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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING ______ B. WING ______	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY FALLS HEALTH AND REHABILITATION	100 SUNSET STREET GRANITE FALLS, NC 28630

(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. Event ID # RWOE11	F 000	F000 Disclaimer clause: F176-483.10 (c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and resident interview, the facility failed to monitor the administration of medication for 2 of 2 residents who were identified as being able to self-administer medications (Resident's # 75 and #128). The findings included: 1. Review of the facility policy and procedure for self-administration of medications dated December 2012 stated in part, "Nursing staff will review the bedside medication record on each nursing shift, and they will transfer pertinent information to the medication administration record (MAR) kept at the nursing station, appropriately noting that the doses were self-administrated". Review of the medical record revealed Resident #75 had been admitted to the facility on 10/03/16 with diagnoses of Parkinson's disease and heart failure. Review of the Minimum Data Set (MDS) Quarterly assessment dated 12/12/16 revealed	F 176	Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. On March 2nd, 2017, Medication administration records were placed in Resident #75 and Resident #128's room. Resident #75 and Resident #128 were educated on how to properly utilize the record to record each time they self-medicated themselves by the Assistant Director of Nursing. An audit of all resident rooms checking for any bedside medications was completed by the Nursing Administration Team on March 2nd, 2017. All resident rooms were free from medications. All nurses were in-serviced by the Director of Nursing and Assistant Director of Nursing on March 2nd and March 3rd, 2017 regarding the procedure for verifying proper documentation of self-administration medication records.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brandee R. Jones, LNHA
TITLE: Administrator
(X6) DATE: 3/24/17

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 176	Continued From page 1 Resident #75 had been identified as cognitively intact. Review of a current care plan dated 10/03/16 for Resident #75 revealed that self-administration of medications had not been identified. Review of the administration of med assessment dated 01/06/17 revealed Resident #75 had been approved by the interdisciplinary team to be able to self-administer artificial tears. Review of the medication administration record (MAR) dated February 2017 revealed nasal 0.65% spray instill two sprays to each nostril as needed every 4 hours for congestion with no indication on the MAR they could be self-administered. Further review revealed artificial tears and hemorrhoid cream were not listed on the MAR. Review of the treatment administration record (TAR) for February 2017 revealed preparation H to hemorrhoids every shift as needed, may self-administer. An observation on 02/28/17 at 10:14 AM revealed (1) tube of hemorrhoid cream, and a full bottle of saline nasal spray in a clear storage drawer on Resident #75's bedside dresser. An interview on 02/28/17 at 10:45 AM with the Medication Aide revealed she had been aware that Resident #75 had hemorrhoid cream, nasal saline spray, and artificial tears at the bedside. She stated they were stored in the clear container, on the bedside night stand. She stated when Resident #75 was feeling well he could administer those medications himself. She stated	F 176	To ensure quality assurance, Nursing Administration or designee will make daily rounds to ensure each resident with bedside medications has a properly completed self-administration medication record for a minimum of twelve weeks. Findings from these rounds will be presented in the Quality Assurance Meeting for a minimum of three consecutive meetings. All corrective action will be completed by March 28th, 2017.	

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she had not been aware of where to document self-administered medications.

An interview on 02/28/17 at 10:59 AM with the Unit Coordinator revealed Resident #75 had self-administration assessments for the nasal spray and hemorrhoid cream.

An interview on 03/01/17 at 4:35 PM with Nurse #1 revealed he had not known Resident #75 was able to self-administer any medications, and had not known they had been in his room. He stated Resident #75 had never told him when he took his self-administered medications. He further stated he had only worked at the facility 6 days.

An interview on 03/02/17 at 1:33 PM with the Director of Nursing (DON) and Administrator revealed their expectations for monitoring medications that were self-administered by residents would be to check the medication administration record at the residents' bedside every shift, to monitor what the resident had taken that shift. The Administer stated they had developed a bedside monitoring tool, and would be implementing that, as they had not had one in place to monitor the medications for residents that had been approved for self-administration. Further interview revealed the nurse doing the self-administration assessment had been educated because she had not entered the medications into the computer correctly, so they had not printed to the MAR for Residents' #75 and #128, so the nurses had not monitored when they took the medications in their room.

2. Review of the facility policy and procedure for self-administration of medications dated December 2012 stated in part, "Nursing staff will

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F 176	Continued From page 3 review the bedside medication record on each nursing shift, and they will transfer pertinent information to the medication administration record (MAR) kept at the nursing station, appropriately noting that the doses were self-administrated". Review of the medical record revealed resident #128 had been admitted to the facility on 09/21/16 with diagnoses of hypertension and hypokalemia. Review of the Minimum Data Set (MDS) Quarterly assessment dated 01/06/17 revealed Resident #128 had been identified as cognitively intact. Review of a current care plan dated 09/21/16 for Resident #128 revealed that self-administration of medications had not been identified. Review of the administration of med assessment dated 01/06/17 revealed Resident #128 had been approved by the interdisciplinary team to be able to self-administer robitussin dm, mylanta, milk of magnesia, pepto-bismol, ibuprofen, and silvadene cream. Review of the medication administration record (MAR) for the month of February 2017 revealed robitussin dm, mylanta, milk of magnesia, pepto-bismol, ibuprofen, and silvadene cream had not been listed on the MAR. An observation on 02/28/17 at 8:59 AM revealed Resident #128 had (1) bottle of advil, (1)- 4 ounce bottle of pink bismuth, (2) packages of (Zarbees) cough drops, and (1) - 4 ounce bottle of robitussin dm in his room, in a basket, sitting on	F 176		

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the seat of his wheelchair.

An interview on 02/28/17 at 8:59 AM with Resident #128 revealed his family had brought the medications when he needed them. He stated he had not told the nurses when he had taken the medications, and he further stated they had not asked him when he had taken them. Further interview revealed he had always kept the medications either on the seat of his wheelchair next to the bed, or on his bedside table.

An interview on 02/28/17 at 10:45 AM with the Medication Aide revealed she had been aware that Resident #128 had silvadene cream that had been provided by the treatment nurse. She stated Resident #128 would ask for it, and the nurse had taken it to him. She stated Resident #128 had been able to apply it himself. She stated she had not known he had any other medications in his room. She further stated she had not been aware of where self-administered medications were documented.

An interview on 02/28/17 at 10:59 AM with the Unit Coordinator revealed Resident #128 had self-administration assessments for the medications in his room.

An interview on 03/01/17 at 4:35 PM with Nurse #1 revealed he had not known Resident #128 was able to self-administer any medications, and had not known they were in his room. He stated Resident #128 had never told him when he took his self-administered medications. He further stated he had only worked at the facility 6 days.

An interview on 03/02/17 at 1:33 PM with the Director of Nursing (DON) and Administrator

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F 176	Continued From page 5 revealed their expectations for monitoring medications that were self-administered by residents would be to check the medication administration record that is at the residents' bedside every shift to monitor what the resident had taken that shift. The Administer stated they had developed a bedside monitoring tool and would be implementing that, as they had not had one in place to monitor the medications for residents that were approved for self-administration. Further interview revealed the nurse doing the self-administration assessment had been educated because she had not entered the medications into the computer correctly, so they had not printed to the MAR for Residents' #75 and #128, so the nurses had not monitored when they took the medications in their room.	F 176		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental	F 279	F279-483.20 (d)483.21 (b)(1) DEVELOP COMPREHENSIVE CARE PLANS Self-administration of medications was added to Resident #75 and Resident #128's care plans by the MDS Coordinator on February 28, 2017. No other residents are currently performing self-administration of medications; therefore care plans are not needed. On March 1st and March 2nd, 2017 all nursing staff was in-serviced on properly entering Physician orders to reflect self-administration on the Medication Administration Record by the Assistant Director of Nursing.	

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F 279	Continued From page 6 and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 279	The Nursing Administration Team will review electronic order entries for all newly admitted residents and/or any resident that requests to self-administer medications and are deemed safe. They will compare to the electronic orders to the hospital discharge summaries to ensure accuracy for any self-administration medications within twenty four hours. This information will be relayed to the MDS nurse to ensure proper instruction is placed in the resident's care plan. All resident's care plans will be reviewed and updated if needed at least quarterly by the MDS nurse and/or the Interdisciplinary Care Plan Team to ensure all care plans are person-centered and accurate. To ensure quality assurance, the MDS Coordinator will audit all care plans of residents performing self-administration monthly for a minimum of three months. Findings from this audit will be presented in the Quality Assurance meeting for a minimum of three months. All corrective action will be completed by March 28th, 2017.	

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F 279	Continued From page 7 section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and resident interview, the facility failed to develop a comprehensive care plan for 2 of 21 residents whose care plan was reviewed (Resident's #75 and #128). The findings included: 1. Review of the medical record revealed Resident #75 had been admitted to the facility on 10/03/16 with diagnoses of Parkinson's disease and heart failure. Review of the Minimum Data Set (MDS) Quarterly assessment dated 12/12/16 revealed Resident #75 had been identified as cognitively intact. Review of a current care plan dated 10/03/16 for Resident #75 revealed that self-administration of medications had not been identified. Review of the administration of med assessment dated 01/06/17 revealed Resident #75 had been approved by the interdisciplinary team to be able to self-administer artificial tears. An observation on 02/28/17 at 10:14 AM revealed (1) tube of hemorrhoid cream, and a full bottle of saline nasal spray in a clear storage drawer, on Resident #75's bedside dresser. An interview on 02/28/17 at 10:45 AM with the Medication Aide revealed she had been aware that Resident #75 had hemorrhoid cream, nasal saline spray, and artificial tears at the bedside.	F 279		

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She stated they were stored in the clear container, on the bedside night stand. She stated when Resident #75 had been feeling well he could administer those medications himself. She stated she had not been aware of where to document self-administered medications.

An interview on 02/28/17 at 10:59 AM with the Unit Coordinator revealed Resident #75 had self-administration assessments for the nasal spray and hemorrhoid cream.

An interview on 03/01/17 at 4:35 PM with Nurse #1 revealed he had not known Resident #75 had been able to self-administer any medications, and had not known they had been in his room. He stated Resident #75 had never told him when he had taken his self-administered medications. He further stated he had only worked at the facility 6 days.

An interview with the Director of Nursing (DON) and Administrator on 03/01/17 at 4:45 PM revealed self-administration of medications for Resident #75 and Resident #128 had not been care planned until last night (2/28/17) when they became aware it had not been care planned previously. They further stated it was the expectation of the nurse that had completed the self-administration of medications assessment to have care planned it.

2. Review of the medical record revealed resident #128 had been admitted to the facility on 09/21/16 with diagnoses of hypertension and hypokalemia.

Review of the Minimum Data Set (MDS) Quarterly assessment dated 01/06/17 revealed

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Resident #128 had been identified as cognitively intact.

Review of a current care plan dated 09/21/16 for Resident #128 revealed that self-administration of medications had not been identified.

Review of the administration of med assessment dated 01/06/17 revealed Resident #128 had been approved by the interdisciplinary team to be able to self-administer robitussin dm, mylanta, milk of magnesia, pepto-bismol, ibuprofen, and silvadene cream.

An observation on 02/28/17 at 8:59 AM revealed Resident #128 had (1) bottle of advil, (1)- 4 ounce bottle of pink bismuth, (2) packages of (Zarbees) cough drops, and (1)- 4 ounce bottle of robitussin dm in his room, in a basket, sitting on the seat of his wheelchair.

An interview on 02/28/17 at 8:59 AM with Resident #128 revealed his family had brought the medications when he needed them. He stated he had not told the nurses when he had taken the medications, and he further stated they had not asked him when he had taken them. Further interview revealed he had always kept the medications either on the seat of his wheelchair next to the bed, or on his bedside table.

An interview on 02/28/17 at 10:45 AM with the Medication Aide revealed she had been aware that Resident #128 had silvadene cream that had been provided by the treatment nurse. She stated Resident #128 would ask for it, and the nurse had taken it to him. She stated Resident #128 had been able to apply it himself. She stated she had not known he had any other medications in his

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F 279	Continued From page 10 room. She further stated she had not been aware of where self-administered medications were documented. An interview on 02/28/17 at 10:59 AM with the Unit Coordinator revealed Resident #128 had self-administration assessments for the medications in his room. An interview on 03/01/17 at 4:35 PM with Nurse #1 revealed he had not known Resident #128 was able to self-administer any medications, and had not known they were in his room. He stated Resident #128 had never told him when he took his self-administered medications. He further stated he had only worked at the facility 6 days. An interview with the Director of Nursing (DON) and Administrator on 03/01/17 at 4:45 PM revealed self-administration of medications for Resident #75 and Resident #128 had not been care planned until last night (2/28/17), when they became aware it had not been care planned previously. They further stated it was the expectation of the nurse that had completed the self-administration of medications assessment to have care planned it.	F 279		