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CLEAR CREEK NURSING & REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the Complaint Investigation. Event ID # UH3F11.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		4/13/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/08/2015

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 272 Continued From page 1

F 272

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to conduct a comprehensive assessment for 3 of 16 sampled residents to identify how condition affected each resident's function and quality of life (Residents #39, #110 and #153).

The findings included:

1. Resident #153 was admitted to the facility on 11/26/14 with diagnoses which included end stage dementia and anxiety.

Review of Resident #153's admission Minimum Data Set (MDS) dated 12/03/15 revealed an assessment of severely impaired cognition. The MDS indicated physical and verbal behavior directed toward others with receipt of antipsychotic and antianxiety medication. The MDS triggered the Care Area Assessment (CAA) for falls.

Review of the Fall CAA dated 12/09/15 revealed Resident #153 was at risk for falls related to impaired balance, medication use, cognitive impairment, anxiety, agitation and the presence of pain.

Further review of the Fall CAA revealed there was no documentation of an analysis of the findings supporting the decision to proceed or not to

Clear Creek Nursing and Rehabilitation Center acknowledges receipt of the statement of Deficiencies and proposes this Plan of Correction to the ectent that the summay of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.

Clear Creek Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Clear Creek Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F272
Comprehensive Assessments
Criteria 1
One-on- one in-service completed with Minimum Data Set Nurse on 3/19/2015 on Care Area assessments and Care

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F 272	Continued From page 2 proceed to the care plan. The CAA did not indicate contributing factors such as source of pain with supporting documentation specific to Resident #153. The CAA section entitled: "Describe impact of this problem/need on the resident and your rationale for care plan decision" listed interventions for fall prevention. The interventions included provision of assistance, verbal and tactile cues, allowance of extra time for mobility, ensure appropriate footwear, bed to low position, and observe for adverse side effects of meds. Interview with the MDS Coordinator on 03/19/15 at 3:44 PM revealed the CAA should contain a documented analysis of findings specific to Resident #153. The MDS Coordinator reported the care plan interventions were not an analysis of Resident #153's risk for falls. 2. Resident #110 was admitted to the facility on 03/24/14 with diagnoses which included anxiety, depression, dementia and history of traumatic brain injury. Review of Resident #110's admission Minimum Data Set (MDS) dated 03/31/14 revealed an assessment of severely impaired cognition. Review of the Psychotropic Drug Use Care Area Assessment (CAA) dated 04/10/14 revealed Resident #110 received antidepressants. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. The CAA section entitled: "Describe impact of this problem/need on the resident and your rationale for care plan decision" listed interventions. The interventions included administer medications as ordered and	F 272	Planning Process. ADON Reviewed CAA for Resident #153 all triggered risk factors was assessed and reviewed as applied to the resident□s current status. An analysis of these findings to include input from resident□s family was documented by ADON in the residents chart. ADON reviewed CAA for Resident #110 all triggered risk factors was assessed and reviewed as applied to the resident□s current status. An analysis of these findings to include input from resident was documented by ADON in the residents chart. ADON reviewed CAA for resident #39 all triggered risk factors was assessed and reviewed as applied to the resident□s current status. An analysis of these findings to include input from resident was documented by ADON in the residents chart. Criteria 2 Review of Care Area Assessments for the last month was conducted to audit for weakness in documentation related to care areas, to include contributing factors, interventions and analysis of findings that would support or not support continuing the plan of care. Minimum Data Set Nurse Consultant in-serviced 100% of departments to include: Social Worker, Minimum Data Set Nurse , Dietary Manager, Activities,	

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F 272	Continued From page 3 monitor for adverse reactions with physician and pharmacist review on a regular basis. Review of Resident #110's most recent quarterly MDS dated 12/24/14 revealed the resident received daily administration of an antianxiety and antidepressant medication. Review of Resident #110's March 2015 monthly physician's orders revealed Resident #110 received Cymbalta 60 milligrams (mg.) daily for depression and Xanax 1 mg. at bedtime for anxiety. Interview with the MDS Coordinator on 03/19/15 at 3:48 PM revealed the CAA should contain a documented analysis of findings specific to Resident #110. The MDS Coordinator reported the care plan interventions were not an analysis of Resident #110's psychotropic drug use. 3. Resident #39 was admitted to the facility on 12/16/14 with diagnoses which included adult failure to thrive and insomnia. Review of Resident #39's admission Minimum Data Set (MDS) dated 12/23/14 revealed an assessment of intact cognition. The MDS indicated Resident #39 required the physical assistance of one person with transfers and walking. Review of Resident #39's Activities of Daily Living (ADL) Functional/Rehabilitation Care Area Assessment (CAA) dated 12/29/14 revealed Resident #39 required assistance with ADLs related to recent hospitalization, mood decline, changing cognitive status, psychoactive medication, contractures, incontinence,	F 272	Director of Nursing, Assistant Director Of Nursing and Staff Facilitator concerning Care Area Assessments and documentation related to care areas, to include contributing factors, interventions and analysis of findings that would support or not support continuing the plan of care. In-service was completed on 4/12/2015. Criteria 3 The Director of Nursing, Assistant Director of Nursing, Staff Facilitator and Minimum Data Set Nurse will monitor Care Area Assessments to ensure all areas are completed accurately. This will be will be monitored using the Care Area Assessments audit tool Monday- Friday in clinical meeting for one week then weekly for one month then monthly for two months. Criteria 4 The Executive Quality Improvement Committee will review the results of the audits Monthly with recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring.	

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F 272	Continued From page 4 depression, and weakness. There was no documentation of resident input, type of contracture and no documentation of an analysis of findings supporting the decision to proceed to care plan. The CAA section entitled: "Describe impact of this problem/need on the resident and your rationale for care plan decision "listed interventions. The interventions included provision of set up for ADLs, allow to perform tasks as able and assist with task completion, allow for rest breaks during care and evaluate and treat for pain. Interview with the MDS Coordinator on 03/19/15 at 3:48 PM revealed the CAA should contain a documented analysis of findings specific to Resident #39. The MDS Coordinator reported the care plan interventions were not an analysis of Resident #39's ADL assessment.	F 272		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review, the facility failed to use a right knee brace during transfers for a resident with a history of falls for 1 of 3 sampled residents at risk for falls. (Resident #59)	F 323	F323 Free of Accident Hazards/Supervision/Devices Criteria 1	4/10/15

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The findings included:

Resident #59 was admitted to the facility on 02/05/15. Diagnoses included dementia, personal history of falls, generalized muscle weakness, difficulty walking, atrial fibrillation and hypertension.

Medical record review for Resident #59 revealed a physician's order dated 02/05/15 for physical therapy (PT) evaluation and treatment. Resident #59 started PT on 02/05/15.

A physical therapy (PT) progress note dated 02/10/15 documented the use of a right knee brace during therapy sessions because the Resident's knee gave out at times during ambulation which required increased staff attention to prevent falls.

An admission minimum data set dated 02/12/15 assessed Resident #59 with impaired cognition, a fall prior to admission, requiring extensive assistance of one staff person for transfers, moving from a seated to a standing position, walking, moving on/off the toilet and surface-to-surface transfers.

A care plan dated 02/06/15 identified that Resident #59 was at risk for falls due to a history of falls, actual falls, and impaired cognition, balance and mobility. Interventions included staff to assist Resident #59 during transfers and with mobility. The Care Guide (nursing care communication tool) for Resident #59 documented "Equipment/Instructions/Precautions: Right knee brace, black, to be worn when ambulating and

F 323

On 03/19/2015, Resident #59 was assessed by Assistant Director of Nursing with no negative findings and the MD was notified with no new orders.
On 03/19/2015, Resident #59 care plan and care guide were updated to include a right knee brace.

Criteria 2
On 03/27/2015, a 100% audit was completed of all residents and resident care guide with orders for a brace.
On 03/27/2015, the facility initiated a 100% in-servicing of nursing staff on following care guides. This in-serving will be completed by 04/12/2015.
On 03/27/2015, the facility initiated a 100% in-servicing of therapy staff regarding educating and notifying nursing staff of recommendations upon resident s discharge from therapy. This in-servicing will be completed by 04/12/15.

Criteria 3
The Director of Nursing, Assistant Director of Nursing, Staff Facilitator and MDS Nurse will monitor residents that wear assistive devices. Concerns will be immediately addressed by Director of Nursing or Assistant Director of Nursing, This monitoring will be done Monday Friday for one week, then weekly for one month, then monthly for two months. These audits will be documented on the Brace Audit tool. The audit will be reviewed in the morning clinical meeting Monday- Friday for accuracy.

Criteria 4

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F 323	Continued From page 6 with transfers." Review of the medical record and incident reports revealed Resident #59 had the following falls: · 02/13/15 - unassisted transfer from the commode, no apparent injury · 03/08/15 - unassisted transfer from wheel chair, found on floor in room by staff, no apparent injury · 03/15/15 - slid from wheel chair to floor in front of TV, witnessed by another resident, no apparent injury Resident #59 was discharged from PT on 03/14/15. On 03/17/15 at 5:09 PM, nurse aide #1 (NA #1) assisted Resident #59 to her room for toileting. NA #1 explained to the Resident the care that was to be provided. NA #1 asked the Resident to stand, pivot and transfer to the toilet. A second staff member entered the room to assist. During the transfer, Resident #59's knees buckled and she was observed without a knee brace in place. The knee brace was observed in the Resident's room on the dresser. After toileting, Resident #59 was assisted back to the wheel chair without the knee brace in place. Resident #59's knees buckled. NA #1 propelled Resident #59 in her wheel chair to her bedside and asked the Resident if she wanted to lie down until the supper meal. The Resident was agreeable and received assistance to transfer to her bed. During the transfer, Resident #59 stood with the assistance of two staff persons, pivoted both feet, her knees buckled and she sat on the bed as directed and assisted by staff. The knee brace was not applied during these transfers from the wheel chair, to the toilet or to her bed.	F 323	The Director of Nursing or Quality Improvement nurse will report the audit results to the Executive Quality Improvement Committee. The Committee will review the results of the audits monthly and make recommendations as needed for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring.	

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F 323	Continued From page 7 On 03/19/15 at 10:58 AM, Resident #59 was observed lying in a low bed in her room. The knee brace was observed on the over bed table. An interview with NA #2 at the time of the observation revealed NA #2 had just put the Resident to bed. On 03/19/15 at 2:28 PM an interview with PT #1 revealed that during a PT evaluation, Resident #59 was noted having difficulty with ambulation and transfers. PT #1 stated a few days later, she learned from a family member that Resident #59 used a right knee brace for support at home during ambulation and transfers. PT #1 stated she asked the family to bring in the knee brace for use during therapy and the family complied. PT #1 stated she applied a black hinged brace to the Resident's right knee during her therapy sessions for ambulation and transfers which she documented in a progress note. PT #1 stated the addition of the brace provided Resident #59 with the needed support to ambulate and transfer safely. PT #1 stated that since admission, Resident #59 had a decline in her health and as a result no longer ambulated, but that the right knee brace was still necessary for Resident #59's safety with transfers to prevent falls. PT #1 stated Resident #59 discharged from PT on 03/14/15 with the expectation that the right knee brace would still be used to ensure safety during transfers. PT #1 stated she updated the Care Guide to include the use of the right knee brace for safety and to prevent falls during transfers. PT #1 stated she spoke to the Resident's nurse aide, but could not recall her name, to use the right knee brace for Resident #59 for support during transfers.	F 323		

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On 03/19/15 at 2:43 PM, a follow up interview with NA #2 revealed Resident #59 required the assistance of one staff person and a gait belt for safe transfers. NA #2 referred to the Care Guide during the interview and stated that the Care Guide was a communication tool used by the nurse aides to know what care to provide to residents assigned. NA #2 stated she did not use the right knee brace when she assisted Resident #59 with transfers, but rather it was a device used during therapy sessions. NA #2 confirmed she assisted Resident #59 to bed around 2:00 PM that day without the use of the knee brace for support. NA #2 stated she routinely assisted Resident #59 with transfers using a gait belt and without a knee brace for support.

On 03/19/15 at 3:32 PM NA #1 revealed in interview that she was familiar with Resident #59 and had worked with her several times. NA #1 confirmed she was assigned to care for Resident #59 on 03/17/15 and stated she did not review the Care Guide when providing care to the Resident because she knew what care the Resident required. NA #1 stated Resident #59 required the assistance of one staff person and a gait belt with transfers because "Her knees will buckle at times." NA #1 stated on 03/17/15 she forgot her gait belt and had a second staff person to assist with transferring the Resident from the wheel chair to the toilet and then to the bed. NA #1 stated she did not use a right knee brace during the transfers and stated "I didn't know I had to apply it, I didn't know she had that." NA #1 stated she was not aware Resident #59 had a right knee brace in her room for use during transfers.

On 03/19/15 at 3:52 PM an interview with the

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F 323	Continued From page 9 director of nursing (DON) revealed that the Care Guide was the communication to the nurse aides regarding the nursing care that a resident needed. The DON stated that if nurse aides did not know what care to provide a resident, the nurse aide should clarify with the nurse. The DON reviewed the Care Guide for Resident #59 and stated "If the knee brace is on the care guide it should be used during her care." A follow-up interview with the DON on 03/19/15 at 5:00 PM revealed that the nurse aides had not been trained to use a right knee brace during transfers for Resident #59. The DON further stated that if therapy staff wanted nursing staff to use a right knee brace for Resident #59 during transfers, the nursing staff should have been trained. On 03/19/15 at 5:11 PM, PT #1 stated that Resident #59 discharged from PT on 03/14/15 and still required the use of the right knee brace for safety and support during weight-bearing activity, including transfers. PT #1 further stated that she did not train nursing staff regarding the use of the right knee brace for Resident #59; she stated she should have trained nursing staff on the use of the right knee brace for Resident #59 to prevent falls.	F 323		
F 329 SS=E	483.25(l) 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	F 329		4/10/15

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F 329	Continued From page 10 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		
	This REQUIREMENT is not met as evidenced by: Based on observation, staff and physician interviews, and record review, the facility failed to monitor for side effects of an antipsychotic medication (Zyprexa) for 1 of 5 sampled residents who received psychoactive medications (Resident #153). The findings included: Review of Resident #153's emergency room summary and discharge medication list dated 11/25/14 revealed the emergency room physician ordered Zyprexa, 10 milligrams (mg.) twice daily to be administered. The Zyprexa was listed as a "new medication" for Resident #153. (Zyprexa is an antipsychotic medication used to treat schizophrenia and bipolar disorder. According to the United States Food and Drug Administration Medication Guide, "Zyprexa is not approved for		F 329 Drug Regimen Is Free From Unnecessary Drugs Criteria 1 MD notified and resident #153 re-assessed by MD on 03/19/2015. New order for Zyprexa initiated. Criteria 2 A 100% audit of all Psychiatric recommendations was completed by the Assistant Director of Nursing with no negative findings on 03/20/2015. On 04/07/2015 the Assistant Director of Nursing, Staff Facilitator and Social Worker were In-serviced regarding proper follow up on psych recommendations, to include obtaining order, transcribing and	

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F 329	Continued From page 11 treating psychosis in elderly people with dementia." Adverse side effects with increased incidence in the elderly include falls and somnolence.) Resident #153 was admitted to the facility on 11/26/14 with diagnoses which included end stage dementia and anxiety. Resident #153 lived with a family member prior to admission. Review of Resident #153's admission physician orders dated 11/26/14 revealed direction to continue the Zyprexa 10 mg. twice daily. Review of physician's orders dated 12/02/14 revealed Zoloft (an anti-depressant) 25 mg. daily added to Resident #153's medication regime. On 12/03/14, the physician ordered Depakote 125 mg at 8:00 AM, 250 mg. at 2:00 PM and 250 mg. at bedtime to be given routinely for agitated behavior. Review of Resident #153's admission Minimum Data Set (MDS) dated 12/03/14 revealed an assessment of severely impaired cognition. The MDS indicated Resident #153 demonstrated physical and verbal behavior directed toward others. Review of a nursing note dated 12/06/14 revealed Resident #153 fell on the floor next to the bed without injury. Review of a nursing note dated 12/08/14 revealed Resident #153 fell out of a wheelchair without injury. Review of Resident #153's care plan dated 12/11/14 revealed Resident #153 required use of	F 329	alerting staff for behavior monitoring. Criteria 3 The Director of Nursing, Assistant Director of Nursing and Staff Facilitator will monitor Recommendations to ensure orders are followed. This will be done Monday- Friday for one week then weekly for one month, then monthly for two months and as needed. The recommendation audit tool will be used to document the monitoring and any corrective actions taken. Criteria 4 The Executive Quality Improvement Committee will review the results of the audits Monthly with recommendation and follow as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring.	

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psychotropic drugs. Interventions included evaluation of effectiveness and side effects of medication for possible reduction/elimination of psychotropic drugs.

Review of a nursing note dated 01/15/15 revealed Resident #153 fell out of a wheelchair without injury.

Review of a nursing note dated 01/18/15 revealed Resident #153 fell out of a wheelchair without injury.

Review of Resident #153's quarterly MDS dated 01/21/15 revealed an assessment of severely impaired cognition with no behavior problems. The MDS indicated Resident #153 fell two or more times without injury since the last assessment.

Review of a nursing note dated 01/23/15 revealed Resident #153 attempted to stand independently and fell without injury.

Review of a nursing note dated 02/01/15 revealed Resident #153 fell out of bed without injury.

Review of a nursing note dated 02/06/15 revealed Resident #153 fell out of his wheelchair without injury.

Review of a nursing note dated 02/11/15 revealed Resident #153 attempted to walk independently and fell without injury.

Review of a nursing note dated 02/21/15 revealed Resident #153 fell out of bed without injury.

Review of a psychiatric Nurse Practitioner (NP)

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F 329	Continued From page 13 note dated 03/04/15 revealed a recommendation to decrease the Zyprexa dose from 10 mg. to 5 mg. twice daily. The psychiatric NP documented Zyprexa is not recommended for dementia residents in excess of 10 mg. and Resident #153 had no history of schizophrenia. Review of Resident #153's clinical record revealed there was no response to the NP recommendation to decrease the Zyprexa dose. Observations revealed the following: · 03/16/15 at 12:57 PM: Resident #153 asleep on a low bed. · 03/17/15 at 7:54 AM: Resident #153 was seated in a wheelchair asleep in the dining area. · 03/17/15 at 10:13 AM: Resident #153 asleep on a low bed. · 03/17/15 at 5:15 PM: Resident #153 asleep on a low bed · 03/18/15 at 7:51 AM: Resident #153 was seated in a wheelchair asleep in the dining area. · 03/18/15 at 8:21 AM: Resident #153 was awake and ate the breakfast meal. · 03/18/15 at 9:23 AM: Resident #153 seated in a wheelchair asleep in the living area in front of the television. · 03/18/15 at 10:37 AM: Nurse Aide (NA) #3 assisted Resident #153 to the bathroom. Resident #153's balance and gait were unsteady. Interview with NA #3 on 03/18/15 at 10:38 AM revealed Resident #153 responded when redirected orally. NA #3 explained Resident #153 was very agitated and combative upon admission but now slept most of the day except for meals. NA #3 explained Resident #153 usually	F 329		

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responded to conversation regarding his family.

Further observations revealed:
· 03/18/15 at 12:04 PM: Resident #153 shouted a repeated request for staff to assist with transportation "home." NA # 4 engaged the Resident in conversation.
· 03/18/15 at 12:34 PM: Resident #153 fell asleep at the dining table.
· 03/18/15 at 12:48 PM: NA #4 awoke Resident #153 and he consumed the lunch meal.
· 03/18/15 at 12:55 PM: Resident #153 stood up unsteadily in front of the wheelchair. NA #4 immediately assisted Resident #153 back into the wheelchair.

Interview with NA #4 on 03/18/15 at 1:03 PM revealed Resident #153 slept between meals and required assistance due to confusion and unsteadiness of gait. NA #4 reported Resident #153 was extremely agitated upon admission but now slept between meals.

Interview with NA #5 on 03/18/15 at 1:08 PM revealed Resident #153 required one to one supervision when first admitted. NA #5 explained Resident #153 liked to talk and could be redirected.

Interview with NA #6 on 03/18/15 at 4:07 PM revealed Resident #153 responded to conversation. NA #6 explained Resident #153 was very unsteady in walking and required assistance.

Interview with the facility's social worker (SW) on 03/19/15 at 8:41 AM revealed she coordinated the psychiatric NP visits. The SW reported the psychiatric NP did not write orders but made

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F 329	Continued From page 15 recommendations for treatment. The SW explained the recommendation to decrease the Zyprexa dose was forwarded to the Assistant Director of Nursing (ADON). The SW reported she did not inform the physician of the recommendation. Interview with the ADON on 03/19/15 at 9:07 AM revealed she gave the recommendation to medical records to scan and place into Resident #153's electronic record. The ADON explained the SW would notify the physician of the NP recommendation for the dose reduction. The ADON reported she thought she discussed the dose reduction recommendation by telephone with the physician who rejected the suggestion. Interview with Resident #153's physician on 03/19/15 at 11:57 AM revealed he was not aware of the psychiatric NP's recommendation to decrease the Zyprexa dose. The physician reported a reduction should be considered. The physician explained Zyprexa was not indicated for dementia but needed at the time of admission for severe behaviors. Interview with the Director of Nursing (DON) on 03/19/15 at 12:36 PM revealed the NP recommendation should be placed in the physician's book on the nursing unit for the physician to review. The DON reported nursing staff should monitor Resident #153's behaviors and response to medication. The DON explained staff should communicate any changes orally to the physician. Telephone interview on 03/19/15 at 9:47 AM with Nurse #1 revealed Resident #153 did not respond to oral redirection when first admitted to the	F 329		

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F 329	Continued From page 16 facility. Nurse #1 explained Resident #153 required one to one supervision at that time. Telephone interview on 03/19/15 at 10:27 AM with Nurse #2 revealed Resident #153 responded to redirection and slept during the day. Nurse #2 reported Resident #153's family member assisted staff in identifying triggers to behaviors which helped decrease agitation. A second interview with the DON on 03/19/15 at 2:35 PM revealed the physician ordered a medication change. The DON provided a copy of a physician's order dated 03/19/15 for a decrease of Zyprexa from 10 mg. to 5 mg. twice daily, to increase the dose of Zoloft to 50 mg. daily and to increase Depakote to 250 mg. at 8:00 AM, 375 mg. at 2:00 PM and 500 mg. at bedtime for agitation.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, physician, and staff interviews, the facility failed to administer medication as ordered for 1 of 12 residents reviewed for medication administration (Resident #115). The findings included: A record review of annual Minimum Data Set (MDS) dated 01/19/15 revealed Resident #115	F 333	F333 Residents free of Significant Medication Errors Criteria 1 Medication Error report was completed by Assistant Director of Nursing for resident #115 and MD notified on 03/19/2015. Assessment of resident completed by Assistant Director of Nursing with no	4/10/15

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was admitted to the facility on 01/05/15. Resident #115 had intact cognition with Brief Interview for Mental Status (BIMS) score of 12 out of 15. The MDS revealed Resident #115 was diagnosed with anemia, heart failure, thyroid disorder, and anxiety disorder. Resident #115 required limited assistance with bed mobility, transfers, dressing, and toileting.

A record review of physician's monthly orders approved and signed by the physician from January 2015 to March 2015 revealed Resident #115 was to receive Miralax 17 grams every other day in 4-8 ounces of liquid.

An observation of medication administration by Nurse #3 for Resident #115 was conducted on 03/19/15 at 7:50 AM. After reviewing Resident #115 ' s MAR, Nurse #3 verified with physician's order that Resident #115 was to receive Miralax every other day rather than every day. Nursing staff documentation on the March 2015 MAR revealed Resident #115 had received Miralax every day. Nurse #3 did not administer Miralax to Resident #115 on 03/19/15.

A record review of Medication Administration Record (MAR) revealed nursing staff documented Resident #115 received Miralax every day from 02/01/15-03/18/15. Resident #115 received 23 extra doses of Miralax.

An interview was conducted with the Director of Nurses on 03/19/15 at 8:27 AM who verified physician's order was to administer Miralax to Resident #115 every other day. DON verified Resident #115 received Miralax every day from 02/01/15 to 03/18/15 as revealed by nursing staff documentation of administration of Miralax on the

negative findings. New order obtain from MD to give Miralax daily

Criteria 2
Director of Nursing, Assistant Director of Nursing and Staff facilitator completed a 100% audit on 04/08 /15 of MARS to ensure physician□s orders are followed. On 04/02/2015, the Director of Nursing, Assistant and Staff Facilitator in-serviced 100% licensed nursing staff and medication aides to ensure physician orders are properly followed. This in-serving will be completed by 04/12/15.

Criteria 3
The Director of Nursing, Assistant Director of Nursing and Staff Facilitator will monitor physician□s orders to ensure orders are followed. This will be completed during clinical Meeting Monday- Friday for one week then weekly for one month, then monthly for two months and as needed. Any concerns will be immediately addressed. The MAR audit tool will be used to document the monitoring and any corrective actions taken.

Criteria 4
The Director of Nursing or Quality Improvement Nurse will report audit results to the Executive Quality Improvement Committee. The Executive Quality Improvement Committee will review the results of the audits monthly and make recommendations as needed for continued compliance and to determine the need for and or/ frequency

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F 333	Continued From page 18 MAR. The DON stated her expectations were for nursing staff to have followed physician orders or to have clarified with physician the administration time for Miralax for Resident #115. A telephone interview was conducted with Nurse #1 on 03/19/15 at 9:44 AM. Nurse #1's signature on the MAR for the month of February 2015 indicated she had verified physician's orders and accuracy of order transcription for Resident #115. Nurse #1 stated she did not remember if she had crossed out every other day on the MAR that would have alerted nursing staff not to administer Miralax every day to Resident #115. A telephone interview was conducted with Nurse #2 on 03/19/15 at 10:30 AM. Nurse #2's signature on the MAR for the month of March 2015 indicated she had verified physician's orders and accuracy of order transcription for Resident #115. Nurse #2 stated the process for transcribing every other day medication onto the MAR was to cross out every other day on the MAR to alert nursing staff not to administer drug every day. Nurse #2 stated she must have forgotten to cross off every other day on Resident #115's MAR. Nurse #2 stated she made a mistake. An interview was conducted with the physician on 03/19/15 at 12:34 PM who stated he was informed by nursing staff on 03/19/15 that Resident #115 had received Miralax every day rather than every other day for the month of February 2015 and up to 03/19/15. Physician stated his expectations were for nursing staff to follow physician's orders. Physician further stated he had not changed Resident #115's Miralax order to be administered every day. Physician shared if Resident #115 was constipated, he	F 333	of continued QI monitoring.	

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F 333	Continued From page 19 would have expected nursing staff to have notified him and obtained an order for constipation. Physician stated he had not received any communication with nursing staff for clarification of Miralax order for Resident #115. Physician revealed he had not changed Miralax order since it was written. Physician stated adverse effects of increased dose of Miralax was diarrhea and dehydration. Physician revealed he had not been informed by nursing staff that Resident #115 had experienced diarrhea or was dehydrated.	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of the facility temperature log the facility failed to operate the high temperature dish machine at the final rinse cycle temperature of at least 180 degrees Fahrenheit (F) for heat sanitation for 2 of 2 observations. The findings included: Review of the facility dish machine log on	F 371	F-Tag 371 Food Procure, Store/Prepare/Serve-Sanitary Criteria 1 On 03-18-15. The Maintenance Director and Administrator were notified about the dish machine temps. Being inconsistent and not reaching the required temp.	4/10/15

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03/18/15 revealed the following days the final rinse cycle temperatures were recorded less than the minimum requirement of 180 degrees Fahrenheit (F):

- 03/09/15-supper temperature 175 degrees F.
- 03/14/15-supper temperature 175 degrees F.
- 03/16/15-supper temperature 176 degrees F.
- 03/17/15-supper temperature 178 degrees F.

An observation of the dish machine, while in use, occurred on 03/18/15 at 11:57 AM, final rinse cycle failed to reach the minimum final rinse temperature of 180 degrees F. The final rinse cycle was observed to be 170 degrees F. There were 2 large plastic containers being washed and the items were placed on the rack to air dry.

A second observation of the dish machine, while in use, occurred on 03/18/15 at 12:14 PM. The final rinse cycle temperature was observed to be 165 degrees F. The staff member was directed by the certified dietary manager (CDM) at that time to re-wash the items again until the final rinse cycle temperature reached at least 180 degrees F.

Interview with dietary aide #1 (DA #1) on 03/18/15 at 12:59 PM revealed when she came on shift the dish machine was already on and she checked the temperature gauge to make sure the water was hot enough. The DA #1 stated she looked at the wash temperature to make sure it was 165 degrees and revealed the final rinse temperature should range between 178 to 180 degrees F. During the interview the DA #1 stated if the wash

F 371

Criteria 2
03-18-15 The Maintenance Director found a blown fuse as well as a defective heating element to be the contributing cause of dish machine not functioning properly. Parts were ordered for next day air. Assistant dietary manager was placed one to one monitoring of dish machine and document during wash times to ensure temps were correct.

Criteria 3
On 04/07/15 Administrator in-serviced Dietary Manager and Assistant Dietary Manager regarding proper dish machine temps and reporting any temps out of range immediately to maintenance director and administrator.
03/19/15 100% in-service of all dietary employees on proper dishwasher temps and reporting any problems to maintenance director and administrator.

Criteria 4
Dietary manager or designee will monitor dish machine temps daily and report any issues in the daily clinical meeting Monday Friday, 5 times a week for a month, then monthly for two months.
The Executive Quality Improvement Committee will review the results of the audits monthly with recommendations and follow up as needed or appropriate for continued compliance in this area. And to determine the need for and or/ frequency of continued QI monitoring.

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F 371	Continued From page 21 or rinse cycle temperatures were too low they continued to run the dish machine until the temperatures came up and if it did not come up she reported it to the manager. DA #1 further stated she had not reported any problems with wash/rinse cycle temperatures in the last few weeks. Interview with the CDM on 03/18/15 at 1:19 PM revealed the CDM and supervisor checked the dish machine daily to make sure it was operating properly and that the temperatures were good. She stated they did not routinely look at the dish machine temperature log and had not noticed the final rinse cycle temperatures that were recorded below 180 degrees F in March 2015. The CDM stated she had not been advised by the staff of the low temperatures and expected the dietary aides or the supervisor to advise her if the final rinse cycle temperatures were below 180 degrees F. During the interview she stated the contract company checked the dish machine on 02/13/15 and noted the temperatures were low and adjusted the booster. The CDM stated the company informed her to keep monitoring the dish machine temperatures and to advise the facility's maintenance director of the adjustments made to the booster. She stated she checked the dish machine on 02/13/15 and it was 191 degrees for the final rinse cycle and she checked again 02/15/15 and it was fine. The CDM further stated she had not looked at the dish machine temperature log and noticed the final rinse cycle temperatures recorded in March 2015 that were below 180 degrees F. On 03/18/15 at 1:25 PM an interview with the supervisor revealed she monitored the dish machine temperatures every morning and every	F 371		

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F 371	Continued From page 22 evening before she left for the day. The supervisor stated she checked to make sure staff were documenting the temperatures and that the wash cycle temperatures was at least 160 degrees and the final rinse cycle temperature was at least 180 degrees F. During the interview, the supervisor stated she noticed a few days on the dish machine temperature log that there were final rinse cycle temperatures that were recorded at 170 degrees F. She stated that she in-serviced staff that they could not write down temperatures that were less than 180 degrees F for the final rinse. The supervisor further stated, she advised the dietary aides if the temperatures were less than 180 degrees F they needed to continue to watch the dish machine temperatures and wait until the temperature came up to at least 180 degrees F and then document the temperature. The supervisor revealed she advised the staff if the temperature did not come up to 180 degrees F they were required to advise management and she would inform maintenance. Additionally, she added, the last time this happened she informed maintenance and the contract company was called. On 03/18/15 at 3:36 PM an interview with the maintenance director revealed that he was informed of the comments from the contract company in the staff meeting on 02/14/15 regarding adjustments to the dish machine booster. He stated he had not been informed of any malfunctions with the dish machine after 02/13/15. He stated he was notified to report to the kitchen for the first time on 03/18/15 to check the final rinse cycle temperature and the booster heater.	F 371		