STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SVCS PINEHURST	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to dress a resident in street clothes for an outside appointment (x-ray) for one of one sampled resident reviewed for dignity (Resident #167). The findings included: Resident #167 was admitted to the facility on 12/29/15. Cumulative diagnoses included: expressive aphasia and cerebrovascular accident (CVA) with right sided hemiparesis (paralysis). An Admission Minimum Data Set (MDS) dated 1/5/16 indicated Resident #167 was severely impaired in cognition. Resident #167 required extensive assistance of one person for dressing and personal hygiene and total dependence with bathing. It was noted that it was very important for Resident #167 to choose what clothes to wear. A Care Area Assessment (CAA) for cognitive loss/ dementia stated Mr. Turner was able to find appropriate answers during interview. At times, however, they were incorrect. He was able to express his needs with time and encouragement and reassurance was needed when he became frustrated. A Care Area Assessment for ADL's (activities of daily living) completed with the admission MDS	F 241	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility taken or will take the actions set forth in this plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. "All staff" refers to Full-time, PRN, and weekend staff. F 241 It is the act of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Criteria 1 Resident #167 still resides in facility. Criteria 2 All facility residents that leave the facility for appointments. Criteria 3 Director of Nursing initiated education on 3/10/16 with completion on 3/11/16with clinical staff and transportation services in regards to residents wearing proper attire to outside appointments. Newly hired employees in nursing will be	3/24/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Phillip M. Britt, LNHA	Administrator	3/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 stated Resident #167 was alert and able to make his needs known. He had not exhibited any moods/ behaviors that would interfere with care. A care plan dated 1/11/16 indicated the following problems and interventions: ADL deficit as evidenced by need for assistance. Interventions included, in part, assist with daily hygiene, grooming, dressing, oral care and eating as needed. A 30 day MDS dated 1/24/16 noted staff assessment was done for cognition and the MDS indicated Resident #167 had adequate short term and long term memory and was independent in cognitive skills. A review of grievances filed on behalf of Resident #167 was done and revealed a Concern form dated 2/8/16 that stated Resident #167 went to an x-ray appointment in a patient gown. The facility follow-up indicated Resident #167 was alert and oriented x 3 (time, place, person) and the nursing assistant was educated to encourage patient to wear clothes instead of a gown. On 2/24/16 at 11:05 AM, Nurse #5 stated Resident #167 was alert and oriented. Regarding the x-ray order on 2/8/16, she indicated Resident #167 went to the x-ray appointment via an outside transportation. She stated the nursing assistant asked him that morning what he wanted to wear for the day and he stated he wanted to wear a hospital gown. Nurse #5 stated neither he nor the staff were aware that he was going out for an x-ray. Nurse #5 stated she was in the dining room when transportation picked up Resident #167 and she did not realize he was still in a patient gown. She stated Resident #167 did have	F 241	educated during orientation by Human Resources Director. Criteria 4 Director of Nursing or Unit Manager will audit 5 residents per week going to an outside appointment to ensure proper attire is worn for 4 weeks and then 5 residents per month for 3 months or until QAPI committee deems compliance. Director of Nursing or Unit Manager and will bring audit tools to QAPI committee monthly to ensure compliance.	

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F 241	Continued From page 2 street clothes available and would have had staff change him into street clothes if she had seen him prior to him exiting the building for the appointment. On 2/24/16 at 2:30PM, NA #1 stated she was the nursing assistant who provided care for Resident #167 on 2/8/16. She stated she bathed resident that morning and he wanted to have a gown on for the day. She stated she did not know he was going out of the building that day. Resident #167 left for the appointment while she was in the dining room. Therefore, she did not change his clothing to street clothes. On 2/24/16 at 5:04 PM, an interview was conducted with Resident #167. He stated he preferred to wear regular clothes when he left the facility because the patient gown was open in the back and showed "stuff". When asked if he remembered going to any appointments dressed in a patient gown, he stated he remembered going one time to the hospital for an x-ray in a gown and he preferred to go to outside appointments in street clothes. On 2/25/16 at 8:05 AM, the Director of Nursing was interviewed and stated she expected residents to wear street clothes unless they refused when they went out of the facility to appointments.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both	F 242	F 242 It is the act of this facility to allow residents the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care.	3/24/16

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F 242	Continued From page 3 inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews, the facility failed to honor choice to time in bathing for one of one sampled resident reviewed for choices in bathing (Resident #167) and failed to honor food preferences for one of one sampled resident reviewed for food choices (Resident #23). The findings included: 1. Resident #167 was admitted to the facility on 12/29/15. Cumulative diagnoses included: aphasia and cerebrovascular accident (CVA) with right hemiplegia (paralysis). An Admission Minimum Data Set (MDS) dated 1/5/16 indicated Resident #167 was severely impaired in cognition with BIMS 4. Resident #167 was total dependence with bathing and extensive assistance with personal hygiene. It was noted on the MDS that it was very important for Resident #167 to choose between bed bath, tub bath, showers and sponge bath. A Care Area Assessment (CAA) for ADL's (activities of daily living) stated Resident #167 was alert and oriented and able to make his needs known. He was non-ambulatory and participating in therapy. Resident #167 had not exhibited any moods/ behaviors that would interfere with care. A care plan dated 1/11/16 indicated the following	F 242	Criteria 1 Resident #167 still resides in facility and Care Plan meeting was completed on 2/26/16 of which discussed bathing. Resident #23 has discharged from facility. Criteria 2 All facility residents. Audits completed on 3/10/16 by Interdisciplinary Team (IDT) members regarding shower schedules and food choices. IDT members are Human Resources Director, Activities Director, Maintenance Director, Business Office Manager, Director of Rehab-ilitation, AP clerk, Director of Admissions, Houskeeping Director, Director of Social Services. Non-interviewable residents Responsible party were contacted by IDT memebers to ensure choices were met on 3/16/16. Critereria 3 Education was initiated on 3/10/16 and completed on 3/11/2016 with all licensed staff staff in regards to bathing. Education was initiated on 3/9/16 and completed 3/10/16 with clinical staff, dietary staff, and IDT members on accuracy of tray cards to the actual tray being served.	

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F 242	Continued From page 4 problems and interventions: ADL (activities of daily living) deficit as evidenced by need for assistance related to chronic obstructive pulmonary disease, history of CVA with expressive aphasia, hypertension, diabetes, osteoarthritis and hyperlipidemia. Interventions included, in part, staff to assist to bathe/ shower as needed. Assist with daily hygiene, grooming, dressing, oral care and eating as needed. A 30 day MDS dated 1/24/16 noted staff assessment was done for cognition and the MDS indicated Resident #167 had adequate short term and long term memory and was independent in cognitive skills. On 2/24/16 at 12:30PM, an observation was conducted with Nurse #2. Resident #167 was lying in bed and stated he had not had his bath yet today. Resident #167 said NA#1 came in earlier and was getting ready to give him a bath and he had to use the bedpan. He stated the aide came back in and got the pan and said she was coming back to bathe him but had not come back. At that time, Nurse #2 informed Resident #167 that NA#1 was scheduled daily to go to the dining room from 11:45AM until the meal was done and would not be available until later. On 2/24/16 at 2:30PM, an interview was conducted with NA#1. She stated she was just now going in to give Resident #167 a bath. NA#1 stated she was in the dining room from 11:45AM-12:45PM and was scheduled for dining room every day. NA #1 stated she regularly had Resident #167 on her assignment. NA#1 stated Resident #167 had not refused any care that day. An observation on 2/24/16 at 2:42 PM revealed	F 242	The Director of Nursing will complete 5 resident audits per week for 4 weeks and 5 per month for 3 months or until QAPI committee deems compliance to ensure resident receives bath in a timely manner. Audit will include varying shifts and weekends. Food Services Director or Registered Dietician will complete 5 tray audits per week for 4 weeks and 5 per month for 3 months or until QAPI committee deems compliance to ensure the tray card matches the tray being served. Audits will include varying shifts and weekends. Director of Nursing or Nurse Manager will bring audit tools to QAPI meeting monthly to ensure compliance. Food Services Director or Registered Dietician will bring audit tools to QAPI meeting monthly to ensure compliance.	

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F 242	Continued From page 5	F 242		

Resident #167 lying in bed. He said he had not had his bath as of yet.

On 2/24/16 at 3:15 PM, an interview was conducted with NA#1. She sated she was going to give Resident #167 a bath before she went to the dining room. When she went in to bathe him, he had to use the bedpan. She stated she checked with him two or three times and, by the time he was finished, she had to go to the dining room so had not had a chance to get to him. NA#1 stated when she went to bathe him around 3:00PM, he refused the full bath and just wanted his face and hands washed.

On 2/24/16 at 5:04 PM, an interview was conducted with Resident #167 who stated he preferred to get bed baths for now and would like to have his baths done by 11:00AM because he likes to get up around 11:00AM after his bath.

On 2/25/16 at 8:05 AM, an interview was conducted with the Director of Nursing who stated she expected residents to receive morning care (bathing/ dressing) at least by noon.

2. Resident # 23 was admitted to the facility on 1/28/16 with multiple diagnoses including Diabetes Mellitus.

The admission Minimum Data Set (MDS) assessment dated 2/4/16 indicated that Resident #23's cognition was intact.

On 2/23/16 at 8:10 AM, Resident #23 was observed in her room eating breakfast. Her tray contained a bowl of oatmeal. Her diet card indicated under special instructions: No oatmeal, no grits, and to send raisen bran at breakfast.

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F 242	Continued From page 6 The dislikes written on the diet card included hot cereal, grits and oatmeal. On 2/23/16 at 9:27 AM, Resident #23 was interviewed. She stated that she was admitted to the facility for rehabilitation. Her only concern was the food especially breakfast. She did not eat oatmeal or grits and she had requested dry cereals for breakfast. Resident #23 revealed that she was always served oatmeal or grits every morning and no dry cereal. She indicated that she and her husband had talked with the dietary staff on several occasions but it didn't do any good. She was tired of telling the staff not to serve the oatmeal and the grits and asking for the dry cereal. On 2/25/16 at 8:35 AM, the breakfast tray of Resident #23 was observed. There was no dry cereal served on the tray. On 2/25/16 at 9:05 AM, the Dietary Manager was interviewed. She indicated that she was very new to the facility and she started working at the facility 3 days ago. She indicated that the dry cereals were available in the cart for the residents. She added that she didn't know why dry cereals were not served in the resident's trays by the dietary staff. On 2/25/16 at 9:10 AM, NA #2 was interviewed. She stated that she read the dietary card for the resident's preferences for beverages but not for food likes and dislikes.	F 242		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		3/24/16

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F 309	Continued From page 7 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 medical record review, pharmacist interview and staff interview, the facility failed to obtain and apply the compression hose as ordered by the physician for swelling/ edema in lower extremities for one of one sampled resident reviewed for well-being (Resident #167). The findings included: Resident #167 was admitted to the facility on 12/29/15. Cumulative diagnoses included, in part, cerebrovascular accident (CVA) with right hemiparesis (paralysis). An Admission Minimum Data Set (MDS) dated 1/5/16 indicated Resident #167 was severely impaired in cognition. Resident #167 required extensive assistance of one person for dressing. A physical therapy note dated 1/11/16 stated Resident #167 complained of increased pain today. Physical therapy requested compression hose for right lower extremity due to swelling and pain. A physician's progress note dated 1/15/16 indicated the physician was asked to see Resident #167 for swelling in both lower extremities. Assessment: dependent edema. Plan: no significant change was indicated at that time. If any worsening in condition, will need compression hose. Further follow up pending response to the above.	F 309	F 309 It is the act of this facility for each resident to receive 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. Criteria 1 Resident #167 still remains in facility. Criteria 2 All facility residents with physician orders to receive compression stockings thigh high, low compression size to fit. Director of Nursing completed an audit on 2/24/16 to ensure all residents with physician orders to receive compression stockings were compliant. Results of audit were one other patient with orders for compression stockings with no issues noted. Criteria 3 Director of Nursing initiated education on 2/25/16 and completed on 3/11/2016 with all licensed nurses in regards to following physician orders.	

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F 309	Continued From page 8 On 1/15/16, a physician's order was noted for compression stockings thigh high, low compression size to fit. A review of the January, 2016 Medication Administration Record (MAR) revealed no documentation that the compression hose was applied. A review of the January, 2016 Treatment Administration Record (TAR) revealed an undated treatment that stated compression stockings thigh high, low compression size to fit-start 2/2/16 related to DVT (deep vein thrombosis) in right leg. There was no documentation that the compression hose was applied. Nursing notes were reviewed and there was no documentation regarding the use of the compression hose. On 2/24/16 at 12:03 PM, an interview was conducted with Nurse #2 and Nurse #6. Nurse #2 stated the facility ordered the compression hose on 1/15/16 from the pharmacy. She stated the procedure was to order the compression hose from the pharmacy and the pharmacy would send back a form that the facility filled out with the measurements for the compression hose. Nurse #6 stated they returned the form with the measurements, requested the compression hose from the pharmacy again but never received the compression hose. Nurse #2 stated she returned to work o 1/18/16 and obtained compression hose from the central supply area that day. Nurse #2 stated the order was missed and not placed on the TAR but was put on the nursing assistant task list as they were the ones who applied the compression hose. A review of the nursing assistant task list revealed no instructions dated 1/15/16 for compression hose placement. Nurse #6 stated the nurse should monitor the	F 309	Criteria 4 Director of Nursing or Unit Manager will audit all new physician orders for compression stockings in daily clinical meeting and match the order to the Treatment Administration Record (TAR) and application of compression stockings on resident. This will be completed for 4 weeks or until QAPI committee deems compliance. Director of Nursing or Unit Manager will bring all audit tools to monthly QAPI meeting to ensure compliance.	

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F 309	Continued From page 9 application of the compression hose and document placement on the TAR or in the nursing notes. An observation on 2/24/16 at 2:42 PM revealed Resident #167 in bed. He stated he did not have his compression hose on. On 2/25/16 at 8:05 AM, the Director of Nursing was interviewed and stated she expected nursing staff to put any orders for compression hose on the Treatment Administration Record (TAR) and document when hose is on/ off. On 2/25/16 at 9:12 AM, an attempt was made to call the nurse who received the order for the compression hose on 1/15/16 with no answer. On 2/25/16 at 10:26 AM, an interview was conducted with pharmacy manager who stated the pharmacy received the order for the compression hose on 1/15/16 and faxed back a request to the facility on 1/15/16 for the measurements so they could send the correct size but did not hear back from the facility so the compression hose had not been delivered to the facility.	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329	F 329 It is the act of this facility to ensure each resident's drug regiment is free from unnecessary drugs.	3/24/16

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F 329	Continued From page 10 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to monitor the laboratory test to determine the adequacy of therapy and possible adverse consequences for 1(Residents #106) of 5 sampled residents reviewed for unnecessary drugs, failed to monitor the behavior and effectiveness of the antipsychotic drug for 1(Resident #154) of 3 sampled residents on antipsychotic drugs and failed to monitor the effectiveness of pain medication for 2 (Residents #167 & #73) of 4 sampled residents reviewed for pain. Findings included: 1. Resident #106 was admitted to the facility on 12/3/13 with multiple diagnoses including Atrial Fibrillation and Hyperlipidemia. The annual Minimum Data Set (MDS) assessment dated 12/10/15 indicated that Resident #106's cognition was intact. The physician's orders for Resident #106 were reviewed. The orders included Digoxin 125 micrograms (mcg.) by mouth daily for Atrial	F 329	Criteria 1 Resident # 106 still remains in facility and digoxin level was 0.3. Triglycerides - 169 HDL-38.2 VLDL-34.0 LDL - 63 Resident # 154 still remains in facility. Resident #167 still remains in facility. Resident #73 still remains in facility Criteria 2 All residents receiving the medication Digoxin, antipsychotic medications, and pain medications. Director of Nursing completed facility wide audit on 2/24/16 to ensure all residents receiving medication requiring laboratory montioring currently in facility - results compliant. Facility wide audit completed by Assistant Director of Nursing on 2/24/2016 for documenting of behavior monitoring and the effectiveness of antipsychotic medcations. On 3/16/2016 Director of Nursing completed facility wide audit of documentation of pain monitoring and the effectiveness of pain medications. Results of audits showed no adverse areas and substantiated compliance. Criteria 3 Director of Nursing or Unit Manager initiated education to all licensed Nurses on 3/10/16 and completed on 3/11/2016 to ensure adequate	

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F 329	Continued From page 11 Fibrillation and Lipitor 10 milligrams (mgs.) by mouth at bedtime for Hyperlipidemia. The resident's Digoxin and Lipitor were originally ordered on 12/3/13. Review of Resident #106's medical record on 02/23/16 revealed there was no laboratory test result for Digoxin level to determine the adequacy of therapy or possible drug toxicity since the resident's admission (2013). There was also no laboratory test result for Lipid panel to determine goal of therapy attainment since admission (2013). On 2/23/16 at 5:25 PM, the Director of Nursing (DON) was interviewed. She stated that the facility had no standing orders for laboratory tests and the tests were only done when the doctor orders for it. The DON confirmed no Digoxin or Lipid panel tests were performed for Resident #106 since the resident's admission to the facility on 12/03/13. The medical records of Resident #106 were again reviewed on 02/24/16. On 02/24/16, a doctor's order was written to obtain Digoxin level, Lipid panel and Liver Function Test (LFT) for the resident. On 2/25/16 at 11:06 AM, the DON was interviewed. She stated that she had talked with the Medical Director and he ordered the laboratory tests for Resident #106 on 2/24/16. She added that from now on residents on Digoxin and cholesterol reducing drugs will have the Digoxin level, Lipid panel and Liver Function Test done on admission and as indicated.	F 329	monitoring of digoxin levels, monitoring behavior and effectiveness of antipsychotic drugs, and monitoring of pain medication and it's effectiveness. Director of Nursing or Unit Manager will audit new physician orders for digoxin for 4 weeks in daily clinical meeting and ensure compliance. Criteria 4 Director of Nursing or Unit Manager will audit at random 5 Medication Administration Records (MAR) per week to ensure monitoring of effectiveness of antipsychotic drugs administered and documented. This will be for 4 weeks and then 5 MAR audits per month for 2 months or until QAPI committee deems compliance. Director of Nursing or Unit Manager will audit at random 5 MAR to ensure documentation of effectiveness of pain meds administered and documented. This will be for 4 weeks and then 5 MAR audits per month for 2 months or until QAPI committee deems compliance. Director of Nursing or Unit Manager will bring audit tools to monthly QAPI committee meeting and ensure compliance.	

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2a. Resident #154 was admitted to the facility on 1/6/16 with multiple diagnoses that included dementia and depression. The admission Minimum Data Set (MDS) Assessment dated 1/13/16 indicated he had significant cognitive impairment and received antipsychotic and antidepressant medications.

The Plan of Care initiated on 1/6/16 indicated Resident #154 was at risk for behavioral symptoms due to diagnoses of dementia and depressive disorder and was at risk for adverse side effects related to the use of psychotropic medications.

The nursing progress notes for 1/6/16 through 1/8/16 were reviewed for Resident #154. There was no documentation of behaviors for Resident #154.

A physician's progress note dated 1/8/16 indicated the physician was asked to see Resident #154 regarding his mental status. The physician indicated Resident #154 had increased agitation, confusion and disorientation; he was trying to get up at night which presented harm to himself; and he was having visual hallucinations and crying out. The physician reported the medical transfer records indicated Resident #154 had previously received a multitude of different medications that included Haldol. He indicated medication changes were going to be adjusted and further treatment would be provided if Resident #154's condition worsened.

A physician's order dated 1/8/16 for Resident #154 indicated the discontinuation of Risperidone

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(antipsychotic). It also indicated an order to start Seroquel (antipsychotic) 50 milligrams (mg) twice daily for dementia and Haldol (antipsychotic) 5 mg every four hours as needed (PRN) for agitation.

An observation of Resident #154 was conducted on 2/23/16 at 3:35 PM. Resident #154 was seated in a wheelchair. He was self-propelling himself up and down the hallway outside of his room. He appeared calm with no agitation noted.

An interview was conducted on 2/23/16 at 3:45 PM with Nurse #1. She stated behaviors were documented in nursing progress notes. Nurse #1 reported Resident #154 had some agitation, confusion and wandering behaviors when he was initially admitted. She indicated she believed the behaviors had decreased over time as Resident #154 adjusted to the facility. She stated Resident #154's baseline behavior was to self-propel himself in his wheelchair throughout the hallway outside of his room.

An interview was conducted on 2/23/16 at 4:44 PM with the Director of Nursing (DON). She stated her expectation was for behaviors to be documented in nursing progress notes. The physician's progress note from 1/8/16 and the nursing progress notes from 1/6/16 through 1/8/16 were reviewed. The DON indicated the behaviors specified in the physician's progress note were not reflected in the nursing progress notes. She stated the facility maintained an acute change log that was documented in and reviewed daily. She indicated that was most likely how the physician was informed of the behaviors that were documented in his 1/8/16 progress note. She stated the acute change log was not part of

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the medical record. She revealed she expected any behaviors that were documented on the acute change log to also be documented in the medical record in nursing progress notes.

b. Resident #154 was admitted to the facility on 1/6/16 with multiple diagnoses that included dementia and depression. The admission Minimum Data Set (MDS) dated 1/13/16 indicated he had significant cognitive impairment and received antipsychotic and antidepressant medications.

The Plan of Care initiated on 1/6/16 indicated Resident #154 was at risk for behavioral symptoms due to diagnoses of dementia and depressive disorder and was at risk for adverse side effects related to the use of psychotropic medications.

The February 2016 physician's orders were reviewed for Resident #154. The orders included Seroquel (antipsychotic) 50 milligrams (mg) twice daily, Trazodone (antidepressant) 50 mg once daily, and Haldol (antipsychotic) 5 mg every four hours as needed (PRN).
The February 2016 Medication Administration Record (MAR) was reviewed for Resident #154. The MAR indicated Resident #154 was administered a PRN dose of Haldol on 2/10/16 and on 2/11/16. There was no documentation that indicated the reason the Haldol was administered or its effectiveness.

An interview was conducted on 2/23/16 at 3:45 PM with Nurse #1. Resident #154's February 2016 MAR was reviewed with Nurse #1. She stated she administered the PRN dose of Haldol to Resident #154 on 2/10/16 and 2/11/16. She

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revealed she had not documented on the MAR the reason for the administration or its effectiveness. She indicated this was an error. Nurse #1 stated Resident #154 was having agitation in the evening on both 2/10/16 and 2/11/16. She indicated that was the reason the PRN Haldol was administered to Resident #154. She stated the Haldol was effective.

An interview was conducted on 2/23/16 at 4:44 PM with the Director of Nursing (DON). She stated that when a PRN medication was administered, the reason for the administration and the effectiveness was expected to be documented on the MAR. She indicated the nurse who administered the PRN medication was responsible for the documentation. The February 2016 MAR for Resident #154 was reviewed with the DON. She revealed the documentation on Resident #154's MAR for 2/10/16 and 2/11/16 was incomplete. She stated the nurse who administered the PRN Haldol to Resident #154 should have documented the reason for the administration and its effectiveness.

3. Resident #167 was admitted to the facility on 12/29/15. Cumulative diagnoses included: chronic obstructive pulmonary disease, aphasia, and cerebrovascular accident with right sided hemiparesis (paralysis).

An Admission/readmission screen completed on 12/29/15 stated Resident #167 provided the information for the pain assessment. He stated the highest level of pain per the numeric pain score of 0-10 was 10 and lowest level of pain at 1. Pain goal was "0" . He experienced pain frequently with the pain located on the right side of his head, right groin, right lower arm, right

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F 329	Continued From page 16 hand, right hand fingers, right neck, right upper back, right hip, right thigh, right lower leg and right foot. The type of pain was a tightness, shooting/radiating, pins/ needles type of pain Position changes exacerbated symptoms and a change in activity was one of the relieving factors. Prescription pain medications were effective in relieving pain symptoms. Resident #167's pain level impacted sitting, standing, sleep and anxiety. Physician admission orders dated 12/29/15 included the following pain medications: Percocet (pain medication) 5/325 milligrams (mg) 1 tab by mouth (Po) every four hours as needed for pain. Physician orders dated 12/30/15 stated to discontinue Percocet. Ultram 50 mg po every 6 hours as needed for pain. An Admission Minimum Data Set (MDS) dated 1/5/16 indicated Resident #167 was severely impaired in cognition. Pain management was reviewed and revealed Resident #167 received PRN (as needed) pain medication. Pain present noted as yes; occasional pain. Pain did not affect sleep or limit activities. Numeric rating score of "4" . A care plan dated 1/11/16 indicated the following problems and interventions: Pain (generalized) related to limitations secondary to diagnoses. Interventions: Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. Administer pain medication per physician orders. Encourage/ assist to reposition frequently/ intensity is worsening or if current analgesia regime has become ineffective. A physician's order dated 1/12/16 indicated to discontinue Ultram. Percocet 5/325 milligrams by mouth every 6 hours as needed for pain.	F 329		

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A physician's order dated 1/28/16 stated to discontinue Percocet. Begin Percocet 3/325 milligrams one by mouth every 4 hours as needed for severe pain
A review of the narcotics record for Percocet (Oxycodone 5 mg-acetaminophen 325 mg) for January 2016 was reviewed and revealed Resident #167 received the medication on 1/24/16 at 9 AM and 8:10 PM and 1/25/16 at 8:00AM, 2:00PM and 10:20 PM.
A review of the January Medication Administration Record (MAR) revealed Resident #167 received Percocet 5 mg-325 mg on 1/24/15 x 1 with a nursing note dated 1/24/16 at 10:52 AM that stated the medication was effective. There was no documentation on the MAR or in the nursing notes that Percocet was administered 1/24/16 at 8:10 PM. No documentation on the MAR or in the nursing notes was noted for Percocet administered 1/25/16 at 8:00AM, 2:00PM and 10:20 PM.
On 2/24/16 at 10:20 AM, an interview was conducted with the Director of Nursing. She stated her expectation was for the nursing staff to assess the level of pain prior to administration of the medication and record the pain level on the MAR or in a nursing progress note. Also, she expected the nursing staff to document the administration of the pain medication immediately on the back of the MAR and reassess the resident in about 1 hour and document on the back of the MAR the effectiveness of the pain medication.

On 2/24/16 at 2:09 PM, a telephone interview was conducted with Nurse #3 who administered the pain medication on 1/25/16 at 10:20 PM. She stated the protocol was to sign the front of the MAR, document the administration of the

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medication on the back of the MAR with date, time, dose, pain level and reassess in 1 hour to see if the medication was effective. She did not know why she did not document it on the MAR but stated she should have documented the administration of the medication.

On 2/25/16 at 10:48 AM, Nurse #4 stated she did not know why she did not document on the back of the MAR (1/24/16) the administration of the Percocet 5 mg-325 mg at 8:10 PM. She stated she was supposed to document the administration, level of pain and effectiveness of the medication on the back of the MAR.
On 2/25/16 at 10:57 AM, Nurse #5 stated she did not know why she did not record the administration of the pain medication on 1/25/16 at 8 am and 2 pm. She stated she usually documented the administration, pain level and effectiveness of the medication on the back of the MAR.

4. Resident #73 was originally admitted 3/26/10 with last readmission on 11/26/12. Cumulative diagnoses included: generalized anxiety disorder and history of deep vein thrombosis.
A Quarterly MDS dated 12/10/15 indicated Resident #73 was moderately impaired in cognition. Pain management was reviewed and indicted Resident #73 received PRN (as needed) pain medication. The pain interview was conducted with Resident #73 who stated pain was rarely present and at a numeric level of "2" . Pain did not affect his sleep or day to day activities.

A care plan dated 5/13/15 and last reviewed on 12/19/15 stated the following: Generalized pain related to limitations secondary to diagnoses.

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Interventions included, in part, to report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. Administer pain medication per physician's order. Notify physician if pain frequency/ intensity worsened or if current analgesia regimen had become ineffective.

A pain assessment dated 1/31/16 indicated onset of pain was greater than 6 months with the frequency of pain noted as occasional over the last five days. Pain could occur at any time throughout the day and had not limited day to day activity nor made it hard for Resident #73 to sleep at night.

Physician's orders for February 2016 were reviewed and revealed the following order for pain management: Hydrocodone--acetaminophen 5 mg--325 milligrams (mg) by mouth (po) every six (6) hours as needed (prn) for pain.

A review of the narcotic administration record for February 2016 was conducted. Resident #73 received Hydrocodone--acetaminophen 5 milligrams (mg)-325 mg. one tablet on 2/8/16 at 8:15 PM. There was no documentation on the Medication Administration Record (MAR) that Resident #73 received the medication. Per the narcotic record, Resident #73 received Hydrocodone--acetaminophen 5 mg-325 mg on 2/16/16 at 7:00PM. There was no documentation on the MAR that Resident #73 received the medication.

A review of the MAR for Resident #73 for February 2016 revealed no documentation that Resident #73 received Hydrocodone-acetaminophen 5 mg-325 mg on

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F 329	Continued From page 20 2/8/16 or 2/16/16. A review of the nursing notes revealed no nursing documentation during the month of February regarding the administration of pain medication, the level of pain experienced by Resident #73 or the effectiveness of the pain medication administered. On 2/24/16 at 10:20 AM, an interview was conducted with the Director of Nursing. She stated her expectation was for the nursing staff to assess the level of pain prior to administration of the medication and record the pain level on the MAR or in a nursing progress note. Also, she expected the nursing staff to document the administration of the pain medication immediately on the back of the MAR and reassess the resident in about 1 hour and document on the back of the MAR the effectiveness of the pain medication. On 2/24/16 at 2:09 PM, a telephone interview was conducted with Nurse #3 who signed out for the medication on 2/8/16 and 2/16/16. She stated the protocol was to sign the front of the MAR and document on the back of the MAR the date, time, dose, pain level and reassess in 1 hour and document the effectiveness of the medication. She did not know why she did not document it on the MAR but should have.	F 329		
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.	F 332	F 332 It is the act of this facility to ensure that it is free of medication error rates of less than five percent.	3/24/16

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F 332	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interview, the facility failed to follow doctor's orders and the manufacturer's specifications for 1 (Resident #35) of 8 sampled residents observed during the medication pass. The medication error rate was greater than 5% as evidenced by 4 medication errors out of 25 opportunities, resulting in a medication error rate of 16%. Findings included: 1. Resident #35 was admitted to the facility on 3/11/15 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). a. On 3/11/15, Resident #35 had a doctor's orders for Spiriva capsule - inhale the contents of 1 capsule orally daily by taking two separate inhalations via hand inhaler device and Advair 250/50 micrograms (mcg) diskus- inhale 1 puff by mouth twice a day (rinse mouth and spit out after each use) for COPD. On 2/24/16 at 7:51 AM, Resident #35 was observed during the medication pass. Nurse #2 was observed to administer the Spiriva inhaler followed with the Advair inhaler without waiting at least a minute between puffs. On 2/24/16 at 8:12 AM, Nurse #2 was interviewed. She stated that the facility had no policy to wait in between puffs. On 2/26/16 at 11:10 AM, the Director of Nursing was interviewed. She stated that she expected the nurses to follow their policy to wait a minute between puffs if administering more than 1 puffs.	F 332	Criteria 1 Resident #35 still resides in facility. Criteria 2 All facility residents receiving hand held inhalers. Director of Nursing completed a facility wide audit on 3/10/16 to denote all residents on hand held inhalers. Director of Nursing completed a facility wide audit on all residents receiving ASA on3/10/2016. Criteria 3 Director of Nursing educated all licensed Nurses to ensure compliant medication administration of hand held inhalers per policy and administration of ASA on 3/10/16. Criteria 4 Director of Nursing or Unit Manager will audit one med pass per week for 4 weeks and one monthly for 2 months or until QAPI committee deems compliance. Med pass audits will include observation of ASA administration and administration of inhalers. Will include varying shifts and weekends. Director of Nursing or Unit Manager will bring audit tools to monthly QAPI committee meeting to ensure compliance.	

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b. The manufacturer's specification for Advair diskus indicated " Advair diskus should be administered by the orally inhaled route inhalation. The patient should rinse the mouth with water without swallowing. "

On 3/11/15, Resident #35 had a doctor's orders for Advair 250/50 micrograms (mcg) diskus-inhale 1 puff by mouth twice a day (rinse mouth and spit out after each use) for COPD.

On 2/24/16 at 7:51 AM, Resident #35 was observed during the medication pass. Nurse #2 was observed to administer the Advair inhaler to the resident without rinsing the resident's mouth with water after use.

On 2/24/16 at 8:12 AM, Nurse #2 was interviewed. She stated that she should have instructed the resident to rinse his mouth with water but she did not.

On 2/26/16 at 11:10 AM, the Director of Nursing was interviewed. She stated that she expected the nurses to follow the policy and the doctor's order in administering the inhalers.

c. The manufacturer's specification for the dose and administration of Spiriva Hand inhaler indicated " two inhalations of the powder contents of a single Spiriva capsule once daily. "

On 3/11/15, Resident #35 had a doctor's orders

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for Spiriva capsule - inhale the contents of 1 capsule orally daily by taking two separate inhalations via hand inhaler device for COPD.

On 2/24/16 at 7:51 AM, Resident #35 was observed during the medication pass. Nurse #2 was observed to prepare the Spiriva by inserting one capsule of Spiriva into the Hand inhaler and handed it to the resident to administer. The resident was observed to inhale the Spiriva but did not take two separate inhalations. The nurse was not observed to give instruction to the resident on how to use the hand inhaler and to take two separate inhalations as ordered.

On 2/24/16 at 8:12 AM, Nurse #2 was interviewed. She stated that she should have instructed the resident to take two separate inhalations but she did not.

On 2/26/16 at 11:10 AM, the Director of Nursing was interviewed. She stated that she expected the nurses to follow the doctor's order in administering the inhalers.

d. On 3/11/15, Resident #35 had a doctor's orders for Aspirin 81 milligrams (mgs) 1 tablet once a day as a blood thinner.

On 2/24/16 at 7:51 AM, Resident #35 was observed during the medication pass. Nurse #2 was observed to prepare and to administer Enteric Coated Aspirin (ECASA) 81 mgs. to the resident instead of Aspirin (regular) 81 mgs as ordered

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F 332	Continued From page 24 On 2/24/16 at 8:12 AM, Nurse #2 was interviewed. She admitted that it was a mistake, she should have administered the regular Aspirin and not ECASA. On 2/26/16 at 11:10 AM, the Director of Nursing was interviewed. She stated that she expected the nurses to follow the doctor's order in administering medications.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard outdated, expired foods, failed to discard moldy gravy, rotten tomatoes and failed to label and date foods in the walk-in refrigerator and freezer. The findings included: On 2/22/16 at 10:25 AM, an observation of the walk-in refrigerator was conducted with the interim registered dietician/ dietary manager. The following was noted: one full pitcher of red liquid unlabeled and undated; ½ full pitcher of brown gravy unlabeled and undated with mold around	F 371	F 371 It is the act of this facility to store, prepare, distribute and serve food under sanitary conditions. Criteria 1 No effected residents. Criteria 2 All facility residents dining in the facility. Audit of refrigerator, freezer, and store room areas was completed immediately and identified items removed immediately on 2/21/16 by Food Services Director and Regsitered Dietician. Criteria 3 Food Services Director educated all dietary staff initiated on 2/22/16 and completed on 2/27/2016 regards to proper labeling, dating, and storing of all food items.	3/24/16

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F 371	Continued From page 25 the top of the gravy and pitcher, eleven English muffins opened, unlabeled and undated, sixteen cooked hot dogs dated 2/16/15, 1.2 container of cottage cheese opened and dated 1/23/16, ½ container of cottage cheese opened and dated 1/9/16, ½ box (22) tomatoes that were spoiled, ½ package of diced onions that were not sealed and were dated 2/17/16, 1/2 plastic tube of buttercream icing opened and undated (instructions on the tube of icing indicated " if thawed, use within 14 days " , and 1.2 pitcher of pineapple slices dated 2/9/16. On 2/22/16 at 10:25 AM, an observation of the freezer was conducted with the interim dietician/ dietary manager. The following was noted: ½ bag of beef patties unsealed and undated and ½ bag of uncooked chicken unsealed and undated. On 2/22/16 at 10:25 AM, the interim dietician/dietary manager stated she had been at the facility for two weeks and the new dietary manager just started on 2/22/16. She stated the cooks/ dietary aides, and dietary manager were supposed to check the cooler, freezer and refrigerator at least daily. She stated she guessed she was responsible for checking for labeled, dated, expired foods. On 2/24/16 at 11:04 AM, the dietary manager stated it was her responsibility for checking the cooler, refrigerator and freezer daily.	F 371	Criteria 4 Food Services Director or Registered Dietician will audit cooler, refrigerator, and freezer weekly for 4 weeks and monthly for 2 months or until QAPI committee deems compliance. Audits will include varying shifts and weekends. Food Services Director will bring audit tools to monthly QAPI committee meeting to ensure compliance.	
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428	F 428 It is the act of this facility to ensure proper pharmacy reviews of drug regimens.	3/24/16

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F 428	Continued From page 26 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's pharmacy consultant failed to report drug irregularities to the attending physician regarding laboratory tests for 1 (Residents # 106) of 5 sampled residents reviewed for unnecessary drugs. Findings included: Resident #106 was admitted to the facility on 12/3/13 with multiple diagnoses including Atrial Fibrillation and Hyperlipidemia. The annual Minimum Data Set (MDS) assessment dated 12/10/15 indicated that Resident #106's cognition was intact. The physician's orders for Resident #106 were reviewed. The orders included Digoxin 125 micrograms (mcg.) by mouth daily for Atrial Fibrillation and Lipitor 10 milligrams (mgs.) by mouth at bedtime for Hyperlipidemia. Digoxin and Lipitor were ordered on 12/3/13. The medical records of Resident #106 were reviewed. There were no laboratory tests results for Digoxin level or Lipid panel since admission (2013). The drug regimen reviews were reviewed and	F 428	Criteria 1 Resident #106 still resides in facility. Criteria 2 All residents in facility on medications that require laboratory tests. Resident #106 was ordered a digoxin level, lipid panel, and Liver Function Test on 2/24/16 of which came back within normal limits per Medical Director. Director of Nursing audited all in-house residents receiving medications requiring laboratory monitoring on 2/23/16. Criteria 3 Director of Nursing educated all licensed nursing staff regarding medications that require laboratory monitoring initiated 3/10/2016 and completed on 3/11/2016. Pharmacy consultant educated on 3/9/2016 by Director of Nursing regarding monitoring and recommendation of lab tests for medications requiring monitoring. Criteria 4 Director of Nursing or Unit Manager will monitor all new admissions receiving medications requring laboratory monitoring daily clinical meeting for 4 weeks and monthly for 2 months to ensure labs are ordered accordingly.	

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F 428	Continued From page 27 indicated that the facility's pharmacy consultant had reviewed the resident's drug regimen every month. There was no recommendation made to the attending physician or Director of Nursing for laboratory tests for Digoxin level or Lipid panel for Resident #106. On 2/24/16 at 10:20 AM, the facility's pharmacy consultant was interviewed. He stated that if a resident was on a maintenance dose/low dose of the drug, he did not recommend laboratory tests. The medical records of Resident #106 were again reviewed. A doctor's order was written dated 2/24/16 to obtain Digoxin level, Lipid panel and Liver Function Test (LFT) for the resident. On 2/25/16 at 11:06 AM, the Director of Nursing was interviewed. She stated that she had talked with the Medical Director and he ordered the laboratory tests for Resident #106 on 2/24/16. She added that from now on residents on Digoxin and cholesterol reducing drugs will have the Digoxin level, Lipid panel and Liver Function Test done on admission and as indicated.	F 428	Director of Nursing or Unit Manager will bring all audit tools to monthly QAPI committee to ensure compliance.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520	F 520 It is the act of this facility to maintain an effective quality assessment and assurance committee.	3/24/16

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F 520	Continued From page 28 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation , resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in 7/15/15 complaint survey. Choices (F 242) was originally cited in 7/15/15 complaint survey and again recited on the 2/25/16 recertification/complaint survey. The continued failure of the facility during the two federal surveys of record showed a pattern of the facility ' s inability to sustain an effective QA program. The findings included: This tag is cross referenced to: F 242 - Choices - Based on record review, observation, resident and staff interview, the facility failed to honor choice of time in bathing for one of one sampled resident reviewed for choice in bathing (Resident #167) and failed to honor	F 520	Criteria 1 No effected residents. Criteria 2 All residents residing in facility. The Quality Assurance Consultant educated IDT members on 3/10/16 on QAPI Guidelines per company policy. Criteria 3 The Director of Nursing or QAPI Chairperson will audit monthly QAPI committee meetings for 3 months to ensure effective practice. Criteria 4 The Director of Nursing or QAPI Chairperson will bring audit tools to each QAPI committee and submit to regional QA for company.	

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F 520	Continued From page 29 food choice for one of one sampled resident reviewed for food choices (Resident #23). The facility was cited for F 242 on the complaint survey of 7/15/15 for failure to allow a resident to remain in a food related activity that was being held in the dining room. On 2/25/16 at 11:06 AM, the Director of Nursing (DON) was interviewed regarding their QAA program. The DON indicated that she was the contact person for the facility's QAA program. The members were the administrator, medical director and all the department heads. She indicated that the committee had met monthly and quarterly. The DON indicated that she was aware that F 242 was a repeat tag and she said that the food choices not being honor was due to dietary department had no dietary manager (DM) for quite some time and a new DM just started on Monday (2/22/16). She also stated that she expected residents to receive morning care (bathing/dressing) at least by noon.	F 520		