on stoma, stool all over resident ' s hands, blanket, radio, bed and bed control, stool puddle on resident ' s left side, saturating the dressing. The resident was eating crackers with stool on his hands. The room had foul odor. The resident demanded that nurse only replace the colostomy bag. The nurse talked the resident into dressing changes, noted no changes to wounds appearance and wrote, " Continue with current intervention. There was no documentation indicating resident ' s noncompliance or new interventions done by the facility. The nurse indicated Resident #3 was given an update of wound status, there was no documentation of what information of the wound was provided.</p> <p>Review of wound observation note dated 1/14/15 pressure to bilateral buttock measures 43x33x0 wound has tunneling and undermining present the wound bed has granulation non granulation slough tissue present with extremely heavy serious serosanguineous purulent odorous drainage wound continue to get worse, Resident often refused to have treatment done resident currently is not taking any meds and refuses to be treated for anything that could potentially help</p>	F 314	<p>to progress of audit tools and education.</p> <p>The Director of Health Services will review the weekly wound report for refusal, attending physician notification and new interventions to ensure appropriate follow up completed weekly x 6 months or until compliance is sustained. The results of the monitoring with tracking and trending will be reported to the Quality Assurance and Performance Improvement Committee by the Director of Health Services for suggestion and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p>		



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F 314	<p>Continued From page 80</p> <p>with healing. ....Self: resident does nothing help himself he continues to lie in feces and urine for days at a time refusing any type of care. Often cussing and being mean to staff, wound rapidly declining and spreading to mid back, will continue to treatment as res allows.</p> <p>Review of the wound observation note dated 2/2/15, resident allowed dressing to be change for first time on 1/25/15 noted decline with increase in measurement. Stage IV pressure ulcer to bilateral buttocks measure 50x53x0 due to slough in wound bed. Mixed tissues noted in wound bed. 10% slough 10% purple ischemic tissue 0% non- granulation 60% granulation heavy serosanguineous drainage. Resident #3 refuses meds double meats ordered to promote wound healing resident continues to refused ostomy care, turn and reposition , meds wound care reeducated on importance of compliance in relation to wound healing resident refused to acknowledge this nurse. Continue with interventions as resident allows. Resident updated on decline. There was no documentation to indicate what information was provided to the resident.</p> <p>During an observation on 2/4/15 at 8:30 AM, the surveyor was in room and attempted to speak with resident who had a strong, foul odor on his person and in the room. He was verbally abusive (swearing, cursing and refusing care) toward anyone who entered the room. Resident#3 had a urostomy and colostomy. A large decubitus on the sacrum area was exposed once bedroom door was opened. The area had black tissue around the edges and raw tissue surrounding the base of the buttocks. The odor was very strong and foul. The director of nursing was asked to</p>	F 314			

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F 314	<p>Continued From page 81</p> <p>enter the room to assist Resident #3. She attempted to ask Resident #3 what he needed. She exited the room and asked for nursing assistant care from NA#2. Resident #3 refused care from NA#2. The nursing assistant indicated he refused care and he had the right per nursing to refuse care and Resident #3 would be offered care again later.</p> <p>During an interview on 2/4/15 at 8:42AM, Nurse#1 indicated the resident had a bath two days ago when his dressing for pressure ulcer to sacral area was cleaned. He indicated that the resident was verbally abusive and refused all care and medications. Nurse#1 indicated that when the resident would refuse care and treatment, attempts would be made to reoffer but if he refused he was not provided the care or treatment until he accepted.</p> <p>During an interview on 2/4/15 at 8:58AM, Nurse #6 indicated that the resident had the right to refuse care and when he did not want his wounds checked or changed, she did not force him. She indicated that Resident #3 was combative with all treatments and care in addition to refusals of mediations. She added that she provided wound care when Resident #3 would allow. She did her measurements and basic treatment as ordered. The resident refused supplements that would promote wound healing. Nurse #9 indicated that wound care center would not accept the resident due to noncompliance. She added that the physician and nurse practitioner were made aware of the condition of the wounds and had not ordered any new or aggressive treatments. The current wound treatments were for maintenance of the wound. Resident refused and he had the right to</p>	F 314			

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F 314	<p>Continued From page 82</p> <p>Refuse care, therefore nothing else would be done, until Resident #3 allowed staff to provide care.</p> <p>During an interview on 2/4/15 at 2:15PM, NA #2 indicated that Resident#3 had been verbally and physically aggressive toward staff when care was attempted to be provided. Resident#3 would curse and tell staff to get the hell out of the room, would refuse to have colostomy bag changed, baths etc. He tells staff when he wants these things done. The last bath was on 2/2/15. NA#2 indicated that on occasions there would be fluid oozing from the wound to the buttocks and they would have a very bad odor. " We were by told by nursing if the resident refused just to come back and try later. " NA#2 indicated that he may go several days before he would let staff bathe him or do any kind of care. " We don ' t know what else to do for him our hands are tied. " NA#3 indicated Resident#3 ate well and in the past few months the behaviors have gotten worse and the resident wanted to stay in room more with covers over his head and the odors from the wounds have been worst. She added that he would allow her on occasion to bathe him but it was on his terms. The wound on the buttocks/calf area had gotten worse. " We do what we can when we are allowed by the resident. "</p> <p>During a follow-up interview on 2/4/15 at 2:30PM, Nurse#6 indicated that the wound doctor did not make regular rounds with her when she did wound care. She added that she had made the NP and physician ' s aware of the resident's refusal of care and the increased size of the wounds, refusal of supplements, care and treatment. Resident#3 had been referred to wound care center and the wound care center</p>	F 314			

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F 314	<p>Continued From page 83</p> <p>refused to treat resident due to noncompliance. She further stated that she had been documenting the changes and the increase in the wound size, but there had been no real or different changes to the treatment. Resident#3 received santyl, an absorbent dressing for maintenance of the wound. Resident#3 was not on any medications. She reported that she had discussed with the team last week about the conditions of the wounds on the buttocks and legs and no final decision had been made. She added that she was uncertain of when the physician directly looked at the wound. She indicated Nurse#9 would look and check after her treatments.</p> <p>During an interview on 2/4/15 at 3:30PM, the physician indicated that he felt Resident #3 was alert and oriented enough to make decisions about his care even though in his medical opinion the decisions were poor and contraindicated to the care he really needed for the wound and anemia. The physician indicated that the pressure wounds have worsened and essentially were decaying/rotting and the resident needed intensive medical treatment. Resident #3 continued refusals of all treatment, care, labs, hospitalizations, which impacted on the quality of care he would receive. The physician indicated that he discussed all the risk and health factors with Resident #3 and he demonstrated understanding of his decision not to have proper care. The physician also stated that since Resident #3 indicated that the pressure ulcers didn ' t bother him and he could not force treatment on the resident because he had the right to refuse. The physician indicated that he accepted that Resident #3 made poor and bad decisions after he had explained all the risks</p>	F 314			

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F 314	<p>Continued From page 84</p> <p>factors associated with poor and lack of care. The physician indicated that nursing staff had reported the condition of the pressure ulcers had worsen but he had not directly looked at the wound himself in about 3 months. The physician depended on the nursing staff to inform him of the wound condition and changes. " I can give recommendations for care and treatment and Resident#3 would refuse. I had been discussing blood transfusion with Resident #3 and refused treatment. The medications were stop because of the resident ' s refusal. If Resident#3 refused medication doesn ' t make sense to keep asking, if Resident #3 refused for a month it made sense to stop medications all together. If Resident#3 refused wound care nothing he could do about if resident continued to refuse. " Physician indicated that he was certified in wound care treatment and felt that Nurse#6 was trained in wound measurements and he felt confident that nurse was capable of measuring wound. The physician was asked his expectation of the time frame of wound care treatment when stool was observed in the wound to prevent infections. The response was for staff to provide care/treatment to the area immediately, but if Resident#3 was going to continue to refuse care, staff would wait until resident became compliant as to when an how long the stool would remain in wound. He further stated he had no recommendation for the wound care treatment.</p> <p>Resident #3 was sent to the hospital on the critical care unit on 2/5/15, the hospital records revealed he received 2 units of red blood cells, normal saline 1500 milliliters, 1 gram of vancomycin, pro-stat protein supplement 60ml per day, Zyprexa 2.5mg orally at bedtime for depression in the emergency room. Review of</p>	F 314			

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F 314	<p>Continued From page 85</p> <p>hospital labs done on 2/5/15 revealed the CMP results albumin 1.8(3.5-5.5) low, calcium 7.4(8.7-10.2) low, creatinine 0.30(0.76-1.27) low, sodium 135(136-146) low, potassium 3.6(3.7-5.4) low, hemoglobin 5.2((13.0-17.0) low. The lab values revealed a decline in health general condition. Review of the hospital records under the skin assessment documented Resident #3 had multiple unstageable wounds including wounds to coccyx, buttocks and back. Foul purulent drainage noted from all wounds, odorous and copious drainage.</p> <p>The hospital record revealed a magnetic resonance image (MRI) dated 2/6/15. It indicated far advanced acute or chronic osteomyelitis with infection</p> <p>The facility was notified on 2/5/15 at 8:25AM of the immediate jeopardy. The facility provided a credible allegation on 2/6/15 as follows: The credible allegation documented the following: What corrective action will be accomplished for those residents having potential to be affected by the same deficient practice? · Resident # 3 was involuntary committed and sent to a Medical Center. The attending physician and the psych services was calling the hospital to give report and history of the resident. The facility sent to the resident to the hospital with EMS and copies of the attending physician progress notes, wound care notes, medication administration records and psych notes. Upon return the guardianship will continued to be pursued. Guardianship paper was filed at the magistrate office on Feb 4, 2015. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take</p>	F 314			

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F 314	<p>Continued From page 86</p> <p>place?</p> <p>Skin Integrity Nurses has reviewed 100% of residents with wounds to ensure wounds are staged and documented appropriately and treatment is being delivered as ordered. Any residents with document refusal of skin treatments the physician will be immediately notified. The resident ' s responsible party will also be notified of any refusal of skin treatments. The Director of Health Services has validated the audit completed by the Skin Integrity Nurses.</p> <ul style="list-style-type: none"> <li>o Results from current wound review revealed two (2) residents had refused care. The Physician was notified and dressing orders were changed.</li> <li>o Documentation is current for all Residents receiving skin care.</li> </ul> <p>Licensed nurses are completing 100% body audit on all residents 2/5/15 the Director of Health Services is reviewing the body audits as they are completed to ensure that all skin areas have been identified and are being treated, including care plan updates, responsible party and physician notification.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>On 2/5/15 education was begun with the Skin Integrity Nurses and the licensed nurses on reporting to the Director of Health Services and/or Administrator if a resident has refused more than 2 consecutive treatments. The Physician will also be notified of refusal of more than 2 consecutive treatments. Education was completed by the Clinical Competency Coordinator/Unit Manager/Week-end</p> <p>On 2/6/14 at 3:30PM, staff were interviewed on the expectation of the reporting process,</p>	F 314			

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F 314	Continued From page 87 documentation and notification to nursing, social work, physician and administrative staff of residents that refuse care, treatment and medications. The daily rounds and 24 hour report, skin assessments forms were reviewed. Staff were able to describe the expectations for resident refusal of care, treatment and medications as they had received and in-service on 2/5/15 and 2/6/15. The administrative staff were able to describe the expectation for implementing care and treatment for residents that had 2 consecutive refusals of care, treatment and medications. The social worker indicated the expectation for referrals to outside agencies for additional services.	F 314			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  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	F 329		3/11/15	



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NAME OF PROVIDER OR SUPPLIER  <b>UNIHEALTH POST-ACUTE CARE-HIGH POINT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3830 N MAIN STREET HIGH POINT, NC 27265</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 88 drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain the valproic acid level (test to measure the amount of valproic acid or Depakote), failed to administer the amlodipine (antihypertensive drug) as ordered for 2 (Residents # 82 &amp; #85) administered an extra dose of phentermine (a diet medication) for 1 (Resident #105) and failed to administer oxycodone (a pain medication) as ordered for( Resident #15) of 7 sampled residents reviewed for unnecessary medications. Findings included:</p> <p>1. Resident #82 was originally admitted to the facility on 10/23/13 with multiple diagnoses including psychosis. The quarterly Minimum Data Set (MDS) assessment dated 1/8/15 indicated that Resident #82 was cognitively impaired.</p> <p>Review of the physician's orders for February, 2015 revealed that Resident #82 was on depakote 125 milligrams (mgs) six capsules three times a day for mood disorder.</p> <p>On 11/24/14, there was a doctor's order to repeat valproic acid level in one month. Review of the records revealed that there was no valproic acid level report for December, 2014.</p> <p>On 2/4/15 at 3:09 PM, administrative staff #1 was interviewed and stated that the valproic acid level was missed in December and will do it stat today</p>	F 329	<p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>Resident #82 had a valporic acid level done immediately on 2/4/15 and the results were within normal limits.</p> <p>Resident #85 Medication Administration Record (MAR) was reviewed and changes made to have the days of Monday, Wednesday, Friday and Saturday open for signatures of administration and all other days crossed off to acknowledge that the medication is not to be given on Tuesday, Thursday and Sunday. The medical staff was notified on 2/6/15 of the errors in documentation on the MAR and no new orders were received.</p> <p>Resident #103 (identified in example #3, Not 105 as identified in the practice statement) medical staff was immediately notified of the duplicate medication administration on 1/7/15 and no new orders were received.</p> <p>Resident #15's medical staff was notified on 2/5/15 related to pain medication and use of break thru medications and new</p>		

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F 329	<p>Continued From page 89 (2/4/15).</p> <p>2. Resident # 85 was admitted to the facility on 12/24/14 with multiple diagnoses including hypertension. The quarterly MDS assessment dated 1/5/15 indicated that Resident #85 was cognitively impaired.</p> <p>Review of the admission orders and the physician's orders for February, 2015 revealed that Resident #85 was on amlodipine 5 mgs. 1 tablet per tube four times a week on Monday, Wednesday, Friday and Saturday for hypertension.</p> <p>The Medication Administration Records (MARs) were reviewed. The January, 2015 MAR revealed that amlodipine was administered everyday. The February MAR revealed that amlodipine was administered on February 1 (Sunday) and were encircled on February 2 (Monday) and 3 (Tuesday), indicating that the amlodipine was not administered.</p> <p>On 2/4/15 at 10:45 AM, Nurse # 1 was interviewed. He stated that the MAR should have boxes on the days the amlodipine should be given but he acknowledged that nurses should have read the MAR before administering the medication. He further indicated that on February 2 and 3, he did not administer the amlodipine because it was not available.</p> <p>On 2/5/15 at 11:45 AM, administrative staff #1 was interviewed. She reviewed the MARs and stated that nurses were expected to read the MARs before administering the medication.</p>	F 329	<p>order Oxycodone 15mg 2 tabs by mouth every 4 hours as needed was obtained. Medication error completed on each occurrence.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>The consultant pharmacist completed 100% controlled substance audit of all three medications carts on 2/12/15.</p> <p>A 100% Medication Administration Record audit was done by DHS and or licensed nursing management to determine if any other off day medications had not been documented correctly for February and March with change over the monthly orders. 3/1/15</p> <p>A 100% medical record audit was done by the Director of Nursing and the Clinical Competency Coordinator to identify any other Residents that could have a missing lab from December, 2014 to February 28, 2015. Any labs noted as not done have been drawn, and returned.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>Education began on 2/5/15 by the Director of Nursing and Clinical competency coordinator for all licensed nursing staff on lab ordering and follow up completed</p>		

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F 329	Continued From page 90  3. Resident #103 was admitted on 10/11/14, with the diagnoses of low back pain. The quarterly Minimum Data Set (MDS) dated 1/2/15 indicated Resident #103 was cognitively intact. Review of the physician order for January 2015 revealed that Resident #103 was on Phentermine (for weight loss) capsule 37.5mg (milligram) 1 capsule by mouth daily. Review of the medication administration record (MAR) for the month of January 2015 revealed on 1/7/15 the medication was administered at 6:30 AM and at 9:00AM. During interview on 2/4/15 at 8:02 AM, Nurse #1 indicted he had given the medication at 9:00AM he was not aware the medication was administered at 6:30 AM. During an interview on 2/6/15 at 6:30 AM, Nurse # 4 indicated he had given the dose of diet medication at 6:00 AM and was not aware of the 9:00AM administration time. During an interview on 2/6/15 at 2:27 PM administrative staff #1 had no comment. 4. Resident #15 was admitted on 11/7/14 with the diagnoses of chronic pain, pressure ulcers, seizures and anemia. The most recent minimum data set (MDS) dated 11/19/14, revealed Resident #15 was cognitively intact. During an interview on 2/3/15 at 10:08 AM, Resident #15 indicated the facility frequently was out of the PRN (as needed) medication that was ordered for pain. He indicated he received 2 tablets. Review of the physician prescription dated 1/22/15 revealed Oxycodone 15mg (milligrams) 1 po (by mouth) q (every) 4 hrs (hours) prn (as needed) for pain. Review of the physician ordered dated 2/1/15, Oxycodone tablet 15 mg, 1 tablet by	F 329	by 3/11/15. Any staff member not receiving the in-service, due to PRN status and/or out on FMLA will be removed from the schedule and will be educated prior to return to work.  Labs will be monitored daily by the licensed nurses who will report any discrepancies directly to the Director of Health Services or week end supervisor for immediate correction for four weeks. The Director of Health Services will monitor weekly for four weeks and then monthly for two months or until compliance is sustained. The Director of Health Services will track and trend results of the monitoring of labs and will report the findings to the Quality Assurance and Performance Improvement Committee bi-monthly x 6 months or until compliance is sustained.  On 2/5/15 educated for Licensed Nurses staff began on Policy and Procedure medication general guidelines referring to notification of physician of 2 consecutive doses of a vital medication including but not limited to cardiac medications, anticoagulants, anti-seizure medications, psych medications, psych medications, and anti-diabetic medication, are withheld or refused the physician will be notified, education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due to PRN status and/or out on FMLA will be removed from the schedule and will be educated prior to return to work.		

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F 329	<p>Continued From page 91</p> <p>mouth every 4 hours as needed for pain. Review of the previous the order dated 1/7/14 revealed he had received 30 mg of Oxycodone po Q 4 hours for pain.</p> <p>Review of the medication administration record (MAR) revealed Oxycodone tablet 15 mg, 1 tablet by mouth every 4 hours as needed for pain.</p> <p>Review of the controlled drug record dated 2/2/15 revealed, Oxycodone 15mg 1 tablet oral intake every 4 hours as needed for pain. Entries were dated: Each entry had two tablets administered.</p> <p>2/2/15 11:00 PM 2/3/15 6:30 AM 2/3/15 9:00 AM 2/3/15 3:00 PM 2/3/15 7:00 PM 2/4/15 12:00 AM 2/4/15 5:00 AM 2/4/15 10:00 AM 2/4/15 2:00 PM 2/4/15 6:00PM 2/5/15 12:30 AM 2/5/15 6:30 AM</p> <p>During an interview on 2/3/15 at 12:58 PM Nurse #1 indicated resident #15 ran out of Oxycodone frequently. He indicated he spent a lot of time on the phone with the pharmacy trying to get his narcotics.</p> <p>During interview on 2/5/15 at 11:24 AM, Nurse #1 read the MAR and then he realized the physician order was changed from 2 tablets to 1 tablet. He indicated he had not read the MAR, and was administering the medication based on the previous order for two tablets.</p> <p>During interview on 2/5/15 at 4:40 PM, Nurse #2 indicated the order was for 2 tablets and the new order was "messed up" and she continued to give 2 tablets. She indicated she knew the order was for 1 tablet every 4 hours and indicated it</p>	F 329	<p>All new medication orders will be discussed in morning clinical meeting by the Director of Health Services (DHS) or Clinical Competency Coordinator (CCC) Monday thru Friday and by Licensed Nursing Management on Saturday and Sunday to ensure proper transcription daily for four weeks. The monitoring will continue weekly for four weeks and then monthly for two months or until compliance is sustained. The Director of Health Services will track and trend results of the monitoring of medications orders and will report the findings to the Quality Assurance and Performance Improvement Committee bi-monthly x 6 months or until compliance is sustained.</p> <p>A daily narcotic audit will occur by the Director of Health Services or Clinical Competency Coordinator or by licensed Nursing Management daily for four weeks. The monitoring will continue weekly for four weeks and then monthly for two months or until compliance is sustained. The Director of Health Services will track and trend results of the monitoring of narcotics and will report the findings to the Quality Assurance and Performance Improvement Committee bi-monthly x 6 months or until compliance is sustained.</p> <p>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p>		

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F 329	Continued From page 92 was a pharmacy mistake. During interview on 2/6/15 at 6:30 AM, Nurse #3 indicated the order for the Oxycodone had always been for 2 tablets for break through pain. He indicated the pharmacy had made a mistake and no one caught it. Observation of the medication card on 2/6/15 at 10:00 AM, revealed there was one card of Oxycodone 15mg 1 tablet oral intake every 4 hours as needed for pain. During interview on 2/6/15 at 2:27 PM, the Director of Nursing indicated she expected the nurses to call and obtain a hard prescription for the medications and follow the physician order.	F 329	A daily narcotic audit will occur by the Director of Health Services or Clinical Competency Coordinator or by licensed Nursing Management daily for four weeks. The monitoring will continue weekly for four weeks and then monthly for two months or until compliance is sustained. The Director of Health Services will track and trend results of the monitoring of narcotics and will report the findings to the Quality Assurance and Performance Improvement Committee bi-monthly x 6 months or until compliance is sustained.  All new medication orders will be discussed in morning clinical meeting by the Director of Health Services (DHS) or Clinical Competency Coordinator(CCC) Monday thru Friday and by Licensed Nursing Management on Saturday and Sunday to ensure proper transcription daily for four weeks. The monitoring will continue weekly for four weeks and then monthly for two months or until compliance is sustained. The Director of Health Services will track and trend results of the monitoring of medications orders and will report the findings to the Quality Assurance and Performance Improvement Committee bi-monthly x 6 months or until compliance is sustained.  Labs will be monitored daily by the licensed nurses who will report any discrepancies directly to the Director of Health Services or week end supervisor for immediate correction for four weeks. The Director of Health Services will		

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F 329	Continued From page 93	F 329	monitor weekly for four weeks and then monthly for two months or until compliance is sustained. The Director of Health Services will track and trend results of the monitoring of labs and will report the findings to the Quality Assurance and Performance Improvement Committee bi-monthly x 6 months or until compliance is sustained.		
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and nurse practitioner interviews, the facility failed to maintain the medication error rate 5% or below by not administering the medications as ordered. There were two errors of 26 opportunities for error resulting in a 7.69 % error rate (Resident #12). Findings included:</p> <p>1 a. Resident #12 had doctor's orders for reglan 5 mgs ½ tablet per tube daily with breakfast and supper for gastroparesis. The February, 2015 physician's order indicated " may give medications by mouth or by tube. "</p> <p>On 2/3/15 at 4:01 PM, Resident #12 was observed during the medication pass. Nurse #7 was observed to prepare ½ tablet of reglan 5 milligrams (mgs), crushed it, mixed with pudding and administered it by mouth including the norco</p>	F 332	<p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>Resident #12's medical staff was called by the licensed nurse on 2/3/15 at 6:00 PM. A new order was received to not re-administer the 4 PM dose of Reglan and Norco and to give the other routine 6 PM medications.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>There are no other Residents currently in the facility that takes medications by</p>	3/11/15	

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F 332	<p>Continued From page 94 (pain medication). Nurse #7 encouraged Resident #12 to swallow. After more than 5 minutes, Resident #12 was still holding the medications in her mouth. Nurse #7 requested the resident to spit out the medications.</p> <p>On 2/3/15 at 4:10 PM and 5:05 PM, Nurse #7 was interviewed. She stated that she would administer the reglan later on, didn't specify what time.</p> <p>Review of the MARs revealed that the reglan was not administered to Resident #12 on 2/3/15. The nurse initial on the MAR for 2/3/15 was encircled indicating that reglan was not administered and the reason was resident spit out.</p> <p>On 2/5/15 at 10:45 AM, tried to contact Nurse #7 but was not available.</p> <p>On 2/5/15 at 11:02 AM, administrative staff # 1 was interviewed. She stated that her expectation was when the resident refused to swallow the medications, the nurse should have called the physician and follow his/her orders.</p> <p>On 2/5/15 at 4:30 PM, the Nurse Practitioner was interviewed. She stated that her expectation was when the resident spit out the medications by mouth, the nurse should administer the medications by tube.</p> <p>1 b. Resident #12 had doctor's orders for norco 5/325 mgs 1 tablet by mouth every 6 hours as needed for pain. The February, 2015 physician's orders indicated " may give medications by mouth or by tube. "</p> <p>On 2/3/15 at 4:01 PM, Resident #12 was</p>	F 332	<p>mouth and/or tube.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>The Pharmacy Consultant educated the Clinical Competency Coordinator on Feb 12, 2015 on medication Administration and competencies.</p> <p>The Director of Health Services/ RN licensed nurses were educated by the Clinical Competency Coordinator on medication administration and competencies (,medication administration pass) completed by the consultant pharmacist and Clinical Competency Coordinator completed on 3/11/15</p> <p>Licensed nurse identified with a medication pass error rate of greater than 5% will be removed from the schedule and reeducation including medication administration observations before returning to the schedule.</p> <p>All new hired licensed nurses will be educated on medication administration in orientation and will be observed for medication administration compliance of less that 5% by the Clinical Competency Coordinator (CCC) and Director of Health Services prior to working the floor unsupervised .Any licensed nurse found to have a medication pass error rate of greater than 5% will be not be allowed to work the floor until reeducation of</p>		

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F 332	<p>Continued From page 95</p> <p>observed during the medication pass. Nurse # 7 was observed to ask the resident if any pain and the pain level (1-10) and the resident responded that her pain level was 9. Nurse #7 was observed to prepare 1 tablet of norco 5/325 mgs., crushed it, mixed it with pudding and administered it by mouth including the reglan. Nurse #7 encouraged Resident #12 to swallow. After more than 5 minutes, Resident #12 was still holding the medications in her mouth. Nurse #7 requested the resident to spit out the medications.</p> <p>On 2/3/15 at 4:10 PM and 5:05 PM, Nurse #7 was interviewed. She stated that she would administer the reglan and the Norco later on, didn't specify what time.</p> <p>Review of the MARs and the controlled drug record revealed that the norco was not administered to Resident #12 on 2/3/15. The nurse initial on the MAR for 2/3/15 was encircled indicating that the norco was not administered and the reason was resident spit out and didn't swallow.</p> <p>On 2/5/15 at 10:45 AM, tried to contact Nurse #7 but was not available.</p> <p>On 2/5/15 at 11:02 AM, administrative staff # 1 was interviewed. She stated that her expectation was when the resident refused to swallow the medications, the nurse should have called the physician and follow his/her orders.</p> <p>On 2/5/15 at 4:30 PM, the Nurse Practitioner was interviewed. She stated that her expectation was when the resident spit out the medications by mouth, the nurse should administer the medications by tube.</p>	F 332	<p>medication administration has occurred and achieving a medication error rate of less than 5% during observed medication pass.</p> <p>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p> <p>Results of observed medication passes will be tracked and trended daily for four weeks by the Clinical competency coordinator (CCC then every other week for two months and then monthly for three months. These results will be reported to the Quality Assurance and Performance Improvement Committee monthly for recommendations and changes for six months or until continued compliance is achieved.</p>		



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F 333 SS=D	<p><b>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</b></p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to administer the amlodipine (anti hypertensive drug) and oxycodone (pain medication) as ordered for 2 of 5 sampled residents reviewed (Resident #85 &amp; # ). Findings included:</p> <p>Resident # 85 was admitted to the facility on 12/24/14 with multiple diagnoses including hypertension. The quarterly MDS assessment dated 1/5/15 indicated that Resident #85 was cognitively impaired.</p> <p>Review of the admission orders and the physician's orders for February, 2015 revealed that Resident #85 was on amlodipine 5 mgs. 1 tablet per tube four times a week on Monday, Wednesday, Friday and Saturday for hypertension.</p> <p>The Medication Administration Records (MARs) were reviewed. The January, 2015 MAR revealed that amlodipine was administered everyday. The February MAR revealed that amlodipine was administered on February 1 (Sunday) and were encircled on February 2 (Monday) and 3 (Tuesday), indicating that the amlodipine was not administered.</p>	F 333	<p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>Resident #85 Medication Administration Record (MAR) was reviewed and changes made to have the days of Monday, Wednesday, Friday and Saturday open for signatures of administration and all other days crossed off to acknowledge that the medication is not to be given on Tuesday, Thursday and Sunday. The medical staff was notified on 2/6/15 of the errors in documentation on the MAR and no new orders were received.</p> <p>There were no other Residents identified in the 2567 nor was Resident #85 identified as having a problem with Oxycodone administration.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>A 100% Medication Administration Record audit was done by DHS and or licensed nursing management to determine if any other off day medications had not been</p>	3/11/15	

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F 333	<p>Continued From page 97</p> <p>On 2/4/15 at 10:45 AM, Nurse # 1 was interviewed. He stated that the MAR should have boxes on the days the amlodipine should be given but he acknowledged that nurses should have read the MAR before administering the medication. He further indicated that on February 2 and 3, he did not administer the amlodipine because it was not available.</p> <p>On 2/5/15 at 11:45 AM, administrative staff #1 was interviewed. She reviewed the MARs and stated that nurses were expected to read the MARs before administering the medication.</p>	F 333	<p>documented correctly for February and March with change over the monthly orders. 3/1/15</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>The Director of Health Services/Clinical Competency Coordinator/ RN licensed nurses were educated on medication observation and competencies completed by the Pharmacy Consultant completed on March 3, 2015.</p> <p>Licensed nurse were observed on medication administration, Pharmacy Consultant/Clinical Competency Coordinated/Director of Health Services and/or RN licensed nurses, any nurses identified with a medication pass error rate of greater than 5% will be removed from the schedule and re-education including medication administration observations before returning to the schedule.</p> <p>All new hired licensed nurses will be educated on medication administration in orientation by Clinical Competency Coordinator and will be observed for medication administration compliance of less than 5% by the Clinical Competency Coordinator and/or RN licensed nurse prior to working the floor unsupervised. Any licensed nurse found to have a medication pass error rate of greater than 5% will be not be allowed to work the floor</p>		

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F 333	Continued From page 98	F 333	until reeducation of medication administration has occurred and achieving a medication error rate of less than 5%.  How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.  Results of observed medication passes will be tracked and trended daily for four weeks by the Clinical competency coordinator (CCC then every other week for two months and then monthly for three months. These results will be reported to the Quality Assurance and Performance Improvement Committee monthly for recommendations and changes for six months or until continued compliance is achieved.		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356		3/11/15	

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F 356	<p>Continued From page 99</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to prominently post the nurse staffing information for the entire nursing home on a daily basis on 2 of 3 halls (halls number 2 and 3). Findings included:</p> <p>During the observation on the initial tour on 2/2/15 at 9:20 AM, the staff posting information was observed near the nurses ' station on 100 hall, which was located at the back of the facility. It was not a prominent place readily accessible to residents and visitors. The information posted on 100 hall reflected 100 hall staffing for the day. There was no staff posting available on 200 and 300 halls.</p> <p>The continued observation of 100, 200 and 300 halls during the five days of the survey revealed that there was no staff posting information</p>	F 356	<p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>There were no named Residents identified in the 2567. The posting of the nurse staffing information was removed from the 100 hall on 2/6/15 and placed on the 200 hall immediately inside the front entrance to the facility.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All Residents and visitors have the potential of being affected by the nurse</p>		

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F 356	Continued From page 100 available on the 200 and 300 halls.  On 02/05/2015 3:05 PM, during the interview, the assistant of director of nursing (ADON) indicated that the staff posting was only available on the 100 hall bulletin board. When asked how visitors would know what the staffing was for the facility the ADON answered they could ask a nurse.	F 356	staffing information not readable available for review.  What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?  The nurse staffing information is now placed on the 100 hall, 200 hall and 300 hall on the wall in a prominent place readily available to the Residents and visitors. 2/25/15 The Director of Health Services (DHS) was educated by the Administrator on updating the nurse staffing data with the beginning of each shift. The Director of Health Services (DHS) will educate the week end Supervisors and Licensed Nurses on updating the nurse staffing data at the beginning of each shift.  Monitoring: The Director of Health Services (DHS) and Week end Supervisors will audit and monitor the nurse staffing data daily for four weeks, then weekly for eight weeks for tracking and trending. The results of the tracking and trending will be done by the DHS. She will take these results and report them to the monthly Quality Assurance and Performance Improvement Committee for suggestions and recommendations for changes for three months or until compliance is achieved.		
F 371	483.35(i) FOOD PROCURE,	F 371		3/11/15	

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F 371 SS=D	<p>Continued From page 101 STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to discard spoiled vegetables, fruits and dented cans. Cover and date stored food and to clean the floor in the kitchen and the walk-in coolers and freezer, the ice machine, ice cream machine and plate warmer.</p> <p>The findings included: On 2/2/15 at 9:25 AM, during the observation of the walk-in cooler in the kitchen, there were observed three paper boxes of spoiled and rotten vegetables and fruits mixed in with good quality products on the shelves ready for use with cucumbers, peppers and lemons. A plastic bag of parsley and turkey sausages were on the shelf uncovered and not dated in paper boxes. On 2/2/15 at 9:25 AM, during an interview, the Food Service Director stated that the staff member, who placed the boxes in the cooler, was responsible for ensuring that all produce was in good condition and removing the bad quality</p>	F 371	<p>Corrective action will be accomplished for the resident found to have been affected by the deficient practice:  The spoiled vegetables and fruits were removed on 2/2/15. The dented jelly can was moved to the dented section of the store room on 2/2/15. The parsley and turkey sausage were covered and dated on 2/2/15.  On 2/2/15 the Dietary Manager and dietary staff cleaned the kitchen floor, cooler floor, freezer floor, ice cream freezer/ machine and plate warmer.  Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:  The Dietary Manager inspected all food in the kitchen on 2/2/15 and found no other spoiled foods in the kitchen.</p>		

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F 371	<p>Continued From page 102</p> <p>vegetables and fruits. He stated that the plastic bag with parsley should be stored closed to air. The box of turkey sausages needed to be kept covered and dated.</p> <p>On 2/2/15 at 9:30 AM, during an observation in the kitchen a meal plate warmer that was greasy and had food debris. The reach-in cooler floor had sticky dark red substance. The ice cream machine and ice machine were observed with many light brown and yellow spots inside. In the meat freezer, there was a plastic pan that had food crumbs on the bottom of it.</p> <p>On 2/2/15 at 9:35 AM during the interview, the Food Service Director stated that the meal plate warmer, reach-in cooler, ice cream machine and ice machine needed to be cleaned. The food service director continued that a plastic pan in the meat freezer should be kept clean.</p> <p>On 2/2/15 at 9:40 AM, during the dry food storage room observation, there was one dented can of jelly found on the shelf.</p> <p>On 2/2/15 at 9:40 AM, during the interview, the Food Service Director removed a dented can with the comments that all of the dented cans need to be removed from shelves.</p> <p>On 2/4/15 at 10:20AM, during the interview, the Food Service Director indicated that he had a cleaning schedule for all kitchen staff for the week as well as daily assignments, included cleaning. He indicated that all kitchen employees were assigned to clean their working area at the end of the shift and as needed. He indicated that it was his responsibility to clean the ice cream</p>	F 371	<p>The Dietary Manager inspected all canned products on 2/2/15 and confirmed that there were no other dented cans on food stock shelves.</p> <p>The Dietary Manager inspected all food in the kitchen on 2/2/15 and found no other foods without covers and/or labels.</p> <p>The Dietary Manager completed a sanitation inspection on 2/2/15 and found no other areas of the kitchen in need of cleaning.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On March 3, 2015 education began by Certified Dietary Manager and the Registered Dietician for all dietary employees on FIFO (First in / First out) method of food storage and the shelf life of refrigerated foods, where and how items are to stored, removal of dented cans to appropriate areas, cleaning schedules clean as you go and as assigned and document, documentation of logs for refrigerators, freezers, 3 compartment sinks, dish machines.</p> <p>On March 3, 2015 checks were started and documented daily by morning cook, Certified Dietary Manger, and PM closer on appropriate check list to include but not limited to: temperature of refrigerators and freezers, checks for unwrapped and outdated or soiled food, check for dented cans, and assign cleaning schedules and date.</p>		

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F 371	Continued From page 103 and ice machines today.  On 2/4/15 at 10:25AM, during the interview, the cook-staff supervisor stated that was her responsibility that the kitchen staff followed policies and procedures, and cleaned. A person was assigned to check for spoilage and restock the fruits and vegetables on the weekly schedule. Her expectation was for all staff members, who obtain vegetables and fruits from the walk-in cooler, to check for spoilage.  Record review of the kitchen cleaning schedule revealed the daily, weekly and monthly kitchen cleaning assignments with AM and PM schedule for cleaning per kitchen areas per shift. All of the assignments were posted and marked as done by the kitchen staff but the kitchen equipment and storage areas, mentioned above, were not clean at the time of observation.	F 371	Dietary Manager will review audit sheets after morning cook, in the pm and reassign if necessary or clean. Closer for the day will review and document that all items are clean and in place before they clock out.  Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained:  Dietary Manager will summarize findings of daily and weekly audit to Quality Assurance and Performance Improvement Committee monthly x 3 months until pattern of compliance is achieved.		
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.	F 431		3/11/15	



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F 431	<p>Continued From page 104</p> <p>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.</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 record review, observation and staff interview, the facility failed to date multi dose medications and supplements when opened on 2 (100 and 200 hall medication carts) of 3 medication carts observed. Findings included:</p> <p>1. On 2/4/15 at 3:40 PM, the medication cart on 100 hall was observed. There was a used advair diskus (steroid/bronchodilator) observed that was undated.</p> <p>The manufacturer's specification for advair diskus was " discard 30 days after opening the foil pouch. "</p> <p>On 2/4/15 at 3:45 PM, Nurse #1 was interviewed. He acknowledged that the advair was undated and stated that it should have been dated when</p>	F 431	<p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>There were no named Residents in the 2567.</p> <p>The Advair diskus on the 100 hall medication cart was immediately removed on 2/4/15 from the medication cart. Another Advair diskus was ordered from the pharmacy on 2/4/15 The opened and undated UTI stat (supplement) and prostat (protein supplement) were removed from the cart on the 100 hall on 2/4/15. They were replaced with newly opened and dated</p>		

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F 431	<p>Continued From page 105</p> <p>opened. He added that he would discard the advair.</p> <p>On 2/5/15 at 12:40 PM, administrative staff #1 was interviewed. She stated that the advair diskus would expire 30 days after opening. She added that she expected the nurses to date the medications when opened.</p> <p>2. On 2/4/15 at 3:40 PM, the medication cart on 100 hall was observed. Opened bottles of UTI stat (supplement) and prostat (protein supplement) were observed with no date of opening.</p> <p>The instruction on the bottle of the UTI stat and prostat read " discard 3 months after opening. "</p> <p>On 2/4/15 at 3:45 PM, Nurse #1 was interviewed. He acknowledged that the UTI stat and prostat were undated and stated that they should have been dated when opened. Nurse #1 stated that he would discard the undated UTI stat and prostat.</p> <p>On 2/5/15 at 12:40 PM, administrative staff #1 was interviewed. She stated that she had verified it with the consultant who stated that the UTI stat and the prostat would expire according to the manufacturers' expiration date. She added that she expected the nurses to date the medications/supplements when opened.</p> <p>3. On 2/4/15 at 4:15 PM, the medication cart on 200 hall was observed. There was a used symbicort ( steroid/bronchodilator) observed that was undated.</p>	F 431	<p>UTI and prostat supplements.</p> <p>The Symbicort on the 200 hall medication cart was immediately removed on 2/4/15 from the medication cart and another Symbicort was ordered from the pharmacy.</p> <p>The opened and undated UTI stat (supplement) and prostat (protein supplement) were removed from the cart on the 200 hall on 2/4/15. They were replaced with newly opened and dated UTI and prostat supplements.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All medication carts (100 hall, 200 hall and 300 hall) were audited by the consultant pharmacist all medications, and supplements that were found to be open without dates were removed from the carts and replacements from pharmacy were ordered and new supplements were opened and dated.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>100 % of all licensed nurses were inserviced by Clinical Competency Coordinator (CCC) on medications that have an expiration date after opening and then requirement to date clearly these medications.</p>		

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F 431	<p>Continued From page 106</p> <p>The instruction on the box read " expire 3 months after foil package opened. "</p> <p>On 2/4/15 at 4:20 PM, Nurse #3 was interviewed. He acknowledged that the used symbicort was undated and stated that it should have been dated when opened.</p> <p>On 2/5/15 at 12:40 PM, administrative staff #1 was interviewed. She stated that the symbicort would expire 30 days after opening. She added that she expected the nurses to date the medications when opened.</p> <p>4. On 2/4/15 at 4:15 PM, the medication cart on 200 hall was observed. Opened bottles of UTI stat (supplement) and prostat (protein supplement) were observed with no date of opening.</p> <p>The instruction on the bottle of the UTI stat and prostat read " discard 3 months after opening. "</p> <p>On 2/4/15 at 3:45 PM, Nurse #3 was interviewed. He acknowledged that the UTI stat and prostat were undated and stated that they should have been dated when opened.</p> <p>On 2/5/15 at 12:40 PM, administrative staff #1 was interviewed. She stated that she had verified it with the consultant who stated that the UTI stat and the prostat would expire according to the manufacturers' expiration date. She added that she expected the nurses to date the medications/supplements when opened.</p>	F 431	<p>A list of these medications will be located in the front of the Medication Administration Record for easy reference. The licensed nurses were inserviced on dating supplements when opened. No licensed nurse will be allowed to work the nursing unit until they have had this education.</p> <p>All new hired licensed nurses will have this education in orientation prior to working the floor by the Clinical Competency Coordinator.</p> <p>Monitoring:</p> <p>The medication carts will be audited daily for out of date medications or medications that require dates when opened and supplements dated when opened. The Medication Administration Records (MAR) will also be audited to ensure the listing of medications that need to be dated in current and located in the front of the MAR. These audits will be done by the Director of Health Service (DHS), Clinical Competency Coordinator or Licensed nurse week end supervisor for four weeks. The audits will continue weekly for one month and then monthly for two months.</p> <p>The Consultant Pharmacist will also monitor the dating of required medications when open on all three medication carts with each monthly visit and check to ensure the listing of medication in the MAR is current for three months. They will</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	Continued From page 107	F 431	report any non-compliance concerns to the DHS immediately.		
F 520 SS=J	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify</p>	F 520	<p>The tracking and trending of the audits will be done by the Director of Health Services and the licensed nurse week end supervisor who will report the results to the monthly Quality Assurance and Performance Improvement Committee for suggestions and recommendations for changes to ensure continued compliance for three months or until continued compliance is achieved.</p>	3/11/15	

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NAME OF PROVIDER OR SUPPLIER  <b>UNIHEALTH POST-ACUTE CARE-HIGH POINT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3830 N MAIN STREET HIGH POINT, NC 27265</b>		
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F 520	<p>Continued From page 108 and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain and implement procedures and monitor interventions that the committee put into place in January 2014. This was in response to deficiencies cited in December 2014 on a complaint investigation survey and in January 2015 resulting in deficiencies in the areas of housekeeping and maintenance and maintaining well-being. On the current survey, the facility failed to assess and implement mental health treatment which resulted in failure to provide wound care and personal care for 1 of 3 sampled residents (Resident #3). The facility further failed to administer arginaid (a protein supplement) and pro-stat (a protein supplement) as ordered and failed to provide cushion in wheelchair to promote wound healing (Resident #24).</p> <p>Immediate Jeopardy (IJ) began on 1/6/15 for Resident #3 when the wounds to the bilateral calves declined. The IJ was removed on 2/6/15 at 6:00PM when the facility provided an acceptable allegation of compliance. The facility remains out of compliance at a scope and severity of D, isolated deficiency that constitutes no actual harm with potential for more than minimal harm, for example #2, Resident #24, and due to on-going in-service training of staff and allowing time for the facility to implement the changes through the Quality Assurance program.</p>	F 520	<p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>Resident # 103 has had no requested any further overnight Leave of Absences. Auditing for other residents has reviewed no problems or issues obtaining medications for overnight Leave of Absences.</p> <p>Resident # 3 was involuntary committed and sent to Novant Health Forsyth Medical Center. The facility sent to the hospital with EMS copies of the attending physician progress notes, wound care notes, medication administration records and psych notes.</p> <p>Upon return the guardianship will continued to be pursued. Guardianship paper was filed at the magistrate office on Feb 4, 2015.</p> <p>Resident # 24 Prostat 30 and arginaid were placed on the medication administration record and given as ordered.</p> <p>Resident # 24 wheel chair cushion was obtained.</p>		

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F 520	<p>Continued From page 109</p> <p>Findings included:</p> <p>F 520 is cross referenced to F252 and F309.</p> <p>1. F 309. Based on record review, staff and resident interview, the facility failed to provide 1 of 3 sampled residents (Resident #103) medications for a leave of absence during a complaint survey of 1/15/15. The facility was recited at F 309 for failure to assess and implement mental health treatment which resulted in failure to provide wound care and personal care for 1 of 3 sampled residents (Resident #3) and to administer arginaid (a protein supplement) and pro-stat (a protein supplement) as ordered and failed to provide cushion in wheelchair to promote wound healing (Resident #24).</p> <p>The facility was notified on 3/4/15 that the severity of this deficiency was increased to immediate jeopardy. The facility provided an acceptable credible allegation on 3/4/15 that was based on their actions during the survey of 2/6/15. The credible allegation documented the following:</p> <p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> <li>· Resident #3 was involuntary committed and sent to Novant Health Forsyth Medical Center. The facility sent to the hospital with EMS and copies of the attending physician progress notes, wound care notes, medication administration records and psych notes.</li> <li>· Upon return the guardianship will continued to be pursued. Guardianship paper was filed at the magistrate office on Feb 4, 2015.</li> </ul>	F 520	<p>Resident council meeting will be conducted on 2/6/15 by the Social worker, and activities director to review resident's rights to refuse care and services.</p> <p>Example 2 F 309 as followed</p> <p>Example 1 F 252 as followed</p> <p>Example #1 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All Residents have the potential to be affected by odors in the facility. All interview able Residents have been interviewed for their perception of the odors in the facility by use of the compliance rounds.</p> <p>Example # 1 What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>Clinical Competency Coordinator (CCC) and Environmental Director, began in-service on March 3, 2015, in-service 100% nursing and environmental department that all linen and trash barrels will be located in soiled utility room, no linen or trash barrels will be located on hallways.</p> <p>Compliance rounds will be completed daily by assigned team members including but not limited department managers and staff from each</p>		

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F 520	<p>Continued From page 110</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> <li>· Skin Integrity Nurses has reviewed 100% of residents with wounds to ensure wounds are staged and documented appropriately, treatment is being delivered as ordered and care plans are individualizes. The Director of Health Services has validated the audit completed by the Skin Integrity Nurses.</li> <li>· Licensed nurses are completing 100% body audit on all residents 2/5/15 the Director of Health Services is reviewing the body audits as they are completed to ensure that all skin areas have been identified and are being treated, including care plan updates, responsible party and physician notification.</li> <li>· Licensed Nurse, Unit Managers are reviewing the Medication Administration Records for refusal of medications. Any residents identified with more than 2 consecutive doses of a vital medication, including but not limited to cardiac medications, anticoagulants, anti-seizure medications, psych medications and anti-diabetic medication, are withheld or refused the physician will be notified. Care plan will be reviewed and updated for behavior and mental health services as needed.</li> <li>· Activity of Daily Living (ADL) documents were reviewed by the Director of Health Services for any refusal of care. Noted refusal of care for more than 2 instances will be addressed with a care plan review and update, education of resident, responsible party notification, physician notification and mental health services as indicated.</li> </ul> <p>What measures will be put in place or what</p>	F 520	<p>department. Education with staff was completed on 2/6/15 on responsibilities, items to review and items that need to be reported to the Director of health Services and/or the Administrator for immediate corrective action. Education was completed by Administrator in Training and Administrator.</p> <p>On March 5, 2015 Lennox will service the ventilation system on the 200 and 300 hall.</p> <p>On Feb 13, 2015 Architect Kurmaskie Associates visited the facility to review the existing environmental conditions of the 100 hall, specific to the HVAC system. As a result, a mechanical design will be proposed that will introduce conditioned outside "Fresh Air" ventilation and will be exhausted at a similar rate of exchange.</p> <p>Example # 1 How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p> <p>Monitoring of the effectiveness of the education and changes of monitoring for odors, cleaning of common areas and linen disposition will occur by use of daily compliance rounds by the Department Managers and Licensed nurses Monday thru Friday. Week end Manager on duty and week end licensed nurses will do the compliance rounds on Saturday and Sunday. If any areas are found not to be</p>		

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F 520	Continued From page 111 systemic changes will be made to ensure that the deficient practice will not reoccur?  · On 2/5/15 education for nursing staff and therapy on what to do of a resident refuses care, and who to report refusal of care to, education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work. · On 2/5/15 educated for Licensed Nurses staff began on Policy and Procedure medication general guidelines referring to notification of physician of 2 consecutive doses of a vital medication including but not limited to cardiac medications, anticoagulants, anti-seizure medications, psych medications, psych medications, and anti-diabetic medication, are withheld or refused the physician will be notified, education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work. · On 2/5/15 education was begun with the Skin Integrity Nurses and the license nurses on reporting to the Director of Health Services and/or Administrator if a resident has refused wound care for more than 2 consecutive treatments. The Physician will also be notified of refusal of 2 consecutive treatments. Education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work. · On 2/5/15 education for nursing staff, including licensed and non-licensed staff, and therapy on	F 520	in compliance the Department Manager or Licensed Nurse will be responsible for initiating corrective action. All compliance rounds will be turned into the Administrator.  The monitoring will occur daily for four (4) weeks, then weekly for four (4) weeks and then monthly for three (3) months or until compliance is continuous.  Results of the monitoring for tracking and trending will be done by the Administrator and reported to the monthly Quality Assurance and Performance Improvement (QAPI) Committee for recommendations and suggestions for changes for continued improvement.  The results of the monitoring, of the compliance rounds, with tracking and trending will be reported to the Quality Assurance and Performance Improvement Committee by the Administrator for suggestion and recommendations for change.  Example #2a How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?  Skin Integrity Nurses has reviewed 100% of residents with wounds to ensure wounds are staged and documented appropriately, treatment is being delivered as ordered and care plans are individualizes. The Director of Health Services has validated the audit		



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F 520	Continued From page 112 what to do of a resident refuses care and treatments, including but not limited to bathing, dressing, peri-care, turning and reposition, eating, medications, wound treatments, outside appointments and procedures including labs and x-rays, staff are to document in the medical record and report refusal of care to the charge nurse, unit manager, Director of Health Services to ensure proper interventions were implemented, education was completed by the Clinical Competency Coordinator/Unit Manager/Director of Health Services. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work. · Resident council meeting will be conducted on 2/6/15 by the Social worker, and activities director to review resident 's rights to refuse care and services. · Residents that are currently refusing care and services will be reviewed by the Interdisciplinary Team, including but not limited to the attending physician, social worker, Director of Health Services, responsible party and resident in question, to determine the plan of care including but not limited to treatment alternatives, engaging the ombudsman, Adult protective services, psych services referrals and applying for guardianship. Cognition status will be reviewed during this meeting to determine how the facility will proceed with referral and treatment alternatives. · Quality Assurance Performance Improvement (QAPI) Committee met on Jan 27, 2015 to discuss old issues and new issues related to recent survey. · Quality Assurance Performance Improvement Committee met on Feb 5, 2015 to discuss identified citations at the IJ level during current survey. Team discussed Credible Allegation	F 520	completed by the Skin Integrity Nurses.  Licensed nurses completed 100% body audit on 2/5/15 for all residents, the Director of Health Services has reviewed the body audits as they are completed to ensure that all skin areas have been identified and are being treated, including care plan updates, responsible party and physician notification.  Licensed Nurse, Unit Managers are reviewing the Medication Administration Records for refusal of medications. Any residents identified with more than 2 consecutive doses of a vital medication, including but not limited to cardiac medications, anticoagulants, anti-seizure medications, psych medications and anti-diabetic medication, are withheld or refused the physician will be notified. Care plan will be reviewed and updated for behavior and mental health services as needed.  Activity of Daily Living (ADL) documents were reviewed by the Director of Health Services for any refusal of care. Noted refusal of care for more than 2 instances will be addressed with a care plan review and update, education of resident, responsible party notification, physician notification and mental health services as indicated.  Skin integrity nurse audited 100% of wheel chairs to ensure cushions are in wheel chair. Wheel Chair cushions were ordered on Feb 9, 2015.		

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F 520	<p>Continued From page 113 submitted to progress of audit tools and education.</p> <p>Date of Compliance: All items were completed as of 2/6/15</p> <p>On 2/6/14 at 3:30PM, staff were interviewed on the expectation of the reporting process, documentation and notification to nursing, social work, physician and administrative staff of residents that refuse care, treatment and medications. The daily rounds and 24 hour report, skin assessments forms were reviewed. Staff were able to describe the expectations for resident refusal of care, treatment and medications as they had received an in-service on 2/5/15 and 2/6/15. The administrative staff were able to describe the expectation for implementing care and treatment for residents that had 2 consecutive refusals of care, treatment and medications. The social worker indicated the expectation for referrals to outside agencies for additional services.</p> <p>2. F 252 Based on observations, a resident and staff interview the facility failed to eliminate odors of urine and feces on the hall and keep the floor clean on two of the three hallways (hallways 100 and 200).</p> <p>The facility was recited for F 252 for failing to prevent the odors of urine and feces on the 100 and 200 halls during the 2/6/15 recertification, follow up and complaint survey.</p> <p>On 02/05/2015 at 2:20 PM the Administrator indicated he was not aware of odors in the hallways. He had not smelled strong odors of urine or feces, other than when an aide was</p>	F 520	<p>Skin integrity coordinator completed an audit of all residents with wounds to ensure medications ordered for wound healing are current on the medication administration records.</p> <p>Example # 2a What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>On 2/5/15 education for nursing staff, including licensed and non-licensed staff, and therapy on what to do if a resident refuses care and treatments, including but not limited to bathing, dressing, peri-care, turning and reposition, eating, medications, wound treatments, outside appointments and procedures including labs and x-rays. Licensed staff are to document in the medical record and on the 24 hour report. Non-Licensed staff and therapy are to report refusal of care to the charge nurse, unit manager, Director of Health Services to ensure proper interventions were implemented, education was completed by the Clinical Competency Coordinator/Unit Manager/Director of Health Services. Any staff member not receiving the in-service, due to PRN status and/or out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>The 24 hour reports will be reviewed daily by the Director of Health Services, and/or Licensed Nurse Manager for behaviors including but not limited to refusal of care and treatment. The Director of Health</p>		

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F 520	Continued From page 114 providing care. The Interim Administrator indicated she had no ability to smell, and relied on the directors to monitor and they had identified the odors. Then it was up to the environmental director to resolve the odors. The Interim Administrator indicated she had read the plan of correction and had the impression that it had gotten better, but the smell was still unpleasant and still lingering. The Administrator indicated the quality assurance committee was monitoring medications for residents who were going on leave of absence only.	F 520	<p>Service will track and trend any noted behaviors and present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>On 2/5/15 educated for Licensed Nurses staff began on Policy and Procedure medication general guidelines referring to notification of physician of 2 consecutive doses of a vital medication including but not limited to cardiac medications, anticoagulants, anti-seizure medications, psych medications, psych medications, and anti-diabetic medication, are withheld or refused the physician will be notified, education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due to PRN status and/or out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>On 2/5/15 education began with the Skin Integrity Nurses and the license nurses on reporting to the Director of Health Services and/or Administrator if a resident has refused wound care for more than 2 consecutive treatments. The Physician will also be notified of refusal of 2 consecutive treatments. Education was completed by the Clinical Competency Coordinator. Any staff member not receiving the in-service, due PRN status and/or out on FMLA will be removed from the schedule and will be educated prior to return to work.</p>		

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F 520	Continued From page 115	F 520	<p>The Director of Health Services will review the weekly wound report for refusal, attending physician notification and new interventions to ensure appropriate follow up completed weekly x 6 months or until compliance is sustained. The results of the monitoring with tracking and trending will be reported to the Quality Assurance and Performance Improvement Committee by the Director of Health Services for suggestion and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>Residents that are currently refusing care and services will be reviewed by the Interdisciplinary Team, including but not limited to the attending physician, social worker, Director of Health Services, responsible party and resident in question, to determine the plan of care including but not limited to treatment alternatives, engaging the ombudsman, Adult protective services, psych services referrals and applying for guardianship. Cognition status will be reviewed during this meeting to determine how the facility will proceed with referral and treatment alternatives.</p> <p>The Social Worker with track and trend the residents with refusal of care and treatments there were discussed with the Interdisciplinary Team and present the findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until</p>		

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F 520	Continued From page 116	F 520	<p>compliance is sustained.</p> <p>Education was started on 2/28/15 by the Clinical Competency coordinator with licensed nursing staff on physician order regarding order transcription. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</p> <p>All new medication orders will be discussed in morning clinical meeting by the Director of Health Services (DHS) or Clinical Competency Coordinator (CCC) Monday thru Friday and by Licensed Nursing Management on Saturday and Sunday to ensure proper transcription daily for four weeks. The monitoring will continue weekly for four weeks and then monthly for two months or until compliance is sustained. The Director of Health Services will track and trend results of the monitoring of medications orders and will report the findings to the Quality Assurance and Performance Improvement Committee bi-monthly x 6 months or until compliance is sustained.</p> <p>Education was begun on 2/28/15 by the clinical competency coordinator for licensed and non-licensed nursing staff of what to do if cushion is not in wheel chair, and where to obtain a cushion from. Any staff member not receiving the in-service, due PRN status and out on FMLA will be removed from the schedule and will be educated prior to return to work.</p>		

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F 520	Continued From page 117	F 520	<p>Education on compliance rounds, including but not limited to signs of neglect, dignity, odors and wheel chair cushions, was completed on 2/6/15 for assigned staff on responsibilities, items to review and items that need to be reported to the Director of Health Services and/or the Administrator for immediate corrective action. Education was completed by Administrator in Training and Administrator</p> <p>Compliance rounds will be completed daily by assigned team members including but not limited to department managers and staff from each department. Administrator will track and trend the results from the compliance and will present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>Quality Assurance Performance Improvement (QAPI) Committee met on Jan 27, 2015 to discuss old issues and new issues related to recent survey.</p> <p>Quality Assurance Performance Improvement Committee met on Feb 5, 2015 to discuss identified citations at the IJ level during current survey. Team discussed Credible Allegation submitted to progress of audit tools and education.</p> <p>Example # 2a How will the corrective action be monitored to assure that the</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>UNIHEALTH POST-ACUTE CARE-HIGH POINT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3830 N MAIN STREET HIGH POINT, NC 27265</b>		
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F 520	Continued From page 118	F 520	<p>deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p> <p>Quality Assurance Performance Improvement Committee met on Feb 5, 2015 to discuss identified citations at the IJ level during current survey. Team discussed Credible Allegation submitted to progress of audit tools and education.</p> <p>The 24 hour reports will be reviewed daily by the Director of Health Services, and/or Licensed Nurse Manager for behaviors including but not limited to refusal of care and treatment. The Director of Health Service will track and trend any noted behaviors and present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>Compliance rounds will be completed daily by assigned team members including but not limited to department managers and staff from each department. Administrator will track and trend the results from the compliance and will present findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained.</p> <p>All new medication orders will be</p>		

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F 520	Continued From page 119	F 520	<p>discussed in morning clinical meeting by the Director of Health Services (DHS) or Clinical Competency Coordinator (CCC) Monday thru Friday and by Licensed Nursing Management on Saturday and Sunday to ensure proper transcription daily for four weeks. The monitoring will continue weekly for four weeks and then monthly for two months or until compliance is sustained. The Director of Health Services will track and trend results of the monitoring of medications orders and will report the findings to the Quality Assurance and Performance Improvement Committee bi-monthly x 6 months or until compliance is sustained.</p> <p>The Social Worker with track and trend the residents with refusal of care and treatments there were discussed with the Interdisciplinary Team and present the findings to the Quality Assurance and Performance Improvement Committee for suggestions and recommendations for change bi-monthly x 6 month or until compliance is sustained</p> <p>Example #2b How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>A 100% audit by Director of Healthcare Services of Resident sign out forms for the last 30 days was done on January 13, 2015 to determine other Residents that leave the facility for overnight visits and could be affected by the same alleged deficient practice. No other Residents</p>		



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F 520	Continued From page 120	F 520	<p>were identified to have gone on a LOA and not have medications available for use on LOA. A letter will be mailed (2/3/15) to family members to inform them of the process to let the licensed nurses know 24 hour in advance of an overnight LOA to ensure medications available.</p> <p>Example # 2b What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?</p> <p>The Clinical competency coordinator (CCC) will in-service all licensed nurses for leave of absence policy and obtaining medication for Residents. This in service will also include review of the medication release form for leave of absence for the licensed nurses. In-services were started on January 29, 2015. Licensed nurses will complete in services by February 4, 2015 or will not be permitted to work until completed.</p> <p>At the next Resident Council meeting on February 3, 2015 all Residents will be reminded of the need to have a 24 hour notice to obtain medications for a LOA. For the Residents not at Resident Council meeting activities staff will deliver notification to all other Residents.</p> <p>Example # 2b How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure</p>		

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F 520	Continued From page 121	F 520	<p>continued compliance.</p> <p>Monitoring of effectiveness of education and continuum medication regimen for all leave of absence residents will occur by daily audits of 24 hour report sheets and leave of absence books by Director of Healthcare Services and Clinical Competency Coordinator (CCC) Monday thru Friday. Weekend license nurses will complete audits on Saturday and Sunday. All audits will be turned into the Administrator for verification and tracking and trending.</p> <p>The monitoring will occur daily for four (4) weeks, then weekly for four (4) weeks and then monthly for three (3) months or until compliance is continuous.</p> <p>Results of the monitoring for tracking and trending will be done by the Administrator and Director of Healthcare Services and reported to the monthly Quality Assurance and Performance Improvement (QAPI) Committee for recommendations and suggestions for changes for continued improvement.</p>		