STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: WILMINGTON HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 820 WELLINGTON AVENUE WILMINGTON, NC 28401

ID & PREFIX TAG: F 000

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Event ID#: C2XJ11.

F 279

SS=D

ID & PREFIX TAG: F 279

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

PRINTED: 11/12/2014
FORM APPROVED
OMB NO. 0938-0391

A. BUILDING

B. WING

C

10/23/2014

No deficiencies were cited as a result of the complaint investigation survey of 10/23/14. Event ID# C2XJ11.

F 279 11/13/14

Based on record review and staff interviews the facility failed to develop an interim care plan for 1 of 17 sampled residents (Resident #195). The findings included:

Resident #195 was admitted to the facility on 10/14/14 and had diagnoses that included S/P 1.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews the facility failed to develop an interim care plan for 1 of 17 sampled residents (Resident #195). The findings included:

Resident #195 was admitted to the facility on 10/14/14 and had diagnoses that included S/P

1. The initial interim care plan and Kardex for Resident #195 was completed on 10/22/14.

2. The Facility initiated transition to Electronic Medical Records on 10/01/2014. An audit was conducted by

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: electronically signed

TITLE: Electronically Signed

DATE: 11/07/2014
### Summary Statement of Deficiencies

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<td>F 279</td>
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<td>(status post) Total Knee Replacement, Myocardial Infarction (Heart Attack) with Congestive Heart Failure after knee surgery and Diabetes.</td>
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The Admission Nursing Assessment dated 10/14/14 revealed the resident was alert and oriented to person and place. The assessment revealed the resident was hard of hearing and had impaired eye sight with the ability to only see shadows. The assessment revealed the resident required assistance with eating, was incontinent and required extensive assistance with bed mobility and transfers.

The Brief Interview for Mental Status dated 10/20/14 revealed the resident was moderately cognitively impaired.

Review of the resident’s medical record on 10/22/14 at 2:15 PM revealed a form titled Interim Plan of Care attached to the Nursing Admission Assessment form. The interim plan of care form had not been filled out.

On 10/22/14 at 2:25 PM, MDS (Minimum Data Set) Nurse #1 stated in an interview that the nurse who did the admission nursing assessment was suppose to complete the interim care plan.

An interview was conducted with NA (nursing assistant) #1 and NA #2 on 10/22/14 at 2:45 PM. The NAs stated they looked at the Resident Care Kardex for information on specific needs for a resident’s care or they could ask the nurse. An observation of the book containing The Resident Care Kardex for the resident’s on the unit where Resident #195 resided revealed there was not a Resident Care Kardex for Resident 195.

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<td>the MDS nurses on 10/22/14, to ensure documentation, including care plans were complete on all other Residents admitted from 10/01/14 to 10/22/14.</td>
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3. Education was conducted by the Staff Development Coordinator to licensed nurses 10/22/14 thru 10/25/14 regarding completion of admission documentation in Electronic Medical Records.

Director of Nursing or Staff Development Coordinator will review admissions from the previous day Monday thru Friday to ensure Admission documentation is complete to include initial plan of care (Admissions on Saturday or Sunday will be reviewed within 72 hours) for the next 60 days.

4. The Director of Nursing will report the findings of admission reviews to the QAPI committee weekly times four weeks, then monthly times two months and action will be taken immediately if indicated, by the Director of Nursing.
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 279</td>
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<td>The Director of Nursing (DON) stated in an interview on 10/22/14 at 3:15 PM that the facility was in the process of transferring to computerized charting and the documentation for admissions beginning on 10/01/14 should have been put in the computer. Review of computerized charting revealed no information was documented on the care plan for Resident #195. Nurse #1 stated in an interview on 10/23/14 at 2:21 PM that she did most of the resident's initial assessment but did not get back to finish the paperwork. The Nurse stated she reported to the next shift that Resident #195 was a new admission and that the paperwork had not been completed. The Nurse stated she thought she worked on another unit the next day and assumed the oncoming shift had finished the paperwork for Resident #195. The Nurse stated the nurses fill out the Resident Care Kardex but they had to wait for therapy to evaluate the resident to see how much assistance the resident required but was usually filled out within 24 hours of admission.</td>
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<td>F 431</td>
<td>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
<td>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</td>
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| (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 345236 |
| (X2) MULTIPLE CONSTRUCTION | B. WING |
| (X3) DATE SURVEY COMPLETED | 10/23/2014 |
| NAME OF PROVIDER OR SUPPLIER | WILMINGTON HEALTH AND REHABILITATION CENTER |
| STREET ADDRESS, CITY, STATE, ZIP CODE | 820 WELLINGTON AVENUE WILMINGTON, NC 28401 |

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*Form CMS-2567 (02-99) Previous Versions Obsolete*  
*Event ID: C2XJ11*  
*Facility ID: 923408*  
*If continuation sheet Page 3 of 6*
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<td>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</td>
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<td>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.</td>
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<td>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.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on observation and staff interviews the facility failed to remove expired medications from 1 of 1 central supply medication storage cabinet and 1 of 3 medication rooms. The findings included:</td>
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<td>1. On 10/23/14 at 10:00 AM, an observation of the medication cart for residents on the 500 Hall was observed with Med (medication) Aide #1. A full bottle of One-Daily Multi Vitamins was observed on the cart that contained the expiration date of August 2014. The bottle was dated as</td>
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<td>1. The expired medications were removed and returned to pharmacy for disposal on 10/23/14.</td>
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<td>2. An audit was completed by the Nursing Management staff of all med carts, medication rooms, and central supply storage areas on 10/23/14. There were no other expired medications.</td>
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<td>3. The Director of Nursing implemented a triple check system on 10/24/14 for all</td>
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opened on 10/23/14. The Med Aide stated earlier
that morning she realized she did not have any
multi vitamins on her cart and asked the ward
clerk who was a Med Aide to get her a bottle of
multi vitamins. Med Aide #1 stated she gave the
medication to 2 residents on the 500 Hall that
morning and stated she should have looked at
the date on the bottle.

The Director of Nursing (DON) stated in an
interview on 10/23/14 at 11:14 AM that a nurse
from their pharmacy came in once a month and
checked all the medications in the facility. The
DON stated someone from the pharmacy did a
complete audit and checked all medications every
6 months and had just made a visit to the facility.
The DON stated she did not know how this
happened.

On 10/23/14 at 12:47 PM an interview was
conducted with the ward clerk and the staff
member that worked in central supply. The Ward
Clerk stated that morning Med Aide #1 asked her
to get a bottle of Multi Vitamins without minerals
or iron. The Ward Clerk stated she went to
central supply and the staff member working
there opened the cabinet where stock
medications were stored. The Ward Clerk stated
she picked up the first bottle of multi vitamins she
saw and took the bottle back to the unit, opened
the bottle, removed the cotton and labeled the
bottle with the date it was opened. The Ward
Clerk stated she did not check the expiration date
on the bottle.

2. On 10/23/14 at 10:15 AM, an observation of
the medication storage room on the 500/600
Halls was made with Med (Medication) Aide #1.
There was one bottle of liquid Banophen on the
medications. Medication expiration dates
will be checked initially with delivery
manifests, by the Nurses for pharmacy
delivered medications or the Central
Supply Coordinator for over the counter
medications. Second check will be done
by the Nurse or Certified Medication Aide
when the medication is stocked in the
med cart. Third check of expiration dates
will be conducted upon administration of
medication.

Medication Storage Audits will be
conducted weekly by the Director of
Nursing times four weeks and monthly
times two months. Medication Storage
Audits will be documented on the
Omnicare Medication Storage Audit Tool.

4. The Director of Nursing will report the
findings of the Medication Storage Audits
to the QAPI committee weekly times four
weeks and monthly times two months.
Any negative findings will be addressed
immediately and findings reported during
QAPI meetings.
Statement of Deficiencies and Plan of Correction

Provider/Supplier/CLIA Identification Number: 345236

Date Survey Completed: 10/23/2014

Name of Provider or Supplier: Wilmington Health and Rehabilitation Center

Street Address, City, State, Zip Code: 820 Wellington Avenue, Wilmington, NC 28401

Summary Statement of Deficiencies

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shelf in a bin with stock medications and contained an expiration date of January 2014. The bottle was almost full and handwritten on the bottle was the following: "Opened 9/25/14."
The Med Aide stated the bottle had been opened and should not be stored there. The Med Aide stated the medication had expired and she would dispose of it.

On 10/23/14 at 11:14 AM the Director of Nursing (DON) stated in an interview that a nurse from their pharmacy checked all the medication carts and medication rooms once a month and another person from the pharmacy did an audit every 6 months and checked all medications. The DON stated an audit had just been done and she did not know how this happened.