STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 06/28/2018

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THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation. See Event ID 7KWB11.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(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 observations, record reviews and staff interviews the facility failed to obtain a Physician's order for a resident to self-medicate a medication found at the resident's bedside for 1 of 1 resident reviewed for choices (Resident # 31). The findings included: Resident #31 was admitted to the facility on 04/18/18 with diagnoses which included atrial fibrillation and cancer. Review of Resident #31's Significant Change Minimum Data Set (MDS) assessment dated 06/14/18 revealed he had short and long term memory problems and severely impaired skills for daily decision making. The MDS also indicated he required extensive assistance with most of his activities of daily living (ADLs). Review of Resident #31's Physician orders since his admission on 04/18/18 revealed no medications were ordered to be left at bedside or for the resident to self-medicate.	F 554	Plan correcting the specific deficiency, and process that lead to the deficiency cited. On 6-27-18 at 3:22pm, the Airborne Gummie Vitamins were removed from Resident #31'□s room and securely placed in the Nurses Station Medication Room. The Airborne Gummie Vitamins were returned to Resident #31□'s spouse on July 5, 2018 at 3:45pm. Resident family member also provided with education requesting that she not bring medications from home to leave at resident□s bedside. Spouse verbalized understanding. The spouse for Resident #31 brought the Airborne Gummie Vitamins from home and left the over-the-counter (OTC) medication in the resident□s room. Staff failed to ensure a physician order for self-administration of the medication, when it was identified the resident had medications at bedside. Procedure for implementing the	7/9/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/09/2018

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 554	Continued From page 1 During the initial encounter with Resident #31 on 06/25/18 at 10:46 AM, an observation was made of a bottle of Airborne Gummies (Immune Support Supplement) that was approximately half full sitting on the resident's bedside table. The label on the bottle indicated it contained 42 orange flavored gummies. An observation on 06/26/18 at 8:26 AM noted the bottle of Airborne Gummies sitting on the window sill in the resident's room. An observation on 06/27/18 at 8:52 AM revealed the half bottle of Airborne Gummies were sitting on the window sill in the resident's room. On 06/27/18 at 11:22 AM during an interview with nurse aide (NA) #1 she stated that the residents were not allowed to keep medications at their bedside unless they have an order to self-medicate. The NA further added that if she found medications in the residents' rooms she took them to the nurse. During an interview with Nurse #1 on 06/27/18 at 3:22 PM she reported that medications were not left in the residents' rooms unless there was an order for them to self-medicate. Nurse #1 was shown the bottle of Airborne Gummies in Resident # 31's room then went to see if he had an order to self-medicate. The Nurse reported he had no order to self-medicate and removed the medication from Resident #1's room. During an interview with MDS Nurse #1 on 06/27/18 at 3:40 PM she indicated that before a resident could have medications at their bedside they have to be evaluated by the MDS Nurses to be mentally and physically able to administer	F 554	acceptable plan of correction (POC) for the specific deficiency cited. From July 5-July 7, 2018, all resident rooms were evaluated for any medications, prescribed and/or over the counter (OTC) to ensure self-administration guidelines are followed. 1.) active physician order for medication, 2.) physician order to keep medication at bedside to self-medicate, 3.) resident assessment to ensure safe self-administration and securement of the medication. Monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. Effective July 5, 2018, weekly audits of resident□s rooms will be included in the environment of care rounds conducted by the DON/ADON/designee. Medications found at bedside will be reconciled against active physician orders for self-administration of medication(s) and continued appropriateness of the medication at bedside. Medications found at bedside without an active physician□s order to self-administer will be removed from the resident□s room pending physician approval and secured in the appropriate medication room. Title of the person responsible for implementing the acceptable POC. The Director of Nursing (DON) will be responsible for implementing the POC.	

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F 554	Continued From page 2 medications safely and the medications should be locked up in their bedside table. MDS Nurse #1 stated Resident # 31 would not mentally or physically be able to self-medicate himself. On 06/28/18 at 11:30 AM an interview with the Director of Nurses stated her expectation would be for the medication to be removed from Resident #31's room since he was not able to self-medicate.	F 554	The Assistant Director of Nursing (ADON) will be responsible in the absence of the DON. Dates when the corrective action will be completed. Immediate corrective action to correct the cited deficiency was completed on June 27, 2018. Corrective action to identify residents having potential to be affected by the same deficient practice began on July 5th and was completed on July 7, 2018. All review of all resident rooms was conducted to ensure no medications were at bedside without physician orders for self-administration. Corrective action to ensure continued compliance with the regulatory requirements will be initiated July 9, 2018. Weekly monitoring will be conducted by the DON/ADON/designee and reported to the monthly Quality Assurance and Performance Improvement (QAPI) meeting. The DON/ADON/designee will report the findings at the monthly QAPI meeting monthly x (3) months to ensure compliance with changes are sustained, with a decision for continued monitoring if needed.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		7/9/18

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F 761	Continued From page 3 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to store a bottle of Tuberculin Purified Protein (PPD) solution (an injectable solution used to aid in the determination of tuberculosis) according to the product manufacturing guidelines found on 1 of 4 medication carts reviewed for proper storage of medications. The findings included: According to the product manufacturing guidelines printed on the bottle of the PPD solution stated the solution should be stored between 35-46 degrees F (Fahrenheit). On 06/27/18 at 1:25 PM accompanied by Nurse	F 761	Plan correcting the specific deficiency, and process that lead to the deficiency cited. On 6-27-18, it was identified that a medication (Tuberculin Purified Protein/PPD) requiring refrigeration per the manufacturers recommendation was found on Nurse #1□s Medication Cart. The medication was immediately discarded by the Infection Control Nurse upon identification of inappropriate storage of the medication. It was later identified that the medication was inadvertently left of the Medication Cart after a scheduled dose of PPD for a resident the previous shift.	

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F 761	Continued From page 4 #1, a review of the split medication cart for 100/200 halls was conducted which yielded an opened bottle of PPD solution dated 06/22/18. When Nurse #1 was asked where the bottle of solution should be stored the Nurse stated the solution should be stored in the refrigerator. On 06/27/18 at 1:35 PM the Infection Control Nurse (ICN) was interviewed about the PPD solution and confirmed the PPD solution should be refrigerated. During an interview with the Director of Nursing (DON) on 06/28/18 at 11:30 AM she stated her expectation for the PPD solution would be for it to be returned to the refrigerator after use.	F 761	Procedure for implementing the acceptable plan of correction (POC) for the specific deficiency cited. Effective July 5, 2018 all medications requiring specific storage requirements will come from the pharmacy provider indicating the specific safe storage requirements, i.e. refrigeration. All current medications currently in the facility were reviewed on July 5, 2018 to ensure proper storage and special storage requirement labels were added if indicated. This was accomplished in collaboration with the pharmacy services. Monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. On July 5, 2018 the DON met with the Pharmacy consultant to review special storage recommendations for medications provided by the pharmacy service. Medications requiring any special storage requirements will be clearly identified with additional alert labeling to indicate the appropriate storage requirement, i.e. Keep in Refrigerator. A review of medications requiring refrigeration will be added to the current weekly Medication Cart Audit effective July 9, 2018. Additionally, pharmacy will provide the DON a notification when pharmacy fills any medication requiring refrigeration. This will allow additional tracking of medications with special storage requirements.	

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F 761	Continued From page 5	F 761	Title of the person responsible for implementing the acceptable POC. The DON will be responsible for implementing the POC. The ADON will be responsible in the absence of the DON. Dates when the corrective action will be completed. Immediate corrective action to correct the cited deficiency was completed on June 27, 2018. Corrective action to identify other improperly stored medications was conducted on July 5, 2018. Corrective action to ensure continued compliance with the regulatory requirements was initiated on July 9, 2018. Daily monitoring of newly filled medications requiring refrigeration will be conducted, as needed in response to notification from pharmacy services at the time of medication delivery to the facility. Weekly monitoring will be conducted by the DON/ADON/designee effective July 9, 2018 and reported to the monthly QAPI meeting. The DON/ADON/designee will report the findings at the monthly QAPI meeting on a monthly basis x (3) months to ensure compliance with the changes are sustained, with a final decision for continued monitoring if needed.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		7/9/18

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F 842	Continued From page 6 resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(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 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842		

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F 842	Continued From page 7 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(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, staff, nurse practitioner, and physician interviews the facility failed to maintain a complete and accurate medical record for 1 of 5 residents reviewed for unnecessary medication (Resident #53). The findings included: Resident #53 was admitted to the facility on 11/21/16 with diagnoses that included dementia, depression, and psychotic disorder. The most recent quarterly minimum data set (MDS) dated 05/22/18 indicated Resident #53 was cognitively intact and required limited assistance with activities of daily living.	F 842	Plan correcting the specific deficiency, and process that lead to the deficiency cited. After it was identified that Resident #53 had incomplete physician documentation in the medical record, the Director of Social Work presented the resident and resident family member with another opportunity to choose a new physician provider. At the request of Resident #53, she opted to change physician coverage to the facility Medical Director, Dr. Kevin Clark. Resident #53 has been accepted as a new patient under the care of Dr. Kevin Clark effective June 29, 2018. The medical record for Resident #53 has been	

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F 842	Continued From page 8 A review of the medical record revealed no physician progress notes in the medical record since 07/13/17. On 06/27/18 at 10:27 AM an interview was conducted with the Director of Nursing (DON) who verified Resident #53's medical record did not contain physician progress notes since 07/13/17. The DON stated the Medical Records Clerk (MRC) had sent the physician letters that requested physician progress notes and documentation for Resident #53's medical record. The DON stated her expectation was that the physician's progress notes would be on the medical record to indicate the physician had visited Resident #53. On 06/27/18 at 10:49 AM an interview was conducted with the MRC who stated she notified the physician regarding missing progress notes, documentation, and missing physician signature. The MRC stated she sent an e-mail to the physician's office manager on 08/18/17 that indicated physician progress notes were to be completed every 30 days per facility policy and the facility had not received progress notes for Resident #53 since 07/13/17. The MRC stated the physician's office manager indicated on 8/20/17 that the physician was aware of the missing progress notes and documentation. On 06/27/18 at 11:05 AM a telephone interview was conducted with the Health Information Management Operations Manager (HIMOM) who stated the physician's office manager was notified of missing physician progress notes and documentation for Resident #53's medical record. The HIMOM stated there was no physician	F 842	updated with a History and Physical as of July 5, 2018 at 3:33pm. Procedure for implementing the acceptable plan of correction (POC) for the specific deficiency cited. The Health Information Management (HIM) designee will monitor all resident medical records for timely physician documentation on a monthly basis to ensure complete and accurate physician progress notes and History and Physicals per regulation are in the medical record for each resident. As of July 9, 2018, a review of all resident medical records was conducted to ensure physician progress notes and History and Physicals were present based on regulatory requirements for each current resident. Monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The HIM designee will track physician compliance regarding medical record documentation on a monthly basis. Lack of compliance regarding resident medical record documentation will be reported to the Facility Administrator, the physician responsible for the documentation, as well as to the facility medical director directly by the HIM designee on a monthly basis, as needed. Medical record compliance will be tracked by the HIM designee on a monthly basis beginning July 9, 2018 to ensure sustained compliance with regulatory requirements.	

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F 842	Continued From page 9 progress notes for Resident #53's medical record since 07/13/17. On 06/27/18 at 11:18 AM an interview was conducted with the Administrator who stated the MRC sent him a deficiency list every month that indicated physicians who were out of compliance with progress notes and documentation. The Administrator stated he was aware that the physician had not provided the facility with progress notes and documentation for Resident #53's medical record. The Administrator stated he sent a memo to the physician on 08/31/17 that requested the physician make every effort to complete needed documentation for Resident #53's medical record. The Administrator stated he was aware that the physician was deficient in providing physician progress notes and documentation for Resident #53's medical record. The Administrator stated it was his expectation that the physician would have provided progress notes and documentation for Resident #53's medical record after he sent the memo to the physician on 08/31/17. On 06/27/18 at 01:02 PM an interview was conducted with the physician's nurse practitioner who stated she was not credentialed to see residents in the facility and had never seen Resident #53. The nurse practitioner stated she had written a phone note on 12/29/17 for Resident #53 regarding medication for oral thrush (fungus infection mouth). On 06/27/18 at 4:32 PM a telephone interview was conducted with the physician who stated he had seen Resident #53 on 2-3 visits and had not completed his dictation for progress notes because he had been out of town. He stated	F 842	Title of the person responsible for implementing the acceptable POC. The HIM designee will be responsible for implementing the POC to ensure complete, accurately documented, readily accessible; and systemically organized medical records. The Facility Administrator will maintain oversight of physician compliance to ensure accurate and complete resident medical records. Dates when the corrective action will be completed. Immediate corrective action to correct the cited deficiency was completed on July 5, 2018. Resident #53 chose to have the facility medical director as her primary care physician. Physician visits will be documented and maintained in the resident medical record per regulatory requirements. Corrective action to identify other resident medical records was conducted on July 6, 2018. All current resident medical records have all required physician documentation per regulatory requirements. Corrective action to ensure continued compliance with the regulatory requirements was initiated on July 9, 2018. The HIM designee will track physician medical record documentation on a monthly basis to ensure compliance with regulatory requirements. Lack of compliance regarding resident medical record documentation will be reported by the HIM designee to the Facility Administrator, the physician responsible for the documentation, as well as to the	

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F 842	Continued From page 10 when he returned from out of town he would have to complete his dictation and progress notes for Resident #53's medical record. The physician stated he was aware that the facility had contacted him about missing progress notes and documentation for Resident #53's medical record. The physician stated he was aware that he needed to provide physician progress notes to the facility after each visit for Resident #53.	F 842	facility medical director on a monthly basis, as needed. Findings will also be presented at the monthly QAPI meeting x (3) months to ensure compliance with changes are sustained, then on an as needed basis.	