STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345413	A. BUILDING _____ B. WING _____	C 03/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLESHERS FAIRVIEW HEALTH CARE	3016 CANE CREEK ROAD FAIRVIEW, NC 28730

(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 No deficiencies were cited as a result of the complaint investigation Event ID #8WY911.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 157		4/12/17

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

Electronically Signed | 04/04/2017

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F 157	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to notify the physician when insulin had been held for 1 of 5 sampled residents (Resident #144). Findings include: Review of the facility face sheet revealed Resident #144 had been admitted to the facility on 06/03/16 with diagnoses of Diabetes Mellitus type 2, with polyneuropathy, hypertension, and depression. Review of physician orders dated 06/07/16 revealed give 40 units of humulin N insulin (intermediate acting) at 8:00 AM and 5:00 PM subcutaneously. Review of a care plan dated 06/23/16 identified a problem for Resident #144 of potential for abnormal blood glucose levels for diagnosis of diabetes. Interventions included: Administer insulin as ordered and monitor for signs and	F 157	Affected resident is no longer in the facility. All other residents MAR's were reviewed by DON on 4/5/17 for held or not given medications to make sure the MD was notified. Nurse was counseled on 4/5/17 on notification to MD and documentation when a medication is held or refused. Set up in the eMAR system was changed so that anytime a resident is selected an alert will pop up if there have been any missed medications since the last log in to help the nurses make sure everything is given as ordered. In-service training to all nursing staff on 4/6/17 by Admin, DON and ADON on notification of changes policies and procedures. Things to help-Nurse can	

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F 157	Continued From page 2 symptoms of hyperglycemia or hypoglycemia. Review of the MAR for the month of October 2016 revealed humulin N insulin, inject 40 units subcutaneously at 8:00 AM and 5:00 PM. On the dates of 10/10/16, 10/12/16, 10/17/16, 10/26/16, and 10/28/16, there was no documentation on the MAR to indicate the humulin N insulin had been given at 8:00 AM on those dates, and no documentation as to why the MAR had not been signed, or if the physician had been notified. An interview on 03/16/17 at 9:06 AM with Nurse #1 revealed she would sometimes have to hold Resident #144's morning insulin, as Resident #144 often refused his breakfast. An interview on 03/17/17 at 9:18 AM with the Medical Director revealed he would expect the nurses to follow physician orders and give the insulin as ordered. He stated Resident #144 would often refuse medications, but he had not been notified. He stated he would consider it a significant med error if a routine dose of insulin had not been given, and he had not been notified. He stated that he may have told the nurses in passing to hold insulin if Resident #144 had not eaten breakfast, but he stated he had not written it as an order. He further stated he expected the nursing staff to notify him if insulin had not been given and added he had not received notification when the insulin had been held for Resident #144. An interview on 03/17/17 at 1:26 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed if there were no initials on the MAR for the administration of the humulin N insulin, it had not been given.	F 157	pull up missed medication report at end of every shift to verify that all medications ordered where given on their shift and documented if not given and notification made to MD. In-service training to staff and monitoring of the policies will ensure that residents are protected against similar situations in the future. QAA to ensure monitoring by DON, ADON, or designated administrative nurse of "Missed Medication Report" 5 times weekly to check that all medication was given as ordered and if not that MD was notified and documentation made in the record. If any were missed and MD was not notified the nurse will be counseled, the MD will be notified at that time, and documentation will be made in the clinical record. Documentation of monitoring will be turned into the QA coordinator weekly for review of compliance and then reviewed in the monthly QA meetings to ensure effectiveness of plan of correction and need for changes, if any. This will be monitored until 90 days of compliance is achieved and maintained. DON, ADON or designated administrative nurse will continue to monitor eMAR's for Missed Medications and MD notification at least weekly on an ongoing basis as part of the QAA program after compliance is maintained to ensure it is sustained.	

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F 157	Continued From page 3 A telephone call had been placed to Nurse #1 on 03/17/17 at 3:19 PM for a follow-up interview, but there had been no return call.	F 157		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to maintain dignity for visual privacy by exposure of a Foley catheter bag during observations on three days of the survey for 1 of 3 sampled residents with indwelling catheters. (Resident #114). The findings included: Resident #114 was admitted to the facility under hospice care on 07/14/16 with diagnoses which included atrial fibrillation, low back pain, dyspnea, osteoporosis, cardiac heart failure, end-stage chronic obstructive pulmonary disease, neuromuscular dysfunction of the bladder, anxiety, neurogenic bladder, respiratory failure and debility. A review of the Minimum Data Set (MDS) dated 01/20/17 revealed Resident #114 was cognitively intact for daily decision making skills. The MDS indicated Resident #114 required total assistance by staff for activities of daily living. The MDS further indicated an indwelling catheter was used for neurogenic bladder.	F 241	Foley Catheter bag cover was placed on the affected resident's catheter bag during the survey 3/17/17. All other resident's with Foley Catheters were checked on 3/17/17 by Administrator to ensure the catheter bags were covered as per policy. Use of Foley Catheter Bag now placed on eTAR for nurse to sign that it is in place every shift. In-service training with all nursing staff on 4/6/17 by Admin, Don and ADON regarding Dignity, specifically catheter bags being covered-review of policies and procedures. In-service training to staff and monitoring of the policies will ensure that residents are protected against similar situations in the future.	4/12/17

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F 241	Continued From page 4 Review of the medical record and physician's history and physical revealed Resident #114 was admitted with diagnoses of neuromuscular dysfunction and neurogenic bladder requiring the use of an indwelling urinary catheter. The care plan dated 08/02/16 revealed care was planned for the use of an indwelling urinary catheter with interventions including, but not limited to, providing a dignity privacy bag for the bedside drainage bag. On 03/13/17 at 9:15 AM Resident #114 was observed in her room during the initial tour of the facility. Resident #114 was observed in bed, the door was open and her catheter drainage bag was observed from the hall, on the bedside, exposed without a privacy cover bag. On 03/13/17 at 12:45 PM Resident #114 was observed in bed with the indwelling urinary catheter bag hanging on the bottom of the bed, as viewed from the hallway, and exposed without a privacy bag covering it. On 03/14/17 at 4:48 PM Resident #114 was observed sitting up in bed with the indwelling urinary catheter bag hanging on the bottom of the bed, as viewed from the hallway, and exposed without a privacy bag covering it. On 03/15/17 at 10:42 AM Resident #114 was observed in bed with the indwelling urinary catheter bag hanging on the bottom of the bed, as viewed from the hallway, and exposed without a privacy bag covering it. On 03/15/17 at 1:18 PM Resident #114 was	F 241	QAA to ensure monitoring by designated administrative nurse of all resident's with Foley catheters 2 times weekly to ensure covers are in place. Documentation of monitoring will be turned in to QA coordinator weekly to review for compliance. Reports will be reviewed by the QA committee at the monthly QA meetings to ensure effectiveness of the plan, need for changes, if any. This will be monitored until 90 days of compliance is achieved and maintained. New checklist put in place as a QA tool to be done monthly by administrator or designated administrative staff on an ongoing basis. The checklist will include items to be reviewed during facility rounds and includes dignity issues such as covering Foley catheter bags.	

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F 241	Continued From page 5	F 241		

observed in bed with the indwelling urinary catheter bag hanging on the bottom of the bed, as viewed from the hallway, and exposed without a privacy bag covering it.

An interview was conducted on 03/15/17 at 1:18 PM with Resident #114. Resident #114 stated that she did not like having her catheter bag exposed to the view of others. She further stated, "it is too personal" and thought it should be covered.

An interview was conducted on 03/15/17 at 1:19 PM with nursing assistant (NA) # 1 who was familiar with the care required and was assigned to Resident #114 on 03/15/17. NA # 1 stated that catheters were emptied twice a shift and as needed. NA # 1 further stated that catheter bags should always be placed in privacy bags. The NA # 1 verified the catheter bag for Resident # 114 was exposed and not in a privacy bag. The NA # 1 further verified the catheter bag should have been placed in a privacy bag.

An interview was conducted on 03/15/17 at 2:03 PM with Nurse # 1 who was familiar with the care required for Resident #114. Nurse # 1 stated that catheters were changed every month or as needed including the tubing and drainage bags. Nurse # 1 further stated the NAs provided daily and as needed catheter care, emptied the drainage bags and recorded output. Nurse #1 explained that all catheter drainage bags should be in privacy bags at all times.

An interview was conducted on 03/15/17 at 2:47 PM with NA # 2 who was familiar with the care required for Resident #114 and was assigned to Resident #114 on Tuesday 03/14/17. NA # 2 stated that catheters were emptied twice a shift

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and as needed. NA # 2 further stated that catheter bags should always be placed in privacy bags. NA # 2 revealed that she had replaced the drainage bag due to leaking and hadn't replaced the privacy bag. The NA # 2 verified the catheter bag for Resident # 114 was exposed and not in a privacy bag. The NA # 2 further verified the catheter bag should have been placed in a privacy bag.

An interview was conducted on 03/16/17 at 1:29 PM with Nurse # 2 who was familiar with the care required for Resident #114 and was assigned to her care on Tuesday 03/14/17. Nurse # 2 stated that catheters were changed every month or as needed including the tubing and drainage bags. Nurse # 2 further stated the NAs provided daily and as needed catheter care, emptied the drainage bags and recorded output. Nurse # 2 explained that all catheter drainage bags should be in privacy bags at all times. Nurse # 2 revealed he recalled that Resident #14 did not have a privacy bag on Tuesday. Nurse # 2 explained that he got busy and forgot to replace it. Nurse # 2 further revealed he should have replace a new privacy bag or had the NA to do it.

An interview was conducted on 03/16/17 at 2:07 PM with NA # 3 who was familiar with the care required for Resident #114 and was assigned to Resident #114 on Monday. NA # 3 stated that catheters were emptied twice a shift and as needed. NA # 3 further stated that catheter bags should always be placed in privacy bags. The NA 3 verified the catheter bag for Resident # 114 was exposed and not in a privacy bag. The NA # 3 further verified the catheter bag should have been placed in a privacy bag.

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F 241	Continued From page 7 An interview was conducted on 03/16/17 at 2:25 PM with the Director of Nursing (DON). The DON stated she was not aware that Resident #114's catheter bag did not have a privacy bag. The DON further stated that it was her expectation that all catheters should be in privacy bags. An interview was conducted on 03/17/17 at 3:26 PM with the Administrator. The Administrator stated that the DON had informed her of the missing privacy bag on Resident #114's urinary catheter. The Administrator further that it was her expectation for all catheters were placed in privacy bags and especially if the bags were visible.	F 241		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews, the facility failed to transcribe a physician's order to apply a medicated cream at the prescribed frequency onto the Medication Administration Record (MAR) for 1 of 5 residents reviewed for medication use (Resident #144). Findings included: Resident #144 was admitted to the facility on 06/03/16 with diagnoses including diabetes	F 281	Affected resident is no longer in the facility. MAR's were audited by Administrative Nurse on 4/4/17 and 4/5/17 to ensure there were no other transcription errors. The nurse making the transcription error was counseled on 4/5/17. In-service training to all nurses on 4/6/17	4/12/17

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F 281	Continued From page 8 mellitus II, diabetic polyneuropathy and peripheral vascular disease. The resident was discharged to the hospital on 12/13/16 where he was placed on hospice care and did not return to the facility. Resident #144's care plan dated 06/23/16 included appropriate goals and interventions for the problem of actual and potential for impaired skin integrity. Resident #144's most recent quarterly Minimum Data Set (MDS) dated 09/08/16 assessed Resident #144 with full and intact cognition and requiring extensive two person assistance for bed mobility, transfers, dressing, toileting, personal hygiene and bathing. Resident #144 was coded as at risk for pressure ulcers with no other skin conditions. Review of Resident #144's medical record revealed a dermatologist note dated 10/10/16 with the resident presenting with itching and a rash. The dermatologist prescribed triamcinolone 0.1% topical cream, 60 grams of which was to be mixed with 180 grams of cetaphil lotion and applied four times a day for itching. Review of a hard prescription from the dermatologist dated 10/10/16 revealed triamcinolone 0.1% topical cream, 60 grams of which was to be mixed with 180 grams of cetaphil lotion and applied four times a day. Further review of Resident #144's medical record revealed a dermatologist note dated 10/18/16 for a follow up visit and further evaluation and management, with a diagnosis of eczema and a plan to continue the triamcinolone/cetaphil mixture four times a day for itching.	F 281	by Admin, DON, ADON regarding transcription of medication policies and procedures with emphasis on clarifying if another order is being changed or discontinued, it is an addition to something resident is already on, etc. MD and other practitioners in facility counseled to be clear upon writing the orders. Nurses told to contact MD/Provider if there is confusion over the orders. In-service training to staff and monitoring of the policies will ensure that residents are protected against similar situations in the future. DON,ADON or other designated nurse will double check and verify all new orders at least 4 times weekly to ensure they are accurate and document findings. Monitoring reports will be turned in to the QA Coordinator weekly for review of compliance. The reports will be reviewed at the monthly QA committee meetings to ensure effectiveness of plan of correction, need for changes, if any. Monitoring will continue until compliance is achieved and maintained for 90 days. DON, ADON or other designated administrative nurse reviews all MAR's at the beginning of each month to verify that all orders are transcribed correctly from orders written the previous month. DON, ADON or other designated administrative nurse will monitor any new	

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F 281	Continued From page 9 Review of a nurses noted dated 10/28/16 by Nurse #1 revealed the "triamcinolone cream order clarified to twice daily." Review of a clarification order dated 10/28/17 by Nurse #1 and signed by the attending physician on 11/03/16 revealed triamcinolone cream 0.1% to be applied twice a day. Review of the October 2016 MAR revealed the original triamcinolone/cetaphil order was discontinued on 10/28/16 and then renewed on 10/28/16 and written for four times per day, with the administration times assigned as 9:00 AM and 9:00 PM, or twice a day, and documented as administered from 10/28/16 through 10/31/16. Review of Resident #144's November MAR revealed the order for triamcinolone 0.1%/cetaphil lotion apply four times a day for itching with administration times of 9:00 AM and 9:00 PM and documentation of administration from 11/01/16 through 11/17/16. On 11/17/16 the order was discontinued then renewed for continued administration at 9:00 AM and 9:00 PM through 11/30/16. Review of Resident #144's December 2016 MAR revealed the order for triamcinolone 0.1%/cetaphil lotion apply four times a day but with ordered times at 9:00 AM and 9:00 PM and documentation of administration from 12/01/16 through 12/2/16. Review of a dermatology note dated 12/08/16 revealed Resident #144 following up for an unspecified dermatitis which had improved. The treatment plan was to continue the triamcinolone/cetaphil mixture twice a day as needed and to keep his skin very well lubricated.	F 281	orders at least weekly on an on-going basis after compliance maintained to ensure compliance is sustained as part of the QAA program.	

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On 03/17/17 at 8:35 AM the dermatologist was called but was not available for a telephone interview and did not return the call.

On 03/17/17 at 9:17 AM the attending physician/medical director was interviewed and he revealed his expectation was that all aspects of medical orders, including frequency of administration, be followed.

On 03/17/17 at 1:26 PM the Assistant Director of Nursing (ADON) and Director of Nursing (DON) were interviewed. The DON stated new medication orders were faxed to the pharmacy and the pharmacy would input the orders into a computer system that would connect the order to the electronic MAR as a pending order. These pending orders popped up on the computer screen on the medication carts and the nurse would confirm with the paper order to determine accuracy, either accepting or rejecting orders. The pharmacy assigned medication administration times, but in regard to Resident #144's triamcinolone/cetaphil order it looked like someone in the facility, and not the pharmacy, changed the times. They stated that on the computer screens on the medication carts that nurses were able to see the whole written order, but without pulling up a MAR, nurses would not know the other times of the day the medication would be administered. They stated in their review of the transcription of the dermatologist's hard prescription to the paper order slip it looked like the nurse did not read the rest of the order to see the time frequency was to be four times a day.

On 03/17/17 at 3:19 PM Nurse #1 was called for

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F 281	Continued From page 11 an interview but she was not available and a phone call was not returned. On 03/17/17 at 3:58 PM the Administrator was interviewed. She stated medication orders were sent to pharmacy and the pharmacy inputted orders except after business hours and weekends, in which case the facility nurse put them in the electronic MAR. She expected medication orders to be followed as written.	F 281		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323		4/12/17

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F 323	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to identify and repair a loose side rail for 1 of 4 residents reviewed for accident and hazard prevention (Resident #101). Findings included: Resident #101 was admitted to the facility on 08/12/16 with diagnoses including muscle weakness and age-related osteoporosis without current pathological fracture. Review of a physician's admission note dated 08/16/16 documented advancing dementia. Review of medical orders dated 08/12/16 directed one full side rail and one-half side rail to his bed for mobility. Review of Resident #101's care plan dated 09/01/16 and updated on 09/10/16 included the problems of impaired thought processes, impaired physical mobility and self-care deficit, bladder elimination related to incontinence and falls risk related to a falls history and poor safety awareness. Review of Resident #101's nursing notes dated 02/11/17 documented that the majority of the resident's needs were anticipated and met by staff, that on some days he was aware enough to ask to use the toilet with the assistance of 2 people, he was very unsteady and did not ambulate, he had no safety awareness, and he was monitored closely as he would get himself out of his wheelchair and into his bed or to the toilet.	F 323	The loose side rail was fixed on affected resident's bed while the survey team was in facility 3/17/17. Maintenance Director and Assistant checked all other side rails in use in the facility to ensure they were in good working order from 3/17/17 to 4/5/17. Side Rails have been added to the preventative maintenance checklist to be checked for correct functioning by maintenance staff quarterly and documentation maintained. In-service training on 3/16/17 by ADON with all nursing staff on duty regarding side rails-reporting malfunctioning or broken equipment to maintenance immediately. In-service training with all staff 4/6/17 by Admin, DON and ADON regarding reporting malfunctioning or broken equipment to maintenance immediately and reviewed the dangers of side rail use in general. In-service training to staff and monitoring of the policies will ensure that residents are protected against similar situations in the future. QAA to ensure monitoring by designated administrative staff of all side rails in use 2 times weekly and document. Documentation to be turned in to QA	

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F 323	Continued From page 13 The most current quarterly Minimum Data Set (MDS) dated 02/17/17 revealed the resident to have severely impaired cognition, inattention and disorganized thinking. Resident #101 required extensive one person assistance with activities of daily living which included bed mobility, transfers, locomotion, dressing, toileting and personal hygiene. Review of his most current fall risk assessment dated 02/17/17 documented an overall risk score of 14 (a score above 10 was considered high risk). Review of another medical order for Resident #101 dated 03/03/17 directed that one full length and one half length side rail be placed on his bed. On 03/14/17 at 4:27 PM Resident #101 was observed in his room, dressed and lying on top of his made bed. He appeared confused and sat up in the bed. The side rail to the resident's right while lying in bed was a full length rail, locked securely in the up position with no gap between the rail and the mattress, and on the side of the bed closest to the wall. The side rail to the resident's left while lying in bed ran half the length of the bed and was very loose in the bracket which was attached to the bed frame. The bracket connection to the bed frame was also loose. It was located at the head of bed and on the side of the bed with floor space sufficient for a wheelchair for transfers. A nurse aide (NA) was observed responding to the resident's call light and the NA was leaning on the left side half rail. On 03/14/17 at 4:39 PM Resident #101 was observed out of bed and in his wheelchair, placed in front of the doorframe of his room. Observation of the left half side rail revealed lateral movement away from the side of the	F 323	coordinator weekly to review compliance. Reports will then be reviewed in the QA monthly committee meeting to ensure effectiveness of plan of correction or needed changes, if any. The monitoring will continue until 90 days of compliance is achieved and maintained. Maintenance will monitor quarterly on the preventative maintenance checklist to ensure compliance is sustained.	

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mattress with an approximately 3 1/2 inch gap at the widest point between the rail and the mattress. Observation of vertical movement of the left side rail revealed an approximately 5 inch gap at the widest point between the rail and the mattress at the end closest to the head of the bed.

On 03/15/17 at 10:37 AM and on 03/16/17 at 10:11 AM Resident #101's room was observed. The side rails were down on bed, the left rail underneath bed covers and lowered to floor, but remained loose at the bracket connection to bed for increased lateral movement, and as the rail rested in the bracket for increased vertical movement.

On 03/15/17 a family member of Resident #101's was interviewed. She stated she was not aware of any loose side rails.

On 3/16/17 at 2:20 PM Hospitality Aides #1 and #2 were observed in Resident #101's room, making his bed and Hospitality Aide #1 was observed raising the left half rail to the up position.

On 03/16/17 at 2:20 PM Hospitality Aides #1 and #2 were interviewed in Resident #101's room. They stated they do make beds and therefore were familiar with moving bed rails. They stated rails should move up and down, lock into place and not be loose so that residents do not hurt themselves. During the interview, Hospitality Aide #1 demonstrated moving the full right rail up and down, with no appreciable gap between the rail and mattress and the rail locked in place in the up position. When asked about the left half rail Hospitality Aide #1 stated it was fine with no

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problems. They stated if a rail was too loose, Maintenance was notified to fix it.

On 03/16/17 at 2:45 PM NA #4 was interviewed in Resident #101's room. She stated rails that were loose or did not lock into place when raised were reported to Maintenance to fix them. She stated when she came to work, Resident #101 was already up, but she did assist him to and from bed for naps. Upon checking the left rail she stated it was loose, but she was not sure why. When she attempted to tighten the bracket against the bed frame, it would not tighten and she was not sure why. She stated "to be honest with you, there are a couple of rails like that" and a loose rail could catch a resident's leg or arm.

On 03/16/2017 at 3:02 PM the Maintenance Director was interviewed in Resident #101's room. Upon inspecting the left rail, he stated the rail in the current condition was very loose, it should have been reported to him to fix and he did not have a work request slip for it. Staff had been told to fill out a work request slip and that way he would know to fix it. He stated he did not routinely go into every room to check for loose bed rails. He stated the housekeeping supervisor was responsible for checking on furniture and reporting current condition issues, which included bed rails. He stated the left half rail on Resident #101's bed was broken, the hand tightening mechanism just spun around and would not tighten the bracket against the bedframe. He stated he was not the person to train staff the signs which would indicate a broken rail, as that was something nursing would do.

On 03/16/17 at 3:35 PM Nurse #4 was interviewed. She stated she was not aware of

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F 323	Continued From page 16 any loose bed rails on Resident #101's bed and it should have been reported to her so that Maintenance could be made aware to fix it. On 03/16/17 at 4:48 PM the Assistant Director of Nursing was interviewed. She expected staff to report maintenance concerns by using a work order form kept at nursing stations, filling it out and reporting the issue to the nurse. She stated bed rails were considered unsafe if loose and if when lifted did not fasten properly. She stated half rails could be tightened, but if staff attempted to tighten and there was no improvement then Maintenance was to be notified. She stated she recalled assisting Resident #101 in bed the previous week and at that time the half rails seemed steady. She stated rails were checked when residents moved to a different room as staff wanted to make sure the rails were on the correct side of the bed based on the positioning of the bed in the room and what side of bed they transfer in and out of. On 03/17/17 at 3:51 PM the Administrator was interviewed. She stated she did not know if Maintenance routinely checked bed rails, but that staff were expected to report concerns on a work order for repairs. She stated if a bed rail was loose, not working or not working like they were they supposed to, she expected the concern to be reported.	F 323		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 425		4/12/17

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F 425	Continued From page 17 biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to provide 3 doses of antidepressant medication and 2 doses of antipsychotic medication as prescribed by the physician for 1 of 5 sampled residents (Resident #135). The findings included: Resident #135 was admitted to the facility on 01/16/17 with diagnoses which included anxiety, depression, left hip arthroplasty (12/27/16) and dementia without behavioral disturbance. Medications ordered on admission included Effexor (an antidepressant) 75 milligrams every day. A physician's progress note dated 01/19/17 noted Resident #135 was having behavioral issues and suspected it might be delirium following surgery and ordered Risperdal (an antipsychotic) 0.25 milligrams twice a day. The admission Minimum Data Set (MDS) for Resident #135 dated 01/24/17 assessed mild cognitive impairment and noted both antidepressant and antipsychotic medication were part of the plan of care. The Care Area Assessments related to the admission MDS	F 425	Medications were obtained and administered on 3/17/17 to affected resident. All other residents MAR's were reviewed by DON on 4/5/17 for held or not given medications to make sure the MD was notified and reason not administered is correctly documented. Set up in the eMAR system was changed so that anytime a resident is selected an alert will pop up if there have been any missed medications since the last log in to help the nurses make sure everything is given as ordered. Policy changed that all medication reorders will only be done through the computer system at the beginning of the 7 day reorder period. (no longer faxed) All overflow medications were organized to ensure they are easily assessable to the nursing staff. Third shift nurses to review carts per schedule weekly to make sure that any medications running low have been reordered. Nurses to keep the pink short slip on medication until the yellow copy and the remaining medication	

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F 425	Continued From page 18 included: -Behavior-Resident had diagnosis of dementia, delirium and depression. Since admission to this facility his sensorium had fluctuated from confused and disrobing to alert and oriented X 3. Denied any mood issues. Did exhibit behaviors at times, grabbing at things in the air, hitting staff, screaming/yelling and rummaging. Utilized psychoactive medications Risperdal and Effexor. -Psychotropic-Resident had diagnosis of dementia, delirium and depression. Since admission to this facility his sensorium had fluctuated from confused and disrobing to alert and oriented X 3. Denied any mood issues. Did exhibit behaviors at times, grabbing at things in the air, hitting staff, screaming/yelling and rummaging. Utilized psychoactive medications Risperdal and Effexor. Physician started Risperdal in hopes of helping his delirium. Medications were reviewed monthly by pharmacy with recommendations to decrease dosage/number of medications as indicated. The care plan for Resident #135 included the following problem areas: -Thought processes impaired related to dementia related delirium with behavioral indicators....grabbing the air, yelling/screaming, hitting staff, rummaging, etc....Approaches to this problem area included to administer psychoactive medications as ordered. -Potential for side effects related to psychoactive medication use. Approaches to this problem area included resident uses antidepressant due to diagnosis of depression and resident uses antipsychotic due to diagnosis of delirium. On 03/03/17 Resident #135 was seen by a Psychiatrist to evaluate and treat for anxiety and	F 425	is delivered. In-service training with all nurses on 4/6/17 by Admin, DON, and ADON along with several key pharmacy staff regarding the policies on reordering medication and what to do if you do not have the medication. Look through overflow, make sure it has been reordered, call pharmacy, notify administration,etc. Recommend nurses write on the card the date and time reordered and keep card in cart until the new medication arrives. In-service training to staff and monitoring of the policies will ensure that residents are protected against similar situations in the future. QAA to ensure monitoring by DON, ADON or designated administrative nurse of medications not given by monitoring the "Did Not Administer Report" 5 times weekly and maintaining documentation of such. Nurses will be counseled and MD notified as needed if medication not given. The documentation will be turned in to QA Coordinator weekly to be reviewed for compliance. The reports will be reviewed in the monthly QA meetings to ensure effectiveness of the plan and whether changes need to be made. Monitoring will continue until compliance is achieved and maintained for 90 days. DON, ADON or designated administrative nurse will continue to monitor eMAR's for missed medications at least weekly on an	

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F 425	Continued From page 19 restlessness in dementia. The assessment and plan noted by the Psychiatrist on 03/03/17 included: -Neurocognitive disorder due to Alzheimer's disease with behavioral disturbance: moderate with poor insight and judgment. Delusions of being able to go home and go back to work. Delirium appears to have cleared at this point. Will taper off of Risperdal and monitor agitation. -Major depression, history of depressed mood. Continue Effexor. Review of the February 2017 Medication Administration Records (MAR) for Resident #135 noted the following: Risperdal .25 milligrams was scheduled to be given at 9:00 AM and 5:00 PM. Review of the MAR noted the 5:00 PM dose of Risperdal was not given to Resident #135 on 02/20/17 due to "not available-pharmacy contacted." Review of the MAR noted the 9:00 AM dose of Risperdal was not given to Resident #135 on 02/21/17 due to "not available-pharmacy contacted." Review of the March 2017 MAR for Resident #135 noted the following: Effexor 75 milligrams was scheduled to be given at 9:00 AM. Review of the MAR noted the Effexor was not given to Resident #135 on 03/01/17, 03/16/17 and 03/17/17 due to "not available-pharmacy contacted." On 03/17/17 at 9:20 AM the physician of Resident #135 stated he expected medication to be administered as ordered. The physician stated he did not feel the missed Risperdal and Effexor caused any harm to Resident #135. On 03/17/17 at 11:35 AM the psychiatrist stated	F 425	ongoing basis as part of the QAA program after compliance is maintained to ensure it is sustained.	

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she expected medication to be administered as ordered. The psychiatrist stated the Risperdal had been used for Resident #135 initially because of issues with delirium. The psychiatrist noted the delirium had since cleared and Resident #135 was weaned off the Risperdal. The psychiatrist stated Effexor should not be abruptly stopped because it could potentially have unpleasant side effects. The psychiatrist stated the side effects would not harm a resident but, because of that potential, the Effexor should be given as ordered.

On 03/17/17 at 1:05 PM Nurse #3 stated he was on duty 03/16/17 and 03/17/17 when the 9:00 AM dose of Effexor was not available to be administered to Resident #135. Nurse #3 explained the manner medications were received from the pharmacy. Nurse #3 stated multiple single doses of a medication were sent from the pharmacy on a card. The nurse stated when there were approximately seven doses of a medication remaining on the card the nurse on duty was supposed to alert the pharmacy of the need for a refill. Nurse #3 stated the pharmacy could be informed electronically (if the internet was available), fax'd or from the reorder sticker located on the card containing the medication. Nurse #3 stated because the pharmacy was located so close to the facility the medication typically came right away. Nurse #3 stated he sent a fax to the pharmacy on 03/16/17 to request a refill of the Effexor for Resident #135.

On 03/17/17 at 1:30 PM the Director of Nursing (DON) and Assistant Director of Nursing (ADON) stated nurses were responsible for reordering medications. The DON stated medications were reordered either electronically, by fax or from the reorder sticker located on the medication card.

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The DON stated if a medication was reordered too soon the pharmacy would typically report that to the facility. The DON stated medications were delivered twice a day-mid afternoon and in the evening. The DON stated the facility had a back up pharmacy if medications were not available at the facility pharmacy. The DON and ADON stated they were not aware of any problems with medications not being available to be administered to residents.

On 03/17/17 at 2:00 PM the pharmacy director was interviewed and indicated medications would typically be sent to the facility the same day they are ordered. The pharmacy director stated if a nurse indicated they were completely out of a medication they would ensure a quicker delivery. The pharmacy director stated if a medication wasn't available it would be obtained from a back up pharmacy. The pharmacy director reviewed the order of Effexor for Resident #135 and noted a 30 day supply of Effexor had been sent to the facility on 03/01/17. The pharmacy director stated there should have been Effexor available to be administered on 03/16/17 and 03/17/17 and said the fax request from 03/16/17 would not have been filled because it was too soon for a refill. The pharmacy director stated the fax request for Effexor from 03/16/17 did not indicate the facility did not have the medication available for Resident #135. The pharmacy director checked with the pharmacy technician that processed the fax request for Effexor for Resident #135 and this pharmacy technician stated they did not call the facility to report it was too soon to refill the Effexor. The pharmacy director stated the Risperdal was requested to be refilled on 02/21/17 at 8:30 AM and there was no indication the facility did not have the medication

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F 425	Continued From page 22 available for Resident #135. The pharmacy director stated the Risperdal was sent the afternoon of 02/21/17. On 02/17/17 at 4:20 PM the DON stated she could not explain why the 30 day supply of Effexor was not available to be given to Resident #135 on 03/16/17 or 03/17/17. The DON reviewed the facility refill request and noted the refill for Risperdal for Resident #135 had been made 02/20/17 at 7:27 PM. The DON suspected the pharmacy did not receive the request until they opened the morning of 02/21/17. The DON stated they could not track which nurse had not ordered the Effexor (for the 03/01/17 dose) and Risperdal to ensure it was refilled and available for administration to Resident #135. The DON stated all nurses were responsible for reordering medications when they noted there was approximately 7 doses remaining to ensure medication were refilled and available to be given as ordered.	F 425		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 514		4/12/17

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F 514	Continued From page 23 (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate Medication Administration Record (MAR) for the administration of insulin for 1 of 5 sampled residents (Resident #144). Findings include: Review of the facility face sheet revealed Resident #144 had been admitted to the facility on 06/03/16 with diagnoses of Diabetes Mellitus type 2, with polyneuropathy, hypertension, and depression. Review of physician orders dated 06/07/16 revealed give 40 units of humulin N insulin (intermediate acting) at 8:00 AM and 5:00 PM	F 514	Affected resident is no longer in facility. All other residents MAR's were reviewed by DON on 4/5/17 for held or not given medications to make sure medications were given as ordered, MD was notified and accurate documentation made if not given. Nurse was counseled on 4/5/17 on documentation when a medication is held or refused and not administered. Set up in the eMAR system was changed so that anytime a resident is selected an alert will pop up if there have been any missed medications since the last log in to	

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	345413	A. BUILDING _____ B. WING _____	C 03/17/2017

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F 514	Continued From page 24 subcutaneously. Review of a care plan dated 06/23/16 identified a problem for Resident #144 of potential for abnormal blood glucose levels for diagnosis of diabetes. Interventions included: Monitor capillary blood glucose (CBG), administer insulin as ordered, and monitor for signs and symptoms of hyperglycemia or hypoglycemia. Review of the MAR for the month of October 2016 revealed humulin N insulin, inject 40 units subcutaneously at 8:00 AM and 5:00 PM. On the dates of 10/10/16, 10/12/16, 10/17/16, 10/26/16, and 10/28/16, there was no documentation on the MAR to indicate the humulin N insulin had been given at 8:00 AM on those dates. An interview on 03/16/17 at 9:06 AM with Nurse #1 revealed she would sometimes have to hold Resident #144's morning insulin, as Resident #144 often refused his breakfast, but did not state specific dates when she had held the insulin for Resident #144. An interview on 03/17/17 at 1:26 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed if there had been a slash on the MAR, it meant it was a" hole" in the MAR, which meant the medication should have been given, but if there were no initials in the box, it had not been given. The DON stated they had been having trouble with the electronic MAR not recording the nurse's initial when the humulin N insulin had been given. Further interview revealed it would be their expectations that the nurse who administered the medication would record it on the MAR, or record a reason if it had not been given.	F 514	help the nurses make sure everything is given as ordered. In-service training to all nursing staff on 4/6/17 by Admin, DON, ADON on accurate documentation of medication administration. Nurse can pull up missed medication report at end of every shift to verify that all medications ordered where given on their shift and documented if not given. QAA to ensure monitoring by DON, ADON or designated administrative nurse of "Missed Medication Report" 5 times weekly to check that all medication was given as ordered and documentation made in the record. If medication not documented nurse to be counseled and MD notified as needed. Monitoring reports will be turned into the QA Coordinator weekly to review compliance. The reports will be reviewed in the monthly QA meetings to ensure effectiveness of plan of correction and need for changes, if any. This will be monitored until 90 days of compliance is achieved and maintained. DON, ADON or designated administrative nurse will continue to monitor eMAR's for missed medications at least weekly on an ongoing basis as part of the QAA program after compliance is maintained to ensure it is sustained.	

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F 514	Continued From page 25 A telephone call had been placed to Nurse #1 for a follow-up interview on 03/17/17 at 3:19 PM, but a return call had not been received.	F 514		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as	F 520		4/12/17

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F 520	Continued From page 26 such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 staff interview, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in February of 2016. This was for two recited deficiencies which were originally cited in February of 2016 on a recertification survey and on the current recertification survey. The deficiencies were in the areas of dignity and respect of individuality and services provided meet professional standards. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. F241 Dignity and Respect of Individuality: Based on observations, interviews and record reviews the facility failed to maintain dignity for visual privacy by exposure of a Foley catheter bag during observations on three days of the survey for 1 of 3 sampled residents with indwelling catheters. (Resident #114). The facility was recited for F241 for failing to respect a resident's dignity. F241 Dignity and	F 520	Quality assurance policies and procedures have been updated to better reflect steps that need to be taken to ensure identification of issues and maintaining compliance. QA Committee meetings have been increased to Monthly and as needed. QA Committee chairman attended Webinar on "Using data in QAPI: collect, analyze, and communicate" to better assist with directing the program. In-service training with all staff on 4/6/17 by Admin, DON and ADON regarding the QAA program and what is expected, how communication will be made, how the staff will be made aware of what is being monitored, improvements or changes to systems, ways to provide input for issues in facility, attendance at QA meetings and participation in the QA meetings and the QA process, etc. QA will ensure weekly monitoring throughout facility by various staff not directly responsible for the area being monitored using a checklist of items to	

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F 520	Continued From page 27 Respect of Individuality Privacy and Confidentiality was originally cited during the February 19, 2016 recertification survey for failing to assist a resident to eat in a manner to maintain dignity. 2. F281 Services Provided Meet Professional Standards: Based on record review and staff and physician interviews, the facility failed to transcribe a physician's order to apply a medicated cream at the prescribed frequency onto the Medication Administration Record (MAR) for 1 of 5 residents reviewed for medication use (Resident #144). The facility was recited for F281 for failing to transcribe a physician's order to apply a medicated cream at the prescribed frequency onto the Medication Administration Record (MAR). F281 Services Provided Meet Professional Standards was originally cited during the February 19, 2016 recertification survey for failing to administer medications consistent with orders sent on admission. During an interview on 03/17/17 at 3:58 PM the Administrator stated dignity issues were monitored "for a long time" and included checking staff knocking on doors. She expected catheter bags to be covered per their facility policy. She stated facility staff walked through the facility to "check on things." She stated medication orders were sent to the pharmacy and the pharmacy inputted orders except after business hours and weekends, in which case the facility nurse put them in the electronic MAR. She expected medication orders to be followed as written.	F 520	look for on rounds-dealing with issues of dignity, meeting professional standards of care, or any other issues that may need to be addressed through the QAA program, etc. The checklist will be reviewed in the monthly QA meetings to review compliance of the QA program. The committee will use all monitoring and reporting devices as well as levels of compliance maintained and sustained to determine effectiveness of the program or if changes need to be made.The monitoring will continue weekly for 90 days until compliance is maintained. The QA Checklist will be continued Monthly as an on-going QA measure to ensure any issues are addressed, plans put in place to correct, monitoring of plans to ensure effectiveness to maintain and sustain compliance.	