STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425303	A. BUILDING _____ B. WING _____	**03/19/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE EMORY POST ACUTE CARE	**59 BLACKSTOCK ROAD INMAN, SC 29349**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0155 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Let the resident refuse treatment or refuse to take part in an experiment and formulate advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure that 1 of 21 sampled residents reviewed for advance directives was afforded the opportunity to formulate their own advance directive. The family signed a South Carolina Emergency Medical Services Do Not Resuscitate Order (DNR) form for Resident #59 and there was a physician's orders [REDACTED]. The findings included: The facility admitted Resident #59 with [DIAGNOSES REDACTED]. Record review on 3/18/2015 at 8:47 AM revealed a South Carolina Emergency Medical Services Do Not Resuscitate Order (DNR) form for Resident #59, dated 1/30/2014. The form was signed by the resident's wife and physician. Further review revealed a 1/30/2014 Telephone Order indicating the resident's status was DNR. Review of the 2/3/2014 History and Physical revealed that the physician documented the resident's code status as Full code per patient. The physician documented that the resident was Oriented to person, place, month and year and that the resident's Judgment/insight was Appropriate. Review of Physician and Nurse Practitioner Progress Notes revealed more discrepancies regarding the resident's code status. A physician progress notes [REDACTED]. A Nurse Practitioner Progress Note dated 2/11/2015 revealed that the resident was a DNR. There was no documentation in the record to indicate that 2 physicians had certified the resident as incapable of formulating his/her own advance directive. During an interview with Licensed Practical Nurse (LPN) #1 on 3/18/2015 at 8:57 AM, LPN #1 confirmed the resident's code status as DNR. LPN #1 also verified that there was no documentation by 2 physicians that the resident was unable to make his/her own healthcare decisions. LPN #1 also confirmed that the physician documented the resident was a Full code.
F 0156 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Give each resident a notice of rights, rules, services and charges. Tell each resident who can get Medicaid benefits about 1) which items and services Medicaid covers and which the resident must pay for.** Based on observation and interview, the facility failed to ensure that the names and phone numbers of State advocacy groups were posted in a public area for easy access by visitors and residents in 1 of 1 main entrances. This had the potential to affect any interested residents and/or visitors. The findings included: On initial tour of the facility on 03/16/15 at 10:00 AM, it was noted that the posting of the names and phone numbers of State advocacy groups was in a hall near the therapy room, away from the main public areas of the facility. The posting did not include the number for the Medicaid Fraud Unit. During an interview at approximately 10:20 AM on 03/16/15, the Nursing Home Administrator confirmed that the postings were not in the main public area in the facility. Further interview revealed that the posting was near the former main entrance to the facility, but had not been moved following renovations to move the facility entrance to the opposite hall in the building. Observation of the door to the outside near the postings revealed a sign on the door directing visitors to use another door to enter the facility.
F 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure family members were notified of a change in condition requiring physician intervention for 1 of 5 sampled residents reviewed for unnecessary medications. There was no evidence that the family was notified of a new order for and administration of [MEDICATION NAME] to Resident #145. The findings included: The facility admitted Resident #145 with [DIAGNOSES REDACTED]. Record review on 03/17/15 at 2:53 PM revealed that Resident #145 had 02/20/15 physician's orders [REDACTED]. Review of the Daily Skilled Nurse's Notes for February 2015 and March 2015 on 03/17/15 at 3:49 PM revealed [MEDICATION NAME] was administered on 02/20/15 for agitation and 02/21/15 for restlessness . Additional review of Resident #145's Daily Skilled Nurse's Notes revealed no documentation that his/her family had been notified that [MEDICATION NAME] had been ordered on [DATE] and given on both 02/20/15 and 02/21/15. During an interview on 03/18/15 at 11:48 AM, Registered Nurse (RN) #2 stated that when [MEDICATION NAME] was ordered and administered, the nurse should have notified the interested family member and documented that notification in the Daily Skilled Nurse's Notes. Additional interview confirmed there was no documentation of notification of Resident #145's family that [MEDICATION NAME] had been ordered and given.
F 0226 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and a review of the policy provided by the facility entitled Abuse, Neglect and Misappropriation of Property, the facility failed to implement their policy related to thoroughly investigating and reporting alleged neglect for Resident A, 1 of 2 sampled residents reviewed for abuse and neglect. The findings included: During an interview with Resident A on 3/17/2015 at 9:58 AM, the resident was asked if anyone at the facility had mistreated her/him in any way. The resident stated a few nights ago s/he asked a CNA (certified nurse aide) to assist her/him to the

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) bathroom for toileting. The resident stated the CNA refused to help her/him to the toilet because the resident had been urinating too frequently. The resident also stated that the CNA told her/him that s/he would have to wear a brief (adult diaper) because I wet too much. The resident stated that the CNA put a brief on her/him. The resident also stated that s/he was scared of the CNA and that s/he held her urine all night. When the day shift CNA came on duty in the morning the resident told the CNA what had happened during the night. The resident stated the CNA then brought another staff member into her/his room and the resident reported the incident to that staff member also. The resident stated that the staff member brought in to her/his room by the CNA was someone who was serving in the capacity as a supervisor to the CNA. The resident stated s/he told this staff member about the incident and that I was scared to death because of the incident. Record review of the resident's bowel and bladder assessment on 3/17/2015 at 1:22 PM revealed that the resident was usually continent of bowel and bladder. Record review of the physician's orders [REDACTED]. Record review of the Nurse's Notes on 03/17/2015 at approximately 1:25 PM, revealed a note describing the resident's cognitive status as alert and oriented to person, place and time. There was no documentation in the Nurse's Notes related to the incident reported by the resident. During an interview with CNA #5 on 03/17/2015 at 2:57 PM s/he described the resident as continent of bowel and bladder with occasional accidents. CNA #5 stated the resident does not wear briefs, but does wear a pull up due to occasional incontinence. S/he stated the resident had no incontinent episodes during the day shift today and the resident calls for help when s/he needs to go to the bathroom. CNA #5 stated that the resident did not report any concerns or issues related to toileting, personal care or staff to her/him. During an interview with CNA #3 on 03/17/2015 at 3:03 PM s/he stated s/he works 1st and 2nd shift. When asked if the resident had reported any concerns related to toileting or personal care to her/him, CNA #3 stated that on the morning of 3/12/2015 s/he was working the day shift and when s/he saw the resident that morning the resident was wearing a brief. CNA #3 stated the resident wears pull ups and does not wear briefs. CNA #3 asked the resident why s/he was wearing a brief and said the resident was upset. CNA #3 stated the resident reported that the 3rd shift CNA had refused to help her get up to the bathroom during the night and put a brief on her/him. CNA #3 stated s/he removed the resident's brief, assisted her/him with toileting and then put a pull up on the resident. CNA #3 stated s/he then reported this to the nurse on duty. CNA #3 stated s/he could not recall the name of the nurse s/he reported this to. During an interview with Licensed Practical Nurse (LPN) #4 on 03/17/2015 at 3:06 PM s/he stated that the resident was alert and oriented, continent of bowel and bladder, and that the resident wears pull ups and does not wear briefs. LPN #4 stated that the resident asks when s/he needs to go to the bathroom and s/he had assisted the resident to the bathroom [ROOM NUMBER] times today. When asked if s/he was aware of any issues or concerns related to toileting, personal care or problems with staff related to the resident, LPN #4 stated s/he was not aware of any concerns. On 03/17/2015 at 3:21 PM this surveyor called the State Agency and inquired if the facility had reported any concerns regarding this resident. There was nothing reported to the State Agency regarding this resident or this incident. During an interview with the Nursing Home Administrator (NHA) on 03/17/2015 at 3:39 PM, the NHA stated s/he had no knowledge of this incident. Review of the facility's Reportable Incident Tracking Log and the 2015 Grievance Log on 03/17/2015 at 3:47 PM, revealed no entries or documentation regarding this incident. During an interview with Registered Nurse (RN) #1 on 03/18/2015 at 9:36 AM and 10:11 AM, RN #1 confirmed there was no documentation in the medical record regarding this incident. RN #1 stated that the resident did report this incident to her the morning of 3/16/2015 around 9:00 AM, before the morning meeting. RN #1 stated s/he talked to the resident about the incident and the resident told her/him s/he did not feel like s/he was abused. RN #1 stated s/he filled out a grievance report but did not feel like the incident needed to be reported to the state agency because the resident reported s/he did not feel like s/he was abused. RN #1 stated it was a customer service grievance. RN #1 retrieved the grievance report from her/his office on 03/18/2015 at approximately 9:36 AM. RN #1 confirmed this incident was not reported to the state agency and was not entered into the Grievance Log. During an interview with the NHA on 03/18/2015 at 4:31 PM, the NHA reported that s/he had talked with CNA #3 and that CNA #3 told her/him that LPN #4 was the nurse who s/he reported this incident to the morning of 3/12/2015. During an interview with the NHA on 3/19/2015 at approximately 10:00 AM, the NHA reported that s/he talked to LPN #4 and s/he stated that this incident was not reported to him/her. A review of the policy provided by the facility entitled Abuse, Neglect and Misappropriation of Property revealed that neglect is defined as Failure to provide goods and services or treatment and care necessary to avoid physical harm, mental anguish, or mental illness. The facility Leadership prohibits neglect, mental or physical abuse. All alleged violations concerning abuse, neglect or misappropriation of property are reported verbally immediately to the Administrator or his/her designee and other enforcement agencies according to state law including the State Survey and Certification Agency. The facility maintains that all allegations of abuse, neglect or misappropriation of property, etc. are thoroughly investigated and appropriate actions are taken.
F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** Based on observations and interviews, the facility failed to promote the dignity of 24 residents during the dining experience. The staff failed to ask residents if they wanted clothing protectors prior to placing them on the residents in one of one main dining room observed during two of two seatings. The findings included: On 03/16/2015 at 12:01 PM, during observation of the first seating of the lunch meal in the main dining room, 2 Certified Nursing Assistants (CNA) were observed placing cloth napkins as clothing protectors on 15 residents without asking, tucking them under each resident's chin and covering the front of their clothing. A total of 16 residents had the napkins placed under the chin at the first seating. On 03/16/2015 12:49 PM, during the second seating for the lunch meal, a CNA placed cloth napkins on 9 residents as clothing protectors tucking them under the residents' chins and covering the front of their clothing. On 03/18/2015 at 10:33 AM, during an interview with CNA #2, the CNA verified that s/he did not ask residents before placing the napkins over the residents' clothing. The CNA added that s/he knew s/he was supposed to ask everyone before putting them on. During an interview on 03/18/2015 at 10:26 AM when observations were discussed, Certified Nursing Assistant (CNA) #1 did not dispute the surveyor's observations.
F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that the Minimum Data Set (MDS) Assessment reflected accurate information for 1 of 5 sampled residents reviewed for unnecessary medications. The MDS did not reflect accurate [MEDICAL CONDITION] medication use and mental health [DIAGNOSES REDACTED]. The findings included: The facility admitted Resident #145 with [DIAGNOSES REDACTED]. Review of the 03/05/15 14 day MDS on 03/17/15 at 3:15 PM revealed that Resident #145 had received an antidepressant during all 7 days and an antipsychotic on 2 days of the look back period. Review of the February 2015 and March 2015 Medication Administration Records (MARs) on 03/17/15 at 3:49 PM revealed that Resident #145 had not received antipsychotic medication on any day during the look back period. During an interview on 03/18/15 at 4:18 PM, the facility MDS Coordinator confirmed that the 7 day look back period for the 03/05/15 MDS was 02/27/15¿03/05/15 and Resident #145 had not received any antipsychotic medication during that time period.

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F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) The MDS Coordinator said the information regarding the use of antipsychotic medication must have been pulled forward from a previous MDS and not corrected. Continued review of the 03/05/15 MDS revealed that depression was not listed as an active [DIAGNOSES REDACTED]. Review of the Daily Skilled Nurse's Notes on 03/17/15 at 3:17 PM revealed notes dated 02/27/15 (2 notes), 02/28/15, 03/01/15 (2 notes), and 03/02/15 had all reported [MEDICAL CONDITION]. During the interview on 03/18/15 at 4:18 PM, the MDS Coordinator stated s/he had spoken with the nurses and felt the nurses' documentation of [MEDICAL CONDITION] was in error so it wasn't recorded on the MDS. S/he noted this had not been documented in the record. During an interview on 03/18/15 at 4:25 PM, the MDS Coordinator stated that s/he hadn't included depression as a [DIAGNOSES REDACTED].#145 a [DIAGNOSES REDACTED]. Review of the 02/19/15 hospital Discharge Summary on 03/18/15 at 4:40 PM revealed that the resident had been prescribed [MEDICATION NAME] 40 milligrams per day for depression. An interview with Registered Nurse (RN) #2 on 03/18/15 confirmed that Resident #145's 02/19/15 hospital Discharge Summary was present in the record following his/her 02/19/15 admission to the facility.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop care plans to address psychoactive medications for 2 of 5 sampled residents reviewed for unnecessary medication. The care plans for Residents #145 and #117 did not include behavioral interventions. The findings included: The facility admitted Resident #145 with [DIAGNOSES REDACTED]. Record review on 03/17/15 at 2:53 PM revealed Resident #145 had physician's orders [REDACTED]. A review of the February 2015 and March 2015 Medication Administration Records (MARs) on 03/17/15 at 3:49 PM revealed that Resident #145 received [MEDICATION NAME] daily, received Klonopin twice on 02/20/15, and received [MEDICATION NAME] on 02/21/15 for restlessness. Review of the Daily Skilled Nurse's Notes for February 2015 and March 2015 on 03/17/15 at 3:49 PM revealed that 1 additional dose of Klonopin had been administered on 02/19/15 for anxiety and 1 additional dose of [MEDICATION NAME] had been administered on 02/20/15 for agitation. There was no documentation in the record of any behavioral interventions attempted prior to giving the medication. Review of the care plan on 03/17/15 at 3:25 PM revealed that there were no behavioral interventions in the plan to address Resident #145's psycho-behavioral needs for which [MEDICATION NAME], Klonopin, and [MEDICATION NAME] were prescribed. Interview with Registered Nurse (RN) #2 of 03/18/15 at 11:48 AM confirmed that that no behavioral interventions had been included in the care plan for Resident #145. During an interview on 03/18/15 at 4:23 PM, the MDS Coordinator confirmed that the care plan for Resident #145 did not contain behavioral interventions, including interventions to attempt prior to administering PRN psychoactive medications. The facility admitted Resident #117 with [DIAGNOSES REDACTED]. Record review on 3/18/15 at 10:00 AM revealed a physician's orders [REDACTED]. (Diagnosis (DX): Anxiety); [MEDICATION NAME] ([MEDICATION NAME]) tablet; 5 mg; amt: 1 tab; oral (DX: Dementia, unspec(ified) w(ith)/behav(ioral) disturb(ance)) (Mood Disorder) and as needed (PRN); [MEDICATION NAME]- schedule IV tablet; 0.5 mg; amt: 1 tab; oral Special Instructions: one tab by mouth (po) every 4 hours prn for anxiety. Review of the care plan on 03/18/2015 at 9:40 AM revealed no identification of a problem for high risk medication ([MEDICATION NAME] and [MEDICATION NAME]), side effects, behaviors/interventions, interventions prior to administration of PRN medication, gradual dose reduction (GDR), or monitoring for effectiveness of medication. Review on 3/19/15 at 9:46 AM of a Pharmacy Consultation Report revealed a 2/19/15 recommendation for Resident 117's [MEDICATION NAME]: For antipsychotic therapy, it is recommended that.b) the facility interdisciplinary team ensure that the care plan includes: ongoing monitoring of specific target behaviors; documentation of 1) a danger to self or others 2) desired outcome(s) 3) the efficacy of individualized, non-pharmacological approaches and 4) potential adverse consequences. Update and adapt the care plan as needed to provide person-centered care. During an interview on 03/18/2015 at 10:58 AM, Licensed Practical Nurse (LPN) #3 stated that s/he would expect that if they had a condition like that (behaviors/yelling), that it would be addressed in the care plan. During an interview on 3/18/15 at 4:23 PM, the Minimum Data Set (MDS) Coordinator confirmed that if a resident had behaviors, that they should be addressed in the care plan.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to update the care plan to reflect the current needs of 1 of 5 residents reviewed for unnecessary medication. The care plan was not updated to reflect the addition of [MEDICATION NAME] PRN (as needed), what behaviors required the addition of [MEDICATION NAME], and what interventions should be attempted prior to administering [MEDICATION NAME] for Resident #145. The findings included: The facility admitted Resident #145 with [DIAGNOSES REDACTED]. A review of Resident #145's physician's orders [REDACTED]. A review of the February 2015 and March 2015 Medication Administration Records (MARs) and Daily Skilled Nurse's Notes on 03/17/15 at 3:49 PM revealed that Resident #145 received [MEDICATION NAME] on 02/20/15 and 02/21/15 for agitation and restlessness. Review of the care plan on 03/17/15 at 3:25 PM revealed that the care plan had not been updated to include the use of [MEDICATION NAME], interventions to attempt prior to the use of the medication, monitoring for side effects or consideration of future discontinuation or reduction in the use of [MEDICATION NAME]. During an interview on 03/18/15 at 11:48 AM, Registered Nurse (RN) #2 confirmed that [MEDICATION NAME] had not been included in the care plan for Resident #145. During an interview on 03/18/15 at 4:23 PM, the MDS Coordinator confirmed that the care plan for Resident #145 had not been revised/updated to reflect the addition of [MEDICATION NAME] to the drug regimen.
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that necessary care and services were provided related to constipation for 1 of 5 sampled residents reviewed for unnecessary medication. Interventions were not provided for constipation for Resident #117. Also, based on record review and interview, the facility failed to ensure that allergy discrepancies were clarified for 1 of 5 sampled residents reviewed for unnecessary medication. Resident #145 had been receiving medication (Tylenol/[MEDICATION NAME]) to which s/he was noted as being allergic. The findings included: The facility admitted Resident #145 with [DIAGNOSES REDACTED]. Review of physician's orders [REDACTED].#145 had orders for and received Tylenol ([MEDICATION NAME]) ES (Extra Strength) 1000 mg (milligrams) three times daily. Record review on 03/17/15 at 11:30 AM revealed that the allergy sticker at the front of the chart had aspirin listed as the only allergy. Review of the 02/19/15 hospital Discharge Summary on 03/17/15 at 11:33 AM revealed a history and physical listing allergies [REDACTED]. At 12:00 PM on 03/17/15, review of the prescriptions sent with Resident #145 from the hospital revealed listed allergies [REDACTED].

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F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) In an interview on 03/18/15 at 11:49 AM, Registered Nurse (RN) #2 revealed that all resident allergies [REDACTED]. RN #2 stated that if there was a discrepancy between allergies [REDACTED]. During an interview on 03/18/15 at 12:01 PM, RN #2 confirmed that there were no Daily Skilled Nurse's Notes or physician's notes in the record to indicate a review of allergies [REDACTED]. RN #2 also confirmed that Resident #145 was receiving [MEDICATION NAME] three times a day and had [MEDICATION NAME] listed as an allergy in her record. The facility admitted Resident #117 with [DIAGNOSES REDACTED]. Review of physician's orders [REDACTED]. Review of a Vitals Report from 2/18/15-3/18/15 revealed that Resident #117 had no documented bowel movements (BM) from 2/27/15 through 3/2/15 and from 3/12/15 through 3/15/15. Review of Restorative Nursing Policies and Procedures SUBJECT: BOWEL RETRAINING (Bowel Management Program) revealed a Resident should not be allowed to go for more than 3 days without a bowel movement. During an interview on 03/19/2015 at 9:55 AM, the Director of Nursing (DON) stated that nurses tracked BM's and after 3 days with no BM, they called the physician and asked for an intervention. BM reports were brought in to morning meeting every day. The DON stated that the resident's lack of BMs should have been addressed by the nurse on the unit. The nurse should have questioned the CNA (Certified Nursing Assistant) to see if s/he had forgotten to do charting, and if there really was no BM, then the physician should have been called for a PRN (as needed medication). The DON stated that the facility had been working on getting bowel protocols in place, but currently did not have any formal bowel protocols.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure nursing staff provided appropriate care and services related to pressure ulcer treatment and wound documentation for Resident #56, 1 of 3 sampled residents reviewed with pressure ulcers. There were no wound measurements, staging, or descriptions of the resident's pressure ulcers noted on re-admission to the facility on [DATE]. Wound measurements and/or staging were not documented in the record until 1/23/15. There was no documentation that wound treatment orders had been clarified with the physician upon re-admission to the facility. Wounds documented on the re-admission body audit did not match the treatments that had been restarted by the facility. A left lateral foot pressure ulcer noted on re-admission did not have a treatment initiated. physician's orders [REDACTED]. Treatments had been discontinued without orders or notations in the record that these wounds had resolved/healed. Wound documentation indicated that the resident's pressure ulcers were not healing and/or had worsened. The findings included: The facility admitted Resident #56 with [DIAGNOSES REDACTED]. According to the facility's wound nurse, the resident had been in the facility for several years (since 2010) and his/her wounds had been inherited except for a pressure ulcer to the right elbow which had been acquired at the facility. A review of the resident's January 2015 Quarterly Minimum Data Set Assessment revealed a Brief Interview of Mental Status score of 15, indicating the resident was cognitively intact at the time of the assessment. Resident #56 refused to have the surveyor observe his/her wounds/wound care. A review of the facility census report revealed Resident #56 had been discharged to the hospital on [DATE], re-admitted on [DATE]; sent back to the hospital on [DATE], and returned on 12/19/14; discharged back to the hospital on [DATE], and returned to the facility on [DATE]. The resident was diagnosed with [REDACTED]. Review of the 12/23/14 hospital transfer information on 03/18/2015 at 2:19 PM revealed the resident had been discharged with stage 3/stage 4 wounds with wet to dry dressings daily and as needed to the left hip, right hip, buttocks; and a [MEDICATION NAME] dressing to the left foot. A re-admission body audit dated 12/23/14 included information that the resident had open areas to the elbows (bilaterally), left lateral foot, left buttocks, left ischium (right ischium noted on body audit?), and right hip. The 12/23/14 re-admission Nurse's Note documented that the dressings had been changed that day per hospital report. A second note documented, Skin warm and dry. Dressing to open areas (two places) to lateral outer L(eft) foot, dressing to both elbows, dressing to R(ight) hip, R(ight) ischium. A review of the December 2014 Treatment Administration Record revealed the Normal Saline wet to dry treatments noted on the hospital transfer summary had not been continued. Previously ordered facility treatments (to the resident's left buttocks, left ischium, right elbow, and right hip; along with skin prep to the left elbow, toes, and bilateral heels) had been continued on 12/24/14 without orders from the physician or documentation that the resident's wounds had been evaluated by facility staff to determine if these treatments were still appropriate. There were no documented wound measurements or staging of the wounds on re-admission. The facility was unable to provide documentation that this had been done until 1/23/15. According to the wound nurse, this is the date that s/he started. Prior to this date, the floor nurses were responsible for the wound care. The wound nurse was unaware of any prior documentation of wound measurements from the resident's re-admission to the facility on [DATE]. The wounds documented by the nursing staff on the body audit and in the Nurse's Notes on re-admission to the facility did not match all the areas of the body where the treatments had been continued on 12/24/14. According to the re-admission body audit, there was an open area on the resident's left lateral foot, but there were no orders initiated for a treatment to this area until 1/23/15. The first wound measurements and staging for this left lateral foot wound had not been documented until 1/23/15 at which time it had been documented as a stage II pressure ulcer that measured 1.1 cm by 2 cm. There were no treatments to the left lateral foot that had been documented on the Treatment Records until 1/23/15. One Nurse's note in December 2014 documented a treatment to the foot. The area to the left lateral foot was documented as resolved as of 3/17/15. These findings were verified by the wound treatment nurse. The re-admission body audit also indicated an open area with dressing intact to the left elbow. The treatment that had been documented as having been continued was a skin prep to the left elbow every shift. A Nurse's Note dated 12/26/14 documented, Dressing (changed) R(ight) hip- drainage moist, wound bed pink/yellow, no odor. Surrounding skin WNL (within normal limits): R(ight) elbow-moist, yellow drainage, wound bed pink, surrounding skin WNL. R(ight) ischial- moist, wound bed pink, surrounding skin pink. L(eft) ischial- moist, wound bed red, surrounding skin pink. L(eft) lateral foot moist + wound bed yellow/pink, surrounding skin pink. A nurse's note dated 1/11/15 documented a wound treatment to 3 open areas on the buttocks. The nursing documentation was inconsistent and/or unclear and sometimes indicated a right ischial and/or left ischial wound, or wounds noted to several areas on the buttocks with treatment orders noted only for a left ischial/ left buttocks pressure ulcer. A review on 3/18/15 of January 2015 Physician order [REDACTED]. New orders were written to address the right buttocks and the right hip (both stage 4 pressure ulcers) and the right elbow. The orders included treatment to a stage III wound on the perineum and a stage II to the left posterior thigh (not identified before), along with a stage II pressure ulcer to the left lateral foot. When asked how and when the pressure ulcer to the perineum had been identified, the wound care nurse stated the pressure ulcer to the perineum may have been called something else previously. The wound nurse stated the wound care ordered previously for the left buttocks was changed on 1/23/15 to the right buttocks since there was no wound on the left buttocks. The nurse believed the resident did have a wound on the left buttocks at some point in the past. When asked what had happened to the left ischial wound (treatment had been discontinued on the 1/23/15 physician telephone orders), the wound nurse stated that the treatment had been discontinued since there was no wound to the left ischium at that time. The wound nurse could not recall a wound to the right ischium. A review and comparison of the January 2015 Treatment Record (TAR) with the January 2015 Physician order [REDACTED]. However, the January 2015 Treatment Record documented that both treatments had continued to the right elbow on 1/24, 1/25, 1/28. 1/29, 1/30, and 1/31. There was no treatment initialed on the January 2015 MAR for the 1/26/15 right hip, right buttock, left lateral foot, left posterior thigh, and right elbow treatments (ordered once daily). A review of the February 2015 TAR revealed an entry for a treatment daily to the left posterior thigh. The entry had been marked as discontinued as of 2/6/15. However, there was no corresponding order to discontinue the treatment or documentation that the area had healed. According to the wound nurse, the area had healed and the treatment had been taken

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) off the TAR. Treatments to the right elbow had been changed on 2/19/15 and 2/23/15 with no corresponding physician's orders [REDACTED]. A review of Physician/Nurse Practitioner notes in the chart revealed a note dated 2/25/15 which documented information that the resident's wounds were not healing and that they would get a wound center consult. A review of a Wound Center note dated 3/17/15 revealed that Resident #56 had been last seen at the wound center in April of 2013. The facility's wound nurse had been present at the March 17, 2015 wound center appointment and, according to the note, the wound nurse thought that the resident's ischial and hip wounds actually looked worse than 2 months previously. During an interview on 3/18/15, the wound nurse verified this documentation. S/he stated that the wounds had looked worse, but now were improving. Wound measurements were reviewed with the wound nurse on 3/18/15 at approximately 4:30 PM and included the following: Right hip stage IV- -1/30/14 with 10% slough and 90% granulation tissue and measured 4 x 3.5 cm (centimeters) with no undermining. - 2/20/15 the wound measurements were 3.4 x 3.7 cm with a depth of 1.5 cm with undermining, 20% slough and 80% granulation tissue. - 3/17/15 wound center notes indicated a measurement of 3 cm x 3.3 cm with a depth of 0.5 cm and undermining of 1.2-1.4 cm, red moist base. Right buttock stage IV- -1/30/15 with 100% granulation tissue measuring 2 cm x 2 cm. -2/26/15 measuring 3 cm x 1.5 cm x 0.4 cm depth, with wound bed purple. -3/17/15 wound center notes indicated a measurement of 2.7 cm x 1.4 cm, x 0.3 cm depth with red moist base and undermining 0.2 cm. Perineum/Left Buttock stage IV -1/23/15- 7 cm x 3 cm x 0.5 cm. -2/20/15- 6 cm x 1.8 cm, wound bed red to pink with scant amount of slough. -3/17/15 wound center notes indicated a measurement of 2.0 cm x 7.8 cm x 0.2 cm with a red yellow moist base appearance. Observation of the resident with the wound nurse on 3/18/15 at approximately 4:55 PM revealed the resident in bed with a specialty air mattress in place. The resident's heels were elevated on a pillow. According to the wound nurse, the resident refused to wear the soft heel boots while in bed as ordered.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure that residents were free from accidents and hazards for 1 of 4 sampled residents reviewed. Resident #120 was observed with kitchen utensils and scissors with combative behaviors toward staff with no documentation as to how the resident obtained access to the items. The findings included: The facility admitted Resident #120 with [DIAGNOSES REDACTED]. Record review on 3/17/15 at approximately 2:48 PM revealed a communication form and progress note dated 12/15/14 that Resident #120 attempted to jab/stab nursing staff with dining utensils that were hoarded from the breakfast tray. The resident roamed the facility and entered other residents' rooms, destroying personal property. The communication form indicated the resident received physician's orders [REDACTED]. A 12/17/14 Nurse's Note indicated the resident was agitated with increased behaviors trying to hit and cut staff members with butter knife. A 12/19/14 Nurse's Note stated, At 10:30 AM this morning resident went into the court yard and used the end the water hose to bust out the window of another room. A 12/22/14 Nurse Note indicated Resident #120 was found with scissors in his/her hands and was then found with a fork in his/her hand. There was no documentation to indicate how the resident continued to have access to kitchen utensils or scissors to jab/stab at staff. There was no documentation on the care plan to indicate interventions were put in place to monitor the resident's access to sharp objects. An interview on 3/18/15 at approximately 1:37 PM with the Facility Administrator revealed there were no incident reports with interventions put in place for 12/15/14, 12/17/14, 12/19/14 and 12/22/14. The Facility Administrator further stated there had been no investigation as to how the resident obtained access to the kitchen utensils or scissors and there was no documentation to indicate what type of scissors the resident had in his/her possession.
F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to act on recommendations made by the Registered Dietician (RD) in a timely manner for 1 of 1 sampled residents reviewed for weight loss. Recommendations made by the RD were implemented 5 weeks after the initial recommendation, during which time Resident #62 experienced a 6 pound weight loss. The findings included: The facility admitted Resident #62 with [DIAGNOSES REDACTED]. Review of the 10/17/2014 nutritional evaluation on 3/18/2015 at 11:56 AM revealed the resident's weight at the time of the evaluation was 120 pounds. The RD documented the resident had increased protein needs due to the presence of a Stage III Pressure Ulcer. S/he noted the resident had experienced weight loss since admission that was likely due to decreased [MEDICAL CONDITION] (swelling from fluid retention) and the use of [MEDICATION NAME] (a fluid pill). The RD recommended nutritional interventions including Decubi-Vite (a multivitamin product used to treat or prevent vitamin deficiency) daily, Magic Cup (a high calorie, high protein nutritional supplement) once a day, a Pre-[MEDICATION NAME] level (blood work), and no salt packets with meals (to prevent fluid retention). Review of the October, 2014 physician's orders [REDACTED]. Review of the Dietary Notes on 3/18/2015 at approximately 11:56 AM revealed a 11/14/2014 RD note that the resident's Sacral Pressure Ulcer was improving, but the resident was losing weight. The resident's weight was documented as 114 pounds (a 6 pound weight loss). The RD documented Re-request PAB (Pre-[MEDICATION NAME] level) (and) Magic Cup. Will add 60 ml (milliliter) Med Pass (a high calorie, high protein nutritional supplement). BID (2 times a day). Decubi-Vite daily x (for) 4 weeks. Record review of the Telephone Orders on 3/18/2015 at 1:47 PM revealed a 11/21/2014 Telephone Order for a PAB on the next lab draw, Magic Cup once a day, Med Pass 60 ml twice a day, weekly weights for 4 weeks and Decubi-Vite one tablet daily for 4 weeks. During an interview on 3/18/2015 at 1:52 PM, Licensed Practical Nurse (LPN) #1 confirmed that the RD made nutritional recommendations on 10/17/2014 and those recommendations were not implemented until 11/21/2014, one week after a second request. LPN #1 confirmed that the resident lost 6 pounds during that time span.
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure that medications were monitored for effectiveness and interventions were attempted prior to administering as needed (PRN) psychoactive medications for 2 of 5 sampled residents reviewed for unnecessary medication. Resident #117 received PRN [MEDICATION NAME] without monitoring for effectiveness or documentation of interventions attempted prior to administration. Resident #117 also received Vitamin D and Sodium Chloride with no or untimely laboratory monitoring. Resident #145 was receiving psychoactive and pain medication without monitoring for effectiveness and interventions prior to administration.

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F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) The findings included: The facility admitted Resident #117 with [DIAGNOSES REDACTED]. Record review on 3/18/15 at 10:00 AM revealed physician's orders [REDACTED]. The physician gave a 1/14/15 Telephone Order for a Basic Metabolic Panel (BMP) to be drawn on 1/15/15. Review of the lab report revealed that the BMP was not drawn until 1/19/15. Record review revealed physician's orders [REDACTED]. There were no orders for a Vitamin D level to justify use of the medication. Further record review revealed no lab results on file for a Vitamin D level. During an interview on 3/18/15 at 4:50 PM, Registered Nurse (RN) #1 confirmed that no Vitamin D labs had been drawn. Review of the care plan on 03/18/2015 at 9:40 AM revealed no plan/goals related to monitoring for side effects of psychoactive medication, behaviors, interventions prior to administration of as needed (PRN) medications, gradual dose reduction (GDR), monitoring for effectiveness of medications, or Care Plan (CP) for high risk medications ([MEDICATION NAME] and [MEDICATION NAME]). Review of Behavior Monitoring Flowsheets on 3/18/15 at 10:00 AM revealed that documentation was unclear. Numbers were listed that did not have a code for the behavior, and it was unclear if staff should be documenting the # corresponding to the behavior exhibited, or the # of episodes. Review of the January 2015 PRN Medications Flowsheet on 3/18/15 at 10:00 AM revealed that Resident #117 received [MEDICATION NAME] on 1/10/15; 1/11/15; 1/16/15; 1/17/15; 1/19/15; 1/20/15; 1/21/15; 1/22/15; 1/24/15; 1/25/14; 1/26/15; 1/30/15; and 1/31/15. The PRN Medication Notes indicated that Resident #117 only received [MEDICATION NAME] on 1/20/15. The behavior monitoring flowsheet did not indicate that Resident #117 exhibited behaviors on any of those days. Review of Nurses Notes revealed that the notes failed to document specific interventions attempted prior to the administration of PRN medication and were nondescriptive in regards to delusions, verbal behaviors, or what type of care or evaluations were rejected. Review of Daily Skilled Nurses Notes revealed the following behaviors noted on the following dates: 1/3/15 delusions, verbal behaviors, reject evaluation or care; 1/5/15 verbal behaviors, reject evaluation or care; 1/6/15 physical behaviors (.Swing at staff, resident hit nurse to take meds away.) , reject evaluation or care; 1/8/15 verbal behaviors; 1/9/15 reject evaluation or care; 1/11/15 yes was coded but no specific behaviors were marked; 1/12/15 yes (no specific behaviors marked); 1/14/15 verbal behaviors; 1/16/15 verbal behaviors; 1/17/15 verbal behaviors; 1/19/15 reject evaluation or care; 1/21/15 yes (no specific behaviors marked)- The note stated, .Resident received PRN [MEDICATION NAME] this shift R/T (related to) yelling with increased agitation.continued to yell out intermittently during shift.); 1/21/15 additional note of: verbal behaviors, reject evaluation or care. The Nurse's Note detailed asking where her/his spouse was and saying that s/he would pick her/him up. It also stated that s/he was hard of hearing so s/he screamed at everyone, No, no I'm cold. Cover me up. ; 1/25/15 verbal behaviors (screaming), reject evaluation or care; 1/29/15 verbal behaviors, reject evaluation or care; 1/29/15 verbal behaviors, reject evaluation or care; 1/30/15 verbal behaviors, reject evaluation or care; physical behaviors, (The note stated, .screams about being cold or hungry.); 1/31/15 physical behaviors. There were no behaviors recorded on the Behavior Monitoring Flowsheet for the month of January. Review of the February 2015 PRN Medications Flowsheet on 3/18/15 at 10:00 AM revealed that Resident #117 had received [MEDICATION NAME] on 2/1/15, 2/2/15, 2/5/15, 2/6/15, 2/7/15, 2/8/15, 2/14/15, 2/15/15, and 2/28/15. The PRN Medication Notes indicated that Resident #117 only received [MEDICATION NAME] on 2/2/15, 2/5/15, and 2/28/15. The behavior monitoring flowsheet indicated that Resident #117 had been yelling out on 2/1/15, 2/2/15, and 2/3/15. On 2/1/15 interventions included A. Physical Needs Met, C. Redirection, and E. Activity Program with an improved outcome. On 2/2/15 and 2/3/15 interventions included A. Physical Needs Met with an unchanged outcome. Review of Nurses Notes revealed behaviors on the following dates: 2/1/15 physical behaviors; 2/2/15 physical behaviors; 2/3/15 verbal behaviors (screaming, Come here! Where is my husband?), reject evaluation or care; 2/4/15 verbal behaviors (screaming), reject evaluation or care; 2/5/15 reject evaluation or care; 2/6/15 physical behaviors, Nurses Note stated .increased agitation, became combative to CNA (Certified Nursing Assistant). Resident was given a PRN [MEDICATION NAME] ; 2/7/15 physical behaviors; 2/8/15 reject evaluation or care; 2/9/15 physical behaviors, verbal behaviors (screaming), reject evaluation or care; 2/11/15 verbal behaviors (screaming) physical behaviors (hitting), reject evaluation or care; 2/12/15 verbal behaviors, reject evaluation or care; 2/13/15 verbal behaviors, reject evaluation or care; 2/14/15 reject evaluation or care; 2/16/15 yes was noted but no specific behaviors were marked; 2/17/15 verbal behaviors (screaming), reject evaluation or care; 2/18/15 verbal behaviors (screaming), reject evaluation or care; 2/19/15 verbal behaviors (screaming), reject evaluation or care. Review of the March 2015 PRN Medications Flowsheet revealed that Resident #117 received [MEDICATION NAME] on 3/6/15. The PRN Medication Notes included no reference to administration of [MEDICATION NAME]. The Behavior Monitoring Flowsheet noted a behavior of yelling out. There were no interventions documented and the outcome was unchanged. The Daily Skilled Nurses Note on 3/6/15 stated that Resident #117 was yelling down the hall, What time is it? The nurse informed the resident of the time and the resident continued to yell, What time is it? every couple of minutes. The resident was redirected with no change and given PRN [MEDICATION NAME]. Redirection was not specific as to what intervention was attempted that did not have any effect. During an interview on 03/18/2015 at 3:08 PM, Licensed Practical Nurse (LPN) #3 stated, The '# of behaviors' is the number of times throughout the shift s/he has a behavior. It should be either 1 or 2 to show what behavior. During an interview on 3/18/15 at 3:09 PM, when asked what to do if the resident was having a behavior, LPN #3 replied, Try to redirect, refocus or change train of thought; like if s/he's hollering about being hungry, bring up spouse which will change her (him) to a different subject. LPN #3 further stated, If s/he shows increased agitation and they can't get her/him calmed down, we would try a prn if you can get her/him to take it. Before the prn, talk to her/him, try to refocus her/him which will sometimes calm her/him down. The nurse stated that it should be documented on the prn administration sheet every time the prn is given. If s/he gets a prn, her/his behavior should be documented on the behavior monitoring sheet. Verbal behaviors should be documented on the behavior monitoring sheet-also rejection of care anytime. Nurses Notes are checked for those behaviors. They should also be recorded on the behavior monitoring sheet. I would expect that if they had a condition like that (behaviors/yelling), that it would be addressed in the care plan. During an interview on 03/18/2015 at 3:17 PM, when asked how s/he knew what interventions were to be attempted on Resident #117 prior to administration of PRN medication, LPN #3 stated, Trial and error, just sit down and talk to them. Try to tell the next nurse. The nurse will tell them things they could try before giving prns. It's just a matter of getting good reports. The nurse also referred the surveyor to 24 hour reports in a binder with a section for each resident staff could check off for behaviors. When asked about care plans, LPN #3 did not know where they were. S/he stated s/he normally just comes in and goes off of what I am told is going on. I look at the history and physical a lot whenever I have to do anything. LPN #3 asked LPN #2 where the care plans were. LPN #2 stated that s/he thought they kept them up front, but that they could be accessed in the computer. During an interview on 03/18/2015 at 3:23 PM, LPN #3 stated that s/he had been employed since the end of September, 2014 and did not have computer access. During an interview on 03/18/2015 at 4:27 PM, the Minimum Data Sheet (MDS) Coordinator stated, Whatever the behavior is, if you can't calm them down doing one thing, medications should be the last resort. Normally they haven't care planned interventions. They are usually on the behavior tracking sheet as to what interventions to use before giving prn's. Staff go through orientation on how to use the behavior tracking sheet. When asked what redirection meant for this resident, the MDS Coordinator stated, That should be common sense. During further interview, the MDS Coordinator confirmed that there were no behaviors listed on the care plan, and that there should be if the resident was having behaviors. The facility admitted Resident #145 with [DIAGNOSES REDACTED]. Review of physician's orders [REDACTED].#145 had orders for and had received psychoactive medications in February 2015 and March 2015 which included [MEDICATION NAME] 40 milligrams (mg)/day, Klonopin 0.5 mg every 12 hours as needed (PRN), and [MEDICATION NAME] 1 mg every 4 hours PRN for agitation. Additional review revealed the resident had orders for and had received pain medications in February 2015 and March 2015 which included [MEDICATION NAME] 50 mg every 12 hours PRN and [MEDICATION NAME] 50 mg ½ tab every 4 hours PRN. Review of the February 2015 and March 2015 MARs on 03/17/15 at 3:49 PM revealed that Resident #145 received [MEDICATION NAME] daily, received Klonopin twice on 02/20/15, and received [MEDICATION NAME] on 02/21/15. Review of the Daily Skilled Nurse's Notes for February 2015 and March 2015 revealed 1 additional dose of Klonopin administered (on 02/19/15) and 1

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F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) additional dose of [MEDICATION NAME] administered (02/20/15) which were not recorded on the MAR. Review of Resident #145's Daily Skilled Nurse's Notes for February 2015 and March 2015 on 03/17/15 at 3:49 PM revealed documentation that the Klonopin had been administered on 02/19/15 for anxiety and [MEDICATION NAME] had been administered on 02/20/15 for agitation and restlessness. There was no documentation in the record of any behavioral interventions attempted prior to giving the medication. Additionally, there was no documentation to indicate that the duration or intensity of the behavior justified the use of the PRN Klonopin and [MEDICATION NAME] or the effectiveness of the [MEDICAL CONDITION] medications. Review of the care plan on 03/17/15 at 3:25 PM revealed that there were no behavioral interventions in the plan to address Resident #145's psycho-behavioral needs for which [MEDICATION NAME], Klonopin, and [MEDICATION NAME] were prescribed. Further review revealed that the use of [MEDICATION NAME] had not been added to the plan, including monitoring for side effects. Additional review of the February 2015 and March 2015 MARs on 03/17/15 at 3:49 PM revealed that Resident #145 received [MEDICATION NAME] 50 mg for pain on 02/20/15, 03/08/15, 03/09/15, twice on 03/11/15, and on 03/12/15. S/he also received [MEDICATION NAME] 25 mg on 03/13/15. Continued review revealed a pain flow sheet which included information on the location, character, frequency, and intensity of the pain, nonverbal indicators of pain, precipitating/aggravating factors, non-medication interventions, and post administration monitoring for abatement of pain and monitoring of side effects. One of the doses of [MEDICATION NAME] given on 03/11/15 was recorded on the pain flow sheet, but none of the other doses of [MEDICATION NAME] were recorded. Review of Resident #145's care plan on 03/17/15 at 3:25 PM confirmed that Resident #145's use of pain medication was to be monitored for effectiveness and side effects. In an interview on 03/18/15 at 11:48 AM, Registered Nurse (RN) #2 confirmed that Resident #145's [MEDICATION NAME] had not been included in her/his care plan and there were no behavioral interventions in place on the care plan to attempt prior to using PRN [MEDICAL CONDITION] medications Klonopin and [MEDICATION NAME]. S/he also confirmed there were no behavioral interventions in place to support Resident #145 in regards to his/her depression [DIAGNOSES REDACTED]. During an interview on 03/18/15 at 4:23 PM the MDS (Minimum Data Set) Coordinator confirmed that there were no behavioral interventions in Resident #145's care plan and that Resident #145's care plan had not been updated to reflect the addition of [MEDICATION NAME]. Continued interview revealed that it was the responsibility of Social Services to ensure behavioral interventions and [MEDICAL CONDITION] medications were included in the care plan. Interview with RN #1 on 03/17/15 at 4:25 PM revealed that all PRN pain medications, including Resident #145's [MEDICATION NAME], should be documented on the PRN flow sheet and pain flow sheet, with the MARs. RN #1 also confirmed that the pain flow sheet documented the reason why pain medication was given and the result/effectiveness of giving the medication. In an interview on 03/18/15 at 11:28 AM, RN #2 confirmed that Resident #145's [MEDICATION NAME] had not been correctly documented on the PRN flow sheet and pain flow sheet in February 2015 and March 2015. During an interview on 03/18/15 at 4:23 PM, the MDS Coordinator confirmed that Resident #145's care plan should be followed including documenting and monitoring pain medications.
F 0356 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information/data on a daily basis.** Based on observation and interview, the facility failed to ensure that nursing staffing data was posted in a prominent place readily accessible to residents and visitors. public area for easy access by visitors and residents in 1 of 1 main entrances. This had the potential to affect any interested residents and/or visitors. The findings included: On initial tour of the facility on 03/16/15 at 10:00 AM, it was noted that the nursing staffing data was in a hall near the therapy room, away from the main public areas of the facility. It was on a clipboard just outside the conference room. Interview with the Nursing Home Administrator at approximately 10:20 AM on 03/16/15 confirmed that the posting was not in a main public area in the facility, easily accessible to visitors and residents. Further interview revealed that the staffing was posted near the former main entrance to the facility, but had not been moved following renovations. Observation of the door to the outside near the postings revealed that a sign was on the door directing people to use another door to enter the facility.
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Store, cook, and serve food in a safe and clean way** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to store food properly in 1 of 1 kitchen area reviewed to prevent contamination. Items were observed in the freezer and dry storage open to air with no label or date. Resident #54, 1 of 1 sampled residents reviewed for [MEDICAL TREATMENT] services did not have his/her lunch provided in an insulated container to prevent the potential hazard of food borne illness. The findings included: During the initial tour of the facility's kitchen area on 3/16/15 at approximately 11:30 AM with the Dietary Manager, a large bag of peas and carrots were observed opened in the walk-in freezer. The bag contained no label or date. The dry storage area had a 5 pound bag of grits with no label/date also opened to air. The opened items were verified at the time of the observation by the Dietary Manager. The facility admitted Resident #54 with [DIAGNOSES REDACTED]. Record review revealed a physician's orders [REDACTED].#54 attended [MEDICAL TREATMENT] three times a week (Monday, Wednesday, Friday). During an interview on 3/18/15 at approximately 9:33 AM, the Dietary Manager stated that [MEDICAL TREATMENT] residents received insulated meal containers with ice packs to carry meals to [MEDICAL TREATMENT]. The Dietary Manager showed the surveyor the resident's designated lunch for that day's [MEDICAL TREATMENT] appointment and the insulated meal carriers to be used. Observation on 3/18/15 at approximately 10:05 AM revealed the resident had gone to [MEDICAL TREATMENT], but his/her lunch was still in the unit refrigerator and the insulated meal containers were still on top of the unit refrigerator. An interview on 3/18/15 at approximately 10:07 AM with Licensed Practical Nurse (LPN) #2 revealed that the resident must have had two different lunches. Reportedly the resident's lunch consisted of a baloney sandwich with cheese, chips and a soda which was transported in a clear plastic zip lock bag. During an interview on 3/18/15 at approximately 4:40 PM, Resident #54 stated his/her lunch had consisted of a baloney sandwich, potato chips and soda. The resident confirmed the meal was not transported in an insulated meal container. Resident #54 further stated s/he had taken egg salad sandwiches to [MEDICAL TREATMENT] in the past that were not transported in an insulated meal container. Review of the facility's policy NUTRITION POLICIES AND PROCEDURES under #11 stated: When a patient/resident requires a packed lunch to take to workshop, [MEDICAL TREATMENT], etc., the NSD (Nutrition Services Director), in conjunction with the dietitian, plans a menu in writing taking into consideration any diet modifications required by the diet order. This menu is made available to nutrition services department staff to follow when packing the lunch. Temperature control must be taken into account for these packed lunches.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to store reusable resident care equipment in a manner to control and prevent the spread of infection. Resident bedpans and a wash basin were observed stored inappropriately in 2 of 14 resident bathrooms on A Hall. The findings included: During observation of the room [ROOM NUMBER] bathroom on A Hall on 3/17/2015 at 0841 AM, a wash basin was observed on the floor. The wash basin was not stored in a bag and had no other type of protective covering. An observation of the room [ROOM NUMBER] bathroom on 3/18/2015 at 2:09 PM revealed an uncovered wash basin stacked on top of other bagged personal care items on the floor.

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	425303	A. BUILDING _____ B. WING _____	03/19/2015

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LAKE EMORY POST ACUTE CARE	59 BLACKSTOCK ROAD INMAN, SC 29349

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) During observation of the room [ROOM NUMBER] bathroom on A Hall on 3/17/2015 at 10:27 AM, 2 used fracture bed pans were observed stacked on top of each other on top of the toilet tank, uncovered. An observation of the room [ROOM NUMBER] bathroom on 3/18/2015 at 2:15 PM revealed 2 uncovered fracture pans stacked on top of each other on the tank of the toilet. There was no type of protective barrier separating the fracture pans. At approximately 2:32 PM, the same bathrooms were observed with Licensed Practical Nurse (LPN) #1. LPN #1 verified the wash basin was not in a bag and was stacked on other personal care items on the floor. LPN #1 also verified that the fracture pans were not stored in bags and were stacked on top each each other. During an interview on 3/18/2015 at approximately 2:32 PM, LPN #1 stated that the personal care items should be cleaned and then stored in a plastic bag. LPN #1 also stated that personal care items should not be stored on the floor.
F 0502 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give or get quality lab services/tests in a timely manner to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain labs as ordered by the physician for 1 of 5 sampled residents reviewed for unnecessary medications. Resident #117's Basic Metabolic Panel (BMP) was not drawn in a timely manner and a urinalysis was not obtained as ordered. The findings included: The facility admitted Resident 117's with [DIAGNOSES REDACTED]. Record review on 3/18/15 at 10:00 AM revealed a 1/14/15 Telephone Order for a BMP to be drawn on 1/15/15. Review of the lab report revealed that the BMP was not drawn until 1/19/15. During an interview on 3/18/15 at 1:30 PM Registered Nurse (RN) #1 confirmed that there was no evidence of refusal of a blood draw. Review of a 12/2/14 Telephone Order revealed that the physician had ordered a urinalysis and a culture and sensitivity (C+S) if indicated. Review of the chart revealed no lab results available from 12/2/14. Review of 12/3/14 Nurses Notes revealed that Resident #117 refused the urinalysis. During an interview on 3/18/15 at 4:50 PM, RN #1 confirmed that there were no lab results for the urinalysis. RN #1 also confirmed that there was only one attempt to get the urinalysis and that there was no documentation that the physician had been notified that the lab had not been obtained as ordered.
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure that behaviors were consistently documented in the record for 1 of 5 sampled residents reviewed for unneccesary medications. Resident #117 had conflicting information throughout the medical record with regard to the presence or absence of behaviors and medication administration. The findings included: The facility admitted Resident 117 with [DIAGNOSES REDACTED]. Review of Behavior Monitoring Flowsheets on 3/18/15 at 10:00 AM revealed that documentation was unclear. Numbers were listed that did not have a code for the behavior, and it was unclear if staff should be documenting the number corresponding to the behavior exhibited, or the number of episodes. Review of the January 2015 PRN (as needed) Medications Flowsheet on 3/18/15 at 10:00 AM revealed that Resident #117 had received [MEDICATION NAME] on: 1/10/15, 1/11/15, 1/16/15, 1/17/15, 1/19/15, 1/20/15, 1/21/15, 1/22/15, 1/24/15, 1/25/14, 1/26/15, 1/30/15, and 1/31/15. Review of the PRN Medication Notes on 3/18//15 at 10:00 AM indicated that Resident #117 only received [MEDICATION NAME] on 1/20/15. Review of the behavior monitoring flowsheet on 3/18/15 at 10:00 AM did not document that Resident #117 exhibited behaviors on any of those days. Review of the Daily Skilled Nurses Notes on 3/18/15 at 10:00 AM revealed behaviors noted on the following dates: 1/3/15 delusions, verbal behaviors, reject evaluation or care; 1/5/15 verbal behaviors, reject evaluation or care; 1/6/15 physical behaviors (.Swing at staff, resident hit nurse to take meds away., reject evaluation or care; 1/8/15 verbal behaviors; 1/9/15 reject evaluation or care; 1/11/15 behaviors were coded yes but no specific behaviors were marked; 1/12/15 yes (no specific behaviors marked); 1/14/15 verbal behaviors; 1/16/15 verbal behaviors; 1/17/15 verbal behaviors; 1/19/15 reject evaluation or care; 1/21/15 yes (no specific behaviors marked) The Nurse's Note stated, .Resident received PRN [MEDICATION NAME] this shift R/T (related to) yelling with increased agitation.continued to yell out intermittently during shift.); 1/21/15 additional note verbal behaviors, reject evaluation or care, Noted details asking where her/his spouse was and saying that s/he would pick her/him up. The Note also stated that s/he was hard of hearing so s/he screamed at everyone, No, no. I'm cold cover me up. ; 1/25/15 verbal behaviors (screaming), reject evaluation or care; 1/29/15 verbal behaviors, reject evaluation or care; 1/29/15 verbal behaviors, reject evaluation or care; 1/30/15 verbal behaviors, reject evaluation or care; physical behaviors, (The note stated, .screams about being cold or hungry.); 1/31/15 physical behaviors. There were no behaviors recorded on the Behavior Monitoring Flowsheet for the month of January. Review of the February 2015 PRN Medications Flowsheet on 3/18/15 at 10:00 AM revealed that Resident #117 had received [MEDICATION NAME] on 2/1/15, 2/2/15, 2/5/15, 2/6/15, 2/7/15, 2/8/15, 2/14/15, 2/15/15, and 2/28/15. The PRN Medication Notes indicated that Resident #117 only received [MEDICATION NAME] on 2/2/15, 2/5/15, and 2/28/15. The behavior monitoring flowsheet indicated that Resident #117 had been yelling out on 2/1/15, 2/2/15, and 2/3/15. On 2/1/15, interventions included A. Physical Needs Met, C. Redirection, and E. Activity Program with an improved outcome. On 2/2/15 and 2/3/15 interventions included A. Physical Needs Met with an unchanged outcome. Review of Nurses Notes revealed behaviors on the following dates: 2/1/15 physical behaviors; 2/2/15 physical behaviors; 2/3/15 verbal behaviors (screaming, Come here! Where is my husband?), reject evaluation or care; 2/4/15 verbal behaviors (screaming), reject evaluation or care; 2/5/15 reject evaluation or care; 2/6/15 physical behaviors. Nurses Note stated .increased agitation, became combative to CNA (Certified Nursing Assistant). Resident was given a PRN [MEDICATION NAME]. ; 2/7/15 physical behaviors; 2/8/15 reject evaluation or care; 2/9/15 physical behaviors, verbal behaviors (screaming), reject evaluation or care; 2/11/15 verbal behaviors (screaming) physical behaviors (hitting), reject evaluation or care; 2/12/15 verbal behaviors, reject evaluation or care; 2/13/15 verbal behaviors, reject evaluation or care; 2/14/15 reject evaluation or care; 2/16/15 yes (no specific behaviors marked); 2/17/15 verbal behaviors (screaming), reject evaluation or care; 2/18/15 verbal behaviors (screaming), reject evaluation or care; 2/19/15 verbal behaviors (screaming), reject evaluation or care. Review of the March 2015 PRN Medications Flowsheet revealed that Resident #117 had received [MEDICATION NAME] on 3/6/15. The PRN Medication Notes included no reference of receipt of [MEDICATION NAME]. The Behavior Monitoring Flowsheet noted a behavior of yelling out. There were no interventions documented and the outcome was unchanged. The Daily Skilled Nurses Note on 3/6/15 stated that Resident #117 was yelling down the hall, What time is it? The nurse informed the resident of the time and the resident continued to yell, What time is it? every couple of minutes. The resident was redirected with no change and given PRN [MEDICATION NAME]. Redirection was not specific as to what intervention was attempted that did not have any effect. During an interview on 03/18/2015 at 3:08 PM, Licensed Practical Nurse (LPN) #3 stated, The '# of behaviors' is the number of times throughout the shift s/he has a behavior. It should be either 1 or 2 to show what behavior. During an interview on 3/18/15 at 3:09 PM, when asked what to do if the resident was having a behavior, LPN #3 replied, Try to redirect, refocus or change train of thought; like if s/he's hollering about being hungry, bring up spouse which will change her (him) to a different subject. LPN #3 further stated, If s/he shows increased agitation and they can't get her/him calmed down, we would try a prn if you can get her/him to take it. Before the prn, talk to her/him, try to refocus her/him which will sometimes calm her/him down. The nurse stated that it should be documented on the prn administration sheet every time the prn is given. If s/he gets a prn, her/his behavior should be documented on the behavior monitoring sheet. Verbal behaviors should be documented on the behavior monitoring sheet-also rejection of care anytime. Nurses Notes are checked for those behaviors. They should also be recorded on the behavior monitoring sheet. I would expect that if they had a condition like that (behaviors/yelling), that it would be addressed in the care plan. During an interview on 03/18/2015 at 3:17 PM, when asked how s/he knew what interventions were to be attempted on Resident #117 prior to administration of PRN medication, LPN #3 stated, Trial and error, just sit down and talk to them. Try to tell

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F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) the next nurse. The nurse will tell them things they could try before giving prns. It's just a matter of getting good reports. The nurse also referred the surveyor to 24 hour reports in a binder with a section for each resident staff could check off for behaviors. When asked about care plans, LPN #3 did not know where they were. S/he stated s/he normally just comes in and goes off of what I am told is going on. I look at the history and physical a lot whenever I have to do anything. LPN #3 asked LPN #2 where the care plans were. LPN #2 stated that s/he thought they kept them up front, but that they could be accessed in the computer. During an interview on 03/18/2015 at 3:23 PM, LPN #3 stated that s/he had been employed since the end of September, 2014 and did not have computer access. During an interview on 03/18/2015 at 4:27 PM, the Minimum Data Sheet (MDS) Coordinator stated, Whatever the behavior is, if you can't calm them down doing one thing, medications should be the last resort. Normally they haven't care planned interventions. They are usually on the behavior tracking sheet as to what interventions to use before giving prn's. Staff go through orientation on how to use the behavior tracking sheet. When asked what redirection meant for this resident, the MDS Coordinator stated, That should be common sense. During further interview, the MDS Coordinator confirmed that there were no behaviors listed on the care plan, and that there should be if the resident was having behaviors.