

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

PRINTED: 07/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/08/2016
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NAME OF PROVIDER OR SUPPLIER  NC STATE VETERANS HOME-BLACK MOUNTAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711
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(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) COMPLETE DATE
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F278  
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 each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

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.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews the facility failed to accurately assess 1 of 13 sampled residents utilizing the Minimum Data Set (MDS) in the area of pressure sores (Resident #96).

F278

This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.

- MDS for Resident #96 was submitted to CMS with correction of coding on 7/8/2016
- Audit performed on any resident with exiting wounds, over boney prominences or pressure related area to identify potential variance in accuracy of coding wounds. Completion date 07/20/2016. 2 Residents identified GP on 7/27/16 and WW 07/19/2016.
- Systemic process change will begin on admission /Readmission.
  - Medical Director and Skin Integrity Coordinator will assesses and evaluate together any wounds over boney prominences or pressure related area to identify and establish staging and treatment plan
  - Wound Integrity Team will include RN Skin Integrity Coordinator, Director of Health Care Services, Minimum Data Set Coordinators, Dietitian who will weekly meet to document and review progress and for lack of with interventions as indicated.
  - Education provided to Skin Integrity Coordinator on 7/29/16 of process change and expectations to include Pruitt University education on coding and identification of Venous, Arterial and Pressure related wound care
  - Education compliance will be monitored by DHS and signed. Education courses provided by Pruitt University will be completed by Skin

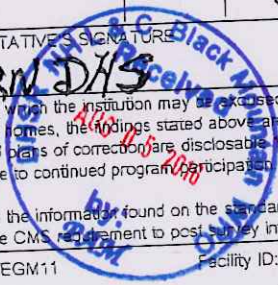
8/5/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Maureen A. Shepard BSN RN DHS*

TITLE  
Electronically Signed

(X6) DATE  
08/05/16

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 the 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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F278	<p>Continued From page 1</p> <p>Resident #96 was admitted to the facility on 02/09/16.</p> <p>A Family Nurse Practitioner (FNP) note dated 02/10/16 indicated Resident #96 had severe progressive peripheral vascular disease and diabetes with bilateral lower extremity foot wounds. Resident #96 had an undetectable pulse in the left lower extremity.</p> <p>A physician's history and physical (H&amp;P) dated 02/16/16 indicated Resident #96 had multiple medical problems including peripheral artery disease with bilateral foot wounds.</p> <p>A foot and ankle physician's note for Resident #96 dated 03/07/16 indicated Resident #96 had a chronic non-pressure ulcer of the left lateral ankle.</p> <p>A significant change Minimum Data Set (MDS) for Resident #96 was dated 03/10/16. The MDS indicated the resident had one unstageable pressure ulcer. Resident #96 was not coded as having any arterial or venous ulcers.</p> <p>An interview was conducted with the wound nurse on 07/05/16 at 2:30 PM with the Director of Nursing (DON) present during the interview. The wound nurse stated she assessed Resident #96's lower extremity wounds on admission. The wound nurse stated she felt Resident #96 had an unstageable pressure ulcer on the left ankle because the wound was over a bony prominence.</p> <p>An interview was conducted with Nurse #1 on 07/07/16 at 9:35 AM who stated the significant change MDS assessment for Resident #96 was incorrectly coded under Section M/skin</p>	F278	<p><i>Integrity nurse and education completion will be monitored by DHS, completion date 7/31/16.</i></p> <p>e. Education provided to Skin Integrity Team on <u>07/28/2016</u> of process change and expectations</p> <p>f. Minimum Data Set nurses will be educated by Director of Health Services OR <i>designee</i> on <i>CRC</i> accuracy and research of information to ensure appropriate coding and subsequent documentation in the Minimum Data Set, individualized Care Plan and subsequent data submission</p> <p>f. <u>New partners will be educated on initial orientation and during job specific orientation of duties</u></p> <p>4. Monitoring of compliance of will be performed</p> <p>3x/week for 2 weeks 2x/week for 2 weeks 1x/week for 4 weeks Monthly for 2 months or until compliance deemed met</p> <p>All monitoring data will be submitted to Quality Assurance and Performance Improvement Committee for review and ongoing monitoring of compliance or change as indicated</p>	<p>8/5/16</p>
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F278	<p>Continued From page 2</p> <p>condition. Nurse #1 stated the significant change MDS assessment dated 03/10/16 should not have been coded to indicate Resident #96 had an unstageable pressure ulcer. Nurse #1 stated Resident #96's significant change MDS assessment dated 03/10/16 should have been coded to reflect the number of venous and arterial ulcers. Nurse #1 verified the physician's note dated 03/07/16 indicated Resident #96 did not have pressure ulcers and the physician's note was written during the look back period for completing the significant change MDS assessment for Resident #96. Nurse #1 stated a correction to Resident #96's significant change MDS assessment dated 03/10/16 would be completed immediately to reflect the number of venous and arterial ulcers rather than pressure ulcers.</p> <p>On 07/07/16 at 11:37 AM an interview was conducted with the DON who stated she verified in the medical record that Resident #96 had arterial and venous ulcers and did not have pressure ulcers and the significant change MDS assessment dated 03/10/16 was miscoded. The DON stated her expectation was that Nurse #1 would have reviewed all the information available in Resident #96's medical record including documents from Resident #96's transferring facility prior to completing Section M/skin condition.</p> <p>On 07/08/2016 at 8:25 AM an interview was conducted with the Administrator. The Administrator stated her expectation was that the wound nurse, physician, DON, and Case Mix nurse would have collaboratively discussed the type of Resident #96's wounds to assure accuracy of wound type prior to the Case Mix nurse coding the MDS assessment for Resident #96.</p>	F278	<p>5. DHS/designee will continue providing education for MDS Coordinator for proper coding of all new and/or current wounds and Wound Care Integrity Team comprised of DHS, Wound Care Skin Integrity Nurse, Dietitian and MDS will meet, evaluate and code all new, existing wounds in facility by 8-05-16. All new admissions with wounds will be evaluated by Skin Integrity Nurse and Medical Director prior to coding and evaluation.</p>	

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F278	Continued From page 3	F278		
F315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and interviews the facility failed to arrange a urology consult for 1 of 2 residents with a catheter to determine the continued need for use of the catheter. (Resident #125).</p> <p>The findings included:</p> <p>Resident #125 was admitted to the facility 06/14/16 with diagnoses which included dementia with behavioral disturbance, cognitive communication deficits, rhabdomyolosis, retention of urine and enlarged prostate without lower urinary tract symptoms.</p> <p>Prior to admission Resident #125 was hospitalized from 06/05/16 - 06/14/16 with diagnoses including a staphylococcal urinary tract infection. The hospital discharge summary noted, Unfortunately patient has history of urinary retention, he has had multiple ins and outs (catheters), required urologic consultation</p>	F315	<p>This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.</p> <ol style="list-style-type: none"> <li>1. Resident # 125 urology consult obtained for 7/11/2016</li> <li>2. Audit of Consult orders from May 1st, 2016 to 7/8/2016 (last day of <del>Survey</del> performed and completed on <u>07/27/2016</u> to establish consult compliance and scheduling. Any consults found in need of scheduling will be processed with the new system intervention</li> <li>3. Following Systems change is implemented to validate consult compliance and scheduling             <ol style="list-style-type: none"> <li>a. Senior Care Partner/designee will collect/received all consult orders. Determination will be made by the Senior Care Partner/Designee whether the Resident designated as a Veteran Consult with the Veterans Administration Process, or if the consult is based as a civilian Medical Consult.</li> <li>b. All Veteran Administration Consults will be processed via the Senior Care Partner/Designee to the Veteran Services Officer with appropriate paperwork and documentation. The Veteran Services Officer will then notify,</li> </ol> </li> </ol>	8-05-2016

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F315	<p>Continued From page 4 for Foley placement; will need to follow-up with urology as outpatient for possible catheter removal.</p> <p>The admission Minimum Data Set dated 06/21/16 assessed Resident #125 with severe cognitive impairment, noted use of a catheter and that Resident #125 had a urinary tract infection in the last 30 days. The admission Care Area Assessment for the catheter included: Resident is a new admission as of 06/14/16 from the hospital. He is admitted to us with a Foley catheter in place. He has a diagnosis of urinary retention. Foley puts him at risk for complications. Will address possible removal of catheter to see if he is able to void. Will proceed to care plan.</p> <p>Review of physician orders on admission noted medications for Resident #125 included: Cefazolin (an antibiotic) 2 grams every 8 hours intravenously for 6 days for urinary tract infection. Review of the June 2016 Medication Administration Record (MAR) for Resident #125 noted the Cefazolin was administered from June 15, 2016 - June 20, 2016.</p> <p>The admission care plan dated 06/21/16 for Resident #125 included the following problem areas:</p> <p>a. Potential for injury related to presence of indwelling catheter. Approaches to this problem area included: -secure catheter to thigh to prevent pulling on tubing. -implement bladder program -report any temperature elevations to physician -observe and document urine appearance and report any abnormalities to physician</p> <p>b. Resident displays increasing behaviors of dementia. Can become agitated.</p>	F315	<p>Senior Care Partner, Director of Health Services, Administrator and Transportation Coordinator of consult appointment time. Transportation Coordinator will then validate content of appropriate paperwork and data and arrange transportation as indicated.</p> <p>c. All Civilian Medical Consults will be submitted by the Senior Care Partner/Designee to the Transportation coordinator for setting up consult, compiling necessary paper work and arranging transportation.</p> <p>d. The Senior Care Partner or Designee will be responsible to create and maintain a log that will include tracking of and review of ordered consults without subsequent validation of scheduling appointment.</p> <ol style="list-style-type: none"> <li>1. Consult order date</li> <li>2. Designation to Civilian/Veteran Services Date</li> <li>3. Date of Scheduled Consult</li> <li>4. Date of Transport to scheduled Consult</li> </ol> <p>e. Education to Senior Care Partner, Veteran Services Officer and Transportation department by Director of Health Services with system change implementation. 07/27/2016.</p> <p>f. New partners will be educated on initial orientation and during job specific orientation of duties</p> <p>4. Monitoring of compliance of will be performed</p>	

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F315	<p>Continued From page 5</p> <p>c. Resident has impaired decision making/memory deficits and has communication deficits related to dementia. Approaches to this problem area included:</p> <ul style="list-style-type: none"> <li>-monitor for signs/symptoms of discomfort/pain such as facial grimacing, guarding, crying, etc.</li> <li>-staff to anticipate and meet needs of resident</li> <li>-monitor and document patient behavior. Report any change in cognitive status to physician</li> </ul> <p>An initial progress note dated 06/17/16 by the Family Nurse Practitioner (FNP) for Resident #125 included that Resident #125 was seen for management of urinary tract infection and severe dementia with behavioral changes. Included with orders from this visit was a urology referral.</p> <p>Review of nurses notes in the medical record of Resident #125 noted the following: 06/15/16-Resident #125 had frequent attempts to remove the catheter 06/24/16-New Foley catheter placed by this nurse on 06/23/16 due to obstruction. Able to insert catheter with minimal difficulty. Resident tolerated fairly well with comforting and redirection from staff. Moderate amount of frank blood noted from meatus with no obvious wound. Bleeding subsided soon after placement and new catheter drained clear urine. Resident has history of tugging at Foley and has likely caused some urethral trauma as a result, which will bear monitoring. Catheter orders have remained in place including checking each shift to make sure tubing is secured to leg with no tension on line. Communication left for physician that resident did not have catheter prior to hospitalization per family and asking if physician might consider trial removal of catheter. 06/26/16-Resident pulled out peripherally</p>	F315	<p>3x/week for 2 weeks 2x/week for 2 weeks 1x/week for 4 weeks Monthly for 2 months or until compliance deemed met</p> <p>All monitoring data will be submitted to Quality Assurance and Performance Improvement Committee for review and ongoing monitoring of compliance or change as indicated</p> <p><i>5. Education and Compliance will be monitored by MOS Coordinator/designee. DHS will monitor as oversight if issues arise AND issues will be addressed by Quality Assurance and Performance Improvement Committee.</i></p>	8/05/16

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F315	<p>Continued From page 6 inserted central catheter (PICC) line (that had been used for intravenous antibiotic administration) 06/29/16-Pulling at catheter but calmed down after medication 07/04/16-Called into resident room-resident was getting personal care done-nursing assistants noticed the meatus on penis had a tear on the posterior (measuring 1 X 2 cm). Resident does have a habit of jerking on catheter and is redirected-wound care notified-will continue to monitor.</p> <p>On 07/07/16 at 3:15 PM Nurse #3 stated orders for consult physician appointments were made by a liaison between the facility and the Veterans Hospital. Nurse #3 stated the liaison was on leave but the transportation aide would be aware if an appointment had been made.</p> <p>On 07/07/16 at 3:00 PM the transportation aide stated she coordinated transportation to physician visits outside the facility with the liaison that received orders for consults. The transportation aide stated she wasn't aware of an appointment with a urologist for Resident #125.</p> <p>On 07/07/16 at 3:18 PM Nurse #4 stated when an order for a consult was received nursing staff was responsible for filling out the Urology Consult-VA form located in the consult book. Nurse #4 stated this form and a copy of the physician order would be placed in the box of the liaison so the Veterans Hospital could be contacted to arrange an appointment. Nurse #4 stated she primarily worked on the unit where Resident #125 resided and wasn't aware of any attempts made to remove the catheter for trial voiding. Nurse #4 stated for some residents a decision was made to see a urologist before</p>	F315		

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F315	<p>Continued From page 7 attempts were made to remove the catheter for trial voiding.</p> <p>On 07/08/16 at 9:07 AM Nurse #2 (who wrote the referenced nurses note dated 06/24/16) stated she recalled writing a note in the physician communication book on 06/24/16 about possible removal of the catheter and trial voiding for Resident #125 but did not recall a response to the note. Nurse #2 stated she was aware there was a urology consult ordered for Resident # 125 and noted the physician may make a decision based on the consult.</p> <p>On 07/08/16 at 9:25 AM unsuccessful attempts were made to telephone interview Nurse #5 (who worked night shift) that took the order for the urology consult on 06/17/16 to determine if the need for the consult had been communicated to the liaison.</p> <p>On 07/08/16 at 10:35 AM a telephone interview was conducted with the liaison. The liaison stated he did not work for the facility but worked with the facility and the Veterans Hospital to schedule any appointments. The liaison stated he was dependent on staff to inform him of any consult orders and, once received, he sent the need for the consult to a physician at the Veterans Hospital. The liaison stated the request was reviewed by this physician and, if approved, the consult order was sent to the specialty clinic to make an appointment. The liaison stated the clinic informed the transportation aide of the appointment so transportation could be arranged. The liaison stated there wasn't a system in place to track to ensure consults were addressed and that he was not able to look in the system to see if an appointment was made. The liaison stated sometimes the nurses, physician or family would</p>	F315		

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F315	<p>Continued From page 8</p> <p>ask about an appointment and that is when he would determine if he had received the initial request. The liaison stated if there was a question, the transportation aide could call the specialty clinic to see if an appointment had been made.</p> <p>On 07/08/16 at 10:40 AM the administrator stated she was able to access the files in the office of the liaison and that it appeared he had never received the order for the urology consult for Resident #125 on 06/17/16 so it had not been sent to the Veterans Hospital for review. The administrator stated the liaison was dependent on the nurses sending the order and Urology Consult-VA sheet so it could be sent to the Veterans Hospital for approval. The administrator stated if approval was not given the facility would be informed so the physician and family could decide how to proceed. The administrator stated that typically the day shift nurses are involved with communicating the need for consult appointments with the liaison. The administrator stated she had not been able to reach night shift Nurse #5 to determine if she had communicated the need for the consult to the liaison so she was not sure where the breakdown in the order occurred. The administrator stated there was not a system in place to track consults to ensure appointments were made as ordered.</p> <p>On 07/08/16 at 11:50 AM the Director of Nursing (DON) stated recommendations placed in the physician communication book were reviewed by the physician and then she reviewed them to ensure the issue was addressed. The DON stated the recommendations were not kept once they had been reviewed. The DON could not recall the specific recommendation related to the catheter for Resident #125 but felt the urologist</p>	F315		

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F315	Continued From page 9 would make the determination if a trial void could be attempted for Resident #125.  On 07/08/16 at 12:45 PM the FNP for Resident #125 was interviewed and noted that Resident #125 was a very complicated case and she ordered the urology consult on 06/17/16 so the urologist could make the determination if the catheter could be removed. The FNP stated she wrote the order just after Resident #125 was admitted with hopes that he could be seen by the urologist after completion of the intravenous antibiotics. The FNP stated usually she did trial voiding on residents right after admission but because of circumstances surrounding Resident #125 she wanted the urologist to make that determination. The FNP stated she was not aware the urology consult had not been addressed by facility staff and that the VA had not been contacted for an appointment.	F315		
F329 SS=D	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 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:	F329	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.  1. Resident #64 Seroquel orders were clarified and corrected on 07/06/2016  2. All Residents with Seroquel reduction orders May 1st, 2016 thru July 8th, 2016 (last day of survey) audited with no further variances observed  3. Systems Change will include the following process	8/15/16

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F329	<p>Continued From page 10 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:</p> <p>Based on observations, record review and staff interview, the facility failed to decrease the dosage of an antipsychotic medication as ordered by the physician and increased the dosage instead for 1 of 5 residents reviewed for unnecessary medication. (Resident #64).</p> <p>The findings included:</p> <p>Resident #64 was admitted to the facility on 05/23/16 with diagnoses which included: diabetes mellitus type 2, atrial fibrillation, hypertension, chronic obstructive pulmonary disease and dementia.</p> <p>The admission Minimum Data Set (MDS) assessment dated 05/30/16 indicated Resident #64 had no delirium, psychosis, behavioral symptoms or rejection of care and required limited assistance with activities of daily living. The MDS indicated he had no history of falls prior to admission and received antipsychotic medication for 7 days of observation period. The admission Care Area Assessment summary for psychotropic drug use indicated he was on Seroquel for behaviors associated with dementia and was at increased risk for falls due to dizziness, which is a side effect of Seroquel.</p> <p>Review of the admission care plan for Resident #64 revealed it addressed his need for psychotropic medication for behaviors</p>	F329	<p>a. Nurses will perform a 24 hour chart check every night initialing last order in red ink to validate review for accuracy, cross check and correct transcription from physicians order to Medication Administration Record and/or the Treatment Administration Record</p> <p>b. All current licensed nurses will be educated on this process and subsequent expectation of compliance by <u>July 31st</u> 2016. Any Licensed partners who have not completed the education will be taken off the schedule until compliance is met with education requirements.</p> <p>c. New partners will be educated on initial orientation and during job specific orientation of duties</p> <p><i>d. ALL education and monitoring will be provided by Clinical Care Nurse.</i></p> <p>4. Monitoring of compliance of will be performed</p> <p>3x/week for 2 weeks 2x/week for 2 weeks 1x/week for 4 weeks Monthly for 2 months or until compliance deemed met</p> <p>All monitoring data will be submitted to Quality Assurance and Performance Improvement Committee for review and ongoing monitoring of compliance or change as indicated.</p>	

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F329	<p>Continued From page 11 associated with dementia. Interventions included to monitor for adverse side effects of medication including dizziness.</p> <p>Review of the nurses notes did not reveal any documentation of Resident #64 having any behavioral problems.</p> <p>Review of the drug regimen reviews completed by the pharmacist revealed a recommendation dated 05/27/16 to begin a gradual dose reduction of Seroquel (Quetiapine), an antipsychotic medication. The recommendation was signed as reviewed by Resident #64's physician on 06/07/16.</p> <p>Review of Resident #64's admission physician orders revealed they included an order for Seroquel 25 milligrams (mg) one-half tablet twice a day. A physician order dated 06/07/16 read: "decrease Seroquel to 12.5 mg every night only." The order was signed as transcribed by Nurse #6. The July 2016 printed monthly recapitulation of physician's orders listed Quetiapine 25 mg one-half tablet (12.5 mg) at bedtime which was marked out. Written in on the orders was Seroquel 25 mg one by mouth daily. The July 2016 monthly recapitulation of physician's orders was signed as reviewed by Nurse #7 on 06/27/16 and by Nurse # 8 on 06/29/16</p> <p>Review of the June 2016 Medication Administration Record (MAR) revealed the Seroquel 25 mg one-half tablet twice a day was discontinued on 06/07/16. Added to the June 2016 MAR on 06/07/16 was: Seroquel 25 mg one tablet every morning and Seroquel 12.5 mg every night. Nurses' initials on the June 2016 MAR indicated the Seroquel was given as transcribed. Review of the July 2016 MAR</p>	F329		

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F329	<p>Continued From page 12</p> <p>revealed Seroquel 25 mg one every morning hand-written on the MAR. Printed on the July 2016 MAR was Quetiapine 25 mg one-half tab by mouth at bedtime. Nurses initials on the July 2016 MAR indicated the Seroquel was given as transcribed.</p> <p>An interview on 07/08/16 at 10:33 AM with Nurse #6 revealed he interpreted the order on 06/07/16 to mean to decrease only the bedtime dose of Seroquel to 12.5 mg. When asked to review the order dated 05/23/16 for Seroquel 25 mg one-half tab twice a day, he was unable to provide any additional explanation.</p> <p>Observation with Nurse #6 on 07/08/16 at 10:33 AM of Resident #64's medications, which were supplied by the pharmacy in individual dose packs, revealed Seroquel 25 mg one-half tablet in a package which was labeled for administration on 07/08/16 at 9:00 PM. Nurse #6 stated he pulled Seroquel 25 mg one tab from the facility's house stock and administered it on 07/08/16 at 7:00 AM.</p> <p>Attempts to reach Nurse #7 and Nurse #8 on 07/08/16 were unsuccessful.</p> <p>An interview with the Director of Nursing (DON) on 07/08/16 at 3:30 PM revealed the facility's system for ensuring accuracy of medication transcription was that the nurse working the night shift was responsible for checking all new orders with the MAR to verify they were transcribed correctly. The DON was unable to verify that the 06/07/16 order was checked by the night shift nurse. The DON verified that the physician's order to decrease Resident #64's Seroquel dosage was transcribed incorrectly. The DON stated at the end of each month two different nurses were assigned to compare the</p>	F329		

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F329	Continued From page 13 monthly recapitulation of physician's orders with the original order and with the MAR.  An interview with the Administrator on 07/08/16 at 3:59 PM revealed she expected the nurses to follow the "Five rights of medication administration: right medication, right dose, right time, right resident and right route" when transcribing medication orders and administering medications. The Administrator stated she expected the nurses to ask for clarification from the prescriber if an order was unclear. The Administrator verified that the physician's order to decrease Resident #64's Seroquel dosage was transcribed incorrectly.	F329	Medical Records Coordinator will evaluate Compliance during monthly/weekly Audits and report results to Director of Health Care Services for follow up.	
F514 SS=D	483.75(I)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  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 and staff interview the facility failed to accurately document current medications in medical practitioner's progress notes for 1 of 13 residents. (Resident #81).  The findings included:	F514	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws.  1. Dictation of Resident # 81 was corrected by FNP and placed in the Medical Record on <u>7/8/2016</u>  2. All Residents evaluated by FNP have a potential need for updated medications from last visit.  3. System implemented to facilitate hands on changes with veterans; visited.  a. Updated copy of Medication Administration Record and Treatment Administration Record will be provided for practitioners on visit days.	8/5/16

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F514	<p>Continued From page 14</p> <p>Resident #81 was admitted to the facility on 04/15/15 with diagnoses including Parkinson's disease, hypertension, coronary artery disease and Lewy body dementia with hallucinations and paranoia.</p> <p>An Annual Minimum Data Set (MDS) assessment dated 04/14/16 indicated Resident #81 was cognitively intact for daily decision making and had no delirium, psychosis, behavioral symptoms or rejection of care. The MDS indicated he required extensive assistance with all activities of daily living except walking in room or corridor and eating for which he required limited assistance. The MDS indicated he received antipsychotic medication for 7 days of the observation period.</p> <p>A Care Plan which was last updated on 04/14/16 addressed Resident #81's multiple medical conditions and need for antipsychotic medication. Interventions were appropriate to address resident's needs and including monitoring for effectiveness and adverse side effects of medication.</p> <p>Review of Resident #81's physician progress notes revealed he was being followed closely by a psychiatrist and the dosage of Seroquel, an antipsychotic medication, was being gradually increased to treat psychosis associated with Lewy body dementia. Gradual dose reduction of Seroquel was contraindicated per 06/03/16 note by psychiatrist, which read in part: "When last seen for mental health review at the end of April, Seroquel was increased to address suspiciousness and paranoia. No adverse effects have been identified. Nursing staff today indicate that he has been stable psychiatrically and behaviorally with no new concerns</p>	F514	<p>b. Medical Record availability will be monitored by nurses to facilitate accurate documentation by practitioner of updated changes.</p> <p>c. FNP education provided telephonically by Medical Director regarding expectations of accurate updated medication documentation on visits and <i>Follow up</i> — —</p> <p>d. All current licensed nurses will be educated on this process and subsequent expectation of compliance by July 31st, 2016. Any Licensed partners who have not completed the education will be taken off the schedule until compliance is met with education requirements. <i>Clinical Care nurse will provide education and monitoring for compliance.</i></p> <p>e. New partners will be educated on initial orientation and during job specific <b>ORIENTATION OF DUTIES</b></p> <p>f. Monitoring of compliance of will be performed</p> <p>3x/week for 2 weeks 2x/week for 2 weeks 1x/week for 4 weeks Monthly for 2 months or until compliance deemed met</p> <p>All monitoring data will be submitted to Quality Assurance and Performance Improvement Committee for review and ongoing monitoring of compliance or change as indicated</p>	

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F514	<p>Continued From page 15 identified. Nursing notes do not reflect any recent psychotic symptomatology, the most recent difficulties being prior to the increase of Seroquel. He does specifically deny any suspiciousness or feelings that others are trying to harm him. No additional hallucinations have been reported, either. Patient does appear to have benefited from the increase of Seroquel without adverse effect identified. Continue psychotropic medications as presently prescribed. Patient is stable at current doses. Dose reduction attempt at this time would risk decompensation of patient."</p> <p>Review of physician's orders revealed the following orders: 04/28/16 - Seroquel 25 milligrams (mg) one tablet twice daily at 9:00 AM and 3:00 PM and Seroquel 50 mg three tablets at bedtime. 03/14/16 - Seroquel 25 mg one tablet daily after lunch and Seroquel 100 mg every night. 12/31/15 - Seroquel 25 mg one-half tablet every morning and every evening at 4:00 PM and three tablets (75 mg) every night.</p> <p>Further review of physician's progress notes revealed Resident #81 was seen by the Nurse Practitioner (NP) and medications were reviewed as follows: 04/08/16 - the medication list indicated Seroquel 12.5 mg 1-one-half tab every morning and at 4:00 PM and Seroquel 25 mg 3 tablets at bedtime, which was incorrect as noted in physician's orders dated 03/14/16. 05/06/16 - the medication list indicated Seroquel 25 mg at 1:00 PM and 100 mg every night, which was incorrect as noted in physician's orders dated 04/28/16. 05/11/16 and 06/24/16 - the medication list indicated Seroquel 12.5 mg one-half tablet every morning and at 4:00 PM and Seroquel 25 mg 3</p>	F514		

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F514	<p>Continued From page 16 tablets at bedtime, which was incorrect as noted in physician's orders dated 04/28/16.</p> <p>On 07/08/16 at 12:18 PM an interview with the NP about her system for reviewing a resident's medications when she visited revealed she looked at the medications listed in the progress notes from the most recent visit then looked at any new orders or changes and updated the medication list at that time. The NP stated she didn't always look at every medication on the list at each visit unless the visit was for a condition that the medication was treating. The NP stated she thought she updated the Seroquel dosage on 05/06/16 with the dose change that was made in March and possibly didn't realize the dose had increased further. The NP reviewed the 05/11/16 and 06/24/16 note and stated she thought the change she put in on 05/06/16 didn't get saved by the system. The NP stated the list should be up to date with medication changes and acknowledged that it wasn't current with Resident #81's current medication regimen.</p> <p>An interview on 07/08/16 at 12:38 PM with the Director of Nursing (DON) revealed her expectation was that the medications listed on the physician's progress notes should be accurate with what the resident was currently receiving because those notes were sent out with the resident if they required hospitalization. The DON further stated she expected the medical staff to review the resident's current Medication Administration Record when they visited.</p> <p>An interview on 07/08/16 at 4:02 PM with the Administrator revealed she expected the medical staff to document accurate information on the progress notes about the resident's current medication doses.</p>	F514	<ol style="list-style-type: none"> <li>1. Nurse Practitioner will review current medication records during time of visit and have current medication record reviewed during time of dictation during each visit.</li> <li>2. Nurse Practitioner will also review any current changes in Medications and or dosages that are in the record per other medical health care providers assuring accuracy of medication changes during each visit prior to dictation.</li> </ol>	

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