STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 254 SS=E	483.10(i)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION (i)(3) Clean bed and bath linens that are in good condition; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview the facility failed to provide linens (towels, washcloths and sheets) to 2 of 3 resident floors. Findings included: An interview on 8/23/17 at 3:00 pm with the Resident Council President, Resident #58, revealed that the complaint that often came up in Resident Council was not enough linen. She also stated the Housekeeping Manager had addressed the problem when it was brought up in the Resident Council meeting. Resident #58 stated she continued to have residents tell her there were not enough linens but she had not taken the complaint to the Resident Council meeting again or notified staff of the complaints. An interview on 8/23/17 at 3:10 pm with Resident #85 revealed he felt there was not enough linen and that it was an issue that comes up frequently. Review of the Resident Council minutes revealed that the Environmental Service Manger #1 came to the March 8, 2017 Resident Council meeting and reported he added more linen into the circulation and was waiting on another order of linen to arrive. The Resident Council minutes were reviewed for the previous eight months and there was no other mention of linens or lack of linens.	F 254	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Winston-Salem Nursing & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. 1.No residents were named in this citation, no residents were directly affected. The facility social work department interviewed alert and oriented residents on each floor on 8/24/2017 to ensure clean linens were available at all times, and that no residents were without clean linens. The social services department, and Administrator audited linen supply's on each floor to ensure closets were fully stocked. 2. All residents have the potential to be affected if the facility failed to provide ample supply of clean linens.Corrective action for those who have the potential to be affected ; On 8/23/17 The Environmental Manager immediately brought carts of linens to each floor as scheduled,each cart contained wash	9/15/17

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

Electronically Signed | 09/15/2017

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F 254	Continued From page 1 Interview on 8/23/17 at 3:35 pm with Nurse #1 revealed she had issues with obtaining linen at least three times a week. She stated there usually is not any linen when they come in at 3:00 pm. She stated that the NAs cannot give baths until after 5 pm and their shift starts at 3 pm. Observation on 8/23/17 at 3:35 pm with Nurse #1 revealed there was no linen in the 2nd floor clean linen closet. Interview on 8/23/17 at 3:45 pm with NA #1 revealed she does not have linen and is not able to provide resident baths until after 5 pm and her shift begins at 3 pm. Interview with the Environmental Service Manager #2 on 8/23/17 at 3:55 pm revealed linen is not delivered on 3pm to 11 pm shift until 4:30 pm. Environmental Service Manger #2 stated he had two machines to do laundry for a four floor building and the laundry staff did the best that they could. He revealed the laundry was delivered to each of the floors between 7am and 8am, 10:30 am and 12:30 pm, 4:30 pm and 4:45 pm, 7:30 pm and 10:00 pm. Environmental Service Manager #2 stated his goal was to have enough linen inventory for two days. He stated he would be doing a linen study and would be buying linen after the study. Interview with the Administrator on 8/23/17 at 4:30 pm revealed she was not aware of the issue of staff not having enough linen and her expectation was there should be enough linen throughout the shifts for care to be completed. Observation on 8/24/17 at 8:15 am revealed there was linen in the 2nd floor, 3rd floor, and 4th floor clean linen closet.	F 254	cloths,towels,flat sheets, fitted sheets, blankets pillow cases,gowns,bed and clothing protectors. 3.Laundry staff were in serviced on linen delivery time and quantity delivered. The in-service also covered coordinating par levels with census to ensure each resident has the required linens available at all times.The Linen delivery schedule was updated to reflect delivery time of 3pm for the start of second shift. A delivery time audit sheet was put into place by the administrator, along with quantity delivered audit counts.Interdisiplinary team will continue to audit linen availability in closets 2 times a day x 2 weeks, then 2 x weekly times 4 weeks then monthly x 3 months 4. Data results will be reviewed and analyzed at the centers monthly QAPI meeting for 3 months with a subsequent plan of correction as needed.	

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F 254	Continued From page 2 On 8/24/17 at 10:00 am interview with NA #2 revealed she has problems with getting linen, especially towels and wash clothes, at the beginning of her shift. She stated she arrives at 7:00 am and sometimes does not have linen before 9:00 am.	F 254		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material	F 278		9/15/17

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F 278	Continued From page 3 and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the resident ' s condition for 2 of 6 residents reviewed for behavioral and emotional status (Resident #241), and medications (Resident #222). Findings Included: 1. Resident #241 was admitted to the facility on 2/20/17 and diagnoses included dementia, insomnia and cerebrovascular disease. A review of the nursing notes for Resident #241 for 2/20/17 through 2/27/17 revealed an entry dated 2/21/17 that stated "She also takes her fingernails and digs them into your skin as you attempt to assist with standing. She got the back of my right arm and the nursing assistants (NA) left hand." An entry dated 2/23/17 stated "Resident has been noted on 2 occasions grabbing the male residents hand and not letting go." A review of the psychiatric evaluation dated 2/24/17 for Resident #241 stated "Staff reports verbal and aggressive behavior towards them when providing care. Resident kicks and screams." The mood and behavior roster for Resident #241	F 278	1.Resident #241 mds assessment dated 2/27/2017 was modified on 8/24/2017 to reflect behaviors that occurred during the assessment look back period.Resident #222 mds assessment dated 7/19/2017 was modified n 9/1/2017 to include diagnosis of anxiety and depressive disorder. 2.An audit was performed by the IDT team(interdisciplinary Team) members on current resident population last mds assessment section E and section I with clinicl record review during the look back period to ensure accuracy on assessment for behaviors and appropriate diagnosis coding for anxiety disorders and depressive disorders.No other records were identified in this audit. 3.The regional mds consultant re educted the IDT team responsible for coding section e(behaviors) and section I(active diagnosis)to the rai (resident assessment instrument)process for mds accuracy. this information will be included in the employee orientation program for newly hired Idt members. The Director of nursing, Assistant director of nursing and the Idt team will monitor 20 new mds assessments weekly x 4 weeks, then monthly x 3 months to ensure ongoing compliance in the accuracy of	

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F 278	Continued From page 4 was provided by the facility Administrator. The roster identified that the resident displayed physical behavior towards others on 2/22/17 at 5:24 pm, 2/24/17 at 11:26 am and on 2/27/17 at 10:05 pm. An admission MDS dated 2/27/17 for Resident #241 revealed her cognition was severely impaired and she had no physical behavior symptoms directed toward others during the 7 day look back period. An interview on 8/22/17 at 2:27 pm with NA #7 revealed she was familiar with Resident #241 and had worked with her since she was admitted to the facility. NA #7 stated when the resident was first admitted to the facility she would physically strike out at staff. An interview on 8/22/17 at 2:49 pm with the Social Worker (SW) for Resident #241 revealed she was familiar with the resident and had completed section E (behaviors) for the MDS dated 2/27/17. The SW stated she used the flow sheets that the NA ' s completed to code the behavior section. She added additional sources of information including the nursing notes could be used when coding this section. The SW reviewed the nursing note entries for 2/21/17 and 2/23/17 and stated if she had reviewed those notes she would have coded section E of the 2/27/17 MDS to reflect Resident #241 did have physical behaviors towards others during the look back period. An interview on 8/24/17 at 1:38 pm with MDS Nurse #1 revealed that the 2/27/17 MDS for Resident #241 was coded incorrectly for behaviors based on the entries made in the	F 278	coding behaviors and anxiety depressive disorders. 4.Data results will be reviewed and analyzed at the centers monthly QAPI meeting for 3 months with a subsequent plan of correction as needed	

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F 278	Continued From page 5 nursing notes and the physical behaviors identified on the mood and behavior roster. 2. Resident #222 was admitted to the facility on 8/26/15 and diagnoses identified on the residents cumulative diagnosis list with onset date of 8/26/15 included anxiety disorder and depression disorder. A quarterly MDS dated 7/19/17 for Resident #222 revealed the following diagnoses cerebral vascular accident, seizure disorder and asthma. Anxiety and depression disorders were not identified as current diagnoses. The MDS also revealed the resident had received antianxiety and antidepressant medications for 7 days of the look back period. An interview on 8/24/2017 at 1:38 pm with MDS Nurse #2 revealed that the diagnoses were coded on the MDS if it was an active diagnoses by the physician in the 60 day look back period. She stated Resident #222 did have active diagnoses of anxiety disorder and depressive disorder and these should have been coded on his 7/19/17 MDS. An interview with the Director of Nursing (DON) on 8/24/17 at 2:09 pm revealed it was her expectation that MDS ' s are coded accurately to reflect the resident.	F 278		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329		9/15/17

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F 329	Continued From page 6 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner interview and staff interviews, the facility failed to implement correct medications on admission for 1 of 5 (Resident # 292) sampled residents	F 329	1.Resident #292 admission medication list from the discharge summary were reviewed and were verified on 7/24/2017 by Nurse Pratcioner.Resident #292 was	

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F 329	Continued From page 7 reviewed for unnecessary medications. The findings included: Resident #292 was admitted on 7/24/17 from the hospital with diagnoses of Progressive Major Neurocognitive Disorder with Behavioral Disturbance, Paranoid Delusions, Extreme Confusion, Progressive Dementia, Ventriculomegaly, and Adult Failure to Thrive. Review of the Discharge Summary received from the hospital on 7/24/17 at 11:39 am revealed there were numbered pages (page 1-2 and 11-12) missing from the Discharge Summary for Resident #292 sent from the hospital and one of the pages was labeled with another patient's name (not a Resident of the facility). Review of the Medication Administration Records for July 2017 and August 2017 revealed Resident #292 received Clotrimazole topically for ringworm of the body, Brimonidine 0.2 % ophthalmic solution with no diagnosis given, Dorzolamide HCL 2 % ophthalmic solution with no diagnosis given, Furosemide with no diagnosis given; Latanoprost 0.005% ophthalmic solution with no diagnosis given, Lovastatin for hypercholesteremia, Pilocarpine HCL 4% ophthalmic solution with no diagnosis given, Prednisone with no diagnosis given, and Senokot with no diagnosis given from her admission on 7/24/17 to 8/8/17. Review of the Physician's Visit note dated 8/8/17 revealed Resident #292's Family Member had brought up concerns regarding her medication list and the Family Member felt Resident #292 was on the wrong medications. The MD Visit note	F 329	receiving medications indicated on her discharge summary. The family Meeting on 8/8/2017 identified resident #292 had medications that were no longer indicated. Resident #292 was assessed at that time and no adverse reactions were identified. The facility notified Medical director and Nurse pratcioner and received orders to discontinue identified medications. A medication error/incident report was completed on 8/25/2017.This resident is receiving the appropriate medications for each diagnosis as indicated. 2.An audit was performed on new admission residents (hospital discharge summary)by The Director of nursing, Assistant director of nursing with in the last 30 days to validate correct medications on admission with an emphasis on appropriate diagnosis for medication, correct name on all pages of the (discharge summary)and correct page number sequencing. All Errors identified through this process will be communicated to the (RP) responsible party and the(MD) Medical Director will be notified , no other errors were identified. 3.The Director of Nursing, and The Staff Development Coordinator in serviced the liscensed nurses on implementing correct medications for new adnmissions with an emphasis on appropriate diagnosis,correct name on all pages and correct page number sequencing from the discharge summary.This information will be reviewed during the orientation process for liscensed nurses. The Director of nursing, Assistant director of nursing, unit coordinators will monitor	

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F 329	Continued From page 8 further revealed that the discharging hospital was called and Resident #292's medication orders were corrected. Review of Physician Telephone Orders dated 8/8/17 for Resident #292 revealed the following medications were discontinued due to incorrect admission medications: Clotrimazole !%, Trusopt, Prednisone, Bystolic, Xalatan, Pilocarpine, Alphagan, Furosemide, Luvox, Lovestatin, Senokot, Nibivolol and Melotonin. The indication for the order to discontinue these meds was "correcting admission medications". No other orders were added on 8/8/17, but the following medications were continued: Gabapentin for Neuropathy, Melatonin for Insomnia, Namenda for Dementia, and Aspirin for anticoagulation. Staff interview on 8/24/17 at 12:40 pm with Nurse #2, Supervisor, revealed he was not aware of any medication errors for Resident #292. Staff interview on 8/24/17 at 1:25 pm with Nurse #3, Primary Nurse, revealed she was not aware of any medication errors involving Resident #292. She stated she was not aware of the telephone orders that were written on 8/8/17 that discontinued medications to "correct admission medications". Nurse #3 stated all of the nurses are responsible processing medication orders for their shift. Interview on 8/24/17 at 1:23 pm with the Nurse Practitioner revealed Nurse #2 called her on 8/8/17 and stated Resident #292's family had questions regarding medications. The Nurse Practitioner stated she reviewed the Discharge Summary that was in the chart and she realized	F 329	10 new discharge summaries for new admissions weekly x 8 then monthly x 3 months to ensure ongoing compliance with implementing correct medications for new admission residents, with an emphasis on validating appropriate diagnosis for the medication, correct name on all pages, and correct page number sequencing. 4.Data results will be reviewed and analyzed at the centers monthly QAPI meeting for 3 months with a subsequent plan of correction as needed.	

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F 329	Continued From page 9 Resident #292 was on Prednisone, a cream for ringworm, and eye drops for Glaucoma. The Nurse Practitioner stated Resident #292 did not have Ringworm or Glaucoma. She stated she approached Nurse #3 and asked where the Ringworm was and asked where the medication was given. The Nurse Practitioner stated Nurse #3 was unable to state where she had given the medication. The Nurse Practitioner stated Resident #292 should not have received Lovastatin, Latanoprost 9.005%, Nebivolol, Pilocapine, Prednisone, Senokot, Clotrimazole or Furosemide. She also stated Resident #292 received the medications for seven days. The Nurse Practitioner called Resident #292's family and explained the medication error. She stated that Resident #292 did not have any adverse reactions to the medication error and may not have received the medications. Interview on 8/24/17 at 2:14 pm with the Director of Nursing revealed that her expectation is the Discharge Summary from the hospital would be sent to the Physician for review, the nurse would check the Discharge Summary to ensure that the pages are in sequence, and the patient name on the pages match the resident that is admitted.	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, interviews and	F 332	1.Resident #269 received enteric coated	9/15/17

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F 332	Continued From page 10 observations the facility failed to have a medication error rate less than 5%, as evidenced by 4 medication errors out of 26 opportunities, resulting in a medication error rate of 15.38 % for 1 of 8 residents observed for medication pass (Resident 269). Findings included: The facility's medication administration policy for enteral feeding tubes dated 05/2016 revealed that crushed medications should not be mixed together. The policy also revealed that each medication should be administered separately to avoid interaction and clumping when being given via an enteral tube (feeding tube.) The policy also stated that enteric coated medications should not be crushed. Resident #269 was admitted on 6/14/17 with the diagnosis of a stroke, sepsis and muscle weakness. Resident's 269's Medication Administration Record for August, 2016 revealed that the resident had a Gastrostomy- Jejunostomy (GJ) feeding tube. (A GJ tube is a type of feeding tube with 2 ports on the end of it. One of the ports runs to the stomach (G tube port) and the other port runs to the small bowel (J tube port.) Resident #269's signed medication orders for 8/2017 revealed the following: Aspirin enteric coating (EC) 81 Milligrams (mg) via Jejunostomy (J tube) tube at 8:00 AM Lisinopril 20 mg tablet via J tube daily at 8:00 AM Metoprolol Tartrate 50 mg tablet via gastrostomy (G tube) tube at 8:00 AM and 8:00 PM Polyethylene Glycol 3350 Powder 17 grams via J tube twice daily Tamsulosin HCL 0.4 mg capsule via J tube daily Medication administration for resident #269 was observed on 8/23/17 at 8:57 AM by Nurse #5. a) According to the manufacturer's instructions,	F 332	aspirin that was crushed and administered via J-tube,resident #269 also received medication from an opened capsule, immediately when identified, the resident was accessed for any adverse reactions, none noted. The enteric coated aspirin was discontinued. The tamsulosin capsules were discontinued. All medications were verified and are being administered separately via J-tube or G-tube according to manufacturers instructions.The medical director and responsible party was notified immediately. A medication error/incident report was completed 8/23/2013. All residents receiving enteric coated aspirins with emphasis on residents receiving medications via j-tube/G-tube have the potential to be effected. 2.The Director of Nursing and the Assistant Director of Nursing preformed an audit on current resident population receiving enteric coated medications to ensure that these medications were not being crushed for administration both by mouth or via Gastrostomy - Jejunostomy tubes also to ensure that medications are administered separately via enteral tube. 3.The Director of Nursing, Assistant Director of Nursing re-educated the licensed nurses about the medications on the do not crush list with emphasis on enteric coated aspirin and the procedures to administer medications separately via enteral tubes. This education will be included in the new employee orientation program for licensed nurses. 4.The Director of Nursing, Assistant	

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F 332	Continued From page 11 Aspirin Enteric coating is a delayed- release safety coating that provides added stomach protection. It is designed to allow the aspirin tablet to pass through the stomach to the small intestines (Duodenum) before dissolving. During the observation on 8/23/17 at 8:57 AM, Nurse # 5 removed an Aspirin EC 81 mg low dose from the medication cart, crushed and mixed it together with the resident's Metoprolol Tartrate, Tamsulosin hydrochloride, and Lisinopril medications then gave via the J port of the feeding tube. The Medical Director was interviewed on 8/23/17 at 2:11 PM. He thought that the hospital had ordered most of the resident's medications and that the orders just carried over from the hospital, which was why the enteric coating Aspirin was possibly ordered instead of a regular Aspirin. He stated that the pharmacy and he would review the resident's medications. He stated he typically would not order an Aspirin EC to be given for residents with a feeding tube. The pharmacy consultant was interviewed on 8/23/17 at 2:22 PM. She state that every month she completed a pharmacy review and that this was her second time completing the reviews for Resident #269. She would expect for the facility to use a chewable Aspirin and not the enteric coated Aspirin. She explained that when residents had medications that were administered through a feeding tube, she would typically review the medications. The resident came from the hospital with the order for the Aspirin EC. She stated that she would add this issue to her report today. She stated that no pharmacy recommendations had been made for this resident except what she was recommending today. Nurse #5 was interviewed on 8/23/17 at 3:07 PM. She stated she typically made sure the feeding	F 332	Director of Nursing will monitor (through direct observation)the administration of medications via enteral tube for 20 residents 2 x weekly x 4 weeks, then weekly x 4 weeks, and monthly x 3 months to ensure ongoing compliance with administering medications separately via enteral tube and enteric coated medications administered whole. Data results will be reviewed and analyzed at the centers monthly QAPI meeting for 3 months with a subsequent plan of correction as needed.	

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tube was in place before administering a tube feeding or medications. She explained she flushed the feeding tube before the medications was given, then she would give the medications via the G port or the J port of the feeding tube and then flushed again after the medications were given. She stated that the resident had an order for the Aspirin EC so she did not question it.

b) During the observation on 8/23/17 at 8:57 AM with Nurse # 5, the Metoprolol Tartrate 50 mg was also crushed, mixed with the resident's Aspirin EC, Tamsulosin Hydrochloride and Lisinopril medications and given via the J port of the feeding tube. This medication was ordered to be given via the G port of the feeding tube.
Polyethylene Glycol 17 grams was mixed with fluid and given via G port of the feeding tube. This medication was ordered to be given via the J port of the feeding tube.
Nurse #5 was interviewed on 8/23/17 at 3:07 PM. She stated she typically made sure the feeding tube was in place before administering a tube feeding or medications. She explained she flushed the feeding tube before the medication was given, then she would give the medications via the G port or the J port of the feeding tube and then flushed again after the medications were given. She stated that she usually did crush all the medications and mix them together before putting them in the feeding tube as long as there wasn't a new medication that was ordered to be given to the resident. In that case, she would give the new medication separately.

c) Manufacturer's instructions revealed that Tamsulosin Hydrochloride should not be crushed, chewed or opened.
During the observation on 8/23/17 at 8:57 AM

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with Nurse # 5, she opened the Tamsulosin hydrochloride (HCL) 0.4 mg capsule and mixed it with Aspirin EC, Metoprolol Tartrate, Tamsulosin hydrochloride and Lisinopril then administered via the J port of the feeding tube.
d) The facility's medication administration policy for enteral feeding tubes dated 05/2016 revealed that crushed medications should not be mixed together.
Tamsulosin hydrochloride (HCL), Lisinopril, Aspirin EC and Metoprolol Tartrate were all mixed together with water before being administered via the J port of the feeding tube.
The pharmacy consultant was interviewed on 8/23/17 at 2:22 PM. She state that every month she would completed a pharmacy review and that this was her second time completing the reviews for resident #269. She explained that when residents had medications that were administered through a feeding tube, she would typically review the medications. She stated that no pharmacy recommendations had been made for this resident except what she was recommending today.
Nurse #5 was interviewed on 8/23/17 at 3:07 PM. She stated she would make sure the feeding tube was in place before administering a tube feeding or medications. She would flush the feeding tube before the medication was given, then she would give the medications via the G port or the J port of the feeding tube and then flushed again after the medications were given. She stated that she usually did crush the medication and mix them together as long as there wasn't a new medication that was ordered to be given to the resident. In that case, she would give the new medication separately.
The Director of Nursing was interviewed on 8/24/17 at 3:09 PM. She stated that she would

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F 332	Continued From page 14 expect for the nurses to use the "6 rights" (right medication, right route, right time, right resident, right dosage, and right documentation) of medication administration and to administrator medications via the G/J tube according to the facility's policy.	F 332		
F 333 SS=E	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to administer the correct dose of anti-anxiety medication as ordered by the physician for a period of 7 months for 1 of 5 residents that were reviewed for unnecessary medications (Resident #222). Findings Included: Resident #222 was admitted to the facility on 8/26/15 and diagnoses included anxiety disorder, depressive disorder, insomnia and traumatic brain injury. A care plan dated 6/7/17 for Resident #222 identified he was at risk for alteration in mood state related to depression, anxiety and traumatic brain injury. Interventions included to evaluate effectiveness of medications and side effects. A quarterly minimum data set (MDS) dated	F 333	1. Resident # 222 had an order for buspar 7.5 three times a day, the order was transcribed on the resident medication administration record for two times a day. The order was clarified and the correct dosage was ordered. The resident was assessed by the director of nursing and noted to have no adverse effects. The medical director ,The psychiatric services provider were notified of Buspar transcription order error . New order was written to continue Buspar 7.5 mg,po,two times daily. The administrative nurses completed a physicians order and medication administration record audit on current resident population receiving Buspar medication to validate transcription accuracy to the medication administration record. Medication error/incident report completed on 8/24/2017.	9/15/17

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F 333	Continued From page 15 7/19/17 for Resident #222 revealed he was alert and oriented and had received anti-anxiety medications 7 days during the look back period. A review of the August 2017 physician orders for Resident #222 identified an order for Buspar (medication for the management of anxiety disorders) 7.5 milligrams (mg) three times daily. A review of the August 2017 medication administration record (MAR) for Resident #222 revealed an order for Buspar 7.5mg three times daily for anxiety. The MAR identified that the Buspar was being administered twice daily at 2:00 pm and 8:00 pm. The August 2017 MAR indicated Resident #222 had no behaviors. A telephone order, provided by the facility medical records staff, identified on 1/30/17 the Psychiatrist ordered Buspar 7.5mg three times a day for Resident #222. A review of the February 2017, March 2017, April 2017, May 2017, June 2017 and July 2017 MAR ' s for Resident #222 revealed that he had received the Buspar 7.5 mg twice daily at 2:00 pm and 8:00 pm. The pharmacy reviews for Resident #222 for February 2017 through July 2017 revealed no recommendations for gradual dose reductions referencing that gradual dose reductions were not recommended by the Psychiatrist. A review of the psychiatric consult for Resident #222 on 7/14/17 revealed he had been seen for a medication check. The consult documented "On exam his affect is flat and his mood is anxious."	F 333	2.All residents have the potential to be effected,The Director of nursing, Assistant Director of nursing re-educated the licensed nursing staff regarding medication order transcription and the medication six rights, right medication, right route, right time, right resident, right dose, right documentation. All residents medication were reviewed for correct administration times and correct dosages. 3.The Director of nursing ,Assistant Director of nursing, unit coordinators will audit the physicians order and medication administration record for transcription discrepancies (with emphasis on anxiety medications)for 20 residents 2 x weekly for 4 weeks, weekly x 4 weeks, then monthly x 3 months for ongoing compliance.This information will be included in the new hire orientation program for licensed nurses. 4.Data results will be reviewed and analyzed at the centers monthly QAPI meeting for 3 months with a subsequent plan of correction as needed.	

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An observation of Resident #222 was conducted on 8/21/17 at 3:18 pm. He repeatedly stated that he was hot. He was observed to move about in his bed re-positioning himself. He stated that he wanted to go back to his home.

An interview with Nursing Assistant (NA) #3 on 8/23/17 at 10:43 am revealed she was familiar with Resident #222. She stated he didn ' t want to get out of bed or go out of his room. She added he would usually get up and take a shower on his bath days, but he wanted to go directly back to bed after his shower. NA #3 explained that he would not get dressed the majority of the time. She stated he could get upset at times and he frequently talked about wanting to go home.

An interview on 8/23/17 at 3:14 pm with Nurse #4 revealed she knew Resident #222 and was his nurse. The August 2017 MAR was reviewed with Nurse #4 and she confirmed he had been receiving Buspar 7.5mg twice a day instead of three times a day. She stated that Resident #222 definitely needed this medication to help him with his mood and depression. She added that he could get "antsy and agitated" at times and that he frequently talked about going home.

An interview on 8/23/17 at 3:25 pm with Nurse #5 revealed she was the unit manager for Resident #222. She stated the Psychiatrist had changed his order for Buspar 7.5mg to three times a day on 1/30/17. Nurse #5 added there must have been a transcription error when this order was placed in the computer and Resident #222 should have been receiving the Buspar 7.5mg three times a day, not twice a day.

A phone interview on 8/23/17 at 5:44 pm with the

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F 333	Continued From page 17 Psychiatrist for Resident #222 revealed she expected the nurses to carry out her orders as written and she thought the resident was receiving his Buspar three times a day. An interview with the Director of Nursing (DON) on 8/24/17 at 2:11 pm revealed it was her expectation that resident ' s medications are administered according to their physician ' s orders.	F 333		
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide the diet consistency as ordered for a resident on a pureed diet for 1 of 1 resident reviewed for nutrition (Resident #14). Findings included: Resident #14 was admitted on 3/23/10 with the diagnoses of dementia, diabetes, and dysphagia (difficulty or discomfort in swallowing). The Minimum Data Set (MDS) dated 5/11/17	F 367	1. Resident #14 was assessed to include lung sounds and vitals with no noted issues or adverse effects. Residents physician and responsible party was notified. Resident#14 was also assessed by speech therapy for appropriate diet textures. All residents with therapeutic restrictions were provided the correct foods and correct consistency. 2.All Residents have the potential to be effected,Any resident with the need for diet modifications also have the potential to be affected by the deficient practice.	9/15/17

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F 367	Continued From page 18 revealed the resident was rarely understood. The MDS coded the resident as not needing any assistance from staff with eating and that the resident was on a mechanically altered and therapeutic diet. Physician orders for 8/2017 revealed that the resident was prescribed a pureed carbohydrate controlled diet (CCD) with no added salt (NAS) and honey thickened liquids and large portions. A dietary note dated 8/3/17 confirmed Resident #14 was on a pureed, carbohydrate controlled diet with honey thickened liquids due to dysphagia and dementia. Review of the care plan updated 8/10/17 revealed a problem with altered nutrition that required a mechanical altered diet. One intervention stated to monitor the resident's tolerance to the diet consistency and report significant findings to the physician or speech therapist and to give oral supplements as ordered. Resident #14 was observed eating a regular consistency brownie on 8/20/17 at 7:17 PM. Review of the tray card stated a pureed, carbohydrate controlled diet, no added salt with large portions and a pureed brownie. The resident was observed eating pureed barbeque, pureed mashed potatoes, pureed cabbage, and pureed rice with thickened tea, milk, and water. Nurse #6 was interviewed on 8/20/17 at 7:19 PM. He stated that Resident #14 was on a no added salt and pureed diet. He stated the nursing assistants usually checked the trays and would let him know if there were any concerns with the food or the diet orders.	F 367	Dietary staff and nursing staff were immediately in serviced on the importance of providing the correct therapeutic diets. 3.The dietary aides will check all trays for accuracy to include checking for correct consistency, correct food items per tray ticket and for any special equipment needed on residents trays. The dietary manager or assistant manager will audit 10% of trays for each meal service 7 days a week x 2 weeks, then 7 x a week x 4 weeks, then 7 x a week x3 months to ensure accuracy. The nursing department will check all trays for accuracy before delivering to the residents to include checking for correct consistency, correct food items per tray ticket and for any special equipment needed on residents trays. 4.Data results will be reviewed and analyzed at the centers monthly QAPI meeting for 3 months with a subsequent plan of correction as needed.	

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The Dietary Manager (DM) was interviewed on 8/24/17 at 11:16 AM who stated that every resident got a meal ticket with their tray and the resident's diet order was on the meal ticket. Further interview with the DM revealed brownies were pureed for residents on a pureed diet. He stated that this resident was on a purred diet with honey thickened liquids.

The Registered Dietitian (RD) was interviewed on 8/24/17 at 11:16 AM with the DM present. The RD stated Resident #14 had a diagnosis of dysphagia and dementia, which required a pureed diet

The Speech Therapist (SP) was interviewed on 8/24/17 at 12:43 PM who stated Resident #14 was prescribed a pureed diet with honey thickened liquids. Continued interview revealed Resident #14 had penetration (meaning it could cause the resident to cough) with all other diet consistencies and the resident's gag reflex was slow to respond and it did not take a lot for the resident to cough. The SP indicated the pureed diet was the safest texture for her.

Nursing Assistant # 7 was interviewed on 8/24/17 at 12:54 PM and stated that the nursing assistants would look at the meal tray and the tray's ticket to make sure they matched when delivering food to residents. If they did not match then they would report it to the nurse so they could get the correct tray for the resident. She stated that resident #14 would cough sometimes. She would have to tell the resident not to eat too fast and would assist her with eating. The resident got a pureed tray and had not noticed Resident #14 had not received what she was supposed to get.

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F 367	Continued From page 20 The Administrator was interviewed on 8/24/17 at 3:06 PM and stated therapeutic diets and texture consistency of foods were followed as ordered.	F 367		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store foods in sealed, labeled and dated containers, failed to maintain clean kitchen equipment and failed to allow dishware to air dry.	F 371	1.No resident named in this citation,All residents have the potential to be affected. 2.Corrective action for those who have the potential to be affected; On 8/25/17 the	9/15/17

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F 371	Continued From page 21 Findings Included: 1. An observation of the kitchen on 8/20/17 at 3:35 pm with Cook #1 and the Dietary Manager (DM) revealed: A. The dry storage room had an opened, unsealed case of lasagna noodles and tortilla chips. The lasagna noodles and tortilla chips were opened to air and unprotected from contamination. B. The walk-in cooler had the following items that were not labeled and dated as to when prepared: 3 quiche, a half full steam table pan of pureed eggs, a half full steam table pan of pureed meat, 4 bowls of soup, 1 bowl of pudding, 10 bowls of applesauce and 51 bowls of strawberries. Also, stored in this walk-in cooler was a case of pork sausage and a box of muffins that were not sealed and exposed to the air. C. The walk-in freezer had the following items that were opened, not sealed and exposed to the air: a box of green beans, a box of carrots, a box of peanut butter cookie dough and a box of oatmeal raisin cookie dough. D. An electric hot box (used to hold cooked foods) that contained 2 uncovered full steam table pans of cooked pork patties, had food spills on the interior and exterior of the box. The steam table had 6 wells that contained insert pans that were filled with brownish, black water with food particles floating in the water. A bowl storage cart that contained clean bowls had dried on brown food substances on the top. Two ingredient bins that contained flour and corn meal had a heavy build-up of dried food particles on the lids and	F 371	Dietary Manager audited and discarded all open unsealed foods, unlabeled and undated food items in the cooler and in the dry storage area. Dietary Manager also assured the kitchen equipment identified was cleaned immediately.All bins, carts, plate dollies, containers and lids were cleaned. All steam table pans and water storage containers were cleaned immediately. The Dietary Manager rewashed identified wet trays, pots, and cups to assure proper drying technique. New drying rack separators were ordered and put in place, the facility also ordered additional trays to keep a set dry at all times. 3. Measures and systemic changes to ensure practice. On 8/25/17 the Dietary Management team in-serviced dietary staff on proper food storage, sealing of food with label and date. The dietary manager also updated the weekly cleaning schedule to reflect cleaning more often and as soiled. On 8/25/17 the Dietary Management team in-serviced dietary staff on proper drying techniques, new drying rack separators, and educated on procedure for extra set of serving trays to be kept dry at all times. On 8/25/17 the Dietary Management team implemented a daily checklist to monitor for wet nesting, cleanliness of equipment, and proper food storage. 4. Monitoring for performance and efficacy. The Dietary Management team will utilize the daily checklist-daily for 4 weeks and then weekly for 4 weeks and report. Data results will be reviewed and analyzed at the centers monthly QAPI	

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WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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F 371	Continued From page 22 around the rims of the bins. E. There were 31 meal trays on a cart at the steam table ready for the supper meal service that were stacked together wet. An interview with Cook #1 on 8/20/17 at 4:00 pm revealed all food items should be labeled and dated. He stated the label should include the storage and the use by date. Cook #1 explained all opened food items needed to be sealed so the food was not exposed to the air. He stated the ingredient bins should not be dirty, but he wasn ' t sure how often they were on the cleaning schedule. Cook #1 stated the wet meal trays had been put away by the first shift after they washed them from the lunch meal. He added the trays should have been allowed to air dry in the rack before being stacked together at the steam table. An interview with the DM on 8/20/17 at 4:15 pm revealed the hot box was usually cleaned once a week, but any food spills should be cleaned off daily. He stated the water in the insert pans for the steam table should be changed daily or more often if the water was dirty and food had spilled into the water. The DM explained it looked like gravy had spilled from breakfast service on the bowl storage rack and no one cleaned up the spill. An interview with the Administrator on 8/24/17 at 2:16 pm revealed she expected the dietary staff to follow the required guidelines for the storage and labeling of foods. She stated she expected the cleaning schedule to be followed and all equipment to be clean. She added that equipment should be cleaned more frequently than scheduled if needed. The Administrator	F 371	meeting for 3 months with a subsequent plan of correction as needed. In addition the Regional Manager will audit weekly for 4 weeks and then monthly as an ongoing performance improvement and review her findings with Administrator monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 23	F 371		

explained there was a drying rack available for the staff to use to make sure the meal trays were air dried before being put away and she expected the staff to be using it so the trays were not wet. She stated the water used for the steam table should be clean and free of any food spills.

2. An observation of the supper meal service on 8/20/17 at 6:44 pm of the 300 hall revealed 2 meal carts that contained the residents meal trays had food debris and sticky substances on the exterior of the carts and on the cart door handles.

An interview with the Dietary Manager (DM) on 8/23/17 at 11:50 am revealed he expected the food carts to be cleaned after each meal.

An interview with the Administrator on 8/24/17 at 2:16 pm revealed she expected the food carts to be clean.

3. An observation of the kitchen on 8/23/17 at 11:40 am with the Regional Dietary Manager (DM) revealed 2 dish dollies that contained racks of clean dishes had a heavy build-up of a black substance.

An interview with the Regional DM on 8/23/17 at 11:45 am revealed the dish dollies needed to be cleaned.