STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345348	A. BUILDING _____ B. WING _____	C 04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES NURSING & REHAB CENTER	523 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301

(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 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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, resident interview, and staff interviews the facility failed to implement the plan of care related to pain management for one (Resident #6) of six sampled residents who were interviewed regarding their care. The findings included: Record review revealed Resident # 6 was admitted on 4/3/17. The resident had diagnoses of a history of stroke with right sided weakness and hypertension. Review of hospital records revealed that prior to his facility residency, the resident had been hospitalized from 3/14/17 to 4/3/17 due to an abscess and cellulitis. A physician documented in the resident's hospital history and physical that the resident was alert and oriented. The physician also noted in the history and physical Resident # 6 experienced pain both from his wound and also from bilateral fractures of his feet which he had sustained in the six months prior to his hospitalization. Review of Resident # 6's admission care plan, dated 4/3/17, revealed the facility had identified pain was a problem for the resident. The facility's	F 282	Resident's pain med order was corrected by the charge nurse on 4/5/17 to include the sliding scale. A medication error report was completed by the Director of Nursing Services (DNS) on 4/5/17 and the attending physician was notified. The scheduled order from the hospital for the Lidocaine 5% patch to the knees was d/ced on 4/5/17 by the charge nurse and changed to "Lidocaine 5% patch apply one patch daily for 12 hours on and 12 hours off as needed to affected ankle" after the resident indicated his pain was in the ankles and not the knee. The DNS contacted the attending physician after a pain observation was completed on 4/6/17. During the pain observation the resident requested to receive 2 tabs since one tab was not effective. The physician d/ced the previous sliding scale order and ordered that 2 tabs be given every 6 hours as needed. The physician also examined the resident on 4/6/17 and the resident stated "pain is under good control today". Physician also examined the resident on 4/13/17 and resident expressed his pain is being controlled. Resident will be asked	4/17/17

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

Electronically Signed | 04/17/2017

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F 282	Continued From page 1 goal for the resident was that he be as comfortable as possible. One of the listed care plan interventions was to administer pain medications as ordered. Review of Resident #6's orders revealed a 4/3/17 order for Oxycodone-Acetaminophen 5-325 mg (milligrams) to be administered every six hours PRN (as needed) for pain. According to the order the resident was to receive 1 tablet if he reported his pain to be a 4 to 7 on a pain scale of 1 to 10. The resident was ordered to receive 2 tablets if he reported his pain to be an 8 to 10 on a pain scale of 1 to 10. Review of Resident #6's MAR (medication administration record) revealed on 4/4/17 at 6:35 PM Medication Aide # 1 had documented Resident # 6's pain was an "8." According to Resident # 6's controlled drug record the resident received only one tablet of Oxycodone-Acetaminophen. Resident # 6 was interviewed on 4/5/17 at 9 AM and reported he had not rested well the previous night. Resident # 6 stated he had broken both of his ankles recently, and at times he experienced spasms and sharp pain that would run up his leg. The resident stated he was supposed to get two pain pills if his pain was an 8 or more on a pain scale. The resident stated the "medication person" was supposed to have given him two pain pills the previous night and he only received one. Resident # 6 stated the one pain pill only worked for about 45 minutes to an hour and he had talked to the medication person about the incorrect number of tablets he had received. Resident # 6 stated the medication person acknowledged he was supposed to have received	F 282	about his pain level every shift. PRN pain medication will be administered every 6 hours as needed. If the resident does not wish to take the PRN pain med, he has may utilize alternative pain medication (lidocaine patch) or other nonpharmacological interventions noted in his care plan. Resident is assessed for pain after pain medication is administered; pain greater than resident's acceptable level of pain (which is a 2) will be addressed by the nurse by notifying the MD for further intervention to address pain. Pain observation again completed on 4/17/17 by the charge nurse. No new reports of pain reported. Pain Observation will be completed by the charge nurse two more times within the month. Attending physician will be contacted if pain is identified to not being controlled by current med order. Care plan for pain was revised on 4/17/17 to add new interventions to evaluate pain every shift; administer pain meds as ordered; offer pain patch when oral medication is refused; encourage and assist to elevate lower extremities; participate in therapy services; and notify the physician if the pain interventions become ineffective". Medication Aide #1 was hired in December 2015 as a PRN (as needed) employee and had 3 ½ years experience at the time. She was orientated to the facility on 12/28/15 and a skills checklist was completed on 12/30/15. At no time, did Medication Aide #1 express any concerns or issues to her supervisor prior the survey. The DNS and Executive	

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F 282	Continued From page 2 two tablets instead of one, but she never gave him another pain pill. The resident stated he couldn't understand why she would acknowledge he was supposed to receive more but still not give it to him. The resident stated since the medication person knew he should have gotten two pills instead of one and didn't do anything about it, he then decided not to bother the staff anymore that night. Nurse # 1 was interviewed on 4/5/17 at 1:15 PM. Nurse # 1 reviewed the record and stated Resident # 6 should have received two pain pills the previous night. Medication aide (MA) # 1 was interviewed on 4/6/17 at 12:45 PM. MA # 1 stated she had only given Resident # 6 one Oxycodone-Acetaminophen tablet when she should have given him two tablets on the night of 4/4/17. The MA stated Resident # 6 did bring it to her attention that he should have received two pain tablets rather than one, and she had acknowledged to him that he was correct and she had made an error. The DON (Director of Nursing) was interviewed on 4/6/17 at 8:45 AM. The DON stated she had talked to Medication Aide # 1 and had confirmed the resident's pain medication had not been given as ordered and Resident # 6 should have received two pain tablets the previous evening.	F 282	Director (ED) met with the medication aide on4/7/17 to discuss her concerns. DNS also met 1:1 with other medication aides and licensed nurses. Only one other employee expressed concerns of being overwhelmed. Additional training and time management skills are being offered to the employee. Med pass audits began by the pharmacy nurse consultant and DNS on 4/11/17 and again, no concerns with med administration have been identified. The DNS and ED conclude that this was an isolated concern for the medication aide #1. DNS and ED will continue to have an open door policy for staff to report concerns. DNS and/or designee will continue to conduct random med pass audits monthly. On 4/5/17 all physicians' orders for pain were reviewed by the DNS/designee to ensure sliding scale was completed if necessary. No other issues were identified. Pain Observations were completed on any resident with a new pain med or PRN pain med orders. Pain med orders were adjusted if needed. Care plans will be reviewed by the Interdisciplinary Team and revised as needed to include appropriate interventions. Training began on 4/5/17 with licensed personnel regarding utilizing sliding scale for medications, if appropriate. Training is conducted by the DNS/designee. Licensed nursing personnel that were not in attendance will be in-serviced prior to the start of their next scheduled shift Training began on 4/17/17 with licensed nurses and medication aides regarding	

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F 282	Continued From page 3	F 282	pain management. Training will be conducted by the DNS/designee. Random audits of pain med orders, pain care plans and Pain Observations (10% of residents) will be completed on a weekly basis x 4 weeks and then monthly for 6 months. If any non-compliance observed, one-on-one counseling will be done with the involved nurse by the DNS and random audits will be increased to 10% daily times one week. Compliance will be discussed weekly X 4 weeks and then monthly for 6 months during morning administrative meeting, any non-compliance will be noted and corrective actions taken. Results of audits were presented to the facility QA committee by the DNS during the first QA meeting held on 4/17/17. Audits will be presented to the QA committee for 6 more months. All discussions, revisions to plan, and additional in-servicing will be noted in the QA Committee Meeting Minutes.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.	F 309		4/17/17

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F 309	Continued From page 4 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interviews the facility failed to give pain medication per the plan of care for one (Resident #6) of six sampled residents who were interviewed regarding their care. The findings included: Record review revealed Resident # 6 was admitted on 4/3/17. The resident had diagnoses of Parkinson's disease with spasticity, a history of stroke with right sided weakness, and hypertension. Review of records revealed that prior to his facility residency, the resident had	F 309	Resident's pain med order was corrected by the charge nurse on 4/5/17 to include the sliding scale. A medication error report was completed by the Director of Nursing Services (DNS) on 4/5/17 and the attending physician was notified. The scheduled order from the hospital for the Lidocaine 5% patch to the knees was d/ced on 4/5/17 by the charge nurse and changed to "Lidocaine 5% patch apply one patch daily for 12 hours on and 12 hours off as needed to affected ankle" after the resident indicated his pain was in	

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F 309	Continued From page 5 been hospitalized from 3/14/17 to 4/3/17 due to an abscess and cellulitis. A physician documented in the resident's hospital history and physical that the resident was alert and oriented. The physician also noted Resident # 6 experienced pain both from his wound and also from bilateral fractures of his feet which he had sustained in the six months prior to his hospitalization. Review of Resident # 6's admission care plan, dated 4/3/17, revealed the facility had identified pain was a problem for the resident. The facility's goal for the resident was that he be as comfortable as possible. One of the listed care plan interventions was to administer pain medications as ordered. Review of Resident #6's orders revealed a 4/3/17 order for Oxycodone-Acetaminophen 5-325 mg (milligrams) to be administered every six hours PRN (as needed) for pain. According to the order the resident was to receive 1 tablet if he reported his pain to be a 4 to 7 on a pain scale of 1 to 10. The resident was ordered to receive 2 tablets if he reported his pain to be an 8 to 10 on a pain scale of 1 to 10. Review of Resident #6's MAR (medication administration record) revealed on 4/4/17 at 6:35 PM Medication Aide # 1 had documented Resident # 6's pain was an "8." According to Resident # 6's controlled drug record the resident received only one tablet of Oxycodone-Acetaminophen. Resident # 6 was interviewed on 4/5/17 at 9:00 AM and reported he had not rested well the previous night. Resident # 6 stated he had broken	F 309	the ankles and not the knee. The DNS contacted the attending physician after a pain observation was completed on 4/6/17. During the pain observation the resident requested to receive 2 tabs since one tab was not effective. The physician d/ced the previous sliding scale order and ordered that 2 tabs be given every 6 hours as needed. The physician also examined the resident on 4/6/17 and the resident stated “pain is under good control today”. Physician also examined the resident on 4/13/17 and resident expressed his pain is being controlled. Resident will be asked about his pain level every shift. PRN pain medication will be administered every 6 hours as needed. If the resident does not wish to take the PRN pain med, he has may utilize alternative pain medication (lidocaine patch) or other nonpharmacological interventions noted in his care plan. Resident is assessed for pain after pain medication is administered; pain greater than resident’s acceptable level of pain (which is a 2) will be addressed by the nurse by notifying the MD for further intervention to address pain. Pain observation again completed on 4/17/17 by the charge nurse. No new reports of pain reported. Pain Observation will be completed by the charge nurse two more times within the month. Attending physician will be contacted if pain is identified to not being controlled by current med order. Care plan for pain was revised on 4/17/17 to add new interventions to evaluate pain every shift; administer pain meds as ordered; offer pain patch when oral	

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F 309	Continued From page 6	F 309		

both of his ankles recently, and at times he experienced spasms and sharp pain that would run up his leg. The resident stated he was supposed to get two pain pills if his pain was an 8 or more on a pain scale. The resident stated the "medication person" was supposed to have given him two pain pills the previous night and he only received one. Resident # 6 stated the one pain pill only worked for about 45 minutes to an hour and he had talked to the medication person about the incorrect number of tablets he had received. Resident # 6 stated the medication person acknowledged he was supposed to have received two tablets instead of one, but she never gave him another pain pill. The resident stated he couldn't understand why she would acknowledge he was supposed to receive more but still not give it to him. The resident stated since the medication person knew he should have gotten two pills instead of one and didn't do anything about it, he then decided not to bother the staff anymore that night.

Nurse # 1 was interviewed on 4/5/17 at 1:15 PM. Nurse # 1 reviewed the record and stated Resident # 6 should have received two pain pills the previous night. Nurse # 1 stated there was a way the pain medication order could have been entered into the computer system in order that it would have alerted a medication aide or nurse to give the correct number of tablets based on a resident's report of pain level. Nurse # 1 stated Resident # 6's Oxycodone order had not been entered into the computer in this manner when Resident # 6 was admitted on 4/3/17. Therefore Nurse # 1 stated the computer had not flagged to the medication aide that she was not giving the correct number of tablets. Nurse # 1 was observed on 4/5/17 at 1:15PM to correct how the medication is refused; encourage and assist to elevate lower extremities; participate in therapy services; and notify the physician if the pain interventions become ineffective".

Medication Aide #1 was hired in December 2015 as a PRN (as needed) employee and had 3 ½ years experience at the time. She was orientated to the facility on 12/28/15 and a skills checklist was completed on 12/30/15. At no time, did Medication Aide #1 express any concerns or issues to her supervisor prior the survey. The DNS and Executive Director (ED) met with the medication aide on4/7/17 to discuss her concerns. DNS also met 1:1 with other medication aides and licensed nurses. Only one other employee expressed concerns of being overwhelmed. Additional training and time management skills are being offered to the employee. Med pass audits began by the pharmacy nurse consultant and DNS on 4/11/17 and again, no concerns with med administration have been identified. The DNS and ED conclude that this was an isolated concern for the medication aide #1. DNS and ED will continue to have an open door policy for staff to report concerns. DNS and/or designee will continue to conduct random med pass audits monthly.

On 4/5/17 all physicians' orders for pain were reviewed by the DNS/designee to ensure sliding scale was completed if necessary. No other issues were identified.

Pain Observations were completed on any resident with a new pain med or PRN pain

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F 309	Continued From page 7 order was entered into the computer. Medication Aide (MA) # 1 was interviewed on 4/6/17 at 12:45 PM. MA # 1 stated she had only given Resident # 6 one Oxycodone-Acetaminophen tablet when she should have given him two tablets on the night of 4/4/17. The MA stated Resident # 6 did bring it to her attention that he should have received two pain tablets rather than one, and she had acknowledged to him that he was correct and she had made an error. The MA stated three or four hours had passed when Resident # 6 brought it to her attention, and she did not give him the second tablet at that time. MA # 1 stated she feared if she had done so and Resident # 6 then requested pain medication at the six hour PRN interval he might have had three pain pills within too close of a timeframe. MA # 1 stated she therefore asked Resident # 6 to wait until a full dose would be available, and she would tell the nurse he could have two. MA # 1 attributed the pain medication error to having too many demands placed on her. MA #1 stated residents, families, and nursing assistants would interrupt her while she was trying to concentrate on accuracy of her medication pass. MA # 1 stated 4/4/17 was such a demanding night and in addition to making the error with Resident # 6's pain medication, she also almost gave another resident the wrong medication. MA # 1 stated she was stopped by this other resident who was alert enough to recognize the error. MA # 1 stated she had come to the conclusion she could not safely administer medications and meet the other demands of the unit, and she had submitted her resignation as a MA the next day. Nurse # 2 was the licensed night nurse for	F 309	med orders. Pain med orders were adjusted if needed. Care plans will be reviewed by the Interdisciplinary Team and revised as needed to include appropriate interventions. Training began on 4/5/17 with licensed personnel regarding utilizing sliding scale for medications, if appropriate. Training is conducted by the DNS/designee. Licensed nursing personnel that were not in attendance will be in-serviced prior to the start of their next scheduled shift Training began on 4/17/17 with licensed nurses and medication aides regarding pain management. Training will be conducted by the DNS/designee. Random audits of pain med orders, pain care plans and Pain Observations (10% of residents) will be completed on a weekly basis x 4 weeks and then monthly for 6 months. If any non-compliance observed, one-on-one counseling will be done with the involved nurse by the DNS and random audits will be increased to 10% daily times one week. Compliance will be discussed weekly X 4 weeks and then monthly for 6 months during morning administrative meeting, any non-compliance will be noted and corrective actions taken. Results of audits were presented to the facility QA committee by the DNS during the first QA meeting held on 4/17/17. Audits will be presented to the QA committee for 6 more months. All discussions, revisions to plan, and additional in-servicing will be noted in the QA Committee Meeting Minutes.	

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F 309	Continued From page 8 Resident # 6 on 4/4/17. Nurse # 2 was interviewed on 4/6/17 at 5:30 PM. Nurse # 2 stated on the night shift of 4/4/17, MA # 1 had reported to her Resident # 6 could have pain medication again at 12:45 PM. Nurse # 2 stated when she had checked on the resident during the night she had found him to be sleeping. Nurse # 2 stated the unit, on which Resident # 6 resided, was a very demanding unit and there were often interruptions in a staff member's work. The DON (Director of Nursing) was interviewed on 4/6/17 at 3:15 PM. The DON stated MA # 1 worked part time and had not been as familiar with Resident # 6's unit. The DON stated medication aides were asked to try to meet residents' other requests if they could do so while giving medications.	F 309		
F 511 SS=D	483.50(b)(2)(ii) RADIOLOGY FINDINGS-PROMPTLY NOTIFY PHYSICIAN (b) Radiology and other diagnostic services. (2) The facility must- (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure medical information was relayed to a consulting physician for one (Resident # 2) out of three sampled residents who had outside consultation appointments. The	F 511	1. Corrective action for resident(s) affected. Resident was seen on 1/18/17 by the neurologist and he ordered a CBC, CMP, Keppra level and MRI. The labs were	4/17/17

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F 511	Continued From page 9 findings included: Resident # 2 was admitted to the facility on 9/6/12. The resident had diagnoses of vascular dementia, epilepsy, history of cerebrovascular accident, and aphasia. Review of Resident # 2's medical record revealed the resident was routinely seen by a consulting neurologist at the neurologist's office. Review of the 1/18/17 neurologist's consultation report revealed his plan was to obtain a MRI (magnetic resonance imaging) study of the brain and complete a CBC (complete blood count), CMP (complete metabolic panel) and a Keppra level. These 1/18/17 neurologist's orders were noted on the consult form and also written on prescriptions that were located on the resident's facility record. Record review revealed the CBC, CMP, and Keppra level were completed on 1/19/17. The MRI was completed on 1/25/17. Record review revealed the resident was next seen by the consulting neurologist on 2/14/17. Review of the neurologist's note revealed he documented, "No MRI of brain done." A staff member at the neurologist office was interviewed on 4/6/17 at 11:55 AM. This staff member stated the MRI and lab work had not been sent with Resident # 2 for her 2/14/17 appointment. The staff member stated the neurologist had planned to discuss the results with the family member during the 2/14/17 appointment, but the facility had not sent the results until the following date of 2/15/17 at 10:08 AM.	F 511	completed on 1/19/17 and the MRI was completed on 1/25/17. The FNP reviewed the lab results with the three daughters on 1/20/17 and no new orders were given. The attending physician reviewed the MRI results with no new orders. The resident returned to the neurologist on 2/14/17. Labs and MRI results were not sent with the resident. The neurologist office called the next day asking for the lab and MRI results. The results were sent and received by the neurologist. Based on the labs and MRI results, the neurologist did not give any new orders or schedule the next follow-up appointment for an earlier date. The resident was supposed to see the neurologist on 4/10/17 and the family cancelled the appointment. Resident was seen by the neurologist on 4/17/17 with the lab and MRI results, no new orders were given. 2. Corrective action for resident(s) with the potential to be affected. On 4/6/17, the previous two weeks of resident appointments were reviewed by the Director of Nursing Services (DNS) and no other residents were missing ordered lab work and/or x-rays. 3. What measures/systems will be put into place to ensure the deficient practice does not occur again? On 4/6/17, the Executive Director and DNS, revised the appointment procedure to ensure consults and all ordered labs and x-rays results are reported to the MD timely. Consult sheets will be reviewed during the morning clinical meeting by the DNS and/or designee and any diagnostic and labs will be logged in the Appointment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345348	A. BUILDING _____ B. WING _____	C 04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 511	Continued From page 10 The facility DON (Director of Nursing) and transportation aide were interviewed on 4/6/17 at 9:30 AM. The transportation aide stated she picked up prepared paperwork from the nurses prior to transporting residents for appointments. Interview with the DON (Director of Nursing) revealed licensed nurses were responsible for preparing a resident's paperwork in order that the transportation aide have it available to take to a consulting physician. Interview with the DON revealed that nurses routinely sent the following paperwork with a resident: a consultation form on which a consulting physician could communicate their findings and orders to the facility; a list of a resident's medications; a medical history; and any other information which had been requested by a physician to be sent. Interview with the DON revealed Resident # 2's MRI and lab work results should have been sent with her on 2/14/17 or faxed to the neurologist prior to the resident's appointment date.	F 511	Checklist for completion and reviewed daily at morning meeting. Any labs or tests ordered will be faxed to the ordering physician upon receipt. Copies will also accompany the resident on the next return appointment. Transportation driver will write any labs/diagnostic results needed in the appointment book on the specific f/u apt date. Training by the DNS began on 4/7/17 for the licensed nursing staff and the transportation driver regarding the new appointment protocol. All new licensed staff will be oriented on the appointment protocol upon hire by the Clinical care Coordinator. 4. How will performance be monitored and how often? Appointment Checklist book will be audited by the DNS/designee weekly x4 and then monthly thereafter for 6 months to ensure compliance with the new appointment protocol. Compliance will be discussed weekly by the DNS/designee X 4 weeks and then monthly for 6 months during morning administrative meeting. Any non-compliance will be noted and corrective actions taken. Results of audits were presented to the facility QA committee by the DNS during the first QA meeting held on 4/17/17. Audits will be presented to the QA committee for 6 more months. All discussions, revisions to plan, and additional in-servicing will be noted in the QA Committee Meeting Minutes.	