STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345354	A. BUILDING _____ B. WING _____	C 08/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY GROVE NURSING AND REHABILITATION CENTER	728 PINEY GROVE ROAD KERNERSVILLE, NC 27284

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation survey. Event ID # 8P4811.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate 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:	F 278		9/12/16

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

Electronically Signed | 09/07/2016

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F 278	Continued From page 1 Based on record review and staff interviews, the facility: 1) Failed to accurately code the Minimum Data Set (MDS) to reflect results of the Preadmission Screening and Resident Review (PASRR) Level II determination for 1 of 1 residents (Resident #85) identified as a PASRR Level II resident; 2) Failed to accurately code the Minimum Data Set (MDS) for Hospice for 1 of 1 residents (Resident #28) reviewed for Hospice care; and, 3) Failed to accurately code the Minimum Data Set (MDS) for the use of an antidepressant for 1 of 4 sampled residents (Resident #14) reviewed who received a controlled substance on an as needed basis. The findings included: 1) Resident #85 was admitted to the facility on 8/29/14 from a hospital. Her cumulative diagnoses included bipolar disorder, major depressive disorder, anxiety disorder, and panic disorder. Resident #85 ' s annual Minimum Data Set (MDS) assessment (Section A) dated 8/3/16 indicated the resident was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. Determination of a Level II PASRR resident is made by an in-depth evaluation. The results of this evaluation are used for formulating a determination of need, determination of an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care. A review of the facility ' s current list of Level II PASRR residents revealed that Resident #85 was named on the list.	F 278	Piney Grove Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Corrections is submitted as a written allegation of compliance. Piney Grove Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any deficiency is accurate. Further, Piney Grove Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 278 On 8/9/2016, the MDS nurse modified Resident #85 8/3/16 MDS assessment to accurately reflect PASSAR level 2. By 8/18/2016, the modified assessment was accepted by the National Repository. On 8/9/2016, the MDS nurse modified Resident #28 8/5/16 MDS assessment to accurately include hospice services provision for Resident #28. By 8/18/2016, the modified assessment was accepted by the National Repository. On 8/9/2016, the MDS nurse modified Resident #14 6/17/16 MDS assessment	

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F 278	Continued From page 2 An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 8/17/16 at 2:48 PM. Upon inquiry, the MDS nurses reviewed Resident #85 ' s records and reported the resident had not been coded on the MDS assessments as a PASRR Level II since 9/5/14. The MDS nurses questioned whether or not the resident was still determined to be a PASRR Level II resident. On 8/18/16 at 9:57 AM, the facility provided a copy of Resident #85 ' s most recent PASRR Level II Determination Notification letter from the State dated 3/5/15. A review of the letter revealed Resident #85 ' s PASRR Number ended with the letter " B " which indicated, in part, no limitation on her stay unless a change in condition was noted. There was no PASRR expiration date indicated on the letter. A notation was made in the Notification letter under the heading of Placement Determination which read, " Nursing Facility Placement is appropriate. " An interview was conducted on 8/18/16 at 10:30 AM with the facility ' s Administrator. During the interview, the Administrator reported Resident #85 was determined to be PASRR Level II and was still classified as a PASRR Level II resident. Upon inquiry, the Administrator stated her expectation was for the MDS to be coded accurately to reflect the resident ' s PASRR Level II determination. 2) Resident #28 was admitted to the facility on 1/6/14 and re-entered the facility on 10/9/15 from a hospital. Her cumulative diagnoses included atherosclerotic heart disease, chronic respiratory failure and a history of acute kidney failure.	F 278	to accurately reflect the administration of antidepressant medication to Resident #14□s within the MDS lookback period. By 8/18/2016, the modified assessment was accepted by the National Repository. On 9/6/2016, the corporate facility consultant audited each resident□s last completed MDS assessment for accuracy of PASSAR coding, hospice services, and antidepressant medications. By 9/7/16 the Administrator in-serviced the MDS Coordinator and MDS nurses on correctly coding sections A, O, and N using the RAI Manual. The in-service is documented on the Complete In-Service Training Report with Staff Attending (BN 1030). On 9/7/16 the DON and/or QI Nurse will begin auditing residents□ MDS assessments for correct PASSAR level, provision of hospice services, and administration of antidepressant coding. The audit results will be recorded on the MDS Accuracy Audit Tool. The DON and or QI Nurse will audit 25% of completed assessments once weekly x 4 weeks, then 25% of completed assessment biweekly x 8 weeks, then 25% of completed assessments monthly x 3months. The DON will present the results of the MDS Accuracy Audits to the monthly QI committee for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and	

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F 278	Continued From page 3 A review of Resident #28 ' s medical record included a Physician ' s Note dated 11/9/15 requesting a Hospice consultation. The resident was admitted to Hospice care on 11/12/15. A Minimum Data Set (MDS) assessment was completed for Resident #28 on 11/19/15 for a significant change. Section O of the MDS assessment indicated Resident #28 received Hospice care. The resident ' s care plan included an area of focus addressing Hospice care (initiated 11/30/15). A review of Resident #28 ' s most recent quarterly MDS assessment dated 8/5/16 was completed. Section O of the MDS did not indicate the resident received Hospice services. A review of the facility ' s list of residents currently receiving Hospice services revealed Resident #28 was named on this list. An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 8/17/16 at 2:55 PM. Upon inquiry, the MDS nurses reviewed Resident #28 ' s records. MDS Nurse #1 stated the resident should have been coded as receiving Hospice care on the 8/5/16 MDS assessment. The nurse also reported she would need to correct and resubmit the resident ' s MDS to indicate she received Hospice services. An interview was conducted on 8/18/16 at 2:20 PM with the facility ' s Director of Nursing (DON). During the interview, the MDS coding for Resident #28 ' s Hospice care was discussed. Upon inquiry, the DON stated she expected the MDS coding to be accurate.	F 278	recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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3) Resident #14 was admitted to the facility on 12/21/15 from a hospital. Her cumulative diagnoses included anxiety and depression.

A review of Resident #14 ' s medical record revealed the resident received sertraline (an antidepressant) once daily as ordered throughout the month of June 2016. Further review of the resident ' s medical record for June 2016 revealed no orders had been received for an antianxiety medication.

A review of Resident #14 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 6/17/16 was completed. Section N of the MDS assessment indicated the resident received an antianxiety medication on 7 out of 7 days during the look back period. Section N of the MDS indicated Resident #14 did not receive an antidepressant medication during the 7-day look back period.

An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 8/17/16 at 2:54 PM. Upon inquiry, the MDS nurses reviewed Resident #14 ' s MDS (Section N) and medication records. MDS Nurse #2 stated she made an error in coding the medication category of the sertraline for this resident. The nurse confirmed the MDS should have been coded to indicate the resident received an antidepressant medication and not an antianxiety medication during the 7-day look back period.

An interview was conducted on 8/18/16 at 2:20 PM with the facility ' s Director of Nursing (DON). During the interview, the MDS coding for Resident #14 ' s medication was discussed. Upon inquiry, the DON stated she expected the

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F 278	Continued From page 5 MDS coding to be accurate.	F 278		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		9/14/16

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F 431	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility: 1) Failed to consistently follow established procedures for the administration and accounting of controlled medications for 3 of 4 sampled residents (Residents #28, #35, and #14) receiving controlled substances prescribed on an as needed basis; and, 2) Failed to securely store medications in 1 of 2 medication store rooms (Middle Hall Medication Room). The findings included: 1a) A review of the facility ' s undated policy entitled, " The Medication Administration Record (MAR), " included the following procedures, in part: " ...G. All medication doses shall be charted immediately following administration, on the Medication Administration Record (MAR) ... I. All PRN (as needed) medication doses shall be charted on the face of the Medication Administration Record (MAR), as well as in the " Nurses Medication Notes " on the reverse side of the MAR by recording the time of administration, name of medication, strength, dosage, route of administration, reason for administration, response or effectiveness observed, and nurse ' s initials ... " Resident #28 was admitted to the facility on 1/6/14 and re-entered the facility on 10/9/15 from a hospital.	F 431	F431 On 9/7/16 the DON assessed Resident 28 for pain and anxiety. On 9/7/16 the DON assessed Resident 35 for anxiety. On 9/7/16 the DON assessed Resident 14 for pain. On 9/6/2016 the facility consultant checked the front medication room to verify the door was locked and medications secure. On 9/6/2016 the facility consultant checked the back medication room to verify the door was locked and medications secure. On 9/6/2016 the DON and facility consultant completed a 100% audit of medication administration records (MARs) vs. narcotic declining count sheets to ensure administered narcotics were signed out on both the MARs and the declining count sheets. Any discrepancy was investigated by the DON and/or QI Nurse, including resident assessment. On 8/19/16 the Staff Facilitator initiated a 100% in-service of all nurses and medication aides. This in-service includes requirement to document the administration of PRN medications on the front and back of the MAR and on the narcotic declining count sheets. This in-service will also include securing medication in the medication rooms and keeping the medication room doors closed and locked. By 9/14/16 the Staff Facilitator and/or DON will complete the in-servicing of 100% of nurses. After 9/14/16 no nurse or medication aide will be allowed to administer medications in	

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F 431	Continued From page 7 A review of Resident #28 ' s medication orders included: 5 milligrams (mg) oxycodone (an opioid pain reliever) to be given as one tablet by mouth every 6 hours as needed (ordered on 6/13/16); and, 0.5 mg lorazepam (an antianxiety medication) to be given as one tablet by mouth every 8 hours as needed for anxiety (ordered on 10/15/15). Oxycodone and lorazepam are controlled substance medications. A review and comparison of Resident #28 ' s Controlled Substance Count Sheet (a declining inventory record) for oxycodone with the corresponding Medication Administration Records (MARs) from 6/15/16 to 8/15/16 were completed. This comparison identified the following documentation discrepancies for the oxycodone administered to Resident #28: 6/15/16 Controlled Substance Count Sheet: 1 tablet was removed at 5:00 AM; June 2016 MAR: No tablets were documented as given on this date. 6/16/16 Controlled Substance Count Sheet: 1 tablet was removed at 6:00 AM; June 2016 MAR: No tablets were documented as given on this date. 6/19/16 Controlled Substance Count Sheet: 1 tablet was removed at 11:00 PM; June 2016 MAR: No tablets were documented as given on this date. 6/20/16 Controlled Substance Count Sheet: 1 tablet was removed at 9:00 PM; June 2016 MAR: No tablets were documented as given on this date. 6/23/16 Controlled Substance Count Sheet: 1 tablet was removed at 5:00 AM; June 2016 MAR: No tablets were documented as given on this date. 6/27/16 Controlled Substance Count Sheet: 1	F 431	the facility until they have completed the in-service. On 9/12/16 the staff facilitator, QI nurse and/or director of nursing will ensure the in-service material is added to the orientation of newly hired nurses and medication aides. Beginning 9/7/16 the DON and/or QI nurse will audit 100% of medication rooms five times weekly for 12 weeks to ensure medications in the medication rooms are secure and the medication room is closed and locked. This audit will be documented on the Medication Room Audit tool. Beginning 9/7/17 the DON and/or QI nurse will audit 10 resident MARs and narcotic declining count sheets one time weekly for 12 weeks to ensure complete, accurate, and corresponding narcotic administration documentation. Any identified discrepancies will be immediately addressed by the DON with the nurse and/or medication aide. The audit will be documented on the Narcotic Audit tool. The DON will present the results of the Narcotic Audit Tools and Medication room audit tools to the monthly QI committee for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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tablet was removed at 9:00 (not designated as AM or PM);
June 2016 MAR: No tablets were documented as given on this date.
6/28/16 Controlled Substance Count Sheet: 1 tablet was removed at 3:00 AM;
June 2016 MAR: No tablets were documented as given on this date.
6/29/16 Controlled Substance Count Sheet: 1 tablet was removed at 9:00 PM;
June 2016 MAR: No tablets were documented as given on this date.

7/5/16 Controlled Substance Count Sheet: 1 tablet was removed at 1:00 PM;
July 2016 MAR: No tablets were documented as given on this date.
7/10/16 Controlled Substance Count Sheet: 1 tablet was removed at 5:00 PM;
July 2016 MAR: No tablets were documented as given on this date/time.
7/11/16 Controlled Substance Count Sheet: 1 tablet was removed at 10:00 AM;
July 2016 MAR: No tablets were documented as given on this date.
7/11/16 Controlled Substance Count Sheet: 1 tablet was removed at 5:00 PM;
July 2016 MAR: No tablets were documented as given on this date.
7/15/16 Controlled Substance Count Sheet: 1 tablet was removed at 12:00 (not designated as AM or PM);
July 2016 MAR: No tablets were documented as given on this date.
7/15/16 Controlled Substance Count Sheet: 1 tablet was removed at 6:00 (not designated as AM or PM);
July 2016 MAR: No tablets were documented as given on this date.

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7/19/16 Controlled Substance Count Sheet: 1 tablet was removed at 9:00 AM;
July 2016 MAR: No tablets were documented as given on this date.
7/20/16 Controlled Substance Count Sheet: 1 tablet was removed at 9:00 (not designated as AM or PM);
July 2016 MAR: No tablets were documented as given on this date.
7/25/16 Controlled Substance Count Sheet: 1 tablet was removed at 11:00 (not designated as AM or PM);
July 2016 MAR: No tablets were documented as given on this date.

8/2/16 Controlled Substance Count Sheet: 1 tablet was removed at 5:00 PM;
August 2016 MAR: No tablets were documented as given on this date.
8/3/16 Controlled Substance Count Sheet: 1 tablet was removed at 10:00 AM;
August 2016 MAR: No tablets were documented as given on this date.
8/6/16 Controlled Substance Count Sheet: 1 tablet was removed at 10:30 (not designated as AM or PM);
August 2016 MAR: No tablets were documented as given on this date.
8/6/16 Controlled Substance Count Sheet: 1 tablet was removed at 9:00 PM;
August 2016 MAR: No tablets were documented as given on this date.

A review and comparison of Resident #28 ' s Controlled Substance Count Sheet (a declining inventory record) for lorazepam with the corresponding Medication Administration Records (MARs) from 6/15/16 to 8/15/16 were completed. This comparison identified the following

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documentation discrepancies for the lorazepam administered to Resident #28:
6/29/16 Controlled Substance Count Sheet: 1 tablet was removed at 9:00 PM;
June 2016 MAR: No tablets were documented as given on this date.

An interview was conducted on 8/17/16 at 2:20 PM with the facility ' s Director of Nursing (DON). During the interview, the DON discussed the facility ' s procedures for documenting the " as needed " (PRN) administration of a controlled substance to a resident. The DON reported a nurse would be expected to sign out the controlled substance on the Controlled Substance Count Sheet and to document the medication administration on both the front and the back of the resident ' s MAR. The DON stated there was a place on the back of the MAR to write the date/time, the name of the PRN medication given, the nurse ' s initials, and the follow-up results to ensure the medication was effective. Upon inquiry, the DON indicated she expected information from the residents' MARs and Controlled Substance Count Sheets to be consistent with one another.

An interview was conducted on 8/18/16 at 7:05 AM with Nurse #4. Nurse #4 identified her initials on the Controlled Substance Count Sheet as having pulled oxycodone from the med cart for Resident #28 on 6/23/16 without documenting administration of the medication on the resident ' s MAR. Upon review of Resident #28 ' s MAR, Nurse #4 reported the initials written on the MAR for 6/24/16 were hers. The nurse stated she was unsure as to which date (the Controlled Substance Count Sheet dated 6/23/16 or the MAR dated 6/24/16) was correct.

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A telephone interview was conducted on 8/18/16 at 11:20 AM with Nurse #6. Nurse #6 was no longer employed by the facility. Nurse #6 was identified by her initials on the Controlled Substance Count Sheet as having pulled lorazepam from the medication cart for Resident #28 on 6/29/16 without documenting administration of the medication on the resident ' s MAR. Nurse #6 was also identified as having pulled oxycodone from the med cart for Resident #28 without documenting administration of the medication on the resident ' s MAR for each of the following dates: 6/15/16, 6/16/16, 6/19/16, 6/20/16, 6/28/16, and 6/29/16. During the interview, Nurse #6 described the usual process she followed for documenting the administration of controlled substance medications used on an as needed basis. The nurse stated she was supposed to document on the front and back of the MAR and on the declining inventory sheet when a PRN controlled substance was given to a resident. Nurse #6 reported she did not complete the documentation in any specific order. Upon inquiry, the nurse indicated she may have perhaps missed completing some of the documentation on a couple of days.

A telephone interview was conducted on 8/18/16 at 2:49 PM with Nurse #7. Nurse #7 was identified by her initials on the Controlled Substance Count Sheet as having pulled oxycodone from the med cart for Resident #28 without documenting administration of the medication on the resident ' s MAR for each of the following dates: 6/27/16, 7/5/16, 7/10/16, 7/11/16 (two doses), 7/15/16 (two doses), 7/19/16, 7/20/16, 7/25/16, 8/2/16, 8/3/16, and 8/6/16. During the interview, Nurse #7 reviewed

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the process she followed when administering a controlled substance prescribed on an as needed basis for a resident. Nurse #7 reported she documented the medication withdrawal in the narcotic book (Controlled Substance Count Sheet) immediately after pulling the controlled substance from the medication cart. The nurse stated she would also write her initials on the front of the resident ' s MAR and would try to document on the reverse of the MAR as well. Nurse #7 reported she always completed her documentation on both the Controlled Substance Count Sheet and the MAR prior to giving a controlled substance to a resident.

An interview was conducted on 8/18/16 at 10:30 AM with the facility ' s Administrator. During the interview, the Administrator reported the facility had recently identified " holes " in the residents ' MARs and had discussed it at the last Quality Assurance meeting. The Administrator stated this was a concern the facility was planning to address in the near future. The Administrator reported she expected there to be " no holes in the MARs. "

1b) A review of the facility ' s undated policy entitled, " The Medication Administration Record (MAR), " included the following procedures, in part:
" ...G. All medication doses shall be charted immediately following administration, on the Medication
Administration Record (MAR) ...
I. All PRN (as needed) medication doses shall be charted on the face of the Medication Administration
Record (MAR), as well as in the " Nurses Medication Notes " on the reverse side of the

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MAR by
recording the time of administration, name of medication, strength, dosage, route of administration,
reason for administration, response or effectiveness observed, and nurse ' s initials ... "

Resident #35 was admitted to the facility on 2/3/14 with a cumulative diagnoses which included anxiety.

A review of Resident #35 ' s current medication orders included 0.5 milligrams (mg) lorazepam (an antianxiety medication) to be given as one-half (½) tablet by mouth at bedtime as needed for anxiety and agitation (ordered on 10/27/15; discontinued on 6/14/16; and re-ordered for the resident on 6/16/16). Lorazepam is a controlled substance medication.

A review and comparison of Resident #35 ' s Controlled Substance Count Sheet (a declining inventory record) for lorazepam with the corresponding Medication Administration Records (MARs) from 6/15/16 to 8/15/16 were completed. This comparison identified the following documentation discrepancies for the 0.5 mg halved tablets (containing a total dose of 0.25 mg) of lorazepam administered to Resident #35:
7/16/16 Controlled Substance Count Sheet: ½ tablet was removed at 2:45 AM;
July 2016 MAR: No tablets were documented as given on this date.
7/21/16 Controlled Substance Count Sheet: ½ tablet was removed at 12:30 AM;
July 2016 MAR: No tablets were documented as given on this date.

An interview was conducted on 8/17/16 at 2:20

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PM with the facility ' s Director of Nursing (DON). During the interview, the DON discussed the facility ' s procedures for documenting the as needed (PRN) administration of a controlled substance to a resident. The DON reported a nurse would be expected to sign out the controlled substance on the Controlled Substance Count Sheet and to document the medication administration on both the front and the back of the resident ' s MAR. The DON stated there was a place on the back of the MAR to write the date/time, the name of the PRN medication given, the nurse ' s initials, and the follow-up results to ensure the medication was effective. Upon inquiry, the DON indicated she expected information from the residents' MARs and Controlled Substance Count Sheets to be consistent with one another.

A telephone interview was conducted on 8/18/16 at 12:53 PM with Nurse #5. Nurse #5 was identified by her initials on the Controlled Substance Count Sheet as having pulled lorazepam from the medication cart for Resident #35 on 7/16/16 and 7/21/16 without documenting administration of the medication on the resident ' s MAR. During the interview, Nurse #5 reviewed the process she typically followed for the administration and documentation of a controlled substance provided to a resident on an " as needed " basis. The nurse reported she would document the medication as having been pulled from the med cart and document on the front and back of the MAR the administration of the medication prior to giving it to the resident. Nurse #5 also stated she would note the effectiveness of the medication on the back of the MAR one hour after its administration. Upon inquiry, the nurse reported it would have been a mistake on

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her part if she did not complete documentation on the MAR to indicate the medication was administered to the resident.

An interview was conducted on 8/18/16 at 10:30 AM with the facility ' s Administrator. During the interview, the Administrator reported the facility had recently identified " holes " in the residents ' MARs and had discussed it at the last Quality Assurance meeting. The Administrator stated this was a concern the facility was planning to address in the near future. The Administrator reported she expected there to be " no holes in the MARs. "

1c) A review of the facility ' s undated policy entitled, " The Medication Administration Record (MAR), " included the following procedures, in part:
" ...G. All medication doses shall be charted immediately following administration, on the Medication
Administration Record (MAR) ...
I. All PRN (as needed) medication doses shall be charted on the face of the Medication Administration
Record (MAR), as well as in the " Nurses Medication Notes " on the reverse side of the MAR by
recording the time of administration, name of medication, strength, dosage, route of administration,
reason for administration, response or effectiveness observed, and nurse ' s initials ... "

Resident #14 was admitted to the facility on 12/21/15. A review of the resident ' s current medication orders included 5/325 milligrams (mg) hydrocodone/acetaminophen (a combination

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opioid pain medication) given as one tablet by mouth every 6 hours as needed for pain (ordered on 12/23/15 and 7/18/16). Hydrocodone/acetaminophen is a controlled substance medication.

A review and comparison of Resident #14 ' s Controlled Substance Count Sheet (a declining inventory record) for hydrocodone/acetaminophen with the corresponding Medication Administration Records (MARs) from 6/13/16 to 8/15/16 were completed. This comparison identified the following documentation discrepancies for the 5/325 mg hydrocodone/acetaminophen tablets dispensed for Resident #14:
6/13/16 Controlled Drug Record: 1 tablet was removed at 6:30 PM;
June 2016 MAR: No tablets were documented as given on this date.

Nurse #8 was identified by her initials on the Controlled Substance Count Sheet as pulling hydrocodone / acetaminophen from the medication cart for Resident #14 on 6/13/16 without documenting administration of the medication on the resident ' s MAR. Nurse #8 was not available for an interview.

An interview was conducted on 8/17/16 at 2:20 PM with the facility ' s Director of Nursing (DON). During the interview, the DON discussed the facility ' s procedures for documenting the as needed (PRN) administration of a controlled substance to a resident. The DON reported a nurse would be expected to sign out the controlled substance on the Controlled Substance Count Sheet and to document the medication administration on both the front and the back of

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the resident ' s MAR. The DON stated there was a place on the back of the MAR to write the date/time, the name of the PRN medication given, the nurse ' s initials, and the follow-up results to ensure the medication was effective. Upon inquiry, the DON indicated she expected information from the residents' MARs and Controlled Substance Count Sheets to be consistent with one another.

An interview was conducted on 8/18/16 at 10:30 AM with the facility ' s Administrator. During the interview, the Administrator reported the facility had recently identified " holes " in the residents ' MARs and had discussed it at the last Quality Assurance meeting. The Administrator stated this was a concern the facility was planning to address in the near future. The Administrator reported she expected there to be " no holes in the MARs. "

2) An observation made on 8/18/16 at 6:15 AM revealed the Middle Hall Medication Room door was opened. At the time of the observation, Nurse #1 and two other staff members were standing next to a medication cart in front of Resident #93 ' s room. Nurse #1 was the 3rd shift nurse assigned to the Middle Hall.

On 8/18/16 at 6:37 AM, Nurse #1 was observed as he entered and then exited Resident #93 ' s room. The nurse requested assistance from a nursing assistant, then re-entered the room. At 6:41 AM, the nurse and nursing assistant pulled the privacy curtain for Resident #93 while they repositioned the resident in her bed. Nurse #1 was out of view of the open medication room. At 6:43 AM, Nurse #1 was observed as he administered medications to Resident #93 with

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F 431	Continued From page 18 the privacy curtain still pulled. At 6:43 AM, the facility ' s Administrator was observed as she closed/secured the medication room door. At 6:45 AM, Nurse #1 exited Resident #93 ' s room. An interview was conducted on 8/18/16 at 6:52 AM with the Nurse #1. Upon inquiry, the nurse reported he knew the medication room door should be locked at all times. Nurse #1 stated he had just retrieved insulin from the medication room refrigerator prior to being approached by the surveyor. He acknowledged he left the door open and did not go back to close it. An interview was conducted on 8/18/16 at 10:00 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she had been made aware of the medication room door being left open earlier that morning. Upon inquiry, the DON stated she would expect the medication room door to be locked at all times. An observation of the Middle Hall Medication Room was made on 8/18/16 at 2:04 PM. At the time of the observation, the medication room door was locked. When the medication room door was unlocked, an observation revealed the contents of the room included, in part: 11 vials of insulin, 4 vials of vaccines, 3 boxes of prescription inhalation solution, 17 boxes of individually packaged and labeled prescription medications, and a house stock of over-the-counter medications. The medications were fully accessible upon entrance into the medication room.	F 431		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		9/12/16

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F 520	Continued From page 19 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. 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 observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place. This failure was related to 1 deficiency originally cited during the facility's 10/29/15 annual recertification survey and was re-cited during the facility's recertification survey and complaint investigation. The re-cited deficiency was in the area of medication storage. The facility's continued failure during the	F 520	F 520 QAA Committee On 09/12/2016 the facility Executive QI Committee will hold a meeting. The Medical Director, Administrator, DON, QI nurse, MDS nurse, treatment nurse, staff facilitator, maintenance director, and housekeeping supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate.	

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F 520	Continued From page 20 recertification survey and complaint investigation showed a pattern of the facility ' s inability to sustain an effective QAA program. Findings included: This tag is cross referenced to: F431: Labeling and storage of drugs and biologicals. Based on observations, record review and staff interviews, the facility: 1) Failed to consistently follow established procedures for the administration and accounting of controlled medications for 3 of 4 sampled residents (Resident #28, #35, and #14) receiving controlled substances prescribed on an as needed basis and, 2) Failed to securely store medications in 1 of 2 medication store rooms (Middle Hall Medication Room). During the recertification survey of 4/16/15, the facility was cited for failing to properly store medication requiring refrigeration as specified by the manufacturer on one of three medication carts. The facility failed to ensure medication was stored properly and follow procedures for accounting for controlled medications on the current recertification survey and complaint investigation. An interview was conducted on 8/18/16 at 1:40 PM with the facility Administrator. She stated the QAA committee consists of the Director of Nursing, the Assistant Director of Nursing/Quality Improvement nurse, the Staff Development Coordinator, the Social Worker, the Dietary Manager, Activity Director, Medical Director, and Administrator. She stated, " When I arrived here in May 2016 they didn ' t conduct the meetings correctly, like QAPI (Quality Assurance Performance Improvement). In fact, QAPI and the QAA committee were basically non-existent.	F 520	On 9/2/2016 the facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, maintenance director, dietary manager, staff facilitator, and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F431 Drug Records, Label/Store Drugs & Biologicals. As of 9/2/2016, after the facility consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: review rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), resident council minutes, resident concern logs, pharmacy reports, and regional facility consultant recommendations. The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F431 Drug Record, Label/Store Drugs & Biologicals	

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F 520	Continued From page 21 But we have them now. " She also stated, " Pharmacy was not part of the QAA committee before. The newly formed QAA committee will invite the consultant Pharmacist to join the QAA committee to address medication storage issues. "	F 520	as reflected in the plan of correction. The Committee will continue to meet at a minimum of Quarterly with oversight by the Vice President of Operations, Vice President of Clinical Services and the Facility Consultant, The QI Committee meeting agenda and minutes with resulting plans of corrections and audit results will be reviewed as a component of this oversight after each QI Committee meeting. The Executive QI Committee, including the Medical Director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility□s progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.	