STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	**1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909**

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F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		9/17/15

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

Electronically Signed | 09/11/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code diagnoses on the Minimum Data Set (MDS) for 1 of 22 residents reviewed (#74). Findings included: Resident #74 had been admitted to the facility on 2/07/2012. Diagnoses included: Alzheimer's disease, failure to thrive, general osteoarthritis, severe malnutrition, gastrointestinal hemorrhage, schizoaffective disorder, and generalized anxiety. Resident #74 most recent Annual MDS had been dated 7/23/2015. The MDS indicated Resident #74 had received 2 days of antianxiety and 7 days of antidepressant medications. The assessment also indicated Resident #74 had no active diagnoses to justify the use of antianxiety and antidepressant medications during the look back period (7/17/2015-7/23/2015). The Care Area Trigger (CAT) work sheet dated 7/23/2015 indicated Resident #74 had received both antianxiety and antidepressant medications during the look back period. The CAT work sheet also indicated Resident #74 had a history of "dementia of the Alzheimer's type". No other diagnoses were addressed on the CAT work sheet. An interview with MDS Nurse #1 on 8/20/2015 at 5:33 PM was conducted. The nurse stated for a diagnosis to be active and to be able to code that diagnosis on the MDS, a treatment or a medication within the look back period would have to be provided. The nurse further stated if	F 272	Resident #74¿s annual assessment dated 7/23/2015 was corrected on 8/20/2015 to include the diagnosis of anxiety and depression. All MDS nursing staff will be in-serviced on proper coding of diagnosis on the MDS. This will be conducted by the Director of Nursing and completed by 9/17/2015. All resident¿s most recent completed MDS assessments will be reviewed to ensure proper diagnosis are coded. This review will be completed by a MDS nurse and or the Director of Nursing. Any corrections made will be recorded and reviewed by the Administrator and reported to the Quality Assurance (QA) Committee. This will be completed by 9/17/2015. A sample of five completed resident's Minimum Data Sheets will be reviewed by the Staff Development Nurse (SDC), Assistant Director of Nursing (ADON), and or the Director of Nursing (DON) weekly for 3 months. Results will be recorded on the ¿MDS Appropriate Dx Monitoring Tool¿ sheet. Monitoring results will be presented to the QA Committee by the DON. Further monitoring will occur as directed by the QA Committee.	

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F 272	Continued From page 2 there were no medications or treatments provided, diagnoses cannot be counted. The nurse reviewed Resident #74 most recent MDS dated 7/23/2015 and indicated diagnoses of anxiety and depression should have been coded on the MDS. An interview with the Director of Nurses (DON) on 8/20/2015 at 5:45 PM was conducted. The DON stated it was her expectation the MDS would include active diagnoses for the residents.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		9/17/15

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F 279	Continued From page 3 Based on staff interviews and record review the facility failed to develop a care plan with measurable goals for monitoring for the side effects of antipsychotic medication use for 1 of 5 residents (Resident #39) reviewed for unnecessary medication usage who was receiving antipsychotic medications. The findings included: Resident #39 was originally admitted to the facility on 3/26/14. Her acitve diagnoses included depressive disorder, generalized anxiety disorder and senile dementia. The annual Minimum Data Set (MDS) for Resident #39 dated 1/28/15 revealed the resident was severely cognitively impaired and she had physical and verbal behaviors for 1-3 days of the review period. She received antianxiety and antidepressants for all 7 days of the review period. The Care Area Assessment (CAA) indicated psychotropic drug use triggered and indicated it was to be included on the care plan. A review of the physician's orders revealed her medications included Trazodone 50 milligrams (mg) every evening, Lexapro 10mg every day, Buspirone 5mg twice per day and Lorazepam 0.5mg every 6 hours as needed for anxiety or insomnia. The current Care Plan dated 6/30/15 revealed a problem of "displays socially inappropriate behavior at times". There was no care plan problem about the psychotropic medications she was receiving. On 8/21/15 at 9:18 AM the Director of Nursing stated Resident #39 was receiving psychotropic medications and psychotropic medication use should be on the care plan for resident #39.	F 279	Appropriate goals and interventions were added to resident # 39¿s care plan. This was completed on 8/21/2015 All MDS nursing staff will be in-serviced on developing care plans with measurable goals for the monitoring of side effects of psychotropic medication use. This will be completed by the Director of Nursing by 9/17/2015. A complete list of residents receiving psychotropic drugs will be reviewed. Each resident¿s care plan, who is receiving any type of psychotropic medication, will be reviewed to ensure all psychotropic medications are care planned with appropriate goals and interventions. This will be completed by an MDS nurse and reviewed by the Staff Development Nurse, Assistant Director of Nursing, and or the Director of Nursing. This will be completed by 9/17/2015 A review of 5 completed care plans will be conducted weekly for 3 months by the Staff Development Coordinator Nurse (SDC), Assistant Director of Nursing (ADON), and or the Director of Nursing (DON) to ensure psychotropic medications are care planned appropriately. Results of the monitoring will be recorded on the ¿Psychotropic Medication Care Plan Monitoring Tool.¿ Results will be reviewed by the Administrator and reported the Quality Assurance (QA) Committee. Further monitoring will occur as directed by the QA Committee.	

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to provide a diagnosis to justify the use of an indwelling urinary catheter for 1 of 2 residents reviewed (#56). Findings included: The most recent minimum data set (MDS) completed for Resident #56 had been a discharge assessment dated 7/29/2015. The assessment indicated Resident #56 had a memory problem and had been incontinent of bowel and bladder. Her diagnoses included diabetes, hypertension and osteoporosis. Resident #56 had been readmitted to the facility post hospitalization on 8/03/2015. Her diagnoses included: intracerebral hemorrhage, altered consciousness, diabetes and hypertension. The hospital discharge summary dated 8/03/2015 did not indicate indwelling urinary catheter use or include a diagnosis for continued use. Resident #56 readmission orders dated 8/3/2015 did not include an order for indwelling urinary	F 315	A diagnosis was obtained on 8/21/2015 for resident #56 to justify the use of an indwelling urinary catheter. The facility will review all residents with indwelling urinary catheters to ensure that each has a diagnosis that justifies the use of an indwelling urinary catheter. This will review will be completed by the Staff Development Coordinator, Assistant Director of Nursing, and or Director of Nursing. This will be completed by 9/17/2015. All licensed nursing staff will be in-serviced by administrative nursing on the appropriate procedure for obtaining orders and appropriate diagnosis for the use of an indwelling urinary catheter. This will be completed by 9/17/2015. All future residents who receive an indwelling urinary catheter will be	9/17/15

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F 315	Continued From page 5 catheter use or a diagnosis for continued use. The nursing admission assessment dated 8/3/2015 indicated Resident #56 had been admitted with an indwelling urinary catheter. No diagnosis for urinary catheter use had been noted. The physician ' s order dated 8/8/2015 questioned the reason for Resident #56 indwelling urinary catheter use. The nurse ' s note dated 8/08/2015 at 3:30 PM indicated an order had been received to find the reason why Resident #56 had an indwelling urinary catheter and to obtain a copy of the hospital history and physical report for the chart. A care plan dated 8/14/2015 indicated Resident #56 had an indwelling urinary catheter with potential for urinary tract infection but did not indicate a diagnosis for use. An interview with Resident #56 on 8/19/2015 at 8:50 AM was conducted. Resident #56 indicated she had been unaware of having a catheter in her bladder. Resident #56 stated the nurse aides (NA) kept her bottom clean and dry. The nurse ' s note dated 8/18/2015 at 2:41 PM indicated the nurse had spoken with hospital staff regarding Resident #56 reason for indwelling urinary catheter use. The note indicated the catheter had been initiated on 7/27/2015, while the resident was hospitalized, to obtain accurate urinary output measurements. The nurse ' s note also indicated the facility nurse had sent a facsimile to the physician questioning continued catheter use for Resident #56. An interview with Nurse #4 on 8/19/2015 at 3:15	F 315	reviewed by nursing administration at each morning meeting to ensure there is a proper diagnosis for an indwelling urinary catheter. Results will be recorded on the ¿Proper Dx for an indwelling urinary catheter monitoring tool¿ sheet. This monitoring will occur for 3 months. Results will be reviewed by the Administrator and presented to the Quality Assurance (QA) Committee. The need for further monitoring will be determined by the QA Committee	

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F 315	Continued From page 6	F 315		

PM was conducted. The nurse stated the catheter had been placed while Resident #56 had been hospitalized and was not aware of any diagnosis for continued use. The nurse stated she had questioned the physician about Resident #56 urinary catheter use on 8/08/2015, and again 8/18/2015 after being asked about Resident #56 indwelling urinary catheter use. The nurse indicated she had not received a response from the physician. The nurse also stated Resident #56 currently had a " small breakdown " on her sacrum.

An interview with Nurse #3 on 8/20/2015 at 10:22 AM was conducted. The nurse stated the resident had a urinary catheter for a diagnosis of neurogenic bladder. When asked to provide the documentation, the nurse was unable to locate a diagnosis for continued catheter use in Resident #56 medical record.

An interview with the Director of Nurses (DON) on 8/20/2015 at 3:28 PM was conducted. The DON stated a physician order and a diagnosis were necessary for continued indwelling urinary catheter use. The DON reviewed Resident #56 chart and was unable to locate a written order or a diagnosis for continued urinary catheter use.

An interview with the Assistant DON (ADON) on 8/20/2015 at 3:55 PM was conducted. The ADON indicated the resident had a sacral wound and stated " it is not large enough " to justify indwelling urinary catheter use. The ADON also indicated the physician would be contacted to clarify catheter use.

An interview with DON on 8/20/2015 at 5:45 PM was conducted. The DON stated it would be her

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F 315	Continued From page 7 expectation that all residents received from the hospital with indwelling urinary catheters would have an appropriate diagnosis for continued use.	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain a medication error rate of less than 5%. There were 3 errors out of 28 opportunities, resulting in a 10.7 % error rate. The findings included: #1. Resident # 178 was re-admitted to the facility on 5/18/2015 with diagnoses to include chronic obstructive lung disease and hypertension. A physician's order dated 5/18/2015 included Diltiazem (medication for blood pressure) 90 milligrams (mg) 12 hour capsule. Give 2 capsules = 180 mg by mouth every 12 hours, note dosage. On 8/19/2015 at 9:14 AM a medication administration was observed with Nurse #1. The nurse opened one packet with one 90mg capsule of diltizem and placed it in a medicine cup with other morning medication. Medications were taken in to the room and given to the resident. On 8/19/2015 at 10:36 AM an interview was conducted with Nurse #1. After reviewing the medication instructions the nurse stated she should have given 2 diltiazem pills to the resident.	F 332	Nurses #1 and #2 who administered medication incorrectly received counseling and were in-serviced regarding their failure to administer medications correctly on 8/19/15. This was done by a clinical pharmacist on 8/26/2015 and the Staff Development Coordinator Nurse on 9/2/2015. \ Nurses #1 and #2 will be monitored on a weekly basis by administrative nursing staff and or a clinical pharmacist to ensure medications are administered correctly for the next month and then monthly for 3 months to ensure compliance. Results will be reviewed by the administrator and reported to the Quality Assurance (QA) Committee. The QA committee will determine the need for any further monitoring. All licensed nursing staff and certified medication aides will be in-serviced by the Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON),	9/17/15

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F 332	Continued From page 8 An interview was conducted with the Director of Nursing (DON) on 8/21/2015 at 8:43 AM. The DON stated she expected nurses to follow the 5 rights of medication administration, the right resident, right medication, right dose, right route, and right time. If the nurse made a mistake, she should notify the doctor and monitor the resident for adverse effects. #2. Resident # 178 was re-admitted to the facility on 5/18/2015 with diagnoses to include chronic obstructive lung disease. A physician's order dated 5/18/2015 included Symbicort (medication for lung disease) 160-4.5 micrograms (mcg) inhaler, give 1 puff every 12 hours. On 8/19/2015 at 9:14 AM the nurse then handed the resident her inhaler and the resident took a puff of the inhaler, then waited approximately 10 seconds and took a second puff of the inhaler. On 8/19/2015 at 10:36 AM an interview was conducted with Nurse #1. After reviewing the medication instructions the nurse stated she should have had the resident take only one puff on her inhaler. An interview was conducted with the Director of Nursing (DON) on 8/21/2015 at 8:43 AM. The DON stated she expected nurses to follow the 5 rights of medication administration, the right resident, right medication, right dose, right route, and right time. If the nurse made a mistake, she should notify the doctor and monitor the resident for adverse effects. #3. Resident #86 was readmitted to the facility on 10/27/14. Diagnoses included status post left hip	F 332	Director of Nursing (DON) and or clinical pharmacist on proper medication pass administration. This will be completed by 9/17/2015. The clinical pharmacist and or administrative nursing staff will conduct medication pass reviews weekly for three months with at least one randomly selected nurse per week. Any nurse or medication aide identified with deficient practice will receive a one on one in-service education by the Staff Development Coordinator. Results of the clinical pharmacist and administrative nursing monitoring will be reviewed by the administrator and reported to the Quality Assurance Committee. The need for further monitoring will be determined by the QA committee. Any medication errors identified will be reported using the medication error reporting form. The reporting form will be forwarded to the Director of Nursing, Administrator, and the Medical Director. The reported errors will be discussed as they occur with administrative nursing staff and the administrator for corrective action.	

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F 332	Continued From page 9 arthroplasty. August physician orders included ferrous sulfate 325 milligrams (mg) by mouth daily. The August Medication Administration Record included "May use Liquid Iron for Residents requiring crushed Medications." The Liquid Iron bottle was labeled "Serving size = 1 teaspoon (5 milliliters)." Further below the serving size information was "5 milliliters provides 220 mg of iron." On 8/19/15 at 9:16 AM, Nurse #2 was observed to pour 5 milliliters of Liquid Iron for Resident #86. The nurse stated the resident preferred not to swallow pills. The nurse also stated that since 5 milliliters was a serving size, that was the amount she should give. During an interview on 8/19/15 at 10:20 AM, the Pharmacist indicated that 7.5 milliliters of Liquid Iron equaled 330 mg and would be considered the equivalent of the 325 mg dose that was ordered. During an interview on 8/19/15 at 10:28 AM, the Assistant Director of Nursing (ADON) stated the staff nurse should have gotten clarification on how much Liquid Iron to give.	F 332		