STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345526	A. BUILDING: _____ B. WING _____	2/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	**3647 MILLER BRIDGE ROAD CONNELLY SPG, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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

The above isolated deficiencies pose no actual harm to the residents

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This REQUIREMENT is not met as evidenced by:
Based on record review the staff interviews the facility failed to notify a resident of his Residents' Rights upon admission for 1 of 3 sampled residents (Resident #2).

The findings included:

Resident #2 was admitted to the facility on 08/20/14. The admission Minimum Data Set (MDS) dated 08/27/14 specified the resident had moderately impaired cognition.

Review of Resident #2's medical record revealed that the resident had appointed a family member to serve as his Power of Attorney (POA) and Responsible Party (RP). The RP participated in the admission process for Resident #2.

The facility provided a copy of the "Admissions Agreement" packet for Resident #2. Documents inside the packet included a document titled "Resident Rights" signed by the RP on 08/27/14.

On 02/11/15 at 11:12 AM the Admissions Director (AD) was interviewed and explained that she responsible for reviewing the required new admission paperwork, including reviewing Residents' Rights upon admission. She stated that she was trained that the admitting paperwork was to be completed within 24 to 48 hours. She added that there were times when completing the paperwork in that timeframe was not feasible. The AD reviewed Resident #2's admission paperwork and confirmed that it took 7 days after admission to complete the paperwork and notify the resident and his RP of Resident Rights and other notifications required by the State. She stated that she could not recall why Resident #2 was not notified upon admission of his Rights.

On 02/12/15 at 12:05 PM the Administrator was interviewed and reported that she expected residents and/or their families to be notified of Residents' Rights upon admission and that it should not have taken 7 days to notify Resident #2 and his family of his rights in the facility.

F 163 483.10(d)(1) RIGHT TO CHOOSE A PERSONAL PHYSICIAN

The resident has the right to choose a personal attending physician.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review the facility failed to notify a resident of his right to choose a physician for 1 of 3 sampled residents (Resident #2).

The findings included:

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 163	Continued From Page 2 Resident #2 was admitted to the facility on 08/20/14. The admission Minimum Data Set (MDS) dated 08/27/14 specified the resident had moderately impaired cognition. Review of Resident #2's medical record revealed that the resident appointed a family member to serve as his Power of Attorney (POA) and Responsible Party (RP). The RP participated in the admission process for Resident #2. The facility provided a copy of the "Admissions Agreement" packet for Resident #2. Documents inside the packet included a document titled "Business Contract" signed by the RP on 08/27/14. A document titled "General Acknowledgments" signed by the RP dated 08/27/14 appointed physician #1 to serve as attending physician for Resident #2 during his stay in the facility. On 02/11/15 at 10:30 AM the Admissions Director (AD) was interviewed and explained that the facility only had one attending physician (physician #1) credentialed with the facility and that all new admissions were assigned to physician #1. She stated that residents had the right to choose another physician but that she did not verbally explain that to them during the admissions process, unless a family requested another attending physician.
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to correctly code sections of the Minimum Data

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Set (MDS) for 1 of 3 sampled residents (Resident #2).

The findings included:

Resident #2 was admitted to the facility on 08/20/14. The admission Minimum Data Set (MDS) dated 08/27/14 specified the resident had moderately impaired cognition, had corrective lenses, had pulmonary conditions "asthma, chronic obstructive pulmonary disease or chronic lung disease" and had fallen in the last month prior to admission. The sections of the MDS were completed by the MDS Coordinator. In addition, the MDS specified Resident #2 weighed 160 pounds and the Registered Dietitian (RD) documented that information on the assessment.

On 02/11/15 at 2:00 PM the MDS Coordinator was interviewed and explained her process for completing the MDS. She stated that she used several sources of information to complete the required questions on the MDS. She reported that she reviewed hospital records and spoke with the resident and/or family members to gain information. The following items were reviewed with the MDS Coordinator regarding Resident #2's MDS:

- Corrective lenses - the MDS Coordinator reviewed the medical record and a picture of the resident that did not reveal Resident #2 wore glasses nor had any other means of corrective lenses. On 02/11/15 at 2:10 PM the MDS Coordinator stated it was an oversight and that she would correct the MDS.

- Asthma, chronic obstructive pulmonary disease, chronic lung disease - during the interview the MDS Coordinator reviewed Resident #2's medical record and determined that he did not have any of the pulmonary diagnoses reflected on the MDS and stated it was an oversight and that she would correct the MDS.

- Had fallen 1 month prior to admission - the MDS Coordinator reviewed her notes from a meeting with the Resident #2's family that revealed the family reported the resident had fallen 2 to 6 months prior to admission to the facility. The MDS Coordinator reported that it was an error and corrected the MDS to accurately reflect that the resident fell within 2 to 6 months prior to admission.

On 02/11/15 at 2:20 PM the RD was interviewed and about Resident #2's weight documented on the MDS. She explained that the electronic medical record and MDS were linked in a way that a weight documented in the medical record was automatically entered into the MDS. She added that it was her responsibility to review the MDS for accuracy. She stated that she failed to review Resident #2's MDS and that his weight of 160 was inaccurate. She stated that she would change the MDS to reflect the resident's accurate weight during that time period.

F 514 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically

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organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to correctly document the amount of oxygen a resident received for 1 of 3 sampled residents on oxygen (Resident #2).

The findings included:

Resident #2 was admitted to the facility on 08/20/14. The admission Minimum Data Set (MDS) dated 08/27/14 specified the resident had moderately impaired cognition and received oxygen therapy.

Admission orders dated 08/20/14 for Resident #2 specified the resident was to receive 2 liters of oxygen per minute.

Review of Resident #2's medical record revealed a nurse's entry made by Nurse #2 dated 08/22/14, 08/25/14 and 08/26/14 documented the resident was receiving 1 liter of oxygen per minute.

On 02/12/15 at 10:05 AM Nurse #2 was interviewed and reported that she recalled Resident #2 but added that she did not remember specifics about the resident. She reviewed Resident #2's nurses' notes and stated that if the resident was ordered by the physician to receive 2 liters of oxygen per minute then that was what the concentrator should have been set to and felt that her documentation of 1 liter was a typed error. Nurse #2 also reviewed Resident #2's oxygen saturation levels during 08/22/14, 08/25/14 and 08/26/14 that revealed the levels were within normal limits and showed no signs of respiratory distress.

On 02/12/15 at 12:05 PM the Director of Nursing (DON) was interviewed and stated she expected nurses to verify the accuracy of their notes in the medical record.

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and responsible party interview, the facility failed to notify the responsible party of stage II pressure	F 157	The statements included are not an admission and do not constitute agreement with the alleged deficiencies	3/12/15

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

Electronically Signed | 02/26/2015

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F 157	Continued From page 1 ulcer that required treatment for 1 of 3 sampled residents reviewed for pressure ulcer (Resident #1). Findings included: Resident #1 was admitted to the facility on 09/24/14 with diagnoses of hypertension and urinary tract infection. A record review of resident #1's 5 day Minimum Data Set (MDS) dated 10/01/14 revealed an assessment of moderately impaired cognition. Resident #1 required extensive physical assistance of 2 persons for bed mobility, transfers, toileting, and personal hygiene. The MDS coded Resident #1 as occasionally incontinent of urine and always continent of bowel. The MDS indicated Resident #1 was at risk for the development of pressure ulcer and was coded as no pressure ulcers upon admission. Review of Nurse #1's wound assessment of 10/01/14 revealed left heel blister was identified on 10/01/14 and physician's assistant was notified of wound on 01/02/14. Nurse #1 documented Resident #1 (documented as self) was notified of left heel wound on 10/02/14. Nurse #1's documentation did not indicate responsible party was notified of Resident #1's wound. A record review was conducted of nurse's notes from 10/01/14 to 10/06/14. Nurse's notes did not indicate notification of responsible party regarding Resident #1's left heel wound. A telephone interview was conducted with Nurse	F 157	herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F157 How the corrective action will be accomplished for the resident(s) affected. Resident #1 was no longer in the facility at the time of survey. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Residents requiring notification of Responsible Parties for change in condition have the potential to be affected. An Audit of current Skin Assessments completed by the Unit Managers, DON or designee to ensure that any notifications that needed to be made were made. Measures in place to ensure practices will not occur. Licensed nurses will be in-serviced on Nursing Policy 2002 by Unit Managers, DON or RN Designee for notification of physicians and families related to change in condition, specific to significant change in a resident□s physical, mental, and psychosocial well being, or any other condition that may warrant a request for treatments to	

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F 157	Continued From page 2 #1 on 02/12/15 at 9:25 AM. Nurse #1 stated when a resident was identified with a new wound then physician, family member, or responsible party needed to be notified. Nurse #1 stated she did not remember Resident #1 and could not recall if she notified family member or responsible party of wound. A telephone interview was conducted on 02/12/15 at 9:45 AM with responsible party who stated she was not notified by the facility that Resident #1 had a left heel wound. Responsible party revealed when visited Resident #1 during therapy session noticed a bandage on Resident#1's lower leg. Responsible party stated the physical therapist did not know what the bandage on the lower leg indicated. Per responsible party the physical therapist asked nursing staff for an explanation of the bandage. Responsible party was informed that Resident #1 had a scab fall off and the scab was found in Resident #1's bed. The responsible party stated she would not have known about the reason for the bandage if she had not asked the physical therapist. An interview was conducted with the Director of Nursing (DON) on 2/12/15 at 10:15 AM. The DON stated the nurse who initially identified the wound on Resident #1 was responsible to notify the physician, family member, or responsible party of the wound. After reviewing Resident#1's wound assessment documentation by Nurse #1, the DON verified that Resident #1 was notified of left heel wound but not the responsible party. The DON stated her expectations were for the nurse who initially identified Resident #1's wound to notify physician or physician's assistant and family member or responsible party of the wound.	F 157	change. How the facility plans to monitor and ensure correction is achieved and sustained. The DON or UM will randomly audit 5 medical records of residents with Wounds which require physician/RP notification for documentation of notification each week for 4 weeks, monthly x 2 months then quarterly x 3. Trending will be completed by the DON and reported to the QA&A Committee quarterly x 4 for continued compliance/revision of the plan.	

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F 309	Continued From page 3	F 309		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to monitor daily weights for a resident with congestive heart failure and failed to obtain weekly laboratory testing for 1 of 3 sampled residents (Resident #2). The findings included: Resident #2 was admitted to the facility on 08/20/14 with diagnoses that included congestive heart failure and others. Resident #2's hospital discharge instructions dated 08/20/14 specified to monitor weights daily and to obtain magnesium levels weekly. Resident #2's admission orders for the facility were also reviewed and revealed Resident #2 was to be weighed daily and magnesium weekly. The admission Minimum Data Set (MDS) dated 08/27/14 specified the resident had moderately impaired cognition, did not refuse care and took diuretics daily. Review of Resident #2's medical record revealed the following weights were obtained:	F 309	F309 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident #2 was no longer a patient in the facility at the time of the survey. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice An audit of the in-house patients by Unit Managers and DON for discharge orders of Patients admitted January 1, 2015 to present were completed to look for (a) daily weights and (b) scheduled labs to ensure all were ordered and completed as intended. Measures to be put in place or systemic changes made to ensure practice will not re-occur- 100% Nursing education on Order Transcription completed by 03/02/2015. A log of (a) daily weights and (b) scheduled labs compiled and	3/12/15

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08/20/14 197.9 pounds (lbs)
08/21/14 160
08/23/14 198.1
08/28/14 194.9
09/01/14 196.5
09/02/14 196.6
09/03/14 197.5
09/04/14 196.1

Further review of the medical record revealed Resident #2's magnesium level was checked once on 08/21/14 and was within normal limits.

Resident #2 was discharged home on 09/05/14.

On 02/12/15 at 10:20 AM the Director of Nursing (DON) was interviewed and explained the process for transcribing hospital discharge orders with admission orders for the facility. The DON reviewed Resident #2's admission orders that specified the resident was to be weighed daily. She stated that if there were questions regarding an order she expected the nurse to clarify the order with the physician. The DON confirmed that Resident #2 was not weighed daily as ordered and felt the error was an oversight.

On 02/12/15 at 12:05 PM the DON was interviewed again regarding magnesium laboratory testing for Resident #2. She explained that the order was for magnesium levels to be checked weekly but the nurse failed to order routine labs. The DON stated that lab was only performed once on 08/21/14. She stated she expected nurses to enter laboratory orders correctly in the computer system to ensure monitoring was in place as ordered by the physician.

checked for completeness weekly x4, bi-weekly x2 and monthly x2.

How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be reviewed by DON or designee and reported to QA&A Committee monthly to ensure continued compliance/revisions to the plan if needed.

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician assistant interview, the facility failed to obtain a physician's order for wound treatment and implemented incorrect treatment for a stage II pressure ulcer for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #1). Findings included: Resident #1 was admitted to the facility on 09/24/14 with diagnoses of hypertension and urinary tract infection. A record review of resident #1's 5 day Minimum Data Set (MDS) dated 10/01/14 revealed an assessment of moderately impaired cognition. Resident #1 required extensive physical assistance of 2 persons for bed mobility, transfers, toileting, and personal hygiene. The MDS coded Resident #1 as occasionally incontinent of urine and always continent of bowel. The MDS indicated Resident #1 was at risk for the development of pressure ulcer and was coded as no pressure ulcers upon	F 314	F-314 How the corrective action will be accomplished for the resident(s) affected. Resident #1 was no longer a resident at the time of survey. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Nursing staff employed on February 23, 2015 was re-educated on Policy 3201 initiating wound care for any wounds found during Skin Assessments and must have a physician order. Measures in place to ensure practices will not occur. Unit Manager, DON or RN designee will perform audits of current Pressure Ulcer Patients to ensure Physician Orders for Treatment are present. Any new patients and current Pressure Ulcer Patients will be audited weekly x4 weeks, bi-weekly x2, then quarterly x2.to ensure treatments have	3/12/15

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F 314	Continued From page 6 admission. Review of admission nursing assessment dated 09/24/14 revealed Resident #1 had intact skin with no skin impairment. Braden scale for predicting pressure ulcer risk was completed on 09/24/14 and indicated resident was at risk for the development of pressure ulcer. Review of Resident #1's care plan dated 09/25/14 revealed problem of potential for skin infection. Interventions included pressure reduction mattress, keep skin clean and dry, lotion to dry skin, barrier cream as needed for protection of skin, peri-care with incontinence episodes, and weekly skin assessments. Review of Nurse #1's weekly skin assessment dated 10/01/14 revealed left and right buttocks peeling skin and left heel blister which measured 4 cm (centimeter) by 4 cm with 0 cm depth. Nurse #1's wound notes stated redness to buttocks with peeling skin noted, EPC (Extra Protective Cream) cream applied. Left heel blister covered with dressing and granulex. Review of Nurse #1's wound assessment of 10/01/14 revealed left heel blister was identified on 10/01/14 and physician ' s assistant was notified of wound on 01/02/14. Per wound assessment guidelines, Resident #1 had stage II pressure ulcer of the left heel. Left heel was documented as moist, with small amount of serous drainage, epithelial tissue present, without odor and redness. Current wound treatment was documented as dressing and granulex. Nurse # 1's wound comments stated blister popped, drained, and was covered with dressing and granulex.	F 314	physician orders. How the facility plans to monitor and ensure correction is achieved and sustained. Weekly, bi-weekly and quarterly audits will be submitted to the Director of Nursing to review and ensure that Physician orders for treatments of Pressure Ulcers to ensure compliance is met. Results of the audits will be presented to QA&A committee to ensure compliance and revision as needed.	

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	345526	A. BUILDING _____ B. WING _____	C 02/12/2015

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F 314	Continued From page 7	F 314		

An interview was conducted with the Director of Nursing (DON) on 02/12/15 at 8:22 AM who revealed that any nurse who administered wound care using granulex and implemented a specific dressing would need to obtain a physician's order for wound treatment. The DON stated the facility did not have standing orders for wound treatment.

A telephone interview was conducted on 02/12/15 at 9:25 AM with Nurse #1 who no longer worked at the facility. Nurse #1 stated if granulex was used on a wound then a physician's order was needed. Nurse #1 stated she did not remember Resident #1 or remember if she obtained a physician's order for treatment of Resident #1's wound. Nurse #1 stated she inquired of nurses who treated wounds in the past as to what to do for care and treatment of wounds.

An interview was conducted on 2/12/15 at 10:15 AM with the DON. After reviewing Resident#1's physician orders in the medical record, the DON verified that Resident #1 did not have a physician's order for wound care to treat left heel stage II pressure ulcer.

An interview was conducted with the physician's assistant on 2/12/15 at 10:37 AM. After reviewing progress notes and clinical record for Resident #1, the physician's assistant verified he did not write wound treatment orders for Resident #1. Physician's assistant stated a physician's order was required to use granulex as a wound treatment. The physician's assistant verified that there was not a physician's order to treat Resident #1's wound. The physician's assistant revealed if he had been contacted for orders, he would not have used granulex to treat

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F 314	Continued From page 8 Resident#1's open blister on left heel. Physician's assistant revealed he would have ordered an antibiotic cream to prevent infection, covered area with 4 inch x 4 inch gauze, wrapped heel in kerlix and kept heel elevated. An interview was conducted with the DON on 02/12/15 at 11:15 AM. The DON stated her expectations were for the nurse who first identified the wound on Resident #1 to obtain a physician's order for wound treatment.	F 314		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based upon record review and staff interview the facility failed to accurately dispense medications as ordered for 1 of 3 residents (Resident #2). The findings included: Resident #2 was admitted to facility on 08/20/2014 and discharged on 09/05/2014. According to the Minimum Data Set (MDS) dated 09/03/2014, Resident #2 had moderate cognitive impairment. According to the medical diagnosis section of the electronic record, the resident had diagnoses including: congestive heart failure (CHF), generalized muscle weakness, difficulty in walking, acute respiratory failure, acute kidney failure, atrial fibrillation, Alzheimer's disease, unspecified essential hypertension, type-2 Diabetes, acute gastric ulcer with perfusion, depressive disorder, and senile dementia-uncomplicated.	F 333	F333 1. How the corrective action will be accomplished for the resident(s) affected. Resident #2 was no longer a patient at the time of the survey. 2. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Staff nurses that are employed with the facility were in-serviced on Transcribing Medication Orders. 3. Measures in place to ensure practices will not occur. Unit Manager, DON or RN designee will review 2 random chart for each unit for transcription errors a week for 8 weeks, then 10% of charts bi-weekly	3/12/15

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F 333	Continued From page 9 According to the discharge medication orders, the resident's admission medication orders included: 1.) Prilosec (a medication used to treat stomach acidity) 40 milligrams (mg) by mouth once daily. 2.) Spironolactone (a medication used to treat hypertension and edema) 12.5mg by mouth once daily. 3.) Coumadin (a medication used to prevent blood clots) 2mg by mouth every other day, alternating with 1.5mg every other day. Review of Resident #2's Medication Administration Record (MAR) for August 2014 revealed the following: 1.) Coumadin was originally transcribed and entered into the facility's computer system as Coumadin 3mg by mouth every other day. The August 2014 MAR revealed that Coumadin was administered to Resident #2 as follows: Coumadin 1mg administered on 08/20/2014, Coumadin 3mg administered on 08/22/2014, and on 08/26/2014. 2.) Spironolactone was originally transcribed and entered into the facility's computer system as Spironolactone 25mg by mouth one time a day. The August MAR revealed that Spironolactone 25mg was administered to resident #2 on 08/21/2014, 08/22/2104, 08/23/2014, 08/24/2104, 08/25/2104, and 08/26/2014. 3.) The Prilosec order was never originally transcribed or entered into the facility's computer system, and there was not an order to discontinue the Prilosec. Resident #2 did not receive Prilosec until 09/02/2014. According to the electronic medical record, on 08/27/2014 orders were given by the Physician's Assistant (PA) to increase Coumadin to 2mg by mouth once daily and to change Spironolactone dose to Spironolactone 12.5mg by mouth once daily.	F 333	x2, then 10% charts quarterly x2. The audits will be discussed during Risk Meeting New nurses will be in-serviced on Transcribing Orders by SDC/Designee in her absence. 4. How the facility plans to monitor and ensure correction is achieved and sustained. Information obtained during audit will be presented to the QA/QI committee, discussed and reviewed for completeness and revision if need during the monthly QA meeting.	

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F 333	Continued From page 10 According to medical records, on 08/27/2014 a Medication Error Report was completed for Resident #2 which documented and that the facility had identified the transcription and administration errors with Resident #2's Coumadin dosing. The Medication Error Report documented that the error was reported to the DON and to the physician. According to the Medication Error Report, Resident #2 experienced no noted adverse effects due to the error and repeat/follow-up anticoagulation times were ordered for Resident #2. No Medication Error Reports were produced for the Spironolactone dosing error or for the Prilosec order omission error.	F 333		