STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING ______ B. WING ______	C 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	**968 EAST WAIT AVENUE** **WAKE FOREST, NC 27587**

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint survey. Event #BA7J11.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to transfer a resident according to the care guide for 1 of 4 residents reviewed that required a mechanical lift for transfer (resident #125). Findings included: The resident was admitted on 1/22/16 with current diagnoses of dementia, anemia, dysphagia, arthritis and repeat falls. The resident had care plans in place for potential in further decline in upper and lower extremities due to weakness and dementia dated 2/17/16, anticoagulant therapy dated 1/22/16, falls dated 1/22/16 and incontinence. The resident ' s Minimum Data Set (MDS) dated 4/29/16 revealed the resident was severely cognitively impaired. The resident required extensive assistance with transfers, bed mobility, eating, personal hygiene and dressing. The resident required total assistance with locomotion and toilet use. The resident was not steady when moving from a seated to standing positon, walking, turning around or surface to surface transfers. The resident had upper extremity	F 282	#1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 7-28-16 the Staff Development Coordinator initiated an ongoing in-service, that included NA #1, on Care Guide requirements and those residents currently requiring Tempo Lift transfers. Resident #125 care plan, care guide and current transfer status was reviewed by the MDS coordinator during the survey process. All information was found to be accurate. The nursing assistants were re-educated by the Staff Development Coordinator on following care plans and care guides during resident transfers. #2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; An audit was completed by the Staff Development Coordinator during the survey process to ensure the continued	8/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/09/2016

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

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F 282	Continued From page 1 impairment and was always incontinent of urine. The resident was unable to be interviewed due to impaired cognition. Physician telephone order sheet dated 6/14/16 revealed to use the sling lift for transfers. The resident ' s Medication Administration Record (MAR) from 7/1/16 through 7/31/16 revealed the resident was to use the sling lift for all transfers with an initiation date of 6/14/16. Occupational therapy note dated 7/7/16 revealed the resident was non-ambulatory and had very limited use of her bilateral upper and lower extremities. The resident was dependent for Activities of Daily living (ADLs) and required maximum assistance with transfers. The resident ' s right knee was held in 45 degree flexion when supine and tucked under chair in > 100 degree flexion. The resident ' s left knee was able to extend in supine position, but kept tucked under the wheelchair as well. A nursing note dated 6/14/16 stated to use sling lift for all transfers. The ADL log sheet dated 7/1/16 through 7/20/16 revealed the resident required total dependence for transfers with one to two person assistance. Nursing assistant #1 was interviewed on 7/21/16 at 9:14 AM. She stated the resident required total dependence and required one person assistance. She stated she would pick the resident up to put her in the bed or chair. The resident was checked and changed every 2 hours and at the end of 2nd shift. The resident had to be placed in the bed when she needed to be changed. An observation was made on 7/21/16 at 9:21 AM of Nursing Assistant #1 performing incontinent care. The resident was lifted under the arms by NA #1 from the wheelchair and placed in the bed. The resident was unable to assist in any part of the transfer and was unable to follow simple	F 282	compliance for all residents requiring the use of a mechanical lifts for transfers, according to the most current care plan assessment. The audit also included the review and updating of Care Guides. This audit was completed on 8-5-16 and corrections were made as identified. The Staff Development Coordinator in-serviced nursing assistants on resident transfers and following resident care guides between August 4, 2016 and August 8, 2016. #3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur; The Staff Development Coordinator will conduct random monitoring weekly of nursing assistants actual use of care guides as they are providing care, including but not limited to performing appropriate transfers using correct methods and or mechanical lift devices according to residents current care guide. The Staff Development Coordinator or designee will audit one transfer per unit per week to include all halls, all shifts and weekends. The monitoring tools/audits will continue to be completed by the Staff Development Coordinator weekly for four weeks, then monthly for three months. All residents will continue to be assessed upon admission to the facility, at the time of any change in status and quarterly, for appropriate transfer status care planning. The Staff development Coordinator will continue to provide to nursing assistants during new employee orientation and as	

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F 282	Continued From page 2 commands. The resident ' s hands were contracted in a fisting position and was unable to hold onto NA#1 during the transfer. The resident was changed in the bed. The resident was seated on the very edge of the bed, which required assistance from NA #1 to hold the resident in the upright position. The resident was then picked up under her arms by NA #1 and placed back in the wheelchair. The resident was unable to assist with both transfers. Nurse #1 was interviewed on 7/21/16 at 9:57 AM. She stated the resident required assistance with feeding, dressing, and all Activities of Daily living. The resident required maximum assistance for transfers. She stated the resident used the sling lift and it took one NA to transfer. The MDS assistant was interviewed on 7/21/16 at 11:12AM. She stated when a resident required a tempo lift, the facility policy is they need a second person for assistance. She stated that she didn ' t think the resident could not hold on to the standing lift due to her dementia per staff. It was determined the resident was more appropriate for the sling lift. She was the one to write the telephone order. She stated she also entered this under the care guides section of ADLs interventions and this appeared under " scheduled care " on the kiosk that each NA documents on when they pull up the care guide. They are supposed to use the sling lift for all transfers. On 7/21/16 at 1:38 PM, NA #1 pulled up the care tracker kiosk on a computer and logged in. The care tracker stated the resident required the use of the sling lift. NA #1 questioned if she had to use the lift for every transfers because it was in care tracker and went in the equipment room and demonstrated which lift was the sling lift. The Director of Nursing was interviewed on	F 282	needed appropriate transfer status for residents and following resident care guides. #4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Care Plans for all residents to be updated daily, as needed, to ensure continued compliance of the written plan of care. The monitoring tools/audits will continue to be completed by the Staff Development Coordinator weekly for four weeks, then monthly for three months. The Director of Nursing will present the audits to the Quality Assurance Performance Improvement committee, monthly for review and recommendation.	

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F 282	Continued From page 3 7/21/16 at 2:25 PM. He stated that falls would be discussed this week during the Friday morning meeting. He would expect the interventions to be discussed, implemented, care planned, monitored and evaluated.	F 282		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to allow a sufficient period of time to elapse between the administration of opioid pain medication doses as specified by physician orders for 1 of 5 residents reviewed (Resident #42) receiving a pain medication on an as needed basis. The findings included: Resident #42 was admitted to the facility on 2/28/11 from another nursing home or swing bed. The resident's cumulative diagnoses included heart failure, chronic obstructive pulmonary disease, and chronic kidney disease. A review of the resident's medical record revealed comfort measures were initiated on 6/1/14. A review of the resident's current physician orders included the following medications, in part: 100 milligrams (mg) / 5 milliliters (ml) morphine sulfate solution (an opioid pain medication) to be given as 0.25 ml by mouth under the tongue every 12 hours as needed for pain (last ordered	F 333	#1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The provider for resident #42 was notified of the resident receiving the opioid medication before the prescribed time. The provider felt that receiving the medication before the prescribed time caused no harm and as the resident is on comfort care changed the physician's order on 8-4-16 to every four hours as needed. Nurse #2 was counseled by the unit manager on 8-4-16 regarding the deficient practice. The weekend supervisor will conduct a medication pass audit on 8-6-16 with nurse #2 to ensure that she is competent with proper medication administration. #2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Residents who have orders for as needed	8/8/16

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F 333	Continued From page 4 on 3/21/16); and, 12 micrograms / hour fentanyl patch (an opioid pain medication applied topically) to be applied as one patch every 3 days (last ordered on 5/31/16). Resident #42's most recent quarterly Minimum Data Set (MDS) assessment was dated 4/20/16. The MDS indicated Resident #42 had severely impaired cognitive skills for daily decision making. She required extensive assistance from staff for all of her Activities of Daily Living, with the exception of being totally dependent on staff for dressing and bathing. The MDS assessment also revealed Resident #42 received pain medication on a scheduled and as needed basis for pain symptoms observed one to two days out of 7 days during the look back period. A review of the front and back of the July 2016 Medication Administration Record for Resident #42 revealed the resident received 2 doses of morphine during the month to date (one dose on 7/11/16 and one dose on 7/14/16). However, no doses were documented as given to Resident #42 on 7/9/16. A review of the July 2016 narcotic log records indicated two doses of morphine were withdrawn from the medication cart for the resident on 7/9/16; one dose was pulled from the cart at 8:00 AM and a second dose was pulled at 5:00 PM on 7/9/16. Based on information from the narcotic log, only 9 hours had elapsed between the withdrawals of the two morphine doses from the medication cart for Resident #42 on 7/9/16. A review of the resident's paper and electronic medical record revealed no Nursing Notes were made on 7/9/16. There was no documentation in regards to an assessment of the resident's pain	F 333	opioid medications were audited by the Staff Development Coordinator for proper administration of medication, proper interval of time administered and proper documentation for controlled substances. This audit was completed on 8-4-16 and any deficient practices were identified and corrected. This is being done on a daily basis by the Staff Development Coordinator, started on 8-1-16. Any deficient practice will be identified and corrected this is being done daily. #3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur; The facility policy for medication administration was reviewed by the Director of Nursing on 8-4-16 and remains current. The Staff Development Coordinator conducted a facility wide audit of all PRN opioid use on 8-4-16 and any deficient practice identified and corrected. The Staff Development Coordinator in-serviced licensed staff on proper medication administration and the facility policy and procedures on medication administration on 8-4-16 thru 8-8-16 and as needed. The Staff Development Coordinator or designee will monitor medication passes for compliance five times a week for four weeks then monthly for three months starting 8-1-16. This will include med passes on all halls, all shifts and weekends. All newly hired licensed staff will be monitored for medication administration competency and all licensed staff annually and as needed.	

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F 333	Continued From page 5 or effectiveness of pain medication given on that date. Further review of the medical record revealed there was no documentation of Resident #42's vital signs (including respiration rate) on 7/9/16. No documentation was available to indicate the resident was monitored for the potential adverse effects of the opioid pain medications administered. A telephone interview was conducted on 7/21/16 at 1:30 PM with Nurse #2. Nurse #2 was identified by her signature on the July 2016 narcotic log as having withdrawn the two doses of morphine from the medication cart on 7/9/16 for Resident #42. During the interview, the nurse discussed the process she typically employed before administering an as needed (PRN) pain medication to a resident. Nurse #2 reported if she assessed a resident to be in pain, she would first try to utilize alternative, non-drug interventions to try to manage the pain. If use of a PRN pain medication was deemed appropriate, the nurse reported she would pull the medication from the med cart, document the withdrawal of the medication on the narcotic log, administer the medication, then document the medication was given to the resident on both the front and back of the MAR. Additionally, Nurse #2 reported she would document the effectiveness of the pain medication given to the resident on the back of the MAR. Upon inquiry, Nurse #2 confirmed the times recorded on the narcotic log for the withdrawal of morphine from the medication cart were the same as the times she administered the two doses of morphine to Resident #42 on 7/9/16. Nurse #2 reported when she gave Resident #42 the second dose of morphine at 5:00 PM on 7/9/16, she did not realize it was three hours sooner than the physician's order allowed. Nurse	F 333	The pharmacy consultant will monitor medication pass on 8-19-16. #4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The results of the medication pass observations will be reported to the Director of Nursing who will present the results to the Quality Assurance Performance Improvement committee, monthly for review and recommendations.	

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F 333	Continued From page 6 #2 stated if the resident was in pain and she knew it was too early to give another dose of pain medication, she would have called the physician to see if she could give the resident something else. However, the nurse stated she did not call the physician on 7/9/16 because she did not realize it was too early to give another dose of morphine to Resident #42. An interview was conducted on 7/21/16 at 2:15 PM with the facility's Director of Nursing (DON). The DON reported he expected all physician medication orders to be followed, including the timing of medication administration to a resident.	F 333		
F 514 SS=D	483.75(l)(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 reviews and staff interviews the facility failed to document the administration of Levemir (a long-acting human insulin) for 1 of 5 residents reviewed for unnecessary drugs.	F 514	#1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;	8/11/16

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F 514	Continued From page 7 (Resident #100) Findings included: Resident #100 was admitted to the facility on 6/12/15 with cumulative diagnoses which included diabetes mellitus. Review of the May 2016 physician ' s orders revealed Levemir 40 Units (U) subcutaneous (SQ) injection daily at bedtime and blood sugar checks weekly. Review of the Medication Administration Record (MAR) revealed blood sugar results as noted below: ---On 5/5/16 103 milligrams per deciliter (mg/dl). The normal reference range was 70 mg/dl to 100 mg/dl. ---On 5/12/16 149 mg/dl. ---On 5/19/16 92 mg/dl ---On 5/25/16 100 mg/dl Review of the Medication Administration Record (MAR) revealed Levemir 40 units once daily was scheduled to be administered at 9 PM. Continued review of the MAR revealed on 5/6/16 through 5/8/16, 5/14/16-5/15/16, 5/22/16 and 5/28/16-5/29/16 revealed no documentation or written entry that Levemir 40 U SQ was administered. Interview on 07/21/2016 at 11:15 AM via the phone with Nurse #3 (who worked on 5/7/16, 5/8/16, 5/14/16, 5/15/16, 5/22/16, 5/28/16 and 5/29/16) revealed she administered Levemir 40 U SQ, but failed to document the insulin was given.	F 514	Resident #100 Medication Administration Record was reviewed from 7-1-16 to 8-5-16 to ensure that proper documentation was noted that she received her 9:00 pm dose of Levemir. No other discrepancies were noted. Nurse #2 and Nurse #3 were counseled by the unit manager on 8-5-16 regarding the deficient practice. The weekend supervisor will conduct an audit on 8-6-16 and 8-7-16 to ensure the Medication Administration Record documentation for resident #100 is accurate. #2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; An audit was conducted on 8-5-16 of the Medication Administration Records for all residents to ensure proper documentation of medications received. No other discrepancies were noted. No negative outcomes were identified. #3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur; The facility policy for medication administration and documentation was reviewed by the Director of Nursing on 8-4-16 and remains current. The Staff Development Coordinator in-serviced licensed staff on proper medication administration documentation and the facility policy and procedures on medication administration on 8-4-16 thru 8-8-16 and as needed. The Staff Development Coordinator will monitor one	

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F 514	Continued From page 8 Interview on 07/21/2016 at 1:25 PM via the phone with Nurse #4 (who worked on 5/6/16) revealed she remembered the administration of Levemir. Nurse #4 stated she was called to assist another resident and forgot to sign the MAR. Interview on 07/21/2016 at 4:16 PM with the Administrator and Director of Nurses (DON) was held. The DON indicated his expectation was staff to properly document medications administered and follow standards of practice for medication administration.	F 514	(1)cart's Medication Administration Records per day this will include all residents MARs on the audited cart for compliance five times a week for four weeks then monthly for three months starting 8-1-16. All newly hired licensed staff will be monitored for medication administration competency and all licensed staff annually and as needed by the Staff Development Coordinator. The pharmacy consultant will monitor medication pass on 8-19-16. The pharmacy consultant will in-service licensed staff on 8-19-16 for proper documentation on the Medication Administration Record. Any deficient practice will be identified and corrected. #4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The results of the Medication Administration Record monitoring for documentation will be reported to the Director of Nursing who will present the results to the Quality Assurance Performance Improvement. The audits will be presented by the Director of Nursing to the Quality Assurance Performance Improvement committee monthly times six months for evaluation and recommendations.	