

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

7/13/15
PRINTED: 06/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2015
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083		
(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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and facility staff and physician interviews, the facility failed to notify the physician of daily weight changes in accordance</p>	F 157	<ol style="list-style-type: none"> 1. Resident #9 and 227 no longer reside in the facility. The physician was notified immediately after it was brought to the attention of the Director of Clinical Services. Resident # 227 who was receiving Coumadin; was noted to have bleeding gums. The physician/nurse practitioner was not notified. The physician was notified immediately after it being brought to the attention of the Director of Clinical Services. No harm came to either resident. 2. All residents residing in the facility have a potential to be affected. The Director of Clinical Services reviewed the 24 Hour Reports for any resident conditions noted to ensure the physician has been notified which is audited daily by the nursing management team. 3. The Director of Clinical Services re-educated all nursing staff on 7/7/2015 that they are to notify a nurse, unit manager or Director of Clinical Services of any changes of condition with residents and about notifying the physician/nurse practitioner of changes noted during his/her shift within a timely manner for any additional orders. This training included the need to follow the prescribed guidelines established by the physician and to notify the physician when issues are assessed to be outside the parameters. No nursing staff will work until he/she has completed this education. 		

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

TITLE

(X6) DATE

Cheri Bey, Executive Director

7-9-2015

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 157	<p>Continued From page 1</p> <p>with the parameters specified and as ordered by the physician for 1 of 1 residents (Resident #9) reviewed with a diagnosis of congestive heart failure and history of edema; and failed to notify the physician of bleeding gums for 1 of 1 residents (Resident #227) reviewed who was receiving Coumadin (an anticoagulant or blood thinner) and at risk for bleeding.</p> <p>The findings included:</p> <p>1. Resident #9 was admitted to the facility on 11/26/13. His cumulative diagnoses included congestive heart failure. His most recent quarterly Minimum Data Set (MDS) dated 3/4/15 revealed the resident had intact cognitive skills for daily decision making.</p> <p>A review of Resident #9's medical record revealed there was a current physician's order which read, "Weight every day; notify MD (Medical Doctor) of weight gain of 3 pounds (#) in one day or 5 pounds in one week." On 3/12/15, a physician's order was received to discontinue Resident #9's scheduled dose of furosemide (a diuretic medication). An order was also received on 3/12/15 to initiate 20 milligrams (mg) furosemide once daily as needed for lower extremity edema. A review of the physician's Progress Notes on 3/12/15 revealed the scheduled furosemide was held due to an increase in the resident's creatinine level (a blood test which may be an indicator of how well the kidneys are functioning).</p> <p>A review of Resident #9's April 2015 Medication Administration Record (MAR) included documentation of the daily weights obtained. Of the recorded weights, there were two occasions</p>	F 157	<p>4. The unit coordinators, overseen by the Director of Clinical Services, will audit charts:</p> <p>a. To ensure shift nurses have notified physician/nurse practitioner of changes outside of set parameters according to physician/nurse practitioner orders</p> <p>b. To ensure that recommended referrals are implemented</p> <p>5 times weekly for 1 month, then 3 times weekly for 1 month, then 1 time weekly for 2 months, then 1 time monthly for 2 months. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Unit Manager to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.</p>	7-10-15	

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F 157	<p>Continued From page 2</p> <p>where the resident had a weight increase of more than 3 pounds (#) in one day: --On 4/8/15, the resident weighed 158.4#; on 4/9/15, he weighed 166.4# (a difference of 8# in one day). --On 4/24/15, the resident weighed 166.0#; on 4/25/15, he weighed 170.8# (a difference of 4.8# in one day). No notes were made in the resident's medical record to indicate the resident's Medical Doctor (MD) was notified of the weight increases.</p> <p>A review of Resident #9's May 2015 Medication Administration Record (MAR) included documentation of the daily weights. Of the recorded weights, there were two occasions where the resident had a weight increase of more than 3 pounds (#) in one day: --On 5/4/15, the resident weighed 162.3#; on 5/5/15, he weighed 171.3# (a difference of 9# in one day); --On 5/11/15, the resident weighed 166.0#; on 5/12/15, he weighed 170.0# (a difference of 4# in one day). No notes were made in the resident's medical record to indicate the resident's Medical Doctor (MD) was notified of the weight increases.</p> <p>A review of Resident #9's June 2015 Medication Administration Record (MAR) included documentation of the daily weights. Of the recorded weights, there was one occasion where the resident had a weight increase of more than 3 pounds (#) in one day: --On 6/8/15, the resident weighed 167.2#; on 6/9/15, he weighed 170.5# (a difference of 3.3# in one day). No notes were made in the resident's medical record to indicate his Medical Doctor (MD) was</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>notified of the weight increase. There were no notations of this weight increase in the MD's Communication Book.</p> <p>An interview was conducted on 6/11/15 at 10:17 AM with Nurse #8. Nurse #8 was the 1st shift Hall nurse assigned to care for Resident #9. During the interview, Nurse #8 reported she had also worked the same shift and hall assignment on 6/9/15. Upon review of Resident #9's 6/9/15 weight, Nurse #8 confirmed there was a greater than 3# weight increase from the previous day. The nurse reported the daily weights were generally done on the 11PM-7AM shift (3rd shift). The nurse stated it would have been the responsibility of the 11PM-7AM nurse to contact the resident's MD about the weight increase and/or pass along the need to do so to the oncoming nurse (1st shift nurse) in report. Nurse #8 reported she had not been made aware of this weight increase. The nurse noted that she herself did not call the MD to notify him of the weight change on 6/9/15.</p> <p>A telephone interview was conducted on 6/11/15 at 2:04 PM with Nurse #7. Nurse #7 was the 3rd shift nurse assigned to care for Resident #9 on the evenings of 4/24-4/25/15, 5/4-5/5/15, and 5/11-5/12/15 (three dates when a greater than 3# per day weight increase was recorded). Nurse #7 reported weights were typically done on the 3rd shift for residents who had orders for daily weights. Upon inquiry, the nurse stated she would report a daily weight increase greater than a 3# for Resident #9 by writing a note in the MD's book. Nurse #8 also stated she would have reported the weight change to the day shift nurse. When asked, Nurse #8 stated that if she wrote a note about the resident's weight change in the MD's book, she would not have documented this</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>notification in the resident's medical record. The nurse could not recall whether or not she notified the resident's physician about the weight increases noted for Resident #9 on 4/24-4/25/15, 5/4-5/5/15, or 5/11-5/12/15.</p> <p>The 3rd shift nurses assigned to care for Resident #9 on 4/8-4/9/15 and 6/8-6/9/15 were not available for interview.</p> <p>A telephone interview was conducted on 6/11/15 at 4:15 PM with Resident #9's Medical Doctor (MD). During the interview, the daily weight increases noted for Resident #9 were discussed. Upon inquiry, the MD reported he did not recall for certain as to whether or not he had been made aware of the resident's weight increases. The MD stated he expected to be notified of the resident's weight increase in accordance with the MD orders and parameters given so he could evaluate the resident accordingly. The MD indicated he would have expected the nurse to have documented the MD notification in the Nursing Notes and to have communicated this in the MD communication book as well. He stated, "If the notification was not in the (MD) communication book, it was not done (relative to the 6/9/15 weight increase)."</p> <p>An interview was conducted on 6/11/15 at 4:42 PM with the Interim Director of Nursing (DON). The DON indicated that if the MD had given parameters as to when he should be notified for a weight increase, she expected the MD to be notified in accordance with those parameters. The DON stated in addition to notifying the MD, she would expect the resident's Responsible Party (RP) and the DON herself to be notified of such a change. Upon inquiry, the DON stated</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>she expected documentation of MD notification of weight changes to be made both in the MD communication book and in the resident's permanent medical record.</p> <p>2. Resident #227 was admitted to the facility on 3/24/15 and re-admitted on 5/11/15 with diagnosis of pneumonia, chronic airway obstruction, chronic pain, hypertension and left upper extremity deep vein thrombosis.</p> <p>The admission Minimum Data Set (MDS) assessment with assessment reference date of 3/31/15 indicated that Resident #227 was cognitively intact and required extensive assistance with activity of daily living (ADL's). The care plan initiated on 3/24/15 revealed a focus for Cardiovascular-resident is at risk for bleeding with an approach to notify physician for any excessive bleeding and bruising. A physician order dated 6/9/15 revealed Resident #227 was ordered Coumadin (anticoagulant) 4 milligrams (mg) by mouth every day. A physician order dated 6/11/15 revealed to hold Coumadin on 6/11/15 and 6/12/15 and the dosage was reduced to Coumadin 3.5 mg by mouth every day to start on 6/13/15.</p> <p>An interview with Resident #227 on 6/10/15 at 9:55 AM revealed that she had a loose bottom tooth and it was bleeding yesterday (6/9/15), she stated that she told the staff and they swabbed her teeth and mouth. Upon observation, Resident #227 has a lower loose front tooth that was turned sideways and no bleeding was noted. During an interview with nurse aide (NA) #3 on 6/10/15 at 10:00 AM indicated that she did mouth care for Resident #227 yesterday (6/9/15) using a swab and noticed some bleeding and a very</p>	F 157			

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F 157	Continued From page 6 loose tooth on the front bottom gum. She reported the loose and bleeding tooth to nurse #2. During a record review on 6/10/15 revealed no documentation related to Resident #227 having a loose and bleeding tooth or that the physician was notified with the change in condition. An interview with nurse #2 on 6/10/15 at 11:30 AM revealed that NA#3 did report to her about Resident #227 having a loose tooth and some bleeding on 6/9/15 but did not document it or notify the physician because she became busy with an admission. Nurse #2 indicated that she should have notified the physician because the resident is on Coumadin. The physician progress note dated 6/11/15 revealed an acute visit for history of deep vein thrombosis, labs were reviewed, on Coumadin and INR (international normalized ratio-measures coagulation and monitors effectiveness of anticoagulants) today is 3.2 (range .9-1.1). The assessment and plan indicated that the INR is supratherapeutic and will decrease Coumadin dose and repeat INR in one week. Coumadin was reduced to 3.5 mg every day. An interview with the unit manager on 6/12/15 at 11:30 AM revealed that nurse #2 should have notified the physician with signs and symptoms of bleeding gums. It was her expectation that physicians are notified with any changes in resident condition.	F 157			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278	1. Resident #227 no longer resides in the facility.		

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F 278	<p>Continued From page 7</p> <p>each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 5 residents reviewed for oral/dental assessment. (Resident #227) The findings included: Resident #227 was admitted to the facility on 3/24/15 and re-admitted on 5/11/15 with diagnosis of pneumonia, chronic airway obstruction, chronic pain, hypertension and left upper extremity deep vein thrombosis. The admission Minimum Data Set (MDS) assessment with assessment reference date of</p>	F 278	<p>2. All residents residing in the facility have a potential to be affected. The Minimum Data Set Nursing team completed an audit of all current MDS' for residents to ensure accuracy and completed revisions as needed.</p> <p>3. The Minimum Data Set Nurses were reeducated on the accuracy of coding minimum data sets by the Director of Clinical Services on 6/18/15 and again by the Regional Minimum Data Set Nurse to ensure that the Minimum Data Set is coded accurately on 7/8/2015. All nursing staff has been reeducated by Director of Clinical Services on reporting changes/updates in resident's status to ensure that information is available for the Minimum Data Set nurses to accurately code the Minimum Data Set on 6/18/15. The Minimum Data Set Nurses completed a review of the Minimum Data Set of all residents residing in the facility on 7/7/15. Any resident who had any identified issues including oral problems have had appropriate Interventions and referrals implemented. An oral assessment on each resident who was residing in the building was completed by the Director of Clinical Services on 7/7/2015 The assessments were provided to the Minimum Data set Nurses for accurate coding which was completed 7/9/15.</p>		

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F 278	Continued From page 8 3/31/15 indicated that Resident #227 was cognitively intact and required extensive assistance with activity of daily living (ADL 's). The MDS section under Oral/Dental Status was inaccurately coded for none of the above and the care area was not triggered. The care plan initiated on 3/24/15 revealed a problem for nutrition/hydration with an updated intervention on 4/13/15 to consult dentist as ordered. The physician progress note dated 4/13/15 indicated that Resident #227 complained of loose lower teeth, no pain, no bleeding. The assessment indicated a loose tooth and the plan revealed to consult dentist for tooth evaluation. During an observation and interview with Resident #227 on 6/8/15 at 3:42 PM revealed several missing, broken and decayed teeth on upper and lower gums. Resident #227 indicated that she had a loose bottom tooth and had not had a dentist visit yet and was not sure why. Resident #227 indicated that she did not have any pain and the loose tooth did not interfere with eating. During an interview with the MDS nurse on 6/11/15 at 10:40 AM indicated that she completes the MDS based on resident interviews and record reviews and if oral/dental assessment would have triggered she would have contacted the charge nurse to initiate dental services. The MDS nurse did not realize that Resident #227 had missing, loose and broken teeth.	F 278	4. The Director of Clinical Services/Case Management Nurse/ Minimum Data Set Nurse will conduct Quality Improvement monitoring on 3 Minimum Data Sets per week to ensure accuracy for 1 month, then 1 Minimum Data Set per week for 3 months, then 1 Minimum Data Sheet for two months. The results of the Quality Improvement monitoring will be reported by Director of Clinical Services/Assistant Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly for six months for continued substantial compliance and/or revision.	3-10-15	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280			

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	1. Residents # 203 and #227 no longer reside in the facility. The plan of care for resident #48 was updated to reflect the current interventions for treatment of the pressure ulcers and preventive measures to prevent new sores from forming on 7/9/2015.		

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F 280	<p>Continued From page 9 participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, staff interview the facility did not update the plan of care for 3 of 35 sampled residents. The care plan did not address socially inappropriate behaviors for Resident #203 and did not update the care plan to include interventions for pressure ulcers for Resident #227 and Resident # 48.</p> <p>The findings included:</p> <p>1. Resident #203 was admitted to the facility on 5/5/15 with a diagnosis of advanced dementia. The most recent Minimum Data Set (MDS) assessment dated 5/22/15 revealed no behaviors verbal, physical directed at others. Brief interview mental stats (BIMS) revealed Resident #203 was moderately impaired for decision making.</p>	F 280	<p>2. All residents residing in the facility have a potential to be affected. The Minimum Data Set Nursing Team completed an audit of all resident care plans to ensure accuracy and plans were updated as needed.</p> <p>3. The Minimum Data Set Nurses who are responsible for developing and updating plans of care were reeducated on the care planning process and the need to continuously update the care plans by the Director of Clinical Services on 6/18/15 and again by the Regional Minimum Data Set Nurse 7/8/2015. All nursing staff was reeducated by Director of Clinical Services on 7/9/2015 on reporting changes of condition, new orders, and new interventions for all aspects of resident care and on the need to communicate changes to the Nurse Managers and the Minimum Data Set Nurses. The Minimum Data Sets Nurses reviewed the plans of care of all residents currently residing in the facility for accuracy and made necessary updates – completed on 7/8/15. No Minimum Data Set Nurse/Nursing Staff will work until he/she has completed this education.</p>		

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F 280	<p>Continued From page 10</p> <p>Review of Resident #203 care plan revised on 5/21/15 indicated the resident had a problem of (behavior/mood). Focus revealed impaired or inappropriate behaviors; etiologies: cognitive loss, medication use, insufficient safety awareness; as evidenced by wandering, socially inappropriate behavior (removing brief, playing in stool, throwing on floor, threatening to throw on nursing assistants (stool). The goal indicated; resident will wander safely, resident will not leave building unattended; and resident will allow staff to provide care as needed. Approaches included; psych consult as needed, medications per physician, redirect inappropriate behaviors safety check as needed and observe for increase in behaviors or unsafe behavior and report to physician, remove sources of agitation as possible. The resident 's care plan did not address instances of unwanted touching or exposing himself to others.</p> <p>1a. Resident #149 was admitted to the facility on 5/14/15 with a diagnosis that included impaired functional status, status post cardiovascular accident, and left hemiparesis. The Most recent MDS dated 5/26/15 revealed a BIMs of 15 indicating the resident was cognitively intact.</p> <p>Interview with Resident #149 on 6/11/15 at 4:30pm revealed she voiced concerns that Resident #203 entered her room when she was asleep. The resident couldn ' t recall the exact date but stated it was shortly after she was admitted to the facility. The resident stated it had to be about 10:00 PM or 10:30 PM due to her being asleep at the time. Resident #149 stated Resident #203 entered her room in his wheelchair and Resident woke up when she felt Resident #203 touch her leg and run his hand up her leg to</p>	F 280	<p>4. The Director of Clinical Services/Case Management Nurse/Minimum Data Set Nurse will conduct Quality Improvement monitoring on 3 Care Plans per week to ensure accuracy for 1 month, then 1 Care Plan per week for 3 months, then 1 Care Plan for two months.</p> <p>The results of the Quality Improvement monitoring will be reported by Director of Clinical Services/Assistant Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly for six months for continued substantial compliance and/or revision.</p>	7-10-15	

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F 280	<p>Continued From page 11</p> <p>above her knee. Resident #149 stated she told Resident #203 to get out of her room. Resident #149 stated she then observed Resident #203 drink her perineal wash and perfume that was on her bedside table. Resident #149 stated that Resident #203 then went to her roommate and rubbed her foot. Resident #149 stated her roommate (Resident #178) was upset as evidenced by yelling. Resident #149 stated that Resident #203 had his hands down in his pants touching his genitals.</p> <p>Interview on 6/11/15 at 5:40 PM with NA#2, who care for Resident #203 during the 3:00 PM-11:00 PM shift stated Resident #203 goes into other resident ' s rooms. Staff have to watch him close because he can propel his wheelchair fast. He is in falling star program due to elopement risk and fall risk. The staff stated they were aware that Resident #203 had touched a resident ' s leg and thigh and was touching himself. A second Resident #59 on 300 hall complained of Resident #203 in her room. The staff revealed they had reported to the incident to their nurse. Resident #203 is supposed to go to " falling star program " during the day to monitor his whereabouts. During the change of shift, he is back on the hall for about an hour. He is on the hall, and they try to watch him. This is when he goes into other resident ' s rooms.</p> <p>1b. Resident #59 was admitted on 6/30/14 with a diagnosis of personal history of fall, muscle weakness and depressive disorder. The most recent MDS assessment dated 3/7/15 indicated Resident #59 had a BIMS score of 12 indicating she was moderately cognitively impaired.</p> <p>Interview on 6/11/15 at 5:43 PM with Resident</p>	F 280			

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F 280	<p>Continued From page 12</p> <p>#59 revealed Resident #203 came into her room, took his penis out and said, " Come and get it, come and get it. " She yelled for staff to get him out of her room. Staff came and removed him from her room. Resident #59 stated the incident occurred at least a week ago.</p> <p>Interview with the social worker on 6/11/15 at 6:26pm revealed the only behavior they were aware of with Resident #203 was that he wandered the facility in his wheelchair. No one had brought to her attention that the resident had entered any resident ' s rooms exposing himself or touching any residents. The social worker indicated she became aware of issues regarding behavior though the nurses notes or though staff communicating to her what has occurred. The social worker further revealed she became aware of resident behaviors at clinical morning meetings and it was her responsibility to update care plans in regards to resident behaviors. In the instance the social worker was aware of the incident in which Resident #203 entered Resident #149 and Resident #178 ' s room and touched her or exposed himself to resident #59 they would have ensured the care plan updated to reflect the new behavior.</p> <p>Interview with the Director of Nursing (DON) on 6/12/15 at 3:06 pm revealed she was unaware of Resident #203 exhibiting the behavior of unwanted touching or exposing himself. The incident should have been care plan developed due to the occurrences.</p> <p>Interview with the administrator on 6/12/15 at 3:08 pm revealed she was unaware of instances of Resident #203 exhibiting unwanted touching or exposing himself. The administrator stated it was</p>	F 280			

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F 280	Continued From page 13 her expectation that staff to communicate instances of unwanted touching or when a resident exposes himself to others. The instance should have been documented and a care plan should have been developed in regards to these instances. 2. Resident #227 was admitted to the facility on 3/24/15 and re-admitted on 5/11/15 with diagnosis of pneumonia, chronic airway obstruction, chronic pain, hypertension and left upper extremity deep vein thrombosis. The admission Minimum Data Set (MDS) assessment with assessment reference date of 3/31/15 indicated that Resident #227 was cognitively intact and required extensive assistance with activity of daily living (ADL 's). The MDS revealed that Resident #227 was at risk for developing pressure ulcers and pressure reducing devices were in place for the chair and bed. The care plan initiated on 3/24/15 revealed a problem for skin/wound with a focus that resident has the potential for impaired skin. The approaches and interventions listed were diet as ordered, assist with turning and repositioning, inform the physician of any new area of skin breakdown, inform family and caregivers of any new area of skin breakdown, obtain and order lab/diagnostic work as ordered, handle and position to reduce friction, administer treatment as ordered and monitor for effectiveness, provide incontinence care post episode, weekly skin checks, encourage resident to get out of bed and air mattress. On 5/25/15 a physician order was written to float	F 280			

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F 280	<p>Continued From page 14</p> <p>heels while in bed.</p> <p>The treatment sheet for May and June 2015 revealed to float heels while in bed which was implemented May 25, 2105.</p> <p>The new intervention to float heels while in bed was not added to the care plan but was noted on the nurse aide kardex.</p> <p>During several observations on 6/10/15, 6/11/15 and 6/12/15 Resident #227 was observed to have her heels floated on a pillow while in bed.</p> <p>Review of Resident #227 's the weekly pressure ulcer record revealed a pressure ulcer on the coccyx and right heel was resolved on 6/3/15.</p> <p>During an interview with nurse aide (NA) #3 on 6/10/15 at 10:00 AM indicated that resident specific care needs are identified on the nurse aide kardex. Upon review of the kardex, NA #3 identified interventions of float heels, reposition every 2 hours and air mattress in place for skin protection for Resident #3.</p> <p>During an interview with the MDS nurse on 6/11/15 at 10:30 AM revealed that care plans are updated according to new orders, order changes and the 24 hour report and any new information provided in morning meeting. The MDS nurse indicated that new intervention should have been added when the order was received.</p> <p>During an interview with the unit manager on 6/12/15 at 11:30 AM revealed that the care plan interventions should be implemented as planned and any changes or updates should be reviewed during the morning clinical meeting.</p> <p>Resident #48 was admitted to facility on 3/5/08 with diagnosis of Alzheimers, hypertension, and senile dementia. On 4/2/15 Resident #48 was sent to the local hospital due to</p>	F 280			

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F 280	<p>Continued From page 15 unresponsiveness and hypotensive. She returned on 4/8/15.</p> <p>Review of the admission notes dated 4/8/15 wounds were noted on bilateral heels. The skin assessment dated 4/8/15 indicated the right and left heels had "unblanchable redness."</p> <p>Review of the admission orders dated 4/8/15 included treatment of skin prep to both heels.</p> <p>Review of the Treatment Administration Record (TAR) for review for 4/8/15 revealed treatment included use of skin prep to both heels every day. Interventions included to float the heels when in bed.</p> <p>Review of the Minimum Data Set (MDS) dated 4/12/15 included two unstageable pressure ulcers were present. Resident #48 required extensive assistance with bed mobility and all other activities of daily living.</p> <p>The care plan dated 4/23/15 included a problem of "skin/wound" for deep tissue injury to bilateral heels. The approaches included turning and repositioning frequently, float heels at all times and weekly skin checks.</p> <p>Review of the telephone order dated 5/21/15 indicated the left heel skin prep treatment was to be continued. The Santyl treatment to the right heel was to be discontinued. The treatment was changed to start hydrogel with dry protective dressing. Also recommend sponge boot.</p> <p>The care plan did not include the update for use of the sponge boot to the right heel.</p>	F 280			

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F 280	Continued From page 16 Interview with the MDS nurse on 06/12/2015 at 10:05 AM he was not aware the boot had been ordered. The usual method of updating the care plans included reviewing the telephone orders each morning and updating the care plans. He said that order must have been missed.	F 280			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record reviews, the facility failed to implement a care plan intervention for dental services for 2 of 5 sampled residents for dental needs (Resident #227 and #232) and contracture management for 1 of 1 resident (Resident #129). The findings included: 1. Resident #227 was admitted to the facility on 3/24/15 and re-admitted on 5/11/15 with diagnosis of pneumonia, chronic airway obstruction, chronic pain, hypertension and left upper extremity deep vein thrombosis. The admission Minimum Data Set (MDS) assessment with assessment reference date of 3/31/15 indicated that Resident #227 was cognitively intact and required extensive assistance with activity of daily living (ADL 's). The MDS section under Dental Status was inaccurately coded and the care area was not triggered. The care plan initiated on 3/24/15 revealed a	F 282	1. Residents #227and 232 no longer reside in the facility. Resident #129 had a range of motion assessment and was referred to Restorative Nursing on 6/15/15 for splinting and positioning and services initiated. 2. All residents residing in the facility have a potential to be affected. All residents had a ROM assessment completed and interventions implemented if there was a need. 3. The Director of Clinical Services, Minimum Data Set Nurses, and Management Nurses completed a review of all residents' records on 7/2/15 to ensure that any resident residing in the facility with an identified need was be seen by a qualified person either inside or outside of the facility to include: dental and therapy/restorative professionals. The Minimum Data Set Nurses updated the plans of care as indicated on 7/9/15.		

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F 282	<p>Continued From page 17</p> <p>problem for nutrition/hydration with an updated intervention on 4/13/15 to consult dentist as ordered.</p> <p>The physician progress note dated 4/13/15 indicated that Resident #227 complained of loose teeth lower, no pain , no bleeding. The assessment indicated a loose tooth and the plan revealed to consult dentist for tooth evaluation. A physician order dated 4/13/15 indicated to consult dentist for lower loose teeth.</p> <p>During an observation and interview with Resident #227 on 6/8/15 at 3:42 PM revealed several missing, broken and decayed teeth on upper and lower gums. Resident #227 indicated that she had a loose bottom tooth and had not had a dentist visit yet and was not sure why. Resident #227 indicated that she did not have any pain and the loose tooth did not interfere with eating.</p> <p>A record review on 6/10/15 revealed no documentation of a dental consult or dental visit had been made.</p> <p>An interview with Resident #227 on 6/10/15 at 9:55 AM revealed that she had a loose bottom tooth and it was bleeding yesterday (6/9/15), she stated that she told the staff and they swabbed her teeth and mouth. Upon observation, Resident #227 has a lower loose front tooth that was turned sideways.</p> <p>During an interview with nurse aide (NA) #3 on 6/10/15 at 10:00 AM indicated that she did mouth care for Resident #227 yesterday (6/9/15) using a swab and noticed some bleeding and a very loose tooth on the front bottom gum. She reported the loose, bleeding tooth to nurse #2.</p> <p>An interview with nurse #2 on 6/10/15 at 11:30 AM revealed that the NA did report to her about Resident #227 having a loose tooth and some bleeding on 6/9/15 but did not document it or</p>	F 282	<p>4. The Director of Clinical Services/Case Management Nurse will conduct Quality Improvement monitoring on 3 resident records for appointments and consult completion per week for 3 weeks, then 2 records per week for 3 weeks, then 1 record per week for 2 months. The Director of Clinical Services will conduct random audits 2 times per week for 2 months identifying referrals from the report in morning meeting to assure appropriate follow up occurred. The results of the Quality Improvement monitoring will be reported by Director of Clinical Services/Assistant Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly for six months for continued substantial compliance and/or revision.</p>	7-10-15	

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F 282	<p>Continued From page 18</p> <p>notify the physician because she became busy with an admission. Nurse #2 indicated that she would notify the physician today (6/10/15) An interview with nurse #4 on 6/11/15 at 10:30 AM revealed that she signed off the order dated 4/13/15 for the dental consult and made a copy of the order and placed the copy on the clip board for the appointment/transportation staff who makes the appointment and arranges transportation. Nurse #4 could not recall if Resident #227 went to the dentist or not. During an interview with the transportation/appointment staff on 6/11/15 at 1:00 PM revealed that once she gets a copy of the order for consults she makes the appointment and arranges transportation and returns the copy back to the nurse 's station with the appointment date, she then notes it on the calendar. She indicated that there are no record of the the copied physicians order or record of an appointment date on the calendar. She indicated she was not sure what happened with the arrangements for Resident #227 ' s dental appointment. During an interview with the unit manager on 6/12/15 at 11:30 AM revealed that the care plan interventions should be implemented as planned and any changes or updates should be reviewed during the morning clinical meeting.</p> <p>2. Resident #232 was admitted to the facility on 4/6/15 and re-admitted on 4/24/15 with right tibia-fibula fracture, status post above knee amputation, B-cell lymphoma involving right lower extremity and discharged home on 6/2/15. A closed record review revealed an admission MDS assessment with assessment reference date of 4/13/15 that indicated Resident #232 was cognitively intact and required extensive</p>	F 282			

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F 282	<p>Continued From page 19</p> <p>assistance with ADL ' s. The MDS section under Dental Status was coded no natural teeth (edentulous) and dental care area triggered. The care plan initiated on 4/24/15 revealed a problem for ADL ' s with an approach for personal hygiene oral care and dental consult as ordered. A physician order dated for 4/28/15 indicated to consult Dentist for dental care. A closed record review on 6/10/15 revealed no documentation of a dental consult or dental visit had been made.</p> <p>An interview with nurse #4 on 6/11/15 at 10:30 AM revealed that she signed off the order dated 4/28/15 for the dental consult and made a copy of the order and placed the copy on the clip board for the appointment/transportation staff who makes the appointments and arranges transportation. Nurse #4 could not recall if Resident #232 went to the dentist or not.</p> <p>During an interview with the transportation/appointment staff on 6/11/15 at 1:00 PM revealed that once she gets a copy of the order for consults she makes the appointment and arranges transportation and returns the copy back to the nurse ' s station with the appointment date, she then notes it on the calendar. She indicated that there are no record of the the copied physicians order or record of an appointment date on the calendar. She indicated she was not sure what happened with the arrangements for Resident #232 ' s dental appointment.</p> <p>During an interview with the unit manager on 6/12/15 at 11:30 AM revealed that the care plan interventions should be implemented as planned and any changes or updates should be reviewed during the morning clinical meeting.</p> <p>2. Resident #129 was admitted to the facility on 12/12/13 with a diagnosis that included pain in</p>	F 282			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2015
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083		
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F 282	Continued From page 20 joint, hand, contracture of joint of multiple sites, contracture of hand joint, dementia and cognitive communication deficit. The most recent Minimum Data Set (MDS) assessment dated 3/14/15 indicated Resident #129 had impairments of the upper extremities and was totally dependent on staff assistance to complete activities of daily living (ADL). The MDS further revealed Resident #129 was cognitively impaired as evidenced by a brief interview for mental status (BIMS) score of 3. Review of Resident #129 care plan updated 4/2/15 indicated a " Problem " of, pain/comfort. The resident had the potential for alteration in pain/comfort due to contracture of the left hand. The interventions included; observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM (range of motion), withdrawal or resistance to care; therapy consult as needed; identify and treat the existing conditions which may increase pain and or discomfort due to arthritis, and contracture of the left hand. The specifications for nursing stated carrot to left hand as tolerated for contracture management. Update of 5/4/15 indicated continue with carrot. Physician note dated 5/4/15 stated discontinue order for splint to right hand; left hand splint to be applied upon arrival; therapy carrot to left hand for contracture management. Physician note dated 5/20/15 stated hand roll splint to left hand for contracture management; wearing schedule to be established by occupational therapy. Review of Resident #129 Occupational therapy recertification/monthly summary dated 5/21/15 indicated a goal of nursing will demonstrate good understanding of patient functional maintenance program (FMP) for wheelchair positioning and	F 282			

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F 282	<p>Continued From page 21</p> <p>contracture management. The baseline dated 4/20/15 stated nursing not consistently placing therapy carrot in left hand; left hand digits flexion contracture has declined to the point where it is very difficult to extend digits; no functional maintenance program (FMP) being followed for daily range of motion (ROM) to bilateral upper extremities (BUE). Patient with poor + tolerance for PROM to left hand. Previous monthly summary dated 5/1/15 stated nursing not consistently placing therapy carrot in left hand; left hand digit flexion contracture had declined to the point where it is very difficult to extend digits; no FMP being followed for daily ROM to BUE. Patient with impaired tolerance for passive range of motion (PROM) to left hand to fair; new orders from neurologist 4/29/15 to use carrot in left and during the day. At this time patient is only able to tolerate slight extension of digits for application of carrot or similar device. Will continue to monitor. Will continue to provide modalities including short wave diathermy to assist with increasing ROM to left hand with plan to provide appropriate splint to left hand once patient is able to tolerate splint wear.</p> <p>Review of Resident #129 Occupational therapy encounter note dated 6/1/15 revealed therapy carrot not in place; nursing non-compliant with contracture management program for patient.</p> <p>Observation of Resident #129 on 6/8/15 at 11:00am revealed Resident #129 to be seated in her wheelchair. Her hand was observed tightly held. No therapeutic carrot was applied to her left hand.</p> <p>Observation of Resident #129 on 6/8/15 at 4:01pm revealed Resident #129 was seated in her wheelchair. Her hand was observed tightly held. No therapeutic carrot was observed in Resident #129 ' s left hand.</p>	F 282			

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F 282	Continued From page 22 Observation of Resident #129 on 6/9/15 at 9:09am revealed Resident #129 seated in her wheelchair. Her left hand was observed to be tightly held. No therapeutic carrot was observed in Resident #129 ' s left hand. On 6/09/15 at 9:57am the Occupational therapist (OT) provided Resident #129 with ROM to her left hand. The OT indicated that she was stretching Resident #129 hand in order to put in the residents splinting device. The OT said Resident #129 was not on the current OT caseload. The carrot was issued by therapy and was located by the therapist in the resident ' s drawer. The therapist stated that she had observed Resident #129 not to be holding the therapeutic carrot when she walked by the residents room and when she came to assess. The OT stated she may have to do more staff education in regards to Resident #129 therapeutic carrot application. The OT stated that in her assessments she indicated the therapeutic carrot was not being consistently applied due to the resident taking the carrot out and staff not applying the device at all. The OT indicated that nursing was provided education to perform the splinting. Interview with restorative aide #1 on 6/11/15 at 9:24 am revealed she did not have Resident #129 on her caseload for splinting. The Restorative aide stated she only provided Resident #129 with positioning. Therapy had not discharged Resident #129 back to restorative to put the carrot in her hand. Interview with Resident #129 ' s Nurse (Nurse #1) on 6/11/15 at 9:14am revealed she, nursing assistant or restorative nursing applied Resident #129 ' s therapeutic carrot. The nurse could not determine the parameters in which Resident #129 had to wear the splitting device. Nurse #1 was unsure of why the therapeutic carrot was not	F 282			

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F 282	Continued From page 23 applied to Resident #129 ' s left hand. Interview with the DON on 6/12/15 at 3:06pm revealed it was her expectation that restorative would be placing the therapeutic carrot in Resident #129's hand. The DON stated staff should be following the care plan as written. Interview with the Administrator on 6/12/15 at 3:08pm revealed it was her expectation that OT communicate with nursing or administration that the carrot was not being applied consistently. It was further the expectation of the administrator that the staff follow the care plan as written.	F 282			
F 309 SS=D	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 record review, facility staff and physician interviews, the facility failed to obtain, monitor and assess increases in a resident ' s daily weight as ordered by the physician for 1 of 1 residents (Resident #9) reviewed with a diagnosis of congestive heart failure and history of edema. The findings included: Resident #9 was admitted to the facility on 11/26/13. His cumulative diagnoses included congestive heart failure.	F 309	1. The Director of Clinical Services placed Resident #9 on the weekly weight list on 6/13/15 and personally monitored the weights for variances to be reported to the physician. 2. All residents in the facility requiring daily weights or orders requiring specific parameters have the potential to be affected. The Unit Coordinators/Unit Managers completed a review of all residents with orders for daily weights to ensure weights were obtained and the prescribed parameters were followed on 7/9/15.		

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F 309	Continued From page 24 Resident #9 ' s most recent quarterly Minimum Data Set (MDS) dated 3/4/15 revealed the resident had intact cognitive skills for daily decision making. The resident required extensive assistance from staff for most of his Activities of Daily Living (ADLs), with the exception of needing limited assistance for locomotion on/off the unit and supervision with personal hygiene and eating. A review of Resident #9 ' s medical record revealed there was a current physician ' s order which read, " Weight every day; notify MD (Medical Doctor) of weight gain of 3 pounds (#) in one day or 5 pounds in one week. " On 3/12/15, a physician ' s order was received to discontinue Resident #9 ' s scheduled dose of furosemide (a diuretic medication). An order was also received on 3/12/15 to initiate 20 milligrams (mg) furosemide once daily as needed for lower extremity edema. A review of the physician ' s Progress Notes on 3/12/15 revealed the scheduled furosemide was held due to an increase in the resident ' s creatinine level (a blood test which may be an indicator of how well the kidneys are functioning). A review of Resident #9 ' s April 2015 Medication Administration Record (MAR) included documentation of the daily weights obtained. The April 2015 MAR revealed 5 daily weights (4/1, 4/2, 4/5, 4/20, and 4/30) had not been recorded. Of the recorded weights, there were two occasions where the resident had a weight increase of more than 3 pounds (#) in one day: --On 4/8/15, the resident weighed 158.4#; on 4/9/15, he weighed 166.4# (a difference of 8# in one day);	F 309	3. Nursing Staff were reeducated on 6/18/15 by the Director of Clinical Services on the need for following physician's orders and parameters. The retraining stressed the need to contact the physician as prescribed or as required by nursing standards of practice. No nursing staff will work until he/she has completed this education. 4. The Director of Clinical Services/Unit Manager will monitor any residents with physician orders for special monitoring 5 times weekly for 1 month, then 3 times weekly for 1 month, then 1 time weekly for 2 months, then 1 time monthly for 2 months. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Unit Manager to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.	7-10-15	

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F 309	<p>Continued From page 25</p> <p>--On 4/24/15, the resident weighed 166.0#; on 4/25/15, he weighed 170.8# (a difference of 4.8# in one day).</p> <p>A review of the medical record revealed no notations were made to indicate the resident was reweighed or an assessment of the reason for the weight increase was completed. The April 2015 MAR indicated no doses of furosemide (ordered once daily as needed) were given during the month. No notes were made in the resident ' s medical record to indicate the resident ' s Medical Doctor (MD) was notified of the weight increases.</p> <p>A review of Resident #9 ' s May 2015 Medication Administration Record (MAR) included documentation of the daily weights. The May 2015 MAR revealed 4 daily weights (5/6, 5/14, 5/15, and 5/22) had not been recorded. Of the recorded weights, there were two occasions where the resident had a weight increase of more than 3 pounds (#) in one day:</p> <p>--On 5/4/15, the resident weighed 162.3#; on 5/5/15, he weighed 171.3# (a difference of 9# in one day);</p> <p>--On 5/11/15, the resident weighed 166.0#; on 5/12/15, he weighed 170.0# (a difference of 4# in one day).</p> <p>A review of the medical record revealed no notations were made to indicate the resident was reweighed or an assessment of the reason for the weight increase was completed. The May 2015 MAR indicated no doses of furosemide (ordered once daily as needed) were given during the month. No notes were made in the resident ' s medical record to indicate the resident ' s Medical Doctor (MD) was notified of the weight increases.</p> <p>A review of Resident #9 ' s June 2015 Medication Administration Record (MAR) included</p>	F 309			

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F 309	<p>Continued From page 26</p> <p>documentation of the daily weights. The June 2015 MAR revealed 1 daily weight (6/1) had not been recorded through the date of the review (6/11/15). Of the recorded weights, there was one occasion where the resident had a weight increase of more than 3 pounds (#) in one day: --On 6/8/15, the resident weighed 167.2#, on 6/9/15, he weighed 170.5# (a difference of 3.3# in one day).</p> <p>A review of the medical record revealed no notations were made to indicate the resident was reweighed or an assessment of the reason for the weight increase was completed. The June 2015 MAR indicated no doses of furosemide (ordered once daily as needed) were given during the month through the date of the review. No notes were made in the resident's medical record to indicate his Medical Doctor (MD) was notified of the weight increase. There were no notations of this weight increase in the MD's Communication Book.</p> <p>An interview was conducted on 6/11/15 at 10:17 AM with Nurse #8. Nurse #8 was the 1st shift Hall nurse assigned to care for Resident #9. During the interview, Nurse #8 reported she had also worked the same shift and hall assignment on 6/9/15. Upon review of Resident #9's 6/9/15 weight, Nurse #8 confirmed there was a greater than 3# weight increase from the previous day. The nurse discussed the facility's procedures for obtaining weights for those residents having orders for daily weights. She reported the daily weights were generally done on the 11PM-7AM shift (3rd shift). The nurse stated it would have been the responsibility of the 11PM-7AM nurse to contact the resident's MD about the weight increase and/or pass along the need to do so to the oncoming nurse (1st shift nurse) in report.</p>	F 309			

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F 309	<p>Continued From page 27</p> <p>Nurse #8 reported she had not been made aware of this weight increase. The nurse noted that she did not call the MD to notify him of the weight change on 6/9/15. Upon inquiry, Nurse #8 reported that all daily weights were recorded on the resident 's MAR.</p> <p>A telephone interview was conducted on 6/11/15 at 2:04 PM with Nurse #7. Nurse #7 was the 3rd shift nurse assigned to care for Resident #9 on the evenings of 4/24-4/25/15, 5/4-5/5/15, and 5/11-5/12/15 (three dates when a greater than 3# per day weight increase was recorded). Nurse #7 reported weights were typically done on the 3rd shift for residents who had orders for daily weights. Upon inquiry, the nurse stated she would report a daily weight increase greater than a 3# for Resident #9 by writing a note in the MD 's book. Nurse #8 also stated she would have reported the weight change to the day shift nurse and that nurse would subsequently give him the " as needed " furosemide prescribed. When asked, Nurse #8 stated that if she wrote a note about the resident 's weight change in the MD's book, she would not have documented this notification in the resident 's medical record. The nurse could not recall whether or not she notified the resident 's physician about the weight increases noted for Resident #9 on 4/24-4/25/15, 5/4-5/5/15, or 5/11-5/12/15.</p> <p>The 3rd shift nurses assigned to care for Resident #9 on 4/8-4/9/15 and 6/8-6/9/15 were not available for interview.</p> <p>A telephone interview was conducted on 6/11/15 at 4:15 PM with Resident #9 's Medical Doctor (MD). During the interview, the missing daily weights and daily weight increases noted for Resident #9 were discussed. When asked what</p>	F 309			

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F 309	Continued From page 28 his expectation would be in regards to daily weights, the MD stated, "If an order is written for daily weights and to notify the MD for a weight increase, would expect that to be done." Upon further inquiry, the MD reported he did not recall for certain as to whether or not he had been made aware of the resident ' s weight increases. The MD stated he expected to be notified of the resident ' s weight increase in accordance with the MD orders and parameters given so he could evaluate the resident accordingly. The MD indicated he would have expected the nurse to have documented the MD notification in the Nursing Notes and to have communicated this in the MD communication book as well. He stated, " If the notification was not in the (MD) communication book, it was not done (relative to the 6/9/15 weight increase). " An interview was conducted on 6/11/15 at 4:42 PM with the Interim Director of Nursing (DON). The DON indicated if there was an order for a resident to have daily weights taken, she expected them to be done every day. She also noted that if the MD had given parameters as to when he should be notified for a weight increase, she expected the MD to be notified in accordance with those parameters. The DON stated in addition to notifying the MD, she would expect the resident ' s Responsible Party (RP) and the DON herself to be notified of such a change. Upon inquiry, the DON stated she expected documentation of MD notification of weight changes to be made both in the MD communication book and in the resident ' s permanent medical record.	F 309			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318	1. Resident #129 had a range of motion assessment and was referred to Restorative Nursing on 6/15/15 for splinting and positioning and services were initiated.		

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F 318	<p>Continued From page 29</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow physician order and therapy recommendations for contracture management for 1 of 5 sampled residents (Resident #129). The findings included: Resident #129 was admitted to the facility on 12/12/13 with a diagnosis that included pain in joint, hand, contracture of joint of multiple sites, contracture of hand joint, dementia, cognitive communication deficit. The most recent Minimum Data Set (MDS) assessment dated 3/14/15 indicated Resident #129 had impairments of the upper extremities and was totally dependent on staff assistance to complete activities of daily living (ADL). The MDS further revealed Resident #129 was cognitively impaired as evidenced by a brief interview for mental status (BIMS) score of 3. Review of Resident #129 care plan updated 4/2/15 indicated a "Problem" of, pain/comfort. The resident had the potential for alteration in pain/comfort due to contracture of the left hand. the interventions included; observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM (range of motion), withdrawal or resistance to</p>	F 318	<p>2. All residents residing in the facility have the potential to be affected. All residents residing in the facility were assessed for splinting and contractures by the Unit Coordinators/Unit Managers by 7/10/15. Any abnormal findings were reported to the Interdisciplinary Team for referral to Therapy or Restorative Nursing.</p> <p>3. The Director of Clinical Services reeducated all nursing staff on 7/7/15 on reporting missing equipment for residents residing in the facility and any range of motion declines that would warrant a referral to Therapy or Restorative Nursing. Therapy will report any therapy recommendations during the morning meeting for follow up by Nursing Management. Each resident will have a Range of assessment completed quarterly to determine progress or decline. No nursing staff will work until he/she has completed this education.</p>		

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F 318	Continued From page 30 care; therapy consult as needed; identify and treat the residents existing conditions which may increase pain and or discomfort due to arthritis, and contracture of the left hand. The specifications for nursing stated carrot to left hand as tolerated for contracture management. Update 5/4/15 indicated continue with carrot. Review of Resident #129 occupational therapy initial evaluation signed 3/12/15 revealed reason for patient referral due to fall. During OT screen it was noted that patient is poorly positioned in wheelchair with no cushion or leg rests, therapy carrot previously issued during OT not positioned appropriately in left hand. Review of Resident #129 occupational therapy initial evaluation signed 4/22/15 stated Patient referred to OT through referral from rounding process due to lack of appropriate functional maintenance program being consistently followed by nursing. Patient demonstrates significant left hand contracture and would benefit from skilled OT services for contracture management and splinting. Review of consultation report dated 4/29/15 indicated a diagnosis of left hand dystonia with developing left hand contracture and Parkinson disease. Findings included botox was of no benefit for left hand. The recommendations included use carrot in left hand during the day. Physician note dated 4/29/15 stated fashion brace for both hands to use at night, use carrot in left hand during the day. Physician note dated 5/4/15 stated discontinue order for splint to right hand; left hand splint to be applied upon arrival; therapy carrot to left hand for contracture management. Physician note dated 5/20/15 stated hand roll splint to left hand for contracture management; wearing schedule to be established by	F 318	4 The Unit Coordinators/Director of Clinical Services will conduct Quality Improvement monitoring of 4 splinted residents per week for 1 month to ensure splints are in place as prescribed, then 3 splinted residents per week for 1 month, then 2 splinted residents per week for 2 months, 1 splinted resident weekly for 1 month. The Director of Clinical Services/Unit Manager will conduct Quality Improvement monitoring of 4 records per week for the completion of the quarterly Range of Motion Assessments for 1 month, then 3 records per week for 1 month, then 2 records per week for 2 months, then 1 record per week for 1 month. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Unit Manager to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.	3-10-15	

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F 318	Continued From page 31 occupational therapy. Review of Resident #129 Occupational therapy recertification/monthly summary dated 5/21/15 indicated a goal of nursing will demonstrate good understanding of patient functional maintenance program (FMP) for wheelchair positioning and contracture management. The baseline dated 4/20/15 stated nursing not consistently placing therapy carrot in left hand; left hand digits flexion contracture has declined to the point where it is very difficult to extend digits; no functional maintenance program (FMP) being followed for daily range of motion (ROM) to bilateral upper extremities (BUE). Patient with poor + tolerance for PROM to left hand. Previous monthly summary dated 5/1/15 stated nursing not consistently placing therapy carrot in left hand; left hand digit flexion contracture had declined to the point where it is very difficult to extend digits; no FMP being followed for daily ROM to BUE. Patient with impaired tolerance for passive range of motion (PROM) to left hand to fair; new orders from neurologist 4/29/15 to use carrot in left and during the day. At this time patient is only able to tolerate slight extension of digits for application of carrot or similar device. Will continue to monitor. Will continue to provide modalities including short wave diathermy to assist with increasing ROM to left hand with plan to provide appropriate splint to left hand once patient is able to tolerate splint wear. Review of consultation report dated 5/22/15 indicated a diagnosis of left hand contracture. The recommendations stated Occupational therapy stretching with dynamic splinting. Review of resident #129 Occupational therapy encounter note dated 6/1/15 revealed a therapeutic carrot was not in place; nursing non-compliant with contracture management	F 318			

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F 318	<p>Continued From page 32</p> <p>program for patient.</p> <p>Observation of Resident #129 on 6/8/15 at 11:00 am revealed Resident #129 to be seated in her wheelchair. Her hand was observed to be tightly held. Resident #129 had no therapeutic carrot applied to in her left hand.</p> <p>Observation of Resident #129 on 6/8/15 at 4:01 pm revealed Resident #129 to be seated in her wheelchair. Her hand was observed to be tightly held. Resident #129 was observed to have no therapeutic carrot in her left hand.</p> <p>Observation of Resident #129 on 6/9/15 at 9:09 am revealed Resident #129 to be seated in her wheelchair. Her left hand was observed to be tightly held. Resident #129 had no therapeutic carrot to be in her left hand.</p> <p>On 6/09/15 at 9:57 am the Occupational therapist (OT) provided Resident #129 with ROM to her left hand. The OT indicated that she was stretching Resident #129 hand in order to put in the residents splinting device. The OT said Resident #129 was not on the current OT caseload. The carrot was issued by therapy and was located by the therapist in the resident 's drawer. The therapist stated that she had observed Resident #129 not to be holding the therapeutic carrot when she walked by the residents room and when she came to assess. The OT stated she may have to do more staff education in regards to Resident #129 therapeutic carrot application. The OT stated that in her assessments she indicated the therapeutic carrot was not being consistently applied due to the resident taking the carrot out and staff not applying the device at all. The OT indicated that nursing was provided education to perform the splinting.</p> <p>Interview with restorative aide #1 on 6/11/15 at 9:24 am revealed she did not have Resident #129 on her caseload for splinting. The Restorative</p>	F 318			

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F 318	Continued From page 33 aide stated she only provided Resident #129 with positioning. Therapy had not discharged the Resident #129 back to restorative to put the carrot in her hand. Interview with Resident #129 's Nurse (Nurse #1) on 6/11/15 at 9:14am revealed she, nursing assistant or restorative nursing would apply Resident #129 's therapeutic carrot. The nurse could not determine the parameters in which Resident #129 had to wear the splitting device. Nurse #1 was unsure of why the therapeutic carrot was not applied to Resident #129 's left hand on 6/8/15. Interview with the DON on 6/12/15 at 3:06 pm revealed it was her expectation that restorative be putting the therapeutic carrot if Resident #129 was on restorative. Therapy devices should be worn per therapy recommendations. Interview with the Administrator on 6/12/15 at 3:08pm revealed it was her expectation that OT communicate with nursing or administration that the therapy carrot was not being applied consistently. It was further her expectation that the therapy orders be carried out as written and parameters identified.	F 318			
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	F 323	1. Resident #203 no longer resides at the facility. The resident was placed on 1:1 supervision at the time the inappropriate behavior was brought to the attention of the management team.		

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F 323	<p>Continued From page 34</p> <p>by: Based on record review, resident interview and staff interview the facility failed to manage inappropriate behaviors and implement effective interventions for 1 of 1 sampled residents (Resident #203) who exposed himself to a resident (Resident #59) and inappropriately touched residents (Resident #149 and Resident #178).</p> <p>The findings included:</p> <p>1. Resident #203 was admitted to the facility on 5/5/15 with a diagnosis of advanced dementia. The most recent Minimum Data Set (MDS) assessment dated 5/22/15 revealed no behaviors verbal, physical directed at others. Brief interview mental stats (BIMS) revealed Resident #203 was moderately impaired for decision making.</p> <p>Review of Resident #203 care plan revised on 5/21/15 indicated the resident had a problem of (behavior/mood). Focus revealed impaired or inappropriate behaviors; etiologies: cognitive loss, medication use, insufficient safety awareness; as evidenced by wandering, socially inappropriate behavior (removing brief, playing in stool, throwing on floor, threatening to throw on nursing assistants (stool). The goal indicated; resident will wander safely, resident will not leave building unattended; and resident will allow staff to provide care as needed. Approaches included; psych consult as needed, medications per physician, redirect inappropriate behaviors safety check as needed and observe for increase in behaviors or unsafe behavior and report to physician, remove sources of agitation as possible. The resident 's care plan did not address instances of unwanted</p>	F 323	<p>2. All residents in the facility have the potential to be affected. All residents were discussed in a Behavior Management Meeting to identify and additional behavioral issues requiring intervention on 6/11/15.</p> <p>All residents currently residing in the facility have been assessed for wandering/inappropriate behaviors and proper interventions were put in place and care planning completed on 7/9/15.</p> <p>3. The Director of Clinical Services reeducated all facility staff on reporting inappropriate behaviors to Nurses, Director of Clinical Services, or the Executive Director on 6/29/15. No staff will be allowed to work until he/she has completed this education. New admissions will be assessed by the Admitting Nurse and any indications of behavioral issues will be reported to the Social Service Professional for appropriate interventions and care planning.</p>		

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F 323	<p>Continued From page 35 touching or exposing himself to others.</p> <p>1a. Resident #149 was admitted to the facility on 5/14/15 with a diagnosis that included impaired functional status, status post cardiovascular accident, and left hemiparesis. The Most recent MDS dated 5/26/15 revealed a BIMs of 15 indicating the resident was cognitively intact.</p> <p>Interview with Resident #149 on 6/11/15 at 4:30pm revealed she voiced concerns that Resident #203 entered her room when she was asleep. The resident couldn't recall the exact date but stated it was shortly after she was admitted to the facility. The resident stated it had to be about 10:00 PM or 10:30 PM due to her being asleep at the time. Resident #149 stated Resident #203 entered her room in his wheelchair and Resident woke up when she felt Resident #203 touch her leg and run his hand up her leg to above her knee. Resident #149 stated she told Resident #203 to get out of her room. Resident #149 stated she then observed Resident #203 drink her perineal wash and perfume that was on her bedside table. Resident #149 stated that Resident #203 then went to her roommate and rubbed her foot. Resident #149 stated her roommate (Resident #178) was upset as evidenced by yelling. Resident #149 stated that Resident #203 had his hands down in his pants touching his genitals.</p> <p>Interview on 6/11/15 at 5:40 PM with NA#2, who cared for Resident #203 during the 3:00 PM-11:00 PM shift stated Resident #203 goes into other resident's rooms. Staff have to watch him close because he can propel his wheelchair fast. He is in falling star program due to elopement risk and fall risk. The staff stated they</p>	F 323	4. The Unit Coordinators/Director of Clinical Services will conduct Quality Improvement monitoring of 4 current and new admission residents to ensure all residents are safe and all needed interventions to address behaviors are in place to provide every resident with safety 5x week for 1 month, then 3x week for 2 months, then 2x weekly for 2 months, then weekly for 1 month. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Unit Manager to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.	7-10-15	

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F 323	<p>Continued From page 36</p> <p>were aware that Resident #203 had touched a resident ' s leg and thigh and was touching himself. A second Resident #59 on 300 hall complained of Resident #203 in her room. The staff revealed they had reported to the incident to their nurse. Resident #203 is supposed to go to " falling star program " during the day to monitor his whereabouts. During the change of shift, he is back on the hall for about an hour. He is on the hall, and they try to watch him. This is when he goes into other resident ' s rooms.</p> <p>1b. Resident #59 was admitted on 6/30/14 with a diagnosis of personal history of fall, muscle weakness and depressive disorder. The most recent MDS assessment dated 3/7/15 indicated Resident #59 had a BIMS score of 12 indicating she was moderately cognitively impaired.</p> <p>Interview on 6/11/15 at 5:43 PM with Resident #59 revealed Resident #203 came into her room, took his penis out and said, " Come and get it, come and get it. " She yelled for staff to get him out of her room. Staff came and removed him from her room. Resident #59 stated the incident occurred at least a week ago.</p> <p>Interview with the social worker on 6/11/15 at 6:26pm revealed the only behavior they were aware of with Resident #203 was that he wandered the facility in his wheelchair. No one had brought to her attention that the resident had entered any resident ' s rooms exposing himself or touching any residents. The social worker indicated she became aware of issues regarding behavior though the nurses notes or though staff communicating to her what has occurred. The social worker further revealed she became aware of resident behaviors at clinical morning meetings</p>	F 323			

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F 323	Continued From page 37 and it was her responsibility to update care plans in regards to resident behaviors. In the instance the social worker was aware of the incident in which Resident #203 entered Resident #149 and Resident #178 ' s room and touched her or exposed himself to resident #59 they would have ensured the care plan updated to reflect the new behavior. Interview with the Director of Nursing (DON) on 6/12/15 at 3:06 pm revealed she was unaware of Resident #203 exhibiting the behavior of unwanted touching or exposing himself. The incident should have been care plan developed due to the occurrences. Interventions to prevent the occurrences were not developed due to the occurrences not being brought to the attention of the interdisciplinary team. Interview with the administrator on 6/12/15 at 3:08 pm revealed she was unaware of instances of Resident #203 exhibiting unwanted touching or exposing himself. No new interventions were developed prevent Resident #203 from inappropriate touching or exposing himself due to the interdisciplinary team not being aware of the occurrences. The administrator stated it was her expectation that staff to communicate instances of unwanted touching or when a resident exposes himself to others. The instance should have been documented and a care plan should have been developed in regards to these instances.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services:	F 328	1. Resident #94 was reassessed for the need for oxygen support. The orders were reviewed and the oxygen was to continue on 6/15/15. Resident # 28 was reassessed for the need for oxygen support. The orders were reviewed and the oxygen was to continue on 6/15/15.		

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F 328	<p>Continued From page 38</p> <p>Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide oxygen according to physician orders for two of two sampled residents with oxygen therapy. Residents #94 and 28.</p> <p>The findings included:</p> <p>1. Resident #94 was admitted to the facility on 4/17/15 with left hip fracture and pneumonia.</p> <p>Review of the Minimum Data Set (MDS) dated 4/24/15 indicated Resident # 94 had a diagnosis of pneumonia and oxygen therapy was in place. This MDS assessed Resident # 94 as cognitively intact with short and long term memory.</p> <p>The care plan was updated on 5/7/15 for status post hip fracture with surgical repair and pneumonia. Oxygen was an approach for the problem of pneumonia.</p> <p>On 5/15/15 a physician 's order was written to wean Resident #94 off oxygen (O2) with orders to decrease at 3 pm and check oxygen saturation levels (sats). Instructions to leave oxygen off if sats were above 95%.</p>	F 328	<p>2. All residents residing in the facility with treatment/care for special needs have the potential to be affected. The Director of Clinical Services completed an audit of all residents with special treatments to assure the orders were executed as prescribed on 6/17/15.</p> <p>3. The Director of Clinical Services reeducated all nursing staff on the need to implement physician's orders for special treatments and correct documentation according to facility policy on 6/15/15. No nursing staff will work until he/she has completed this education</p> <p>4. The Unit Coordinators/Director of Clinical Services will conduct Quality Improvement monitoring of 4 residents and resident records with special needs to assure the treatments are administered as prescribed and are documented 5x week for 1 month, then 3x week for 2 months, then 2x weekly for 2 months, then weekly for 1 month. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Unit Coordinator to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.</p>	7-10-15	

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F 328	<p>Continued From page 39</p> <p>Review of the resident ' s May 2015 Medication Administration Record (MAR) revealed an order transcribed " wean off O2 (oxygen): starting @ (at) 3 pm 5/15/15 (arrow down) decrease O2 to 1 L/min (liter/minute) via NC (nasal cannula) x (times) 2 hours to keep sat above 95%. The MAR was initiated at 3 PM and sat of 95% documented at 5 pm. There was no other documentation until 5/25/15 when sats were documented as obtained at 3 pm and 5 pm.</p> <p>Review of the nurses notes " Daily Skilled Nurse ' s Note " for the area of " Respiratory " were as follows:</p> <ul style="list-style-type: none"> - No nurses ' notes for 5/15/15 related to oxygen weaning, oxygen sats, respiratory status or vital signs. - 5/16/15 at 10:00 PM oxygen was in place and sats were 96%. The liters per minute of oxygen was not recorded. - 5/17/15 11-7 at 2:00 AM oxygen was in place via nasal cannula. The sats were not documented and the liters per minute were not documented. The 7-3 shift and the 3-11 had no documentation of oxygen use and/or weaning the oxygen with monitoring of oxygen sats. - 5/18/15 there was no documentation for any shift on the flow sheet. - 5/19/15 there was no documentation for any shift related to oxygen use, weaning of oxygen, or sats obtained. - 5/20/15 night shift had documented the lungs were clear. There was no other documentation for review for this date. <p>Review of the MAR for June 2015 revealed O2 sats were monitored and were above 95%.</p>	F 328			

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F 328	<p>Continued From page 40</p> <p>Oxygen at 4L/min was documented as being provided to Resident #94.</p> <p>On 06/11/2015 at 1:45 PM an interview was conducted with nurse #11, the RN unit manager. Nurse #11 explained the order was written incorrectly on the MAR, the resident was not assessed each shift immediately after the weaning. Nurse #11 had no further documentation to provide indicating Resident #94 had been assessed, the oxygen weaned and oxygen sats were monitored. Nurse #11 explained the nurses ' notes for " Daily Skilled Nurse ' s Note " should document every shift for skilled residents. Resident #94 was skilled and should have documentation each shift. Further interview revealed the O2 at 4L/minute should have been discontinued. An explanation was not provided as to why the orders were not carried out.</p> <p>2. Resident # 28 was admitted to the facility 2/27/14 with diagnosis of hypoxia, congestive heart failure and Alzheimer ' s disease.</p> <p>Review of the Minimum Data Set (MDS) dated 3/24/15 revealed Resident #28 was cognitively impaired with short and long term memory, required extensive assistance with activities of daily living and received oxygen therapy.</p> <p>Record review revealed an order for oxygen at 2 liters per minute via nasal cannula continuous for diagnosis hypoxia dated 3/31/14.</p> <p>Review of the care plan dated 4/10/15 for a problem of respiratory hypoxia continuous oxygen use per nasal cannula. Resident has potential for</p>	F 328			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2015
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083		
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F 328	<p>Continued From page 41</p> <p>an ineffective breathing pattern related to hypoxia. Has removed oxygen tubing at times. Resident has dementia (severe). The approaches included oxygen as ordered, pulse oximetry as ordered, monitor lung sounds, replace O2 tubing when removed, assess for complications related to removing oxygen tubing and report abnormal findings to the physician, keep head of bed elevated while in bed to decrease shortness of breath.</p> <p>Review of the Medication Administration Record for June 2015 revealed Resident #28 was to receive oxygen at 2 Liters per minute via nasal cannula continuous for a diagnosis of hypoxia. The documentation revealed nurses' initials the oxygen was being provided.</p> <p>Observations on 6/8/15 at 10:59 revealed Resident # 28 was in bed with the nasal cannula in her nose. The concentrator was not turned on and the resident was not receiving oxygen.</p> <p>Observation on 06/08/2015 at 11:04 AM revealed staff entered Resident #28 's room and turned the concentrator on.</p> <p>Observations on 06/11/2015 at 9:11 AM revealed Resident #28 had the nasal cannula in her nose while in bed. The oxygen concentrator was not turned on.</p> <p>Observations on 06/11/2015 at 9:46 AM revealed Resident #28 had the nasal cannula in her nose and the concentrator was not turned on.</p> <p>Observations on 06/11/2015 at 10:07 AM revealed Resident #28 's oxygen remained turned off at the concentrator.</p>	F 328			

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F 328	Continued From page 42 Observations on 06/11/2015 at 10:42 AM revealed nurse aide # 3 was providing care for the resident. The oxygen concentrator was turned on. Interview with aide #3 at this time revealed she had turned the resident ' s oxygen on, but it was off when she came in the room. Interview on 06/11/2015 at 2:56 PM with nurse #12 revealed she had checked Resident #28 ' s oxygen saturation level on 06/11/5 at around 12:00 noon and it was 93 %. She explained she did walk a thru this morning of her residents on the hall. She further stated during the morning of 06/11/15 she saw Resident #28 had oxygen in place and did not notice the concentrator was turned off. The last time she had checked Resident #28 was at noon and the resident was up in a wheelchair and using a portable oxygen tank. Further interview revealed that on 06/11/15 the aide did not report any problems to her about the resident ' s oxygen concentrator or that it was off.	F 328			
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	F 329	1. Resident #242 was given an extra dose of 10mg Prednisone on 5/30/15. A medication error report was completed and the physician and responsible party were notified on 6/12/15. No harm came to resident #242.		

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F 329	<p>Continued From page 43</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure medications were administered correctly to prevent extra doses of a medication being given to one of nine sampled residents for unnecessary drugs. Resident #242. The findings included: Resident # 242 was admitted to the facility on 5/29/15 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), chronic hypoxic respiratory failure, oxygen dependent and congestive heart failure (CHF)</p> <p>Review of the admission orders dated 5/29/15 included an order for prednisone 20 milligram (mg) 1 tab (tablet) orally for 2 days and then prednisone 10 mg 1 tab orally for 2 days, then discontinue the prednisone.</p> <p>Review of the medication administration record (MAR) for May, 2015 revealed that 20 mg of prednisone was initialed as first given on 5/30/15. Therefore, the second dose of 20 mg of prednisone was supposed to be given on 5/31/15.</p>	F 329	<p>2. All residents residing in the facility have the potential to be affected. The Director of Clinical Services and the Unit Managers completed a review of all Residents' Medication Administration Records to assure there were no other medication discrepancies. Any discrepancies noted were corrected immediately and Medication Error Reports completed.</p> <p>3. The Director of Clinical Services reeducated the nursing staff on medication errors and properly transcribing orders to the Medication Administration Record/Treatment Administration Record. New admission orders and new orders are to be transcribed to the Medication Administration Record/Treatment Administration Record by the on shift nurse. These orders will be checked again by another nurse to ensure accuracy on that day and again by the Unit Coordinators on the following morning for an additional check of accuracy. No nurse will work until he/she have completed this education.</p>		

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F 329	<p>Continued From page 44</p> <p>The 10 mg of prednisone was not scheduled to be given until 6/1/15 and 6/2/15. However, the order for 10 mg of prednisone was transcribed onto the May MAR below the 20mg dose of prednisone. An line had been drawn from the order block of the 10 mg dose to the end of May. A nurse had initialed in the block that had a line through it for the 10 mg dose of prednisone on May 30th.</p> <p>Review of the June MAR revealed the prednisone 10 mg was scheduled to be given on 6/1 and 6/2 per the physician ' s order.</p> <p>Review of the medication administration record (MAR) for May 2015 revealed one 20 mg tablet of prednisone and one 10 mg tablet of prednisone were initialed as being given on 5/30/15 at 9:00 AM.</p> <p>Interview with the Director of Nursing (DON) on 06/11/15 at 4:06 PM revealed a medication error report was made for the prednisone and nurse #10 had made the medication error.</p> <p>An attempt to interview nurse #5 by phone was made on 06/11/15 at 4:25 PM and a message was left to return the call. Nurse #5 had transcribed the orders from the admission for the prednisone.</p> <p>On 06/12/15 at 9:11 AM a telephone interview with nurse #10 revealed she did not know about a medication error for this resident. Nurse #10 was not aware of the 10 mg prednisone being given in addition to the 20 mg.</p> <p>Review of the medication incident report dated 5/31/15 revealed nurse #10 had given both doses</p>	F 329	<p>4. The Unit Coordinators/Director of Clinical Services will conduct Quality Improvement monitoring of 5 residents to ensure all residents' medications and treatments are accurately transcribed, administered, and documented 5x week for 1 month, then 3x week for 2 months, then 2x weekly for 2 months, then weekly for 1 month. The results of the Quality Improvement monitoring and medication/treatment errors will be reported by the Director of Clinical Services/Unit Coordinator to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.</p>	7-10-15	

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F 329	Continued From page 45 of the prednisone, the 20mg and the 10 mg on the same date. The dose was to be tapered, with the 10 mg not given until 6/1/15. The order was not transcribed on the MAR to indicate when the 10 mg dose was to be given. The description in the order box on the MAR indicated it was to be given after the 20 mg doses.	F 329			
F 332 SS=D	The physician had been notified of the medication error with no new orders given. 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 3 medication errors out of 25 opportunities, resulting in a medication error rate of 12%, for 2 of 4 residents (Resident #1 and Resident #228) observed during medication pass. The findings included: 1) A review of the facility 's policy, " Medication-Administration via Enteral Tube " (dated 11/30/14) included the following statement: "NOTE: If medication cannot be crushed and is unavailable in liquid form, notify physician." Resident #228 was admitted to the facility on 3/24/15. Her cumulative diagnoses included	F 332	1. Resident #228 was admitted to the facility with a gastrostomy tube with orders for medications to be given via the gastrostomy tube per facility policy. Medication administered per gastrostomy requires the medication be crushed. The do not crush medication was not given to resident #1. Nurse #1 did obtain an order for the liquid form of the medication on 6/10/15 and added the medication to the medication administration record. Resident #1 received Senna plus with an order for Senna as well as a multi-vitamin with an order for multi-vitamin with minerals. Resident #1's responsible party and the physician were notified per company policy, medication error paperwork was completed, and the nurse was reeducated on the six rights of medication administration. No harm came to either resident.		

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F 332	<p>Continued From page 46</p> <p>status post placement of a gastrostomy tube (a surgical opening into the stomach whereby a feeding tube may be inserted).</p> <p>On 6/10/15 at 9:01 AM, Nurse #1 was observed preparing medications to be administered via a gastrostomy tube for Resident #228. The medications pulled for administration included one - 600 milligram (mg) guaifenesin 12-hour Extended Release (ER) tablet. Guaifenesin is an expectorant that helps to loosen phlegm and thin bronchial secretions to make coughs more productive. During the medication preparation, Nurse #1 placed the guaifenesin ER tablet into a plastic sleeve for crushing. As the nurse inserted the plastic sleeve containing the guaifenesin ER tablet into the pill crusher, he was asked if he was going to crush the tablet. After Nurse #1 stated, "yes", he was asked to check the resident's Medication Administration Record (MAR) to see if there were any notes regarding the crushing of the guaifenesin ER tablet. A review of the resident's MAR revealed there was a notation for the guaifenesin ER tablet which read, "Do not crush or chew." At that time, Nurse #1 acknowledged the tablet was not supposed to be crushed. The nurse stated he would try to dissolve the guaifenesin ER tablet in water instead of crushing it. Upon observation, the tablet did not dissolve in the water and the nurse administered only the water used as the diluent to the resident via the gastrostomy tube.</p> <p>A review of Resident #228's physician's medication orders included a current order for a guaifenesin 600 mg tablet ER to be given as one tablet via gastrostomy tube twice daily, with a notation which read, "Do not crush or chew."</p>	F 332	<ol style="list-style-type: none"> 2. All residents residing in the facility have the potential to be affected. 3. On 7/7/2015 the Director of Clinical Services reeducated all current nursing staff on the policy of the facility regarding crushing medications (by mouth or by feeding tubes) and to obtain a crushable or liquid form of the medication. The nursing staff was also educated on the six rights of medication administration; right patient, right medication, right time, right route, right dose and right documentation. During this education it was recommended to the nurses to check the medication with the medication administration record a minimum of three times to ensure accuracy. No nurse will work until he/she has received this education. 		

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F 332	<p>Continued From page 47</p> <p>According to Lexi-Comp, a comprehensive on-line medication database, guaifenesin extended release tablets should not be crushed, chewed, or broken upon administration.</p> <p>A follow-up interview was conducted with Nurse #1 on 6/10/15 at 10:10 AM. At that time, inquiry was made as to how a guaifenesin ER tablet was typically given to Resident #228 via the gastrostomy tube. The nurse reported there was usually a liquid formulation of this medication on the med cart that he would use for her instead of using a tablet.</p> <p>An interview was conducted on 6/10/2015 at 1:05 PM with the Interim DON. During the interview, the crushing of the guaifenesin ER tablet for a resident with a gastrostomy tube was discussed. The DON stated, "It's an error because he (Nurse #1) was going to crush it. Normally when we have g-tube (gastrostomy tube) in the building I suggest we get liquid forms of the meds (medications) to keep the g-tube from clogging up." The DON also reported there was a need to educate the nursing staff in regards to medication administration for a resident with a gastrostomy tube.</p> <p>2) On 6/10/15 at 7:51 AM, Nurse #2 was observed preparing medications for administration to Resident #1. The medications pulled for administration included one - Senna Plus tablet. Senna Plus is a combination medication which contained 8.6 milligrams (mg) senna (a stimulant laxative) and 50 mg docusate sodium (a stool softener). The nurse was observed as she administered the Senna Plus tablet to Resident #1.</p>	F 332	<p>4. The Unit Coordinators/Director of Clinical Services will conduct Quality Improvement monitoring (medication pass audits) of 1 nurse per unit covering all shifts and weekends to include immediate education for any medication/treatment error 5x week for 1 month, then 3x week for 2 months, then 2x weekly for 2 months, then weekly for 1 month. The results of the Quality Improvement monitoring and medication/treatment errors will be reported by the Director of Clinical Services/Unit Coordinator to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.</p>	7-10-15	

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F 332	<p>Continued From page 48</p> <p>A review of Resident #1 's physician ' s medication orders included a current order for 8.6 mg senna laxative to be given as one tablet by mouth twice daily.</p> <p>An interview was conducted with Nurse #2 on 6/10/15 at 8:20 AM. Upon review of Resident #1 ' s June 2015 Medication Administration Record (MAR) and the manufacturer ' s labeling on the bottle of the Senna Plus tablet given to Resident #1, the nurse acknowledged the tablet administered to Resident #1 during the medication administration was not the medication prescribed. The nurse confirmed the prescribed medication (containing 8.6 mg senna as a single active ingredient) was available in the floor stock kept on the medication cart. Nurse #2 indicated she had not realized the medication given to the resident was different from the one ordered until it was brought to her attention.</p> <p>An interview was conducted with the Interim Director of Nursing (DON) on 6/11/15 at 4:35 PM. During the interview, the DON indicated her expectation would be that nurses followed the " six rights " for medication administration. She stated the six rights expected to be observed included the right patient, medication, dose, time, route and documentation of the medication administered.</p> <p>3) On 6/10/15 at 7:51 AM, Nurse #2 was observed preparing medications for administration to Resident #1. The medications pulled for administration included one - One Daily with Vitamins tablet (a multivitamin supplement). The nurse administered the One Daily with Vitamins tablet to Resident #1.</p>	F 332			

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F 332	Continued From page 49 A review of Resident #1 ' s physician ' s medication orders included a current order for a multivitamin with minerals to be given as one tablet by mouth once daily. An interview was conducted with Nurse #2 on 6/10/15 at 8:20 AM. Upon review of Resident #1 ' s June 2015 Medication Administration Record (MAR) and the manufacturer ' s labeling on the bottle of the One Daily with Vitamins tablet given to Resident #1, the nurse acknowledged the tablet administered to Resident #1 during the medication administration was not the medication prescribed. The nurse confirmed the prescribed medication (containing both vitamins and minerals) was available in the floor stock kept on the medication cart. Nurse #2 indicated she had not realized the medication given was different from that ordered until it was brought to her attention. An interview was conducted with the Interim Director of Nursing (DON) on 6/11/15 at 4:35 PM. During the interview, the DON indicated her expectation would be that nurses followed the " six rights " for medication administration. She stated the six rights expected to be observed included the right patient, medication, dose, time, route and documentation of the medication administered.	F 332			
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	F 333	1. Resident #178 received extra doses of Diltiazem ER 180mg following a faxed order from the dialysis unit to administer the medication at bedtime. The order did not say to discontinue the Diltiazem ER in the morning.		

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F 333	<p>Continued From page 50</p> <p>by: Based on record reviews and staff interviews, the facility administered duplicate doses of an antiarrhythmic (treatment of irregular heartbeats)/antihypertensive medication for 1 of 5 sampled residents (Resident #178) reviewed for unnecessary medications. The findings included:</p> <p>Resident #178 was admitted to the facility on 3/13/15. The resident's cumulative diagnoses included chronic renal failure, congestive heart failure, cardiomyopathy, and status post placement of an automatic implantable cardioverter-defibrillator (AICD). An AICD is a small device that's placed in the chest or abdomen to help control potentially life-threatening arrhythmias by the use of electrical pulses or shocks.</p> <p>A review of Resident #178's most recent quarterly Minimum Data Set (MDS) dated 3/20/15 revealed the resident had moderately impaired cognitive skills for daily decision making.</p> <p>A review of Resident #178's Care Plan initiated on 3/13/15 included an area of focus entitled, "Cardiovascular." Multiple revisions/updates were included in the care plan, with the most recent update made on 5/27/15. The Care Plan included a checked condition of "Abnormal blood pressure readings" with an undated notation which read, "Tends to be hypotensive."</p> <p>A review of Resident #178's May 2015 Physician's Orders revealed her medication regimen included an order initiated on 3/13/15 for 180 milligrams (mg) diltiazem 24-hour Extended Release (ER) given as 1 capsule by mouth every</p>	F 333	<ol style="list-style-type: none"> The nurse receiving the order from the dialysis center did not discontinue the morning dose of 180mg Diltiazem ER in the morning and the nurse did not call to clarify this order. The physician and responsible party were notified. A medication error report was completed. The resident experienced no harm. All residents residing in the facility have potential to be affected. The Director of Clinical Services reeducated all nurses currently employed on the following topics: always review physician orders and call for clarification if any orders appear questionable, if medications are prescribed that affect vital statistics, notify the physician of any abnormal readings or reading outside parameters prescribed by the physician, and if a new order is for a same medication – question the order if the current medication was not discontinued. No nurse will work until he/she has completed this education. 		

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F 333	<p>Continued From page 51</p> <p>day. Diltiazem is an antiarrhythmic and antihypertensive medication. A review of Resident #178 's May 2015 Medication Administration Record (MAR) revealed she had been scheduled to receive the once daily dose of diltiazem ER at 9:00 AM every day. The May 2015 Physician ' s Orders also included an order initiated on 3/13/15 for the resident ' s vital signs (including blood pressure) to be checked daily.</p> <p>A review of Resident #178 ' s May 2015 MAR revealed the resident received 180 mg diltiazem ER once daily as ordered by the physician from 5/1/15 through 5/6/15.</p> <p>A review of Resident #178 ' s medical record revealed a Physician ' s Order was faxed from the resident ' s Dialysis Center to the facility on 5/7/15. The faxed order read, in part, " ...Give diltiazem at HS (hour of sleep) due to intradialytic hypotension (low blood pressure during the dialysis treatment). " A Telephone Order was also written and placed in the resident ' s medical record on 5/7/15 re-stating the Physician ' s Order which had been faxed from the Dialysis Center. A review of the May 2015 MAR revealed on 5/7/15, " diltiazem 24 180 mg cap at HS " was handwritten on the MAR and scheduled for administration at 8:00 PM. The May 2015 MAR also showed the morning dose of 180 mg diltiazem ER had not been discontinued at that time.</p> <p>A review of Resident #178 ' s May 2015 MAR included details for the administration of diltiazem. Blood pressure (BP) results were obtained from a review of her medical record. A normal blood pressure reading is typically considered to be less than 120/80. A systolic</p>	F 333	<ol style="list-style-type: none"> 3. A Nurse Manager/Director of Clinical Services will review all new orders to ensure that the order was transcribed correctly and that no duplicate orders exist that are not clarified. Any discrepancies will be corrected and the nurse responsible will receive reeducation/corrective actions. 4. The Unit Coordinators/Director of Clinical Services will report all new orders Monday through Friday to the Interdisciplinary Team in the morning meeting. The Unit Coordinators/Director of Clinical Services will audit 2 random residents per unit coordinator per day to review new orders and compare to the Medication/treatment administration record x4weeks, then 1 random resident per day per unit coordinator per day times 12 weeks, then 3 random residents per week x4wks, then 1 random resident per week x4weeks. 	3/10/15	

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F 333	Continued From page 52 blood pressure reading of 90 millimeters of mercury (mm Hg) or less (the top number in a blood pressure reading) or a diastolic blood pressure of 60 mm Hg or less (the bottom number) is generally considered to be low blood pressure. The diltiazem dosing and BP results for Resident #178 included: 5/7/15--2 doses of diltiazem were administered (9:00 AM and 8:00 PM); BP results included 128/76; 120/60; and 92/42 (noted at dialysis). 5/8/15--2 doses of diltiazem were administered (9:00 AM and 8:00 PM); BP results included 132/82. 5/9/15-- 2 doses of diltiazem were administered (9:00 AM and 8:00 PM); BP results included 96/66; 87/52 (noted at dialysis). 5/10/15--1 or 2 doses of diltiazem were administered (one dose at 9:00 AM; no notations were made to indicate whether or not the 8:00PM dose was given); BP results included 124/60. 5/11/15--1 dose of diltiazem was administered (9:00 AM; the 8:00 PM dose was held); BP results were not available. 5/12/15--1 dose of diltiazem was administered (9:00 AM; the 8:00 PM dose was held); BP results included 112/50; and 104/57 (noted at dialysis); 97/54; and 100/57. 5/13/15--2 doses of diltiazem were administered (9:00 AM and 8:00 PM); BP results included 138/90. 5/14/15--2 doses of diltiazem were administered (9:00 AM and 8:00 PM); BP results included 132/68 (noted at dialysis). 5/15/15--2 doses of diltiazem were administered	F 333			

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F 333	<p>Continued From page 53 (9:00 AM and 8:00 PM); BP results were not available. 5/16/15--2 doses of diltiazem were administered (9:00 AM and 8:00 PM); BP results included 138/88 (noted at dialysis). 5/17/15--2 doses of diltiazem were administered (9:00 AM and 8:00 PM); BP results were not available. 5/18/15--1 dose of diltiazem was administered (8:00 PM; the 9:00 AM dose was held); BP results were not available. 5/19/15--1 dose of diltiazem was administered (8:00 PM; the 9:00 AM dose was held); BP results included 124/60; 90/46 (noted at dialysis).</p> <p>After 5/19/15, the morning dose of diltiazem was discontinued with a handwritten notation made on the May 2015 MAR which read, " duplicate. "</p> <p>An interview was conducted on 6/11/15 at 8:30 AM with the Medical Doctor (MD) caring for Resident #178. A review of the resident's pertinent medical record was completed. The review included the medication orders for diltiazem, May 2015 MAR, and BP results. The MD recalled the resident was known to have hypotension at times in the past. Upon inquiry, he indicated the twice daily (duplicate) dosing of diltiazem was a significant medication error that could have potentially had serious effects and a negative outcome on the resident. The MD also noted that based on the information reviewed, this medication error did not appear to have caused harm to the resident.</p> <p>An interview was conducted on 6/11/15 at 3:09 PM with the Nurse #6. Nurse #6 was the 2nd</p>	F 333			

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F 333	<p>Continued From page 54</p> <p>shift Hall nurse assigned to care for Resident #178 on 5/7/15. Upon review of the resident ' s medical record, Nurse #6 confirmed she had received the 5/7/15 order to change the administration time of diltiazem from the morning to the evening. Nurse #6 discussed the facility ' s procedure for receiving new orders and transcribing them onto the MAR. Nurse #6 indicated two nurses needed to sign any Telephone Order received (she was the first signature on the 5/7/15 diltiazem order). She stated the Hall nurse (which would have been herself) was responsible to make changes on the resident ' s MAR to reflect any new orders received. Nurse #6 confirmed it would have been her responsibility to discontinue the 9:00 AM dose of diltiazem when the order was received to change its administration time to the evening. The nurse recalled the resident did refuse the evening dose of diltiazem on occasions during her shift because the resident knew she had already received one dose of diltiazem that morning. Nurse #6 referred to the May 2015 MAR where the evening dose of diltiazem was noted as refused on 5/11 and 5/12.</p> <p>An interview was conducted on 6/11/15 at 2:56 PM with Nurse #5. Nurse #5 worked as the Nursing Supervisor on 5/7/15. Upon review of the 5/7/15 Telephone Order received for Resident #178, Nurse #5 confirmed she was the second nurse who signed off on the order changing the administration schedule for diltiazem. The nurse outlined the facility ' s procedure for receiving Telephone Orders and reported after a medication order was written, the first nurse was responsible to put the medication order/change on the MAR and the second nurse needed to verify it was done. Upon inquiry as to whether it</p>	F 333			

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F 333	Continued From page 55 appeared duplicate doses of diltiazem were given to Resident #178 on multiple occasions from 5/7/15 to 5/17/15, Nurse #5 stated, "That's what it 's looking like." An interview was conducted on 6/11/15 at 4:37 PM with the Interim Director of Nursing (DON). During the interview, the DON indicated her expectation was for all medication orders to be double checked against the resident 's MAR to be sure they are processed correctly.	F 333			
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record reviews, the facility failed to obtain dental services for 2 of 5 sampled residents for dental needs. (Resident #227 and #232) The findings included: 1. Resident #227 was admitted to the facility on 3/24/15 and re-admitted on 5/11/15 with diagnosis of pneumonia, chronic airway obstruction, chronic pain, hypertension and left upper extremity deep	F 412	1. Resident #227 saw the dentist on 6/19/2015 and #232 no longer reside in the facility. Arrangements were made for Dental services of Resident #232 post discharge. 2. All residents residing in the facility have the potential to be affected. Current residents residing in the facility will see the visiting facility dentist or an outside dentist dependent on first availability for routine or emergency oral care. An oral assessment was completed and resident records were reviewed by the nursing management team to identify any oral issues requiring immediate services and other missed recommendations for dental services. This was completed on 7/9/15.		

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F 412	<p>Continued From page 56</p> <p>vein thrombosis.</p> <p>The admission Minimum Data Set (MDS) assessment with assessment reference date of 3/31/15 indicated that Resident #227 was cognitively intact and required extensive assistance with activity of daily living (ADL 's). The MDS section under Dental Status was inaccurately coded and the care area was not triggered.</p> <p>The care plan initiated on 3/24/15 revealed a problem for nutrition/hydration with an updated intervention on 4/13/15 to consult dentist as ordered.</p> <p>The physician progress note dated 4/13/15 indicated that Resident #227 complained of loose teeth lower, no pain , no bleeding. The assessment indicated a loose tooth and the plan revealed to consult dentist for tooth evaluation. A physician order dated 4/13/15 indicated to consult dentist for lower loose teeth.</p> <p>During an observation and interview with Resident #227 on 6/8/15 at 3:42 PM revealed several missing, broken and decayed teeth on upper and lower gums. Resident #227 indicated that she had a loose bottom tooth and had not had a dentist visit yet and was not sure why. Resident #227 indicated that she did not have any pain and the loose tooth did not interfere with eating.</p> <p>A record review on 6/10/15 revealed no documentation of a dental consult or dental visit had been made.</p> <p>An interview with Resident #227 on 6/10/15 at 9:55 AM revealed that she had a loose bottom tooth and it was bleeding yesterday (6/9/15), she stated that she told the staff and they swabbed her teeth and mouth. Upon observation, Resident #227 has a lower loose front tooth that was turned sideways.</p>	F 412	<p>3. The Director of Clinical Services reeducated all nursing staff to report any oral care issues, concerns, recommendations, or requests to the Unit Coordinators/Supervisor/Director of Clinical Services for follow up with appropriate dental care. The Social Service department will be informed of referrals for the residents to be seen by the visiting facility dentist. These referrals will be reviewed in the am meeting with the Interdisciplinary Team Monday through Friday. No nursing staff will work until he/she has completed this education.</p> <p>4. The Director of Clinical Services/Case Management Nurse/Social Services will conduct Quality Improvement monitoring on 5 random residents 5x per week to ensure accuracy for 1 month, then 3x per week for 3 months, then 1x per week for two months. The results of the Quality Improvement monitoring will be reported by Director of Clinical Services/Assistant Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly for six months for continued substantial compliance and/or revision.</p>	7-10-15	

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F 412	Continued From page 59 appointment date on the calendar. She indicated she was not sure what happened with the arrangements for Resident #232 ' s dental appointment. An interview with the administrator on 6/11/15 at 2:00 PM indicated that the facility has dental services that visit every 3 months and the list is kept by the social worker. If dental consults are made then arrangements are made for appointments and transportation at that time.	F 412			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 425	1. Resident #242 no longer resides in the facility. The medication was obtained and administered late. There was no harm noted to the resident. 2. All residents in the facility have the potential to be affected. 3. The Director of Clinical Services reeducated all nursing staff on 6/18/15 on assuring the resident has the prescribed medications to be administered to include: a. If a resident residing in the facility does not have a medication available, the nurse is to check the emergency kit for the medication.		

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F 412	<p>Continued From page 57</p> <p>During an interview with nurse aide (NA) #3 on 6/10/15 at 10:00 AM indicated that she did mouth care for Resident #227 yesterday (6/9/15) using a swab and noticed some bleeding and a very loose tooth on the front bottom gum. She reported the loose, bleeding tooth to nurse #2. An interview with nurse #2 on 6/10/15 at 11:30 AM revealed that the NA did report to her about Resident #227 having a loose tooth and some bleeding on 6/9/15 but did not document it or notify the physician because she became busy with an admission. Nurse #2 indicated that she would notify the physician today (6/10/15)</p> <p>An interview with nurse #4 on 6/11/15 at 10:30 AM revealed that she signed off the order dated 4/13/15 for the dental consult and made a copy of the order and placed the copy on the clip board for the appointment/transportation staff who makes the appointment and arranges transportation. Nurse #4 could not recall if Resident #227 went to the dentist or not.</p> <p>During an interview with the transportation/appointment staff on 6/11/15 at 1:00 PM revealed that once she gets a copy of the order for consults she makes the appointment and arranges transportation and returns the copy back to the nurse 's station with the appointment date, she then notes it on the calendar. She indicated that there are no record of the the copied physicians order or record of an appointment date on the calendar. She indicated she was not sure what happened with the arrangements for Resident #227 ' s dental appointment.</p> <p>An interview with the administrator on 6/11/15 at 2:00 PM indicated that the facility has dental services that visit every 3 months and the list is kept by the social worker. If dental consults are made then arrangements are made for</p>	F 412			

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F 412	Continued From page 58 appointments and transportation at that time. 2. Resident #232 was admitted to the facility on 4/6/15 and re-admitted on 4/24/15 with right tibia-fibula fracture, status post above knee amputation, B-cell lymphoma involving right lower extremity and discharged home on 6/2/15. A closed record review revealed an admission MDS assessment with assessment reference date of 4/13/15 that indicated Resident #232 was cognitively intact and required extensive assistance with ADL ' s. The MDS section under Dental Status was coded no natural teeth (edentulous) and dental care area triggered. The care plan initiated on 4/24/15 revealed a problem for ADL ' s with an approach for personal hygiene oral care and dental consult as ordered. A physician order dated for 4/28/15 indicated to consult Dentist for dental care. A closed record review on 6/10/15 revealed no documentation of a dental consult or dental visit had been made. An interview with nurse #4 on 6/11/15 at 10:30 AM revealed that she signed off the order dated 4/28/15 for the dental consult and made a copy of the order and placed the copy on the clip board for the appointment/transportation staff who makes the appointments and arranges transportation. Nurse #4 could not recall if Resident #232 went to the dentist or not. During an interview with the transportation/appointment staff on 6/11/15 at 1:00 PM revealed that once she gets a copy of the order for consults she makes the appointment and arranges transportation and returns the copy back to the nurse ' s station with the appointment date, she then notes it on the calendar. She indicated that there are no record of the the copied physicians order or record of an	F 412			

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F 425	<p>Continued From page 60</p> <p>facility failed to ensure medication was available for one of one residents receiving an inhalant medication. Resident #242.</p> <p>The findings included:</p> <p>Resident # 242 was admitted to the facility on 5/29/15 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), chronic hypoxic respiratory failure oxygen dependent and congestive heart failure (CHF)</p> <p>Review of the June monthly orders revealed an inhalant Symbicort 160 milligrams (mg) inhalant aerosol 2 puffs to be administered for diagnosis of chronic obstructive lung disease. The original order date was 5/29/15 on admission to the facility. The inhalant reduces inflammation in the lungs and opens up the lungs for patients to breathe easier. According to the online Symbicort information, the medication should be used daily to be effective.</p> <p>Review of the June Medication Administration Record revealed 7 doses of the inhalant was circled and recorded as not given. The medication was not administered twice a day as ordered on 6/8, 6/9, 6/10 and 6/11/15.</p> <p>Interview on 06/11/2015 3:52:53 PM with nurse #4 revealed she had notified pharmacy the medication was needed on 6/7/15. Upon return from work, the medication was not available. Pharmacy called and informed her it was sent and the nurse who received the medication had signed the drug manifest. Nurse #4 explained she had asked the nurse who signed for the medications about the missing inhalant. That nurse was not aware of where the medication</p>	F 425	<p>3. b. If the medication is not in the emergency kit, the nurse is to notify the Unit Coordinator to obtain this medication via back-up pharmacy timey.</p> <p>c. If the Unit Coordinator is unable to obtain the needed medication for any resident residing in the facility the Unit Manager is responsible to contact the physician for orders to replace the medication or to hold the medication until delivered.</p> <p>d. If the physician insists the medication be administered, the Unit Manager is to contact the Director of Clinical Services to address the situation.</p> <p>No nurse will work until he/she has completed this education.</p> <p>4. The Unit Coordinators/Director of Clinical Services will conduct Quality Improvement monitoring for 5 random residents to ensure that needed medications are in the facility 5x week for 1 month, then 3x week for 2 months, then 1x week for 2months, then weekly for 1 month.</p>	7-10-15	

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F 425	Continued From page 61 was located. Nurse #4 explained she continued to look for the medication and did not find it. Nurse #4 stated she notified pharmacy and received the medication today from the back up pharmacy. The process for obtaining a medication that is needed immediately includes calling their pharmacy. Their pharmacy then calls the back-up pharmacy for the medications that would be needed immediately. Interview with the Director of Nursing (DON) on 06/11/2015 at 3:56 PM revealed she would expect the nurse to call after hours Omnicare. If Omnicare can't get the medication to the facility, the pharmacy would call a back-up pharmacy and have it delivered. If the nurse can't get the medication she would expect the nurse to call her. The DON explained she is available by phone 24/7.	F 425			
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	1. The identified expired items were immediately discarded. 2. All residents residing in the facility have the potential to be affected. The Director of Clinical Services and Unit Managers inspected the medication carts and medication storage areas to remove any identified expired medications.		

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F 431	<p>Continued From page 62</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 observations and staff interviews, the facility failed to remove an expired medication from one of four medication hall carts (the 500 Hall medication cart).</p> <p>The findings included:</p> <p>An observation of the 500 Hall medication cart on 6/10/15 at 9:45 AM revealed an opened vial of acetylcysteine was stored on the cart for Resident #228. The vial was dated as having been opened on 5/14/15. Auxiliary labeling on the outside container storing the acetylcysteine vial indicated the medication should be stored at room temperature until opened; and refrigerated after opening. The manufacturer's product information included, in part, the following information on the storage of acetylcysteine solution for inhalation: Store unopened vials at</p>	F 431	<p>3. The Director of Clinical Services reeducated all nurses on 6/18/15 regarding checking for expired medications prior to administering the treatment /medication and removing/ returning expired medications. This education also included proper labeling of multi dose vials/liquids/ointments per facility policy. Nurses were taught to use the guide for recommended medication storage located in their medication administration book to determine if a particular medication expires prior to the expiration date located on the packaging. Nurses were also reeducated that if the manufacturer's recommendations are unable to read for any reason: call the pharmacy for directions.</p> <p>A night shift duty list was revised and implemented 7/8/15 to include inspecting the medication carts, treatment carts, and medication storage areas for expired items.</p> <p>No nurse will be able to work until he/she has completed this education.</p>		

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F 431	<p>Continued From page 63</p> <p>room temperature; once opened, store under refrigeration and use within 96 hours.</p> <p>A review of Resident #228 's June 2015 Physicians Orders revealed there was a current order for the acetylcysteine (initiated 5/12/15) to be used for an inhalation treatment via a nebulizer twice daily. Acetylcysteine solution for inhalation is an antimucolytic medication (decreases mucous secretions) used as adjuvant therapy in respiratory conditions.</p> <p>An interview was conducted with the nurse assigned to the 500 hall medication cart (Nurse #1) on 6/10/15 at 10:10 AM. During the interview, Nurse #1 reported he had obtained the opened vial of acetylcysteine from the medication room refrigerator earlier that morning. The nurse reported it was his handwriting on the outside container which indicated the medication had been opened on 5/14/15. When asked how long the vial of acetylcysteine medication would last, the nurse stated it would be good until, " the expiration date. " At that time, the manufacturer ' s labeling on the vial was reviewed with Nurse #1. A small label with the resident ' s name printed on it was adhered to the acetylcysteine vial. Upon peeling back this label, the manufacturer ' s detailed labeling for proper storage of the medication was exposed. The manufacturer ' s labeling on the acetylcysteine indicated the vial of medication should be discarded after being open for 96 hours. Nurse #1 acknowledged he was not aware of this information. The nurse indicated the medication would need to be discarded and he would have to get another vial of acetylcysteine for Resident #228.</p> <p>During an interview with the DON on 6/10/15 at 1:05 PM, the DON addressed the shortened</p>	F 431	4. The Director of Clinical Services/Unit Coordinators will conduct Quality Improvement monitoring of each cart and medication/biological rooms 2 times weekly for 2 months, then 1 time weekly for 2 months, then 1 time a month for 2 months. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Assistant of Director of Clinical Services to the Quality Assurance Performance Improvement	7-10-15	

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F 431	Continued From page 64 expiration date for an opened vial of acetylcysteine. The DON reported her expectation would be for the manufacturer ' s directions to be followed and an opened vial of acetylcysteine to be discarded after 96 hours.	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to maintain accurate medical records for orders for use of supplements (Resident #144) and oxygen (Resident #94) for two of forty five sampled records. The findings included: 1. Resident #144 was admitted to the facility on 11/22/13 with current diagnosis of pneumonia, dementia and anemia.	F 514	1. Residents # 144 and 94 had their Medication Administration Records and Treatment Administration Records immediately updated to reflect the correct prescribed items. 2. All residents residing in the facility have the potential to be affected. The Director of Clinical Services, Unit Managers, or Shift Supervisor will check new orders daily for accuracy of transcription. The orders are validated daily by the night shift nurse. 3. On 6/15/15, the Director of Clinical Services reeducated the Nursing staff on accurate transcription and when to contact the physician/nurse practitioner for clarification. Dietary slips are to be sent to the dietary department so that any diet or supplement orders can be updated. No nurses will be allowed to work until he/she has completed this education.	

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F 514	<p>Continued From page 65</p> <p>Review of the monthly recap orders for May 2015 included a supplement for weight loss of a magic cup by mouth every day. The original order date was 3/4/14. Three other supplement orders were for a house supplement four times a day, med pass 120cc four times a day and a frozen treat every day with the lunch meal.</p> <p>Review of the June Medication Administration record (MAR) revealed all three supplement orders were transcribed on the pre-printed MAR and documented as being provided to the resident.</p> <p>The dietary nutrition evaluation dated 6/3/15 included a diet order of pureed, fortified cereal every morning, frozen treat and house med pass 120cc four times a day.</p> <p>Review of Resident # 144 's tray ticket for breakfast on 6/11/15 did not include magic cup.</p> <p>Interview with aide #4 on 06/11/2015 at 8:43 AM revealed she remembered the resident used to get a magic cup, but had not seen one recently.</p> <p>Interview with the Registered Dietician on 06/11/2015 at 10:50 AM revealed the resident was not supposed to receive the magic cup. The order was clarified by her. This was a pharmacy error in orders. She further explained it was clarified on 4/2/15 which is on the monthly orders also. The House supplement was not to be given. This order was also clarified on 4/2/15. Chart review with the Registered Dietician revealed a telephone order on 4/2/15 as a clarification order for the supplements.</p> <p>On 06/11/2015 at 1:56PM an interview with the</p>	F 514	4. The Unit Coordinators/Director of Clinical Services will review all new orders and compare them to the medication/treatment administration record to ensure that all orders have been transcribed correctly to the medication/treatment administration record. The Unit Coordinators/Director of Clinical Services will audit 4 random residents per day to review new orders and compare to the Medication/treatment administration record for 4 weeks, then 2 random residents per day for 12 weeks, then 3 random residents per week x 4 wks, then 1 random resident per week x 4 weeks. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Assistant of Director of Clinical Services to the Quality Assurance Performance Improvement	7-10-15	

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F 514	<p>Continued From page 66</p> <p>nurse consultant revealed the monthly orders were checked by two nurses. The two nurses work with changeover (end of the month change out of orders/MARs). She explained the process as one nurse would do the first check of the orders against the MAR. The second nurse would do next check. On the night of changeover, The floor nurse is supposed to check the MAR before putting them out. The explanation provided for the multiple supplements on the MAR was " someone made an error. "</p> <p>2. Resident #94 was admitted to the facility on 4/17/15 with diagnoses of chronic obstructive pulmonary disease and pneumonia.</p> <p>Order 5/15/15 to wean off O2 with orders to decrease at 3 pm and check oxygen saturation levels (sats). Instructions to leave oxygen off if sats were above 95%.</p> <p>Review of the May Medication Administration Record (MAR) revealed an order transcribed " wean off O2 (oxygen): starting @ (at) 3 pm 5/15/15 (arrow down) decrease O2 to 1 L/min (liter/minute) via NC (nasal cannula) x (times) 2 hours to keep sat above 95%. The MAR was initialed at 3 PM and sat of 95% documented at 5 pm. There was no other documentation until 5/25/15 and sats were obtained at 3 pm and 5 pm.</p> <p>Review of the nurses notes " Daily Skilled Nurse ' s Note " for the area of " Respiratory " were as follows:</p> <p>- No nurses ' notes for 5/15/15 related to oxygen weaning, oxygen sats, respiratory status or vital signs.</p>	F 514			

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F 514	<p>Continued From page 67</p> <ul style="list-style-type: none"> - 5/16/15 at 10:00 PM oxygen was in place and sats were 96%. The liters per minute of oxygen was not recorded. - 5/17/15 11-7 at 2:00 AM oxygen was in place via nasal cannula. The sats were not documented and the liters per minute were not documented. The 7-3 shift and the 3-11 had no documentation of oxygen use and/or weaning the oxygen with monitoring of oxygen sats. - 5/18/15 there was no documentation for any shift on the flow sheet. - 5/19/15 there was no documentation for any shift related to oxygen use, weaning of oxygen, or sats obtained. - 5/20/15 night shift had documented the lungs were clear. There was no other documentation for review for this date. <p>Review of the MAR for June 2015 revealed O2 sats were monitored and were above 95%. Oxygen at 4L/min was documented as being provided to Resident #94.</p> <p>On 06/11/2015 at 1:45PM an interview was conducted with nurse #11, the RN unit manager. Nurse #11 explained the order was written incorrectly on the MAR, the resident was not assessed each shift immediately after the weaning. Nurse #11 had no further documentation to provide indicating Resident #94 had been assessed, the oxygen weaned and oxygen sats were monitored. Nurse #11 explained the nurses ' notes for " Daily Skilled Nurse ' s Note " should document every shift for skilled residents. Resident #94 was skilled and should have documentation each shift. Further interview revealed the O2 at 4L/minute should have been discontinued.</p>	F 514			

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F 514	Continued From page 68 Interview with the Director of Nursing on 06/12/2015 at 3:43 PM indicated she would expect nurses to transcribe orders correctly. When writing a new order, the old order should be discontinued.	F 514			