Resident concerns regarding the timeliness of staff answering call lights were addressed individually with resident #1, resident #55 and resident #53 on October 14, 2015 by the Director of Nurses. The Director of Nurses shared the facility’s plan of action to ensure that call lights are answered in a timely manner with these residents on October 14, 2015.

All residents in the facility have a Department Manager assigned as their “Guardian Angel.” Residents are asked during the week day Guardian Angel rounds if their needs are being met and if the call lights are answered in a timely manner. Resident care and call light concerns are immediately addressed and documented as a grievance to ensure appropriate follow up.

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 discloseable 60 days following the date of survey whether or not a plan of correction is proposed. For nursing homes, the above findings and plans of correction are discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
Facility staff have been re-educated on the expectation to answer call lights in a timely manner to ensure the residents' needs are being met and that their dignity is maintained. This education was conducted by the Director of Nurses and the Staff Development Coordinator and was completed by October 21, 2015.

Newly hired facility staff will be educated during their orientation on the expectation to answer call lights in a timely manner to ensure their needs are being met and that their dignity is maintained.

Call light response times will be monitored by utilizing a call light audit. The audit form will be completed by the Director of Nurses or designee to ensure call lights are being answered in a timely manner.

The audits will be randomly performed during all three shifts and at different times during the shifts. The response time to at least six resident call lights will be monitored with each completed audit. The audit will be completed daily (including weekends and holidays) for 3 weeks, weekly for 8 weeks and then monthly for 4 months.
<table>
<thead>
<tr>
<th>F 241</th>
<th>Continued From page 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>clock was on the wall and observed to have the correct time on it.</td>
</tr>
<tr>
<td></td>
<td>An observation of the resident's room on 9/22/2015 at 10:15pm on the wall between the residents' two TV's had been observed and indicated the correct time. The clock was within view of the resident's bed.</td>
</tr>
<tr>
<td></td>
<td>An interview with Resident #53 on 9/22/2015 at 10:15pm indicated that that was how she knew how long it took for staff to answer her call bell and provide care for her. Resident revealed that she had waited up to one hour and a half, or longer, to be changed before, and revealed that this has been going on for months.</td>
</tr>
<tr>
<td></td>
<td>During an interview with the Director of Nursing on 9/22/2015 at 11am revealed her expectation of staff answering call bell she stated that &quot;call bells are No Passing Zone&quot; She indicated that staff needs to be answering the call bell within a few minutes and that 1 hour was to long for any resident's to wait to be cared for. DON stated &quot;we still have a problem with call bells not being answered.&quot;</td>
</tr>
<tr>
<td></td>
<td>Interview with Nursing Aide #1 on 9/23/2015 at 4pm revealed that she had been working with resident #53 for 3 months. NA #1 stated &quot;that I had never been ugly to this resident and admit taking a long time to answer her call bell. I stated also indicated that she never walked in her room and cut off the light without providing care.&quot;</td>
</tr>
</tbody>
</table>

Any concerns identified when completing the audit will be addressed immediately. The call light audit results will be reviewed monthly for a minimum of six (6) months in the facility's QA meeting. Any identified issues will be discussed and recommendations followed to ensure ongoing compliance and determine the need for further audits beyond six (6) months.
Continued From page 3

2. Resident #1 was admitted on 5/29/2006 with a diagnosis of Cerebral Palsy.

The Minimum Data Set (MDS) dated 9/2/2015 indicated that Resident #1 was cognitively impaired, had adequate hearing and clear speech, was able to understand and understand others. There were behaviors exhibited and she rejected care. Resident #1 did not require extensive to total assistance for all her activities of daily care, but Resident #1 claimed herself. Resident #1 was always incontinent of bowel and bladder. Resident #1 sometimes used an in-and-out catheter.

During an interview on 9/21/2015 at 4pm, when asked if staff treated her with dignity and respect, Resident #1 stated staff talked "ugly" to her and are very "rough" with her during care. Resident #1 indicated that "if she rings her call bell she'll wait for 45 min to 1hr for staff to come in and cut it off. When they cut off the bell, they say "I will be back in a few" and "a few" ended up being another hour or so." Resident #1 also reported that one NA (Nursing Assistant) told her that none of the staff members want to help me or provide care for me because of my attitude and because I was mean," Resident #1 revealed that she was not mean and didn't have a bad attitude. Resident #1 revealed that this made her feel really bad and hurt her feelings because she hated that she could not do anything for herself. Resident #1 indicated that she wanted to cry sometimes because of this situation. Resident #1 also revealed that 2nd and 3rd shifts are the worst about answering call bells. Resident #1 indicated that she told the Director of Nursing on Monday 9/21/2015 that...
Continued From page 4
she did not want one NA(Resident #1 named the
NA and one of the Nurses(Resident #1 named
the nurse) to work with her because of them
being rough with her during care. Resident # 1
also stated that Nurse took over an hour of so to
provide her with pain medication. Resident # 1
revealed that this happen all the time during the
second shift.

An observation of the resident's room on
9/22/2015 at 10pm revealed that the clock on the
wall between the resident ' s TV indicated the
current time. The clock was within view of the
resident's bed. Resident indicated that this was
how she knew how long it took staff to answer her
call bell and provide care for her. Resident
revealed that she had waited up to two hours or
longer for someone to provide care for her and
she did also state that this has been going on for
months.

During an interview with the Director of Nursing
on 9/23/2015 at 9:30am, she indicated that
Resident # 1 had informed her several times that
"staff was not answering call bells in a timely
manner that she was not getting the assistance
for her needs. DON indicated that this was why
she conducted in service training about answering
call bell in a timely manner on 6/18/2015.

Interview with Nursing Aide #1 on 9/23/2015 at
4pm revealed that she been working with
resident#1 for 3 months and indicated that she
answered her call bell but, resident does not want
anyone to assist her with her ADL's because she
indicated that she was in pain. NA #1 revealed
that she had never been ugly to this resident and
denies taking a long time to answer her call light.
Continued From page 5
She also indicated that she never walked in her room and cut off the light without providing care for her.

A review of Grievance/complaint report forms from July 2015 until present revealed concerns from 6 other residents indicated that staff are not answering the call bell in a timely manner which posed a major problem on second shift. Several of the grievances/complaint reports were on the same hall with Resident #1.

During an interview with the Director of Nursing on 9/22/2015 at 11am revealed her expectation of staff answering call bell she stated that “call bells are No Passing Zone.” She indicated that staff needs to be answering the call bell within a few minutes and that 1 hour was too long for any residents to want to be cared for. DON stated "we still have a problems with call bells not being answered."

3. Resident #55 was admitted 4/18/2015, with diagnosis of UTI, COPD. His most recent MDS assessment indicates that he is cognitively intact. He also required extensive assistance with transfers and toileting.

During an interview with Resident # 55 on 9/23/2015 at 9:23 am, he was alert and oriented and able to answer questions without difficulty. He expressed that he had trouble getting staff to answer his call light on two occasions recently. He stated that he had used his call light to request a blanket. He said that staff had put him to bed and covered him with a sheet and he was cold. He asked for a blanket and times the staff.
F 241 Continued From page 6

He reported that it took staff 30 minutes to bring him a blanket. He also stated that he is sure of the time because he noted the time he called and when they brought him a blanket. He said he was cold and he has "thin blood" being 95 years old.

He also stated that he had a fall recently. He said that he had called for assistance with falling.

The staff did not answer so he decided to get up on his own. He said he broke his foot in that fall. He said that he did talk to the Administrator and DON about that fall and the staff not answering the call light. He said their response was, I will talk to them.

Record review showed that Resident #55 did have a fall with injury including broken toes on 8/28/2015 as he reported.

During an interview with the Administrator and DON 9/23/2016 11:14 am, they both stated that they were unaware of Resident #55’s fall being related to staff not answering his call light.

F 323 (h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observations, record reviews, and staff

F 323 -- Supervision to Prevent Accidents

1) The shower chair was immediately removed from operation.
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>TAD</th>
<th>(X3) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 323</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Summary Statement of Deficiencies**

Each deficiency must be preceded by full regulatory or local identifying information.

- **Continued From page 7**
  - Interviews, the facility failed to follow the Manufacturer's Safety/Maintenance Information for the shower chair commode resulting in the accident of 1 of 4 sampled resident's fell for accidents. Resident #103.

**Findings Included:**

The facility's "Operation Instructions for the Shower Chair Commode Models (dated 6/1/10)" included: "Precautions: Exaggerated use of movement in any direction or sitting on the edge of the seat may cause the chair to tip. Safety/Maintenance Information: make certain chair is assembled according to enclosed Instructions. Check pipe and fittings for hairline fractures monthly. Check all junctures monthly to make certain the pipe and fittings do not pull apart."

- Resident #103 was admitted to the facility on 5/21/15 with diagnoses which included: diabetes mellitus, peripheral vascular disease, glaucoma, dementia, mood disorder, and major depression.
- Review of the invoices, indicated a shower chair was delivered to the facility on 8/7/15.
- Review of the most recent MDS (Minimum Data Set) dated 8/21/15 indicated Resident #103 had severely impaired cognition; required assistance with bathing; had functional limitations of bilateral lower extremities; and had no falls since her admission. The assessment also revealed the resident weighed 104.5 pounds and was 47½ inches tall. The Care Plan included the resident was at risk for falls due to her bilateral above the

2) All other facility shower chairs were inspected by the facility Maintenance Director. This inspection included ensuring junctures are secure and pipes are free from hairline cracks or fractures.

3) Education will be provided to the facility Maintenance Department by the facility Administrator. Education will include ensuring shower chairs are inspected monthly. Inspection should include ensuring junctures are secure and pipes are free from hairline cracks/fractures.

Per shower chair manufacturer guidelines the following was added to the facility "Shower Chair Audit": Monthly inspection of shower chair to ensure shower chair junctures are secure and pipes are free from hairline cracks/fractures.
An inspection of all facility shower chairs utilizing the facility “Shower Chair Audit” will be performed by the Maintenance Director or Maintenance Assistant monthly. Inspections will involve ensuring junctures are secure and pipes are free from hairline cracks or fractures. Maintenance Director or Maintenance Assistant will review shower chair inspections with the facility Safety Committee and Quality Assurance Committee monthly for a minimum of three (3) months. Any identified issues will be discussed and recommendations followed to ensure ongoing compliance.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F323</td>
<td>Continued From page 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Resident was transported to the hospital.

During an interview on 9/24/15 at 11:43am, NA#1 revealed that while escorting Resident #103 to the shower room, she turned the shower chair and propelled the resident into the shower room backwards over the hump in the floor at the threshold of the shower room. NA#1 revealed that the back of the shower chair came off and the resident fell backwards onto the floor in the shower room. NA#1 stated that the resident did not hit her head, but the resident informed her that her back hurt. NA#1 revealed she was trained to assist residents in the shower chair through the doorway of the shower room by turning the shower chair backwards and pulling chair over the hump in the floor at the threshold.

During an interview on 9/24/15 at 1:00pm, the DON indicated that the shower chair was approximately one month old and there had never been any problems with the shower chair falling apart.

During an interview on 9/24/15 at 1:52pm, the Administrator revealed that the shower chair was delivered to the facility, fully assembled, without instructions. He also revealed that during the facility's monthly Safety Meetings, the general conditions of the shower chairs were checked and both shower chairs were last checked on 9/3/15 by the facility's Human Resource Coordinator/Safety Team Member. He further stated that upon inspection of the shower chair after the accident/incident, he felt the accident was the result of equipment failure because there was no functional purpose for the back of the shower chair to be removed; and there were no missing screws or parts on the shower chair.
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 323 | Continued From page 10  
On 9/24/15 at 3:03pm, the DON indicated the nursing assistants had been instructed to pull residents backwards in the shower chairs through the shower rooms' thresholds because of the slight incline/ramp in the doorways to the shower rooms. She revealed that the incident was an accident because the nursing assistant followed the facility's protocol.  
During an interview on 9/24/15 at 3:25pm, the Maintenance Supervisor revealed the shower chair was inspected monthly by himself or his assistant, but not documented. He also revealed that the shower chair involved in the accident was delivered to the facility already assembled approximately three to six months ago and stated that the shower chair was sturdy and intact.  
On 9/24/15 at 3:45pm, the DON revealed that the resident had just returned from being evaluated at the hospital and the resident had no injuries as a result of the accident in the shower chair.  
483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 6% OR MORE  
The facility must ensure that it is free of medication error rates of five percent or greater.  
This REQUIREMENT is not met as evidenced by:  
Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 25 opportunities for 2 of 8 residents (Resident #25's Pancreaze DR administration time was changed on October 1, 2015. The order now instructs the nurse to administer the medication with meals. | F 323 | | 10/12/15 |
F 332 Continued From page 11 and Resident #129) observed during medication pass, resulting in a medication error rate of 8%.

The findings included:

1) A review of Resident #26's medication orders included a current order for Pancreaze DR to be given as one capsule by mouth with meals. The Pancreaze DR was scheduled for administration three times daily at 8:00 AM, 12:00 PM, and 6:00 PM. It was also noted that the medication was not administered.

On 9/23/15 at 4:34 PM, Nurse #7 observed as she prepared and administered medications to Resident #26. The administered medications included one Pancreaze Delayed Release (DR) capsule containing 10,600 units of lipase, 25,800 units of protease, and 45,760 units of amylase. Pancreaze DR is a medication which contains a combination of digestive enzymes which aid locally in the small intestine to aid in the digestion of fats, protein, and starches. Pancreaze DR is used to replace these enzymes when the body does not have enough of its own. Product information from the manufacturer indicated because of the local action of this medication, Pancreaze DR should be taken with meals or snacks. A snack was not given to the resident at the time of the medication administration.

An interview was conducted on 9/23/2015 at 6:47 PM with Nurse #7. During the interview, Nurse #7 reviewed Resident #26's Medication Administration Record (MAR), along with the physician's order to give Pancreaze DR with meals. Upon inquiry regarding the timing of the medication given in relation to meals, the nurse stated that in the past, the resident had refused to take a snack at the time of the medication pass.

F 332 Nursing management completed an audit of all resident medication administration times on 10/5/15. Orders for medications to be given with food or meals were clarified and rewritten to coincide with the facility's meal times.

The Staff Development Coordinator will educate the nurses on the importance of following the manufacturer's guidelines when administering medications by October 17, 2015.

Newly hired nurses will receive this information during their orientation. It will also be included on the Licensed Nurse Orientation Competency Checklist.

The Director of Nurses or designee will complete a Medication Admin Audit Report on those residents who have specific guidelines or times of administration every day for the month, 3 times a week for 3 months and monthly x 3 months to ensure these medications are administered timely per the product guidelines and manufacturer's instructions. Any identified concerns will be immediately addressed and corrected.
F 332  Continued From page 12

When asked if the medication had been given with the evening meal in the past as specified by the physician’s order, Nurse #7 stated, “the trays (supper) are coming.”

On 9/23/15 at 6:58 PM, an observation was made of Resident #26 in the facility’s Dining Room. At that time, the resident was observed to have taken approximately two bites of the food served with his evening meal. Upon inquiry, the resident stated he had just received his meal tray. When asked, Resident #26 reported he had not experienced any gastrointestinal discomfort although he was aware that he received that medication for this.

A review of the meal intake record for Resident #26 revealed the resident consumed 21%-75% of his evening meal on 9/23/15.

An interview was conducted on 9/24/15 at 9:14 AM with the facility’s Director of Nursing (DON). During the interview, the DON indicated the administration time of the Pancreaze DR medication for Resident #26 probably needed to be changed to better correspond with his mealtime schedule.

A telephone interview was conducted on 9/24/2015 at 11:16 AM with the facility’s consultant pharmacist. During the interview, the administration time observed on 9/23/15 for Resident #26’s Pancreaze DR relative to the scheduled evening meal service was discussed. The pharmacist reported, in general, she has expected a medication ordered with a meal to be administered with the first bite of the meal or within one hour after the meal was consumed.

The audit results will be reviewed at the facility’s monthly Quality Assurance meeting for a minimum of three months. Any identified issues will be discussed and recommendations followed to ensure ongoing compliance and determine the need for ongoing audits beyond three months.

The Staff Development Coordinator completed a G-Tube medication pass skills check with Nurse #7 on October 14, 2015 to ensure knowledge of the correct policy and competency of the procedure.

The Consultant Pharmacist completed an Inservice reviewing G-Tube medication administration with licensed nurses on October 15, 2015. Nurse will be required to complete a G-tube medication pass skills check with a member of Nursing management by October 20, 2015. Newly hired nurses will also be required to complete this skills check during their orientation period, prior to being assigned to a medication cart. The skills check instructs the nurse to follow the physician’s order or the facility’s policy for administering “Medication via Gastrostomy Tube.” These instructions include: Verify the physician’s orders and gather equipment at bedside.
F 332 Continued from page 13

2) A review of the facility's policy, "Medication via Gastrostomy Tube" (Revised 2/19/11) included the following statement:

"15) Do NOT mix medications. Administer each medication separately." 

Resident #129 was admitted to the facility on 5/29/15 with a cumulative diagnoses which included gastrostomy (a surgical opening into the stomach whereby a feeding tube may be inserted and used for feeding) and a history of multiple infections.

On 9/23/16 at 4:47 PM, Nurse #7 was observed as she prepared medications and a tube feeding formula (one-240 milliliter [ml] can of Glucerna 1.5) for administration to Resident #129. The medications pulled for administration included one capsule of Align (a probiotic formulation); and, one-5 milligram (mg) isosorbide dinitrate tablet (a medication typically used for the management of angina or chest pain). The nurse was observed as she opened the Align capsule and placed the contents into a medication cup; she then placed the isosorbide dinitrate tablet in the same medication cup. Nurse #7 put the two medications into a plastic sleeve and crushed the medications together. The crushed medications were poured back into the med cup and approximately 0 milliliters (ml) of water were added to the cup. The two crushed medications were administered together to Resident #129's via his gastrostomy tube at 6:07 PM.

A review of Resident #129's September 2015 Order Summary Report included an order which read, in part: "Flush tube with ... 6 oz [ml] water) between each med."
Continued From page 14

During an interview with Nurse #7 on 9/23/15 at 5:47 PM, the nurse acknowledged all medications administered via a gastrostomy tube needed to be separated and the tube flushed with water in between the administration of each medication. Nurse #7 stated she did not recall whether or not she separated the contents of the Align probiotic capsule from the crushed isosorbide dinitrate tablet.

An interview was conducted with the facility’s Staff Development Coordinator (SDC) on 9/24/15 at 8:18 AM. During the interview, the SDC indicated the expectation would be for all medications to be given individually, one at a time. She also stated it was the facility’s policy that 5 cc (ml) plain water should be used to flush the gastrostomy tubing between each medication given through a gastrostomy tube.

An interview was conducted on 9/24/15 at 9:14 AM with the facility’s Director of Nursing (DON). The 9/23/15 observation of medication administration to Resident #129 via his gastrostomy tube was discussed. During the interview, the DON stated she would have expected the nurse to separate the medications and give them individually via the gastrostomy tube.

A telephone interview was conducted on 9/24/15 at 11:18 AM with the facility’s consultant pharmacist. During the interview, the 9/23/15 observation made of medication administration via a gastrostomy tube was discussed. The pharmacist stated that unless there was a physician’s order indicating otherwise, medications needed to be given separately. She also reported the gastrostomy...
<table>
<thead>
<tr>
<th>ID</th>
<th>PREPREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID</th>
<th>PREPREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 332</td>
<td>Continued From page 16 tube should be flushed with water in between the administration of each of the medications.</td>
<td>F 332</td>
<td>Residents #74 and #92's Controlled Drug Records and MARs have been reconciled and accurately documented. The controlled medications being removed from the medication card as well as administered to the residents.</td>
<td>9/22/15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 514</td>
<td>483.75(1)(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 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 observations, record review and staff interview, the facility failed to follow established procedures for the consistent and accurate documentation of the administration of controlled medications on the Medication Administration Records and Controlled Drug Records for 2 of 5 residents (Resident #74, and #92) reviewed for unnecessary medications. The findings included: 1) A review of the facility's policy, &quot;Med Pass with Medication Cart&quot; (Reviewed 6/10/16) included a section outlining &quot;Procedures&quot; which read, in part: 15. &quot;Document administration on the medication cart at the time of administration.&quot;</td>
<td>F 514</td>
<td>Nursing management completed a facility wide audit on October 8, 2015 of the Controlled Drug Records and the actual MARs of the residents receiving those controlled medications to ensure accuracy and consistency between the two documents. Licensed nurses were re-educated on the correct procedure for administering and documenting controlled medications on October 8, 2015 by the Director of Nurses. Each Controlled Drug Record is now reconciled with the resident's MAR during every shift to shift nursing report/narcotic count. The oncoming nurse must verify and initial in the</td>
<td>9/22/15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>PREFIX</td>
<td>TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID</td>
<td>PREFIX</td>
<td>TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>DUE COMPLETION DATE</td>
</tr>
<tr>
<td>-----</td>
<td>--------</td>
<td>-----</td>
<td>--------------------------------------------------------------------------------</td>
<td>-----</td>
<td>--------</td>
<td>-----</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>F 514</td>
<td>TAO</td>
<td>Continued From page 16 sheet or in the computer, and update the individual Controlled Drug Record for Schedule II drugs. &quot;</td>
<td>F 514</td>
<td>TAO</td>
<td>&quot;checked by&quot; box on that form that every controlled medication signed out on the Controlled Drug Record during the previous shift has also been documented in the resident's MAR. Any discrepancies are to be reported to the Director of Nurses immediately. Newly hired nurses will be educated on this procedure during their facility orientation. It will also be added to the Licensed Nurses Orientation Checklist and signed off by the Staff Development Coordinator when complete. The Director of Nurses or designee will audit the Controlled Drug Records and MARs of five residents to ensure accuracy and consistency between the two documents. Audits will be completed daily for two weeks, three times a week for two weeks, two times a week for two weeks, weekly for two weeks and monthly for three months. Audit results will be reviewed at the facility's monthly Quality Assurance meeting for a minimum of three months. Any identified issues will be discussed and recommendations followed to ensure ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### F 514

9/15/15 at 7:54 AM, 2:00 PM, and 9:11 PM; 9/16/15 at 7:55 AM, 2:00 PM, and 9:00 PM; 9/17/15 at 8:15 AM, 2:30 PM, and 9:00 PM; 9/18/15 at 7:39 AM, 2:00 PM, and 9:05 PM; 9/19/15 at 7:44 AM, 2:00 PM, and 9:00 PM; 9/20/15 at 7:17 AM, 1:45 PM, and 9:00 PM; 9/21/15 at 7:30 AM, 2:00 PM, and 8:20 PM; 9/22/15 at 8:00 AM, 2:30 PM, and 8:55 PM; and, 9/23/15 at 8:13 AM.

Comparison of the resident's Controlled Drug Record with the September 2015 Medication Administration Record (MAR) revealed 15 of the 67 hydrocodone/acetaminophen tablets were not noted on the MAR as having been administered to the resident. There was no documentation on the MAR to indicate hydrocodone/acetaminophen was administered to Resident #74 on the following dates/times:
- 9/1/15 at 2:30 PM;
- 9/2/15 at 8:30 AM and 2:45 PM;
- 9/4/15 at 2:30 PM;
- 9/7/15 at 8:00 AM and 2:45 PM;
- 9/8/15 at 2:25 PM;
- 9/10/15 at 9:00 PM;
- 9/13/15 at 3:00 PM;
- 9/17/15 at 8:15 AM;
- 9/19/15 at 9:00 PM;
- 9/20/15 at 1:45 PM and 9:00 PM;
- 9/21/15 at 7:30 AM; and,
- 9/22/15 at 2:30 PM.

An interview was conducted on 9/23/2015 at 2:55 PM with Nurse #1 and a follow-up interview was conducted with the nurse on 9/23/15 at 4:10 PM. Based on the Controlled Drug Record review, Nurse #1 was identified to have pulled Resident #74's hydrocodone/acetaminophen from the

### F 514

compliance and determine the need for ongoing audits beyond three months.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LCS IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 514</td>
<td>Continued From page 18 medication cart without documenting its administration to the resident (on the MAR) on following dates/times: 9/3/15 at 8:32 AM; 9/3/15 at 9:00 AM; 9/3/15 at 9:30 AM; 9/3/15 at 2:45 PM; 9/3/15 at 5:00 PM; 9/3/15 at 8:00 PM; 9/4/15 at 2:45 PM; 9/4/15 at 3:00 PM; 9/4/15 at 3:00 PM; 9/4/15 at 7:00 PM.</td>
<td>F 514</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 514</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SUMMARY STATEMENT OF DEFICIENCIES**

- Each deficiency must be preceded by full regulatory or LSC identifying information.

**ID**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 514</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PROVIDER'S PLAN OF CORRECTION**

- Each corrective action should be cross-referenced to the appropriate deficiency.

**DATE SURVEY COMPLETED**

- C 09/24/2015

---

**NAME OF PROVIDER OR SUPPLIER**

- SILAS CREEK REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

- 3359 SILAS CREEK PARKWAY
  - WINSTON-SALEM, NC 27103

---

**Continued From page 19**

signature on the Controlled Drug Record. During the interview, the DON stated the Controlled Drug Record only documented the medication was pulled out of the med cart. She reported the nurse also needed to document on the MAR that the medication had been administered to the resident. The DON indicated her expectation was for both the Controlled Drug Record and the MAR to reflect the withdrawal of the medication from the med cart and the administration of this medication to the resident. When asked, the DON acknowledged she would expect documentation on the two records to be consistent with one another.

An interview was conducted on 9/23/2015 at 4:05 PM with Nurse #2. Nurse #2 was identified to have pulled Resident #74's hydrocodone/acetaminophen from the medication cart without documenting its administration to the resident (on the MAR) on following dates/times: 9/1/15 at 2:30 PM; 9/10/15 at 8:00 PM; and 9/20/15 at 1:45 PM. Upon request, the nurse discussed the process employed for the administration / documentation of PRN controlled substance medications to a resident. Nurse #2 stated she would assess a resident, check both the MAR and Controlled Substance Records for the dates/times the resident last received the medication, administer the medication, and then document the med administration on both the resident's MAR and the Controlled Substance Record. Nurse #2 stated she was, "supposed to always document in both places." During the interview, the nurse verified her signature on the Controlled Drug Record for the dates/times in question.

A telephone interview was conducted on...
Continued from page 20

9/24/2015 at 10:39 AM with Nurse #6, Nurse #4 was identified to have pulled Resident #74's hydrocodone/acetaminophen from the medication cart without documenting its administration to the resident (on the MAR) on 9/13/15 at 3:00 PM. Upon request, the nurse discussed the process employed for the administration / documentation of PRN controlled substance medications to a resident. Nurse #4 stated the procedure was to document on the Controlled Drug Record when a medication was pulled, to give the medication, then document its administration on the resident's MAR. When asked about the discrepancy noted between the Controlled Drug Record and the MAR, the nurse reported it probably occurred at a time when she got distracted after coming out of the resident's room. Nurse #4 indicated she would expect both the medication withdrawal from the cart and its administration to be documented on the Controlled Drug Record and the MAR.

A telephone interview was conducted on 9/24/2015 at 10:45 AM with Nurse #5. Nurse #5 was identified to have pulled Resident #74's hydrocodone/acetaminophen from the medication cart without documenting its administration to the resident (on the MAR) on the following dates/times: 9/19/15 at 9:00 PM; and, 9/20/15 at 9:00 PM. Upon request, the nurse discussed the process employed for the administration / documentation of PRN controlled substance medications to a resident. Nurse #5 indicated the procedure included documenting on the Controlled Drug Record and MAR after an administered controlled substance medication was given to a resident. When asked about the discrepancy noted between the Controlled Drug Record and the MAR, the nurse stated she did not recall the
**Continued From page 21**

Specific instances in question. However, Nurse #5 reported sometimes the computer "goes down or messes up" and sometimes she may get distracted or called away. Regardless, Nurse #5 indicated she would expect documentation of the controlled substance medication given to be included on both the declining inventory log and the MAR.

A telephone interview was conducted on 9/24/2015 at 10:55 AM with Nurse #3. Nurse #3 was identified to have pulled Resident #74's hydrocodone/acetaminophen from the medication cart without documenting its administration to the resident (on the MAR) on 9/22/15 at 2:30 PM. Upon request, the nurse discussed the process employed for the administration/documentation of PRN controlled substance medications to a resident. Nurse #3 reported once a controlled substance medication was pulled for a resident she would sign it out on the book (the Controlled Drug Record), give the medication, and then record its administration on the MAR. When asked about the discrepancy noted between the Controlled Drug Record and the MAR, the nurse indicated such a discrepancy would occur if the medication was signed out but the nurse didn't "click on it" to record the entry in the electronic MAR system.

Nurse #8 was not available for an interview during the survey investigation. Nurse #6 was identified as the nurse who pulled Resident #74's hydrocodone/acetaminophen from the medication cart without documenting its administration to the resident (on the MAR) on 9/4/15 at 2:30 PM;

A telephone interview was conducted on 9/24/15 at 11:16 AM with the facility's Consultant.
<table>
<thead>
<tr>
<th>F 514</th>
<th>Continued From page 22</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pharmacist in regards to the documentation required when a controlled substance medication was pulled from the medication cart and administered to a resident. Upon inquiry, the pharmacist stated her expectation was, &quot;as soon as they (the nurse) punch that med out of the cart (it) needs to be documented on the declining inventory log.&quot; The pharmacist also indicated the nurse would be expected to document on the resident's MAR after the medication was administered to the resident, indicating the date/time the medication was given.</td>
</tr>
</tbody>
</table>

2) A review of the facility's policy, "Med Pass with Medication Cart" (reviewed 5/19/15) included a section outlining "Procedures", which read, in part:

16. "Document administration on the medication sheet or in the computer, and update the Individual Control Drug Record for Schedule II drugs."

Resident #92 was admitted to the facility on 5/8/16 with a cumulative diagnoses which included episodes of anxiety. His admission orders included 0.5 milligrams (mg) lorazepam (an antianxiety medication) given as one tablet by mouth every 4 hours as needed (PRN) for anxiety.

On 9/23/15, a review of Resident #92's Controlled Drug Record (a declining inventory record) from July, August and September 2015 was completed. The resident's Controlled Drug Record revealed 7 tablets of 0.5 mg lorazepam were removed from the medication cart between 7/1/16 and 9/23/15 (the date of the review). One tablet of lorazepam was documented as removed from the medication cart for Resident #92 on
Continued from page 23:
each of the following dates/times:
7/6/15 at 10:00 PM;
7/10/15 at 8:00 PM;
7/18/16 at 10:00 PM;
7/18/16 at 10:00 PM;
8/28/15 at 8:20 AM;
9/9/16 at 8:30 AM; and,
9/19/15 at 7:11 PM.

Comparison of the resident's Controlled Drug
Record with the July, August, and September
2015 Medication Administration Records (MARs)
revealed 1 of the 7 lorazepam tablets removed
from the medication cart during the past 3 months
was not noted as having been administered to
the resident. There was no documentation on
the MAR to indicate lorazepam was administered to
Resident #92 on 7/19/15 at 10:00 PM.

An interview was conducted on 9/23/15 at 3:36
PM with the facility's Director of Nursing (DON).
Upon inquiry, the DON outlined the facility's
procedures for documenting the administration of
a controlled substance medication to a resident.
The DON reported she would expect documentation to be completed on both the resident's Controlled Drug Record and the MAR. The DON assisted with the identification of staff nurses' signatures on the Controlled Drug
Record. During the interview, the DON stated the
Controlled Drug Record only documented the
medication was pulled out of the med cart. She
reported the nurse also needed to document on
the MAR that the medication had been administered to the resident. The DON indicated her expectation was for both the Controlled Drug Record and the MAR to reflect the withdrawal of the medication from the med cart and the administration of this medication to the resident. When asked, the DON acknowledged she would
Continued From page 24

A telephone interview was conducted on 9/24/2015 at 10:55 AM with Nurse #3: Nurse #3 was identified to have pulled Resident #92's lorazepam from the medication cart without documenting its administration to the resident (on the MAR) on 7/18/15 at 11:00 PM. Upon request, the nurse discussed the process employed for the administration / documentation of PRN controlled substance medications to a resident. Nurse #3 reported once a controlled substance medication was pulled for a resident she would sign it out on the book (the Controlled Drug Record), give the medication, and then record its administration on the MAR. When asked about the discrepancy noted between the Controlled Drug Record and the MAR, the nurse indicated such a discrepancy would occur if the medication was signed out but the nurse didn't document it to the entry in the electronic MAR system.

A telephone interview was conducted on 9/24/15 at 11:16 AM with the facility's Consultant Pharmacist in regards to the documentation required when a controlled substance medication was pulled from the medication cart and administered to a resident. Upon inquiry, the pharmacist stated her expectation was, "As soon as they (the nurse) punch that med out of the card (it) needs to be documented on the declining inventory log." The pharmacist also indicated the nurse would be expected to document on the resident's MAR after the medication was administered to the resident, indicating the date/time the medication was given.
1) Resident concerns regarding the timeliness of staff answering call lights were addressed individually with Resident #1, Resident #55, and Resident #53 on October 14, 2015 by the Director of Nurses. The Director of Nurses shared the facility's plan of action to ensure that call lights are answered in a timely manner with these residents on October 14, 2015.

2) All residents in the facility have a Department Manager assigned as their “Guardian Angel.” Residents are asked during the week day Guardian Angel rounds if their needs are being met and if the call lights are answered in a timely manner. Resident care and call light concerns are immediately addressed and documented as a grievance to ensure appropriate follow up.
3. The Administrator will review all past facility deficiencies for past 5 years with the appropriate department manager. The facility team will review current policy and procedures to assure all policy and procedures are in action to prevent further deficient practice.

4. The Administrator will report findings from #3 above to the facility QA committee monthly for 3 months. The report will include plans that are in place to assure implemented policy and procedures are working to prevent a repeat deficiency. The committee will be involved with assessing presented plan and present recommendations and changes as necessary.

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 520</td>
<td>Continued From page 26 residents. The continued failure of the facility during two federal surveys of record, showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This tag is cross referred to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F 241: Dignity And Respect of Individuality. Based on record reviews, interviews with resident and staff, the facility failed to answer resident call bals for residents needing assistance, to maintain dignity for 3 of 4 residents (Resident #17, Resident #53 and Resident #55) reviewed for dignity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The facility was visited for F241 when it failed to develop and implement procedures and monitor interventions to maintain resident's dignity as it relates to answering call bals and providing assistance for independent resident. F 241 was originally cited during the February 2015 complaint survey for failed to maintain residents dignity.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|               | During an interview with the Director of Nursing on 9/24/2016 at 3pm regarding the facility's quality assessment and assurance system, the DON indicated that the committee members consisted of the Administrator, all department heads, the pharmacist and medical director. The DON indicated that they had met monthly. The DON revealed that the department heads were responsible for the implementation and monitoring of the action plan for that department with any concerns and/or issues that impacted. When asked about call bals not being answered?
Continued From page 27
The DON stated "we still have a problem with call bells not being answered."

4) Call light response times will be monitored by utilizing a call light audit. The audit form will be completed by the Director of Nurses or designee to ensure call lights are being answered in a timely manner. The audits will be randomly performed during all three shifts and at different times during the shifts. The audit will be completed daily for 4 weeks, weekly for 8 weeks, and then monthly for 3 months. Any concerns identified when completing the audit will be addressed immediately. The call light audit results will be reviewed monthly for a minimum of six (6) months in the facility’s QA meeting. Any identified issues will be discussed and recommendations followed to ensure ongoing compliance and determine the need for further audits beyond six (6) months.