| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| ANSON HEALTH AND REHABILITATION | 405 SOUTH GREENE STREET WADESBORO, NC 28170 |

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| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 9/16/19 through 9/19/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#ZL0211. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced recertification, complaint and facility reported incidents (FRI) survey was conducted on 09/16/19 through 09/19/19. Of the 4 FRI allegations, 2 were substantiated without a deficiency and 2 were unsubstantiated. Of the 7 complaint allegations, 1 allegation was substantiated. See Event # ZL0211. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and resident interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) in the area of nutritional status for 1 (Resident #74) of 23 residents reviewed for MDS accuracy. The findings included:<br><br>Resident #74 was admitted 4/10/17 with cumulative diagnoses of Hypertension and Diabetes.<br><br>Review of Resident #74's weights revealed a 14% weight loss in the past 6 months.<br><br>Review of Resident #74 significant change | F 641 | Address how corrective action will be accomplished for those residents found to be affected by the deficient practice: Registered Dietician (RD) failed to accurately code the Minimum Data Set (MDS) section K for resident # 74. Resident #74 had a desired weight loss and the registered Dietician inadvertently checked weight gain box. Registered Dietician stated this was an oversight. The most recent MDS for resident #74 was corrected by the facility MDS nurse on 9/18/19.<br><br>Address how the facility will identify other | 10/7/19 |

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

Electronically Signed | 10/03/2019

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| F 641 | Continued From page 1<br>Minimum Data Set (MDS) dated 8/4/19 indicated she was cognitively intact and exhibited no behaviors. She was coded for supervision with eating, a weight of 230 pounds, no weight loss and on a Physician prescribed weight gain regimen.<br><br>Review of Resident #74's Care Area Assessment (CAA) for nutrition dated 8/4/19 read as follows: mechanical soft, low concentrated sweets (LCS) and no added salt (NAS), no fired foods and diet soda. Weight of 230 and body mass index (BMI) of 55.4 (morbid obesity). Agree with current plan and will continue to monitor weights. The goal read to maintain weight or 1-2 pound slow weight loss for the next 30 days.<br><br>Review of Resident #74's nutrition care plan revised 8/21/19 read she would not experience further significant weight loss. Interventions included staff to encourage oral intake of food and fluids, offer substitutes and praise attempts to complete her meal.<br><br>Review of Resident #74's September 2019 Physician orders read a diet order as follows: mechanical soft, NAS, LCS and no fried food.<br><br>In an interview on 9/16/19 at 4:03 PM, Resident #74 stated she missed fried foods but was trying to lose some weight.<br><br>In an interview on 9/18/19 at 11:45 AM, the MDS Nurse confirmed she completed section K of the significant change MDS dated 8/4/19 and she incorrectly coded the MDS. She stated she should have coded the MDS for a prescribed weight loss regimen and that it was an oversight. | F 641 | residents having the potential to be affected by the same deficient practice: The most recent MDS for all current residents for census date of 9/19/19 audited for accuracy by the Regional MDS/Reimbursement manager, Director of Nursing (DON), and Staff Development Coordinator (SDC) by 9/25/2019 with no areas of non-compliance noted at that time.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>Registered Dietician and MDS Nurse educated on the importance of accurately coding by the Regional MDS/Reimbursement manager on 9/24/2019 and have provided appropriate verbal responses related to questions regarding coding of section K of the MDS. When coding the MDS Assessment the MDS nurse, Registered Dietician, and care plan team will follow the instructions found in the Resident Assessment Instrument (RAI) Manual to ensure the assessment accurately reflects the resident's current condition. The DON and SDC will audit 5 completed MDS assessments every week for 4 weeks, then bi-weekly x 4 weeks, then monthly x 3 months for accuracy.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>Results of the MDS Assessment audit will be brought to monthly Quality Assurance | |

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| F 641 | Continued From page 2<br><br>In a telephone interview on 9/18/19 at 2:21 PM, the Registered Dietician stated Resident #74 weight loss was desired and she had expressed a desire to lose weight.<br><br>In an interview on 9/19/19 at 9:57 AM, the Administrator and Director of Nursing (DON) stated it was their expectation that Resident #74's significant change MDS dated 8/4/19 would have been coded accurately to reflect a prescribed weight loss regimen. | F 641 | Performance Improvement (QAPI) meeting by the DON to be analyzed for patterns and trends monthly for 3 months. At that time the QAPI committee will evaluate for effectiveness of the plan or correction to determine if further auditing in needed to maintain compliance. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will | F 656 | | 10/7/19 |

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| F 656 | Continued From page 3<br>provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews and record review, the facility failed to complete a comprehensive care plan for desired weight loss (#74) and contractures (#65, #37, #70 and #58). This was for 5 of 23 residents reviewed for comprehensive care planning. The findings included:<br><br>1. Resident #74 was admitted 4/10/17 with cumulative diagnoses of Hypertension and Diabetes.<br><br>Review of Resident #74's significant change Minimum Data Set (MDS) dated 8/4/19 indicated she was cognitively intact and exhibited no behaviors. She was coded for supervision with eating, a weight of 230 pounds, no weight loss and on a Physician prescribed weight gain regimen. | F 656 | Address how corrective action will be accomplished for those residents found to be affected by the deficient practice:<br><br>The registered dietician failed to develop a care plan to address a desired weight loss for resident #74, the registered dietician care planned resident #74 will not experience significant weight changes. MDS nurse failed to develop a comprehensive care plan for contractures for residents # 65, 37, 58, and 70. This failure was an oversight.<br>The care plan for resident #74 was updated/corrected on 9/17/19 by the MDS Nurse/DON to reflect desired weight loss. The MDS nurse did not develop a care plan addressing restorative program for splint/brace for bilateral upper extremities | |

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| F 656 | Continued From page 4<br><br>Review of Resident #74's Care Area Assessment (CAA) for nutrition dated 8/4/19 read as follows: mechanical soft, low concentrated sweets (LCS) and no added salt (NAS), no fired foods and diet soda. Weight of 230 and body mass index (BMI) of 55.4 (morbid obesity). Agree with current plan and will continue to monitor weights. The goal read to maintain weight or 1-2 pound slow weight loss for the next 30 days.<br><br>Review of Resident #74's nutrition care plan revised 8/21/19 read she would not experience further significant weight loss. Interventions included staff to encourage oral intake of food and fluids, offer substitutes and praise attempts to complete her meal.<br><br>Review of Resident #74's September 2019 Physician orders read a diet order as follows: mechanical soft, NAS, LCS and no fried food.<br><br>In an interview on 9/16/19 at 4:03 PM, Resident #74 stated she missed fried foods but was trying to lose some weight.<br><br>In an interview on 9/18/19 at 11:45 AM, the MDS Nurse confirmed the nutrition care plan dated 8/21/19 was for significant weight loss and not therapeutic or desired weight loss as intended. She stated it was an oversight.<br><br>In a telephone interview on 9/18/19 at 2:21 PM, the Registered Dietician stated Resident #74's weight loss was desired, and she had expressed a desire to lose weight. | F 656 | range of motion and pain in left hand for resident #65. The Interdisciplinary Team (ITD) was using the care plan located on the restorative form for contractures.<br>Care plans for resident #65 was updated/corrected on 9/24/19 by the MDS Nurse/DON to reflect restorative program for splint/brace for bilateral upper extremities range of motion and pain in left hand.<br>The MDS nurse did not develop a care plan addressing a contracture for resident #58. The Interdisciplinary Team (IDT) was using the care plan located on the restorative form for contractures.<br>The care plan for resident #58 was updated/corrected on 9/24/19 by MDS Nurse/DON to reflect Right hand contracture, right elbow stiffness, and right ankle contracture.<br>The MDS nurse did not develop a care plan for resident #37 addressing limited range of motion to bilateral lower extremities. The IDT was using the care plan located on the restorative form for range of motion.<br>The care plan for resident #37 updated/corrected on 9/24/19 by MDS Nurse/DON to reflect limited range of motion to bilateral lower extremities.<br>The MDS nurse did not develop a care plan for resident # 70 to address limited range of motion to bilateral upper extremities/shoulders and eft hand. The IDT was using the care plan located on the restorative form.<br>The care plan for resident # 70 was updated/corrected on 9/23/19 by MDS Nurse/DON to reflect limited range of | |

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| F 656 | Continued From page 5<br>In an interview on 9/19/19 at 9:57 AM, the Administrator and Director of Nursing (DON) stated it was their expectation that Resident #74's care plan be accurate and comprehensive to include her desired weight loss.<br><br>2. Resident #65 was admitted 2/21/18 with cumulative diagnoses of Congestive Heart Failure and stiffness of her bilateral shoulders.<br><br>Review of Resident #65's Occupational Therapy Discharge Summary dated 8/16/19 read she discharged from therapy with a resting hand splint to her left hand for contracture prevention.<br><br>Review of Resident #65's quarterly Minimum Data Set (MDS) dated 8/18/19 indicated she was cognitively intact and exhibited no behaviors. She was coded for no impairment to her bilateral upper extremities.<br><br>Review of a Restorative Nursing Program referral form dated 8/28/19 read Resident #65 was to wear her resting hand splint 4-5 hours daily.<br><br>Review of Resident #65's Restorative Care Plan and Flow Record for September 2019 read she was wearing her resting hand splint 4-6 hours daily.<br><br>Review of Resident #65's care plan revised on 9/4/19 did not include a care plan addressing the left hand contracture or restorative nursing for splinting.<br><br>In an observation on 9/16/19 at 11:52 AM, Resident #65 was noted with a contracture to her left hand that did not include her thumb and pointer finger. All other fingers were affected. | F 656 | motion to bilateral upper extremities/shoulders and left hand.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>The Regional MDS/Reimbursement Manager completed an audit of comprehensive care plans for census date 9/25/19, focusing on section K, G and O to ensure any areas of non-compliance corrected at this time. No other areas of non-compliance noted as a result of this audit. Completed 9/30/2019<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>Monthly weight meetings to be held by IDT to discuss weight losses and gains. For all identified residents with weight loss/gain the plan of care will be reviewed to ensures updates to care plans have been made to ensure compliance.<br>Bi-weekly restorative meetings to be held by DON, restorative aides, restorative nurse, and therapy to discuss all residents on case-load and restorative care plans reviewed to ensure restorative programs have been care planned accordingly to ensure compliance.<br><br>The IDT/care plan/MDS team, including the Dietician, received in-service training by the MDS/Reimbursement Manager on the importance of developing comprehensive care plans that addresses potential and/or actual or at-risk problems. | |

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| F 656 | Continued From page 6<br>Resident #65 stated she had a splint for her left hand, but staff did not always put it on.<br><br>In an interview on 9/18/19 at 9:12 AM, Restorative Aide (RA) #1 stated she applied Resident #65's left hand splint daily and she tolerated it at a maximum of 4 hours and on occasion less than the prescribed duration.<br><br>In an interview on 9/18/19 at 11:07 AM, the MDS Nurse stated she was not aware she should be completing a care plan for contractures or splinting. She stated the facility used the Restorative Care Plan and Flow Record as the care plan that was kept in the restorative notebook. The MDS Nurse stated Resident #65's contracture should be part of the comprehensive care plan.<br><br>In an interview on 9/19/19 at 9:57 AM, the Administrator and Director of Nursing (DON) stated it was their expectation that Resident #65's care plan be comprehensive to include her left hand contracture with splinting.<br><br>3. Resident #37 was admitted on to the facility on 3/22/05 with the diagnoses of paraplegia and spinal stenosis.<br><br>A review of the physical therapy notes revealed that the last treatment was dated 10/18/18. No further progress. The resident was not currently on a nursing restorative program.<br><br>The resident ' s quarterly MDS (Minimum Data | F 656 | Completed 9/30/2019<br>The MDS/Reimbursement Manager will audit 5 comprehensive care plans weekly for 12 weeks to determine compliance.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>Results of MDS/Reimbursement Manager Audits reported to the QAPI Committee by the MDS nurse/DON monthly for 3 months so the information can be analyzed for trends and patterns. The QAPI Committee will determine at that time the effectiveness of the interventions to determine the need for further auditing to achieve and maintain compliance. | |

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| F 656 | Continued From page 7 | F 656 | | |

Set) dated 7/22/19 revealed that she was severely cognitively impaired and dependent for all activities of daily living. The active diagnoses were non-Alzheimer's dementia, malnutrition, cerebral vascular accident, and paraplegia.

A review of the comprehensive care plan dated for Resident #37 did not reveal an identified problem or interventions for limited range of motion (ROM) and contracture prevention.

On 7/1/19 at 10:15 am an observation was done of Nursing Assistant #1 provide incontinence care. The resident had limited ROM to all extremities and was bed/chair bound. Brief passive range of motion was provided.

On 9/19/19 at 9:40 am interview was conducted with the Administrator and Director of Nursing who both agreed that the expectation was to have a comprehensive care plan to meet the specific need of each resident to include addressing contracture prevention.

4. Resident #70 was admitted to the facility on 11/18/16 with the diagnoses history of falling, osteoporosis, muscle weakness, rheumatoid arthritis, disorder of peripheral nervous system, and peripheral neuropathy.

The diagnoses stiffness of the right and left hands were added to the record on 2/18/19.

The resident ' s record revealed she was observed to have upper extremity decline and Occupational Therapy (OT) was ordered. The resident also had decline in multiple areas.

The resident had a significant change MDS

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| F 656 | Continued From page 8 | F 656 | | |

completed on 8/20/19 which revealed total dependence of 2 staff for all transfers, bed mobility, toileting, and hygiene and extensive assistance of 1 for locomotion and dressing. The resident was documented as having had functional limitation in ROM, impairment on both sides of upper extremities. The resident ' s active diagnoses were arthritis, Alzheimer's disease, chronic pain, and neuropathy.

The resident ' s comprehensive care planned dated 5/21/19 included side rails for turning and repositioning. There was no identified problem or interventions for range of motion and contracture prevention.

On 9/18/19 at 3:45 pm an interview was conducted with the Rehabilitation Director (RD) who knew the resident and stated she was discharged from services because of pain in her hands. An order for restorative nursing was initiated. The RD commented that the resident had received services on and off since her admission. The RD also commented the diagnosis of "stiffness" was considered a contracture. RD agreed that the decreased use of the resident ' s hands and pain was a decline.

On 9/19/19 9:40 am interview was conducted with Administrator and Director of Nursing who both agreed that the expectation was to have a comprehensive care plan to meet the specific need of the resident to include addressing contracture prevention.

5) Resident #58 was originally admitted to the facility on 1/14/16 with a most recent readmission date of 9/11/19. Diagnoses included Cerebral Vascular Accident (CVA) with right sided

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| F 656 | Continued From page 9 | F 656 | | |

hemiplegia, contracture of right hand and Diabetes.

A review of the Quarterly Minimum Data Set (MDS) dated 8/14/19 revealed the resident to be cognitively intact with no behaviors or rejection of care. He received extensive to total assistance from staff for all Activities of Daily Living (ADL's) except for supervision with eating. He was coded for impairment to one upper and lower extremity.

Review of Resident #58's Occupational Therapy Discharge Summary dated 8/14/19 read he was discharged from therapy with a right-hand splint for contracture and tightness.

Review of a Restorative Nursing Program referral form dated 8/15/19 read Resident #58 was to wear a right-hand splint for 4 to 6 hours a day, 7 days per week.

A review of Resident #58's active care plan revised on 8/27/19 did not include a care plan addressing the right-hand contracture or restorative nursing for splinting.

Review of the Restorative Care Plan and Flow Record for September 2019 indicated he was wearing the right-hand splint 4 to 6 hours daily.

In an observation on 9/16/19 at 11:02am, Resident #58 was noted with a contracture to his right hand and stated he had a splint for his right hand, but staff did not always put it on.

An interview occurred with Restorative Aide (RA) #1 on 9/18/19 at 11:20am. She stated Resident #58's right hand splint was applied daily and was tolerated 4 to 6 hours with no complaints of

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| F 656 | Continued From page 10<br>discomfort.<br><br>The MDS Nurse was interviewed on 9/18/19 at 11:07am and stated she was not aware a care plan was to be completed for contractures or splinting. She stated the facility used the Restorative Care Plan and Flow Record as the care plan that was kept in the restorative notebook. The MDS Nurse stated Resident #58's contracture should be part of the comprehensive care plan.<br><br>An interview occurred with the Administrator and Director of Nursing (DON) on 9/19/19 at 9:40am. They both stated it was their expectation for the care plan to be comprehensive and include the right-hand contracture with splinting. | F 656 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews and record review, the facility failed to ensure an activities of daily life (ADLs) dependent resident was free from unwanted facial hair. This was for 1 (Resident #40) of 3 residents reviewed for ADLs. The findings included:<br><br>Resident #40 was admitted 11/6/18 with cumulative diagnoses of Congestive Heart Failure, Diabetes and legal blindness.<br><br>Review of Resident #40's care plan last revised | F 677 | Address how corrective action will be accomplished for those residents found to be affected by the deficient practice: Resident #40 gave permission for nursing assistant to shave her chin on 9/18/19.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice: 100% skin assessment audit to identify residents in need of shaving completed by Director of Nursing and Nurse Managers | 10/7/19 |

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| F 677 | Continued From page 11 | F 677 | | |

5/2/19 read she was at risk for a deterioration in her ADLs to include personal hygiene due to an overall decline.

Review of Resident #40's quarterly Minimum Data Set (MDS) dated 7/24/19 indicated she was able to make herself understood and understood others. The MDS indicated her vision was severely impaired, she was cognitively intact and exhibited no behaviors. The MDS further indicated she required extensive assistance with her personal hygiene which included shaving.

Review of an undated Total Plan of Resident Care utilized by the nursing assistants (NA) when rendering care read Resident #40 was legally blind and required assistance with grooming.

Review of Resident #40 electronic Point of Care History record from 9/3/19 through 9/17/19 indicated the NA's provided limited, extensive to total assistance with her personal hygiene.

In an observation on 9/16/19 at 1:06 PM, Resident #40 was sitting in her wheelchair in the main dining room. Resident #40 stated she was blind, and staff assisted her with her ADLs. Observed on her chin was facial hair.

In an observation on 9/17/19 at 1:40 PM, Resident #40 was in the rehabilitation room working the therapy. She had visible facial hair to her chin.

In an observation on 9/18/19 at 9:03 AM, Resident #40 was sitting in her wheelchair in the main dining room. Observed on her chin was facial hair. Resident #40 stated she could not see but when asked to feel her chin, she noted facial

on all active residents completed on 9/20/2019. Residents noted to need shaven were shaved at that time.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
Nursing assistants will report daily to the hall nurse when a resident refuses to be shaved and this will be documented in the resident's record.
Administration team will be assigned weekly resident observation rounds to monitor compliance issues including resident clean shaven, male or female. Any resident with facial hair will be reported to DON or Charge Nurse to ensure resident receives a shave unless the resident has refused. The results of resident observation rounds will be reported to Administrator. This will be an ongoing process.
100% of nursing staff was educated on assistance with daily living (ADL) care for all residents with an emphasis on shaving resident's facial hair. Nursing staff not allowed to work until education received. completed by 10/7/2019.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
Written Results of resident observation audits will be presented to Administrator on a weekly basis, this data will be analyzed by the Administrator and presented to the QAPI Committee monthly to determine the need for further

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| F 677 | Continued From page 12<br>hair and stated she unaware that she had visible facial hair. Resident #40 stated she recalled someone shaving her facial hair a "few weeks ago" but she was not aware how grown out her facial hair was.<br><br>In an interview on 9/18/19 at 9:09 AM, NA #2 stated Resident #40 liked to get up early so third shift completed her morning ADLs. NA #2 stated she did not notice Resident #40's facial hair but would address it immediately.<br><br>In an observation on 9/18/19 at 10:20 AM, Resident #40 was sitting in her wheelchair in the main dining room attending a Resident Council Meeting. There was no observed facial hair.<br><br>In a telephone interview on 9/18/19 at 4:40 PM, NA #3 confirmed she worked third shift with Resident #40 on 9/16/19 and 9/17/19. She stated Resident #40 gets up daily at around 6:00 AM. NA #3 confirmed she was responsible for completing Resident #40's personal hygiene on 9/16/19 and 9/17/19. NA #3 stated she did not notice the facial hair on Resident #40's chin, but it was a responsibly of the aides to shave her as needed. She stated it was an oversight.<br><br>In an interview on 9/19/19 at 9:57 AM, the Administrator and Director of Nursing (DON) stated it was their expectation that Resident #40 be free of unwanted facial hair and expected the aides to complete the task for Resident #40 since her vision was impaired. | F 677 | interventions. This will be an ongoing system change. | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility. | F 688 | | 10/7/19 |

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| F 688 | Continued From page 13<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and resident and staff interviews, the facility failed to apply splints to residents with contractures as ordered. This was for 2 of 6 residents reviewed for range of motion (Resident #58 and Resident #66).<br><br>The findings included:<br><br>1) Resident #58 was originally admitted to the facility on 1/14/16 with the most recent readmission date of 9/11/19. Diagnoses included Cerebral Vascular Accident (CVA) with right sided hemiplegia, contracture of the right hand and Diabetes.<br><br>A review of the Quarterly Minimum Data Set (MDS) dated 8/14/19 revealed the resident to be cognitively intact with no behaviors or rejection of care. He received extensive to total assistance | F 688 | Address how corrective action will be accomplished for those residents found to be affected by the deficient practice: Resident #58 had right hand splint applied 9/19/2019 per Restorative Aide. Resident # 66 had right hand splint and bilateral Ankle Foot Orthosis (AFO)/Brace applied 9/19/2019 per Restorative Aide.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 9/23/2019 DON completed an audit for residents on Restorative Caseload for the application of splints or braces to ensure braces or splints applied per Functional Maintenance Program (FMP). All braces noted to be applied per FMP.<br><br>Address what measures will be put into | |

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| F 688 | Continued From page 14<br>from staff for all Activities of Daily Living (ADL's) except for supervision with eating. He was coded for impairment to one upper and lower extremity.<br><br>A review of Resident #58's active care plan revised 8/27/19 did not include a care plan for a contracture to the right hand.<br><br>Review of the Restorative Nursing Program form dated 8/15/19 indicated Resident #58 was to have a right-hand splint for 4 to 6 hours a day 7 days per week.<br><br>Review of the September 2019 physician orders revealed an order dated 8/27/19 to 9/17/19 for Restorative Nursing for passive range of motion (PROM) and splinting and 9/17/19 for Restorative Nursing for PROM and splinting.<br><br>On 9/16/19 at 11:02am, Resident #58 was observed with limited range of motion to his right hand and stated he had not received any type of exercise or splint application to his right hand in a few days. The right-hand splint was observed on the sink counter in his room.<br><br>During an observation on 9/17/19 at 9:00am Resident #58 was lying in bed with no splint to his right hand and stated he did not wear the splint the day prior. The hand splint was observed sitting on the sink counter in his room.<br><br>During another observation on 9/17/19 at 4:42pm Resident #58 was sitting up in his gerichair and indicated he had not worn the right-hand splint that day. The right-hand splint was observed on the sink counter in his room.<br><br>Several observations were made on 9/18/19 at | F 688 | place or systemic changes made to ensure that the deficient practice will not recur:<br>Restorative aides will apply splint and braces according to the FMP daily. Upon completion of application the restorative aide will report to Restorative Nurse who oversees the restorative program, that all splints/braces have been applied or resident refusal. The restorative aides will document on the restorative flow record, which was revised per Therapy director on 9/23/2019 to include the restorative aides' initials that include time splint applied, splint removed and time duration of splint application as well as verbal report of application or refusal of splints and braces to the Restorative Nurse has occurred. This will be an on-going system change.<br>100% of Nursing staff educated on Restorative Programs and revision of flow record for splints/braces, focusing on the application of splints to include notification of a resident removing a splint or a nursing assistant removing a splint during care so the splint can be reapplied by the restorative aide or nurse. Nursing staff not allowed to work until education received. Completed by 10/7/2019.<br>The Restorative Nurse will audit splint application daily times 30 days, then audit weekly times 4 weeks, then monthly times 3 months to ensure compliance.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>The Restorative Nurse will audit splint application daily times 30 days, then audit | |

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| F 688 | Continued From page 15<br>9:00am, 10:15am, 11:45am, 1:35pm. Resident #58's right hand splint was observed sitting on the sink counter in his room.<br><br>An interview was conducted with the Rehab Director on 9/18/19 at 11:05am. She confirmed the resident was to have PROM and a splint applied to his right hand 4 to 6 hours a day 7 days per week.<br><br>On 9/18/19 at 11:20am an interview occurred with Restorative Aide #1 (RA). She confirmed the resident was to have Restorative Nursing daily for PROM and splinting to his right hand. RA #1 stated she normally put splints on by 10:30am and removed them by 3:00 to 3:30pm or as tolerated by the resident. RA #1 further stated the aides would remove the splints during bathing and did not always put them back on or alert the Restorative Nursing staff for the need to reapply. She couldn't explain why the right-hand splint was not observed on the resident 9/16/19 through 9/18/19.<br><br>Nurse Aide (NA) #1 was interviewed on 9/18/19 at 1:45pm. She was the regular aide assigned to Resident #58 during the day. NA #1 indicated splints were applied by the Restorative Aides normally after personal care had been rendered. She further stated if for some reason a splint had to be removed for care she would alert the RA to reapply.<br><br>On 9/18/19 at 2:00pm Resident #58 was observed with the right-hand splint on. He confirmed the aide had just left his room from exercising his hand and applying the splint.<br><br>An interview occurred with the Administrator and | F 688 | weekly times 4 weeks, then monthly times 3 months to ensure compliance of splint applications. Restorative nurse will present Results to the Monthly QAPI Committee to determine the need for further monitoring. | |

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| F 688 | Continued From page 16 | F 688 | | |

Director of Nursing (DON) on 9/19/19 at 9:40am. They both stated it was their expectation for the restorative aide to apply Resident #58's right hand splint as ordered.

2) Resident #66 was originally admitted to the facility on 12/5/17 with the most recent readmission date of 9/14/19. Diagnoses included spastic hemiplegia (paralysis of one side of the body) affecting the right dominant side, contractures to right hand and bilateral ankles and central cord syndrome (incomplete type of spinal cord injury) of the cervical spinal cord.

A review of the Quarterly Minimum Data Set (MDS) dated 8/19/19 revealed the resident to have moderately impaired cognition with no behaviors or rejection of care. He received extensive to total assistance from staff for all Activities of Daily Living (ADL's) to include eating. He was coded for impairment to bilateral upper and lower extremities.

A review of Resident #66's active care plan indicated he was to wear a right-hand splint and bilateral Ankle Foot Orthosis (AFO's) as ordered.

Review of the Restorative Nursing Program form dated 8/15/19 indicated Resident #66 was to have a right resting hand splint on for 4 to 6 hours a day 7 days per week.

Another Restorative Nursing Program form dated 8/28/19 indicated Resident #66 was to have right and left AFO's on for 4 to 6 hours a day 6 days per week.

On 9/16/19 at 11:02am Resident #66 was

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| F 688 | Continued From page 17 | F 688 | | |

observed with limited range of motion to his right hand and bilateral feet and ankles. He stated the splint and braces had not been on for a few days. The right-hand splint was observed on the sink counter and AFO braces were on the floor by the TV in his room.

During an observation on 9/17/19 at 9:00am Resident #66 was lying in bed with no splint to his right hand or AFO braces to his right and left ankle. The right-hand splint was observed sitting on the sink counter and AFO braces on the floor by his TV in his room.

During another observation on 9/17/19 at 4:42pm Resident #66 was observed sitting up in a gerichair and indicated he had not worn the right-hand splint or bilateral AFO's that day. The right-hand splint was observed on the sink counter and AFO braces on the floor by the TV in his room.

Several observations were made on 9/18/19 at 9:00am, 10:15am and 11:45am. Resident #66's right hand splint was observed sitting on the sink counter and AFO braces on floor by the TV in his room.

An interview was conducted with the Rehab Director on 9/18/19 at 11:05am. She confirmed the resident was to have a right-hand splint on for 4 to 6 hours a day, 7 days a week and bilateral AFO braces applied to his feet for 4 to 6 hours a day, 6 days per week.

On 9/18/19 at 11:20am an interview occurred with Restorative Aide #1 (RA). She confirmed the resident was to have Restorative Nursing daily for splint application to his right hand and bilateral

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| F 688 | Continued From page 18<br>AFO braces to his feet. RA #1 stated she normally put splints on by 10:30am and removed them by 3:00 to 3:30pm or as tolerated by the resident. RA #1 further stated the aides would remove the splints during bathing and did not always put them back on or alert the Restorative Nursing staff for the need to reapply. She couldn't explain why the splint and AFO braces were not observed on the resident 9/16/19 through 9/18/19.<br><br>On 9/18/19 at 1:35pm Resident #66 was observed with the right-hand resting splint on, as well as the bilateral AFO braces to his feet. He confirmed the aide had just left his room from applying the splint and braces.<br><br>Nurse Aide (NA) #1 was interviewed on 9/18/19 at 1:45pm. She was the regular aide assigned to Resident #66 during the day. NA #1 indicated splints and braces were applied by the Restorative Aides normally after personal care had been rendered. She further stated if for some reason a splint or brace had to be removed for care she would alert the RA to reapply.<br><br>An interview occurred with the Administrator and Director of Nursing (DON) on 9/19/19 at 9:40am. They both stated it was their expectation for the restorative aide to apply Resident #66's right hand splint and bilateral AFO braces as ordered. | F 688 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. | F 756 | | 10/7/19 |

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| F 756 | Continued From page 19<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff, facility Nurse Practitioner, and pharmacist interviews, the consultant pharmacist failed to identify the maximum dose of an as needed | F 756 | Address how corrective action will be accomplished for those residents found to be affected by the deficient practice:<br>On 9/18/2019 Resident # 53 had the order | |

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medication (Resident #53) for 1 of 5 residents reviewed for unnecessary medication. The pharmacist failed to identify incorrect medication administration route (Resident #2) for 1 of 4 residents observed during medication pass. The facility failed to respond to a pharmacy consultant recommendation regarding the time-limited duration of as needed psychotropic medication (Resident #6) for 1 of 5 residents reviewed for unnecessary medication. Findings included:

1. Resident #53 had a physician medication order for Nitrostat 0.4 milligram sublingual (under the tongue) every 5 minutes prn for chest pain (no maximum for the total amount) dated 2/20/19.

The resident ' s annual Minimum Data Set dated 8/6/19 revealed she had an intact cognition. The active diagnoses were heart failure, hypertension, diabetes, and peripheral vascular disease.

The resident ' s care plan was updated 9/16/19 and revealed the problem of cardiac disease with intervention to follow the physician orders.

The monthly pharmacy review of medication for the past 12 months documented did not reveal that the Pharmacist identified the Nitroglycerin as needed required a maximum dosage.

On 9/18/19 at 11:10 am an interview was conducted with the facility Nurse Practitioner who stated the Nitroglycerin was required to have a maximum milligram amount and would be corrected.

On 9/18/19 at 4:43 pm an interview was conducted with the facility Pharmacist who stated that the resident's Nitroglycerin should have had

for Nitrostat as needed clarified to state Nitrostat one sublingual every 5 minutes as needed for chest pain x 3 doses, notify provider if chest pain persists after 3 doses.
On 9/19/2019 Resident #2 had order for Zoloft 100mg 1 tablet by mouth clarified for gastric tube administration; order for valium 10 mg 1 tablet by mouth clarified for gastric tube administration; and on 10/1/2009 resident #2 had order for Oxycodone 10mg 1 tablet by mouth every 4 hours as needed clarified for gastric tube administration. Resident #2 was receiving medications per the gastro tube the incorrect route was an order input oversight.
On 9/17/2019 resident #6 had order for Xanax 0.25mg every night as needed. Xanax 0.25mg every night as needed discontinued.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
On 9/24/19-9/26/2019 the Consultant Pharmacist (CP) performed a 100% chart review to ensure all current resident orders are accurate with established maximum daily doses and correct routes of administration, as well as psychotropic medications for time durations. No areas of non-compliance were noted at that time.
On 9/24/2019 the DON audited all active records and the last 3 months of Pharmacy Reports, to ensure all pharmacy recommendations have been addressed by facility providers. Results of

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| ANSON HEALTH AND REHABILITATION | 405 SOUTH GREENE STREET WADESBORO, NC 28170 |

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| F 756 | Continued From page 21<br>a maximum amount allowed of 3 doses with the order. The pharmacist stated that he did not identify the missing maximum dosage amount.<br><br>On 9/19/19 9:40 am interview was conducted with Administrator and Director of Nursing who both agreed that the expectation was for the Pharmacist to identify irregularities in the medication orders to include a required maximum dosage for Nitroglycerin.<br><br>2. Resident #2 was admitted to the facility on 03/06/2019. His diagnosis included dysphagia, tracheostomy, and gastrostomy tube placement.<br><br>Most recent quarterly Minimum Data Set (MDS) completed on 9/6/2019 indicated Resident #2 was documented as receiving nutrition by tube feeding.<br><br>Care plan for Resident #2 dated 7/11/2019 stated, Resident #2 required a feeding tube for adequate nutritional intake related to nothing by mouth (NPO) with dysphagia.<br><br>Record review indicated on 4/5/19 speech and language pathology noted Resident #2 was not safe for oral intake.<br><br>On 09/17/19 at 9:26 AM during an observation of medication administration Nurse #1 administered Zoloft 100mg tablet through Resident #2's feeding tube after crushing the medication. The order on the medication administration record indicated the medication was ordered for oral administration. Review of all other medications for this resident revealed two other medication, Valium and Oxycodone, ordered by oral route | F 756 | audit noted all recommendations had been addressed.<br><br>Address what will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>The CP will review all resident medications for maximum dose and appropriate route of medication administration on CP monthly visit. The CP will provide in his monthly report that all medications have been reviewed for maximum dose and appropriate route of medication administration. The CP will meet with DON or Administrator to review monthly audit findings prior to exiting.<br>Upon the receipt of the monthly Pharmacy Medication Review report the DON will place all Physician Recommendations into a binder that will be given to providers for review and changes in residents orders as recommended. Provider will return recommendations to the DON and the actual recommendations will be compared to the summary of recommendations, included in the PC report, to ensure all recommendations have been addressed.<br>The Unit Managers will carry out the physician orders that were initiated by the Pharmacy recommendations approved by the provider. Once all recommendations have been processed by the unit managers the completed recommendations will be returned to the DON for comparison to the summary report to ensure all recommendations and change in orders have been processed.<br>The Pharmacy Consultant Supervisor educated the CP on Drug Regimen | |

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| F 756 | Continued From page 22<br>with all other medications ordered via feeding tube.<br><br>In an interview on 09/18/19 at 8:59 AM Nurse #1 stated Resident #2 does not take any medications or food by mouth. She further stated he was NPO per physician's order.<br><br>In an interview with Nurse # 2, who was administering medications to Resident #2 on 9/18/19, she stated Resident #2 gets all medications by feeding tube and that no medications are given to Resident #2 by oral route.<br><br>On 9/18/19 at 11:10 AM an interview with the facility's Nurse Practitioner was conducted. He stated he was familiar with Resident #2. He further stated the resident's medications are to be given by tube. When the medication administration record was reviewed with NP, he indicated Zoloft, Valium, and Oxycodone were ordered for oral route but should be given via feeding tube. He further stated pharmacy would typically send him a message to change the route of administration if it was ordered incorrectly.<br><br>A physician's order report was obtained. It indicated Zoloft 100mg, 1 tablet, oral , once a day at 10:00 AM was ordered with a start date of 3/6/2019. Oxycodone, schedule II, 10mg oral every 4 hours for pain was ordered with a start date of 3/16/2019. Valium, schedule IV, 10mg tablet, oral, every 6 hours was ordered with a start date of 4/01/2019.<br><br>Resident #2's medical record indicated pharmacy reviews were conducted on the following dates and times: | F 756 | Review and the importance of reporting findings to the facility providers. Completed 9/27/2019<br>The DON educated per Regional Clinical Manager on timely follow through of Pharmacy Recommendations. Completed 9/27/2019<br>The Pharmacy Consultant Supervisor will audit the facility CP monthly x 3 months to ensure the resident medications have been reviewed for maximum dosage and correct medication administration route. The CP will provide the Administrator a copy of the Pharmacy Recommendation Report monthly. The Administrator will review the summary report with the DON upon receipt and the DON will review the completed recommendations with the Administrator monthly. This will be an on-going system change.<br>DON educated nurse managers on Pharmacy Recommendation follow up and processing of recommendations. Completed by 10/7/2019.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>The DON will present the Pharmacy Report and Administrator summary review of completed recommendations in monthly QAPI to ensure compliance and to determine the need for adjustments in the process. | |

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| F 756 | Continued From page 23 | F 756 | | |

09/06/2019 12:07 PM, Resident medications were reviewed and no recommendations were issued for September.
08/05/2019 04:29 PM, Resident medications were reviewed and no recommendations regarding routes of administration were issued for August.
07/02/2019 09:52 PM. Resident medications were reviewed and no recommendations regarding routes of administration were issued for July.
06/04/2019 08:07 PM, Resident medications were reviewed and no recommendations were issued for June.
05/05/2019 09:44 PM, Resident medications were reviewed and no pharmacy recommendations for routes of administration were issued for May.
04/01/2019 10:11 PM Resident medications were reviewed and there were no recommendations made as to routes.

A phone interview was conducted with the Pharmacist on 09/18/19 at 4:21 PM. The Pharmacist stated the zoloft, valium, and oxycodone were on Resident #2's medication administration record as oral route and that was an error. The medication administration record should reflect the medications are to be given per feeding tube.

In an interview with the administrator and the director of nursing on 9/19/19 at 09:57 AM, both stated that all medication administration records should reflect the accurate route of administration.

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| F 756 | Continued From page 24 | F 756 | | |

3) Resident #6 was originally admitted to the facility on 1/3/18 with diagnoses which included depression, sleep apnea, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).

Review of the medical record revealed an order dated 5/10/19 for Xanax 0.25 milligrams (mg) by mouth at bedtime as needed (PRN) insomnia.

A review of the most recent Minimum Data Set (MDS) coded as a quarterly assessment and dated 6/8/19 revealed the resident was cognitively intact and had received 1 day of antianxiety medication out of the 7 day look back period.

Review of the medical record revealed a Consultant Pharmacist Communication to Physician form dated 6/20/19 stating per the guidelines the PRN Xanax would need to have a stop date added or a progress note to document a longer duration for the use of Xanax. The form was not reviewed or signed by the Physician or Nurse Practitioner (NP).

An interview occurred with the Director of Nursing (DON) on 9/17/19 at 2:45pm. She stated the pharmacist provided her with the communication forms and she then handed them to either the physician or NP to address. She felt the Communication form dated 6/20/19 was not addressed in error.

On 9/18/19 at 10:30am, an interview was conducted with the Facility NP. He could not explain why the Pharmacy Communication form addressing the continued order for PRN Xanax had not been reviewed or signed.

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| F 756 | Continued From page 25<br><br>In an interview on 9/19/19 at 8:45am, the Administrator stated she expected the Physician or NP to address drug irregularity as recommended by the pharmacist in a timely manner. | F 756 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a | F 758 | | 10/7/19 |

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| F 758 | Continued From page 26<br>diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, facility Nurse Practitioner and staff interviews, the facility failed to ensure an as needed (PRN) psychotropic medication (Xanax) was time limited in duration for 1 of 5 residents reviewed for unnecessary medication use (Resident #6).<br><br>The findings included:<br><br>Resident #6 was originally admitted to the facility on 1/3/18 with diagnoses which included depression, sleep apnea, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).<br><br>Review of the medical record revealed an order dated 5/10/19 for Xanax 0.25 milligrams (mg) by mouth at bedtime PRN insomnia.<br><br>A review of the most recent Minimum Data Set | F 758 | Address how corrective action will be accomplished for those residents found to be affected by the deficient practice:<br>Resident #6 had an order for Xanax 0.25 milligrams (mg) by mouth at bedtime discontinued on 9/17/2019.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>On 9/24/19-9/26/19 the Pharmacy Consultant (CP) performed a 100% chart review of all residents□ medications to ensure all as needed (PRN) psychotropics medications evaluated for a limited duration unless provider indicated appropriateness to continue the antianxiety medication. No time duration of psychotropic medications non-compliance noted as a result of this | |

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| F 758 | Continued From page 27<br>(MDS) coded as a quarterly assessment and dated 6/8/19 revealed the resident was cognitively intact and had received 1 day of antianxiety medication out of the 7 day look back period.<br><br>Review of the medical record revealed a recommendation from the Consultant Pharmacist to the Physician dated 6/20/19 stating per the guidelines the PRN Xanax would need to have a stop date added or a progress note to document a longer duration for the use of Xanax. The recommendation had not been addressed by the physician or the Nurse Practitioner.<br><br>Review of Resident #6's August 2019 Physician Orders indicated an order for Xanax 0.25mg by mouth at bedtime as needed.<br><br>A review of the Medication Administration Record (MAR) for August 2019 revealed Resident #6 had received the PRN Xanax on 8/13/19, 8/14/19, 8/20/19 and 8/23/19.<br><br>A review of the September 2019 Physician Orders indicated an order for Xanax 0.25mg by mouth at bedtime as needed.<br><br>The MAR for September 2019 revealed Resident #6 had received the PRN Xanax on 9/14/19.<br><br>An interview occurred with the Director of Nursing (DON) on 9/17/19 at 2:45pm and indicated she was aware of the time limited duration for PRN psychotropic medication use. She further stated she would discuss with the NP plans for correction.<br><br>On 9/18/19 at 10:30am, an interview was | F 758 | audit.<br>On 9/24/2019 the DON audited all active records and the last 3 months of Pharmacy Reports, to ensure all pharmacy recommendations have been addressed by facility providers. All Recommendations noted to be addressed as a result of this audit.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>This over sight occurred because a pharmacy recommendation had not been addressed. Upon the receipt of the monthly Pharmacy Medication Review report the DON will place all Physician Recommendations into a binder that will be given to providers for review and changes in residents orders as recommended. Provider will return recommendations to the DON and the actual recommendations will be compared to the summary of recommendations, included in the PC report, to ensure all recommendations have been addressed. The Unit Managers will carry out the physician orders that were initiated by the Pharmacy recommendations. Once all recommendations have been processed by the unit managers the completed recommendations will be returned to the DON for comparison to the summary report to ensure all recommendations and change in orders have been processed.<br><br>The DON educated per Regional Clinical | |

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| F 758 | Continued From page 28<br>conducted with the Facility NP. He was aware of the Xanax PRN order for Resident #6 but was not familiar with the time limited duration of psychotropic PRN medication use until he talked with the DON the day prior.<br><br>In an interview on 9/19/19 at 8:45am, the Administrator stated it was her expectation that Resident #6's PRN Xanax order was time limited in duration. | F 758 | Manager on timely follow through of Pharmacy Recommendations. Completed 9/27/2019<br><br>DON educated nurse managers on Pharmacy Recommendation follow up and processing of recommendations. Completed by 10/4/2019.<br><br>The facility Nurse Practitioner was educated per facility Medical Director on time limit duration for psychotropic PRN medication. Completed 9/27/2019<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>The CP will audit previous months pharmacy recommendations to ensure timely follow-up on recommendations has occurred and CP will provide the Administrator a copy of the Pharmacy Recommendation Report monthly. The Administrator will review the summary report with the DON upon receipt and the DON will review the completed recommendations with the Administrator monthly. This will be an on-going system change.<br>The Pharmacy Report will be presented by DON/CP<br>The DON will present the Pharmacy Report and Administrator summary review of completed recommendations in monthly QAPI to ensure compliance and to determine the need for adjustments in the process. | |

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| F 842 | Continued From page 29 | F 842 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is 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.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§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-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(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, | F 842 | | 10/7/19 |

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| F 842 | Continued From page 30<br>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.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews and record review, the facility failed to maintain accurate Physician orders for 1 (Resident #41) of 23 residents reviewed for accurate medical records. The finding included:<br><br>Resident #41 was admitted on 2/10/17 with cumulative diagnoses of Quadriplegia and multiple contractures. | F 842 | Address how corrective action will be accomplished for those residents found to be affected by the deficient practice:<br>On 9/18/2019 Resident # 41 had order for upper extremity splints every day from 7:00am to 7:00pm discontinued.<br><br>Address how the facility will identify other residents having the potential to be | |

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| F 842 | Continued From page 31<br><br>Review of Resident #41's medical record included a Physician order dated 7/5/18 read to discontinue his splints per his request.<br><br>Review of Resident #41's quarterly Minimum Data Set dated 7/25/19 indicated he was cognitively intact and exhibited no behaviors. He was coded for bilateral impairments to both his upper and lower extremities.<br><br>Review of Resident #41's September 2019 Physician orders read as follows: upper extremity splints every day from 7:00 am to 7:00 PM.<br><br>In an interview on 9/16/19 at 3:12 PM, Resident #41 stated he was aware of his multiple contractures but did not want to wear any splints.<br><br>In an interview on 9/17/19, the Rehabilitation Director stated Resident #41's splints were discontinued in July 2018 due to his refusal. She stated he was last screened by therapy in August 2019 and he continued to refuse his bilaterally upper extremity splints.<br><br>In an interview on 9/19/19 at 9:57 AM, the Administrator stated with facility recently had a switch over in computer programs and it was at time the discontinued order for the daily splints must have repopulated into Resident #41 current active orders. She stated it was her expectation that Resident #41's medical record be accurate to include active Physician orders. | F 842 | affected by the same deficient practice:<br>On 9/23/2019 DON completed an audit of all residents on restorative case load to ensure physician orders were accurate. No order inaccuracies noted as a result of this audit.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>Monthly orders, including Medication Administration Record (MAR) and Treatment Administration Record (TAR) will be reviewed by two nurses to ensure the residents medical record is accurate for new and discontinued orders, any discrepancies will be corrected. The DON, Unit Managers, staff development nurses will audit all new admission orders and daily orders in clinical meeting daily Monday thru Friday. The weekend Nurse Manager will review new orders on Saturday and Sunday to ensure medical record accuracy.<br>DON educated 100% of nursing staff, that upon receipt of new orders, including admission orders, two nurses will verify that new orders have been processed. Nursing staff will not be allowed to work until education received.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>The Don, Unit Managers, Staff Development nurses will audit new admission orders and daily orders in the clinical meeting Monday -Friday and the | |

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|---|---|---|---|
| | 345051 | A. BUILDING _____ B. WING _____ | C 09/19/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANSON HEALTH AND REHABILITATION | 405 SOUTH GREENE STREET WADESBORO, NC 28170 |

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| F 842 | Continued From page 32 | F 842 | weekend Nurse Manager will review new orders received on Saturday and Sunday to ensure all current medications and treatments are transcribed accurately in the resident's medical record.<br>Results of the daily review of physician orders and data obtained from the daily clinical meetings will be presented by the DON to QAPI monthly times 3 months to determine the need for further monitoring. | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, | F 880 | | 10/7/19 |

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| F 880 | Continued From page 33 | F 880 | | |

but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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| F 880 | Continued From page 34<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff interview, the facility failed to follow ordered contact precautions when entering the room of a resident with active shingles infection (Resident #70) for 1 of 1 resident reviewed for contact precautions.<br><br>Findings included:<br><br>Resident #70 was admitted to the facility on 11/18/16 with the diagnoses muscle weakness, rheumatoid arthritis, disorder of peripheral nervous system, and peripheral neuropathy.<br><br>The resident had a significant change Minimum Data Set completed on 8/20/19 which revealed total dependence of 2 staff for all transfers, bed mobility, toileting, and hygiene and extensive assistance of 1 for locomotion and dressing. The resident was severely cognitively impaired.<br><br>The resident ' s comprehensive care plan was dated 5/21/19 and updated on 9/1/19 revealed contact precautions secondary to shingles infection with interventions to follow the facility ' s infection control policy, practice good hand washing, and use principles of infection control and universal/standard precautions.<br><br>The physician order dated 9/1/19 was for contact precautions secondary to active shingles infection.<br><br>On 9/16/19 at 3:49 pm an observation was completed of Nursing Assistant (NA) #1 who entered the resident ' s room and there was a contact precaution notification on the door. The | F 880 | Address how corrective action will be accomplished for those residents found to be affected by the deficient practice:<br>On 9/26/2019 resident # 70 had order for contact isolation discontinued.<br>On 9/16/2019 identified nursing assistant educated on following Isolation Precautions.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>Audit for census date 9/27/2019 by DON found no current resident with an order for isolation precautions.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>DON/Administrator educated 100% of all staff including full-time, part-time, and weekend staff, on Isolation Precautions and required Personal Protective Equipment (PPE). In the event a resident is placed into isolation the assigned staff providing direct care will report to nurse in full PPE prior to entering residents room. Completed by 10/4/2019.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>Should a resident residing in Anson Health and Rehab be placed on isolation precautions in the future, staff will be educated on the required PPE on the date | |

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| F 880 | Continued From page 35<br>resident ' s door was labeled and had supplies for contact precautions which included hand hygiene and to wear a gown, mask, and gloves. NA #1 was observed to only wear a gown and touch the resident's bed and bed control with ungloved hands. NA #1 continued to touch the resident ' s bed without gloves and was asked to please follow the contact precautions as posted on the resident's room door. NA #1 began to glove without hand hygiene. NA #1 was asked to clean her hands before gloving and touching the clean box of gloves.<br><br>An interview was conducted on 9/16/19 at 3:49 pm with NA #1 who stated that she was familiar with contact precautions. NA #1 stated that she would place her gloves on after "this" (which was touching the resident's bed and controller) before actually touching the resident. NA #1 commented that she was aware that shingles were highly contagious. NA #1 commented that she cleaned her hands and placed the gloves with direct care to the resident.<br><br>On 9/16/19 at 4:30 pm an interview was conducted with the Director of Nursing (DON) who stated she expected all staff that enter the resident ' s room to follow the contact precautions as ordered and posted on the door to include cleaning hands and wearing gloves before touching the resident, her bed and objects. The DON commented that she would provide education for NA #1. | F 880 | the isolation begins and the proper PPE and signage for the designated isolation will be provided outside of resident room. Administrative Nursing staff will observe staff properly donning PPE prior to entering isolation room and following required Isolation Precautions while in identified residents' room. Results of observation will be presented to QAPI by DON /Infection Preventionist Nurse monthly x 3 months, from the onset of the order for isolation, to determine the need for further monitoring. | |