STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE REHAB AND HC CTR AT VILLAGE GR	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
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 observation, record review and staff interviews, the facility did not provide timely wound care to 1 of 1 residents (Resident #18) whose dressings were removed after becoming soiled with urine and stool during incontinent care. Findings included: Resident #18 was re-admitted to the facility on [DATE]. Cumulative [DIAGNOSES REDACTED]. Resident #18's care plan identified a problem with onset of 05/14/15 of being at risk for skin breakdown related to impaired bed mobility and incontinence. On 06/08/15 a problem with having a stage 3 to the right toe dorsal and a stage 3 to the right great toe plantar aspect was identified. The most recent Quarterly Minimum Data Set (MDS) assessment of 1105/15 indicated Resident #18 had severely impaired decision making skills and required extensive to total assistance with all activities of daily living. The resident was incontinent of both bowel and bladder. The resident had 2 stage 3 pressure ulcers. A wound assessment of 10/08/15 noted that there was a stage 3 pressure ulcer to the right great toe identified on 10/08/15. The wound bed consisted of 50% granulation tissue and 50% slough with red indurated surrounding skin. It was noted that it presented as a full thickness wound in the previous wound site. Treatment ordered included santyl ([MEDICATION NAME] agent). The wound measured 1.5 centimeters by 1.6 centimeters by 0.3 centimeters. It was also noted that Resident #18 had multiple severe contractures. A physician's orders [REDACTED]. It noted to apply a nickel size layer of santyl to the wound bed and then apply moistened collagen and cover with a foam dressing daily and as needed. A wound assessment of 10/23/15 for Resident #18 noted a stage 3 wound was identified on 10/22/15 to the plantar area of the right heel. The wound bed was consisted of 70% granulation tissue and 30% slough. The wound measured 4.5 centimeters by 5.5 centimeters x 0.3 centimeters. Treatment included santyl for debridement. It was noted that Resident #18 had severe contractures which challenged staff when positioning. A physician's orders [REDACTED]. It noted to apply skin prep to the periwound and apply a nickel size layer of santyl to the wound bed. It was noted to then apply a moistened collagen over the wound bed and cover with a non-bordered foam and wrap with rolled gauze and secure with tape daily and as needed. A wound assessment of 10/30/15 noted the pressure ulcer to the plantar area of the right heel measured 4 centimeters by 5.5 centimeters by 0.3 centimeters with 70% granulation tissue and 30% slough. It was noted there were no changes and the treatment of [REDACTED]. A wound assessment of 10/30/15 for Resident #18 noted the pressure ulcer to the right metatarsal measured 1.5 centimeters by 1.4 centimeters by 0.3 centimeters with a wound bed consisting of 80% granulation tissue and 20% slough. A wound assessment of 11/13/15 noted the stage 3 to the plantar area of the right heel had deteriorated with a wound bed of 30% slough, 50% granulation tissue and 20% eschar. Treatment was changed to santyl with [MEDICATION NAME] gauze and cover with non-bordered foam and wrap with rolled gauze daily. A wound assessment of 11/17/15 noted the area to the right heel was now an unstageable wound with 30% granulation tissue, 30% slough and 40% eschar to the wound bed. It was noted that the wound continued to deteriorate. Resident #18 was observed resting in bed on his left side at 11:00 AM on 11/18/15. There was a slight odor of stool noted in the room. Wound care was observed beginning at 11:15 AM on 11/18/15. The treatment nurse assisted by nurse aide #1(NA #1) prepared to provide care. Both staff members washed their hands and gloved. NA #1 assisted the nurse to reposition Resident #18. It was noted that he had severe contractures of both lower extremities. The right leg was drawn up tight to his waist positioned across the left upper thigh with the right foot resting against the inner upper thigh. The treatment nurse removed both of the green padded boots from his feet. The treatment nurse used scissors to remove the rolled gauze dressing. She cleaned the right metatarsal head of the great toe with normal saline and patted dry. She applied a thick layer of santyl ointment onto the open wound and then placed a moistened piece of collagen. She covered the wound with a foam dressing and taped it in place. Upon observation, the wound to the right metatarsal was approximately the size of a nickel with pink, dark pink and yellow scattered tissue in the wound bed. The treatment nurse cleaned the large black area to the right plantar surface of the right heel with normal saline. She wiped it several times in an effort to remove some of the dry flaky skin from around the wound. She then patted it dry and applied santyl ointment with a moistened piece of collagen over the wound and covered it with a foam pad. She then wrapped the entire foot with a rolled gauze dressing. The right heel wound was approximately 4 inches in size on the bottom of the heel and extended up along the outer side of the heel. The surrounding skin was a fragile pink with dry and flaky pieces of skin. There was no drainage noted. On 11/18/15 at 4:45 PM, one of the green foam boots was noted positioned in the chair in Resident #18's room. On 11/19/15 at 9:00 AM, the green foam boot was noted in the chair in his room. A bed bath was observed being provided to Resident #18 beginning at 11:00 AM on 11/19/15. NA #2 and NA #3 washed their hands and gloved. NA #2 prepared 2 basins of water to provide the bath. As they uncovered Resident #18, it was noted that the green foam boot was not in place on the right foot and there were no dressings noted to the 2 wounds on his right foot. There was a urine soaked white towel folded around the right foot. When NA #2 removed the towel there was also a moderate amount of bloody brownish drainage noted on the towel where the right heel had been. NA #2 washed his upper body with the exception of his hands. His right foot was not washed. When questioned at 11:20 AM, NA #2 stated the third shift NA (NA #4) had reported to her this morning when she came on duty that the dressings had been removed around 3:00 AM due to being soiled with stool and urine. NA #2 stated NA #4 told her she had wrapped a towel around his foot. NA #2 stated she provided care for Resident #18 before breakfast at about 7:10 AM but wasn't sure of the exact time. She reported Resident #18 had been wet and the towel that was around his right foot was wet with urine. She stated she changed his bed pads and placed a clean towel around the right foot. NA #2 also reported that she informed the hall nurse (Nurse #1) about the dressings not being in place around 7:20 AM but she wasn'tt sure of the exact time. NA #2 stated Nurse #1 told her to place the towel around the right foot until the treatment nurse could get to it. NA #2 stated she had not been back into Resident #18's room to change him since her initial check until now. There was a small dressing in place to the right heel of Resident #18's foot on 11/19/15 at 1:30 PM. The treatment nurse was interviewed on 11/19/15 at 1:10 PM. She stated Nurse #1 never reported anything to her about Resident #18's dressings being removed. She stated she saw NA #2 in the hall just a few minutes ago and she reported to her that his dressings were off. The treatment nurse stated the physician's orders [REDACTED]. She stated if the dressing became soiled or came off the hall nurse had access to supplies to replace the dressing. She stated a dressing should not be left off of a wound for a long period of time. The treatment nurse commented that it was the responsibility of the third

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 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) shift nurse to replace the dressing if the dressing was soiled and removed on third shift. The treatment nurse stated no wonder his wound is getting worse. The treatment nurse stated Nurse #1 had placed a dressing to the heel wound but not to the right great toe metatarsal wound. She stated she would provide wound care to both areas on his right foot and replace the green foam boot. Nurse #1 was interviewed on 11/19/15 at 1:30 PM. Nurse #1 stated NA #2 had reported the dressings were not in place to Resident #18's right foot earlier today around breakfast time but she was busy and told her to put something around the foot until she could get down to his room. Nurse #1 stated NA #2 told her later that she had given Resident #18 a bath. She reported she went down to his room and placed a dressing after that. When questioned if she had reported the issue to the treatment nurse she responded that she didn ' t know what her schedule was or when she would get to Resident #18. She stated if it took too long for the treatment nurse to replace the dressing she would do it. NA #4 was interviewed via telephone on 11/19/15 at 2:08 PM. She stated she worked third shift last night and had provided personal care to Resident #18 around 3:00 AM. She stated he had a large bowel movement and his dressings were covered with stool. She stated she removed the dressings and reported it to Nurse #2. She stated she wrapped the right foot with a clean towel. NA #4 reported she provided personal care again at the end of the shift and the towel was wet with urine. She also stated there was bloody brownish drainage noted on the towel. NA #4 commented that she reported it again to Nurse #2 toward the end of the shift. NA #4 reported that she informed NA #2 of the issue when she came on duty this morning. Nurse #2 was interviewed via telephone on 11/19/15 at 2:40 PM. She stated she was aware that Resident #18 had a wound on one of his feet. She stated if the dressing came off she was the only one who would need to address the issue. Nurse #2 stated the NA would let her know if it needed to be replaced or changed. Nurse #2 stated Resident #18 was very contracted and it was difficult to keep the right foot from coming into contact with urine and stool. Nurse #2 reported that the dressing had been off one night earlier in the week and the bed pad was saturated with urine but didn't remember which night. She stated she placed a bed pad between his buttocks and his heel to keep the urine from coming into contact with it. Nurse #2 also commented that she had not reported the dressing not being in place to the oncoming nurse and should have. Nurse #2 commented that the wound to his right heel would never heal if urine continued to come into contact with it. She denied that NA #4 had reported the issue regarding the dressings not being in place last night stating she didn ' t remember being told about it. The Director of Nurses (DON) was interviewed on 11/19/15 at 5:00 PM. She stated the hall nurses were expected to replace the dressings any time they were removed due to being soiled or if the dressing came off for any reason if the treatment nurse was not available. She also commented the right foot should have been washed to remove any residual urine. She also reported that on weekends the day shift nurse was responsible for wound treatments for the even numbered resident rooms and the night shift nurse was responsible for the odd numbered rooms. The DON provided the November 2015 treatment administration records for Resident #18 during the intervivew. Upon review of the November 2015 treatment administration record for Resident #18, it was noted that there were blanks on 11/06/15, 11/07/15, 11/08/15, 11/09/15, 11/14/15, 11/5/15 for the right foot metatarsal head and the full thickness wound to the plantar area of the right heel. The DON reported she did not know why treatments were not being provided on weekends. The DON also reported the third shift nurse (Nurse #2) should have replaced the dressing when it was reported. She commented she would not expect Resident #18 to go from approximately 3:00 AM until after 11:30 AM today without a dressing in place to the right foot.
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility did not provide a complete bed bath for 1 of 1 residents (Resident #18) whose bath was being observed. Findings included: The facility's undated policy for providing a partial bath noted to wash and dry the face, neck, ears, hands, axilla, buttock, perineum and feet. The undated policy for providing a bed bath noted to wash face, chest, abdomen, lower body, legs, hands, back, buttocks and feet. Resident #18 was re-admitted to the facility on [DATE]. Cumulative [DIAGNOSES REDACTED]. Resident #18's care plan identified a problem with an onset date of 05/14/15 as being at risk for skin breakdown related to impaired bed mobility and incontinence. The most recent Quarterly Minimum Data Set (MDS) assessment of 11/05/15 indicated Resident #18 had severely impaired decision making skills and required extensive to total assistance with all activities of daily living. The resident was incontinent of both bowel and bladder. The resident had 2 stage 3 pressure ulcers. A bed bath was observed being provided to Resident #18 beginning at 11:00 AM on 11/19/15. NA #2 and NA #3 washed their hands and gloved. NA #2 prepared 2 basins of water to provide the bath. As they uncovered Resident #18, it was noted that his left hand was contracted with a red/orange carrot-shaped protector in place within the hand. NA #2 washed his face, chest and arms. She did not remove the carrot shaped protector from his left hand nor did she wash his left hand. Resident #18 had a severely contracted right leg which was drawn up close to his abdomen resting on the upper left thigh. The right foot was resting up against the inner upper left thigh within very close proximity to his scrotum. Yellow urine staining was noted on the bed pad. Resident #18 also had a moderate amount of soft brown stool on his skin. It was noted that there was a urine soaked white towel draped across the right foot. When the towel was opened, there was a moderate amount of bloody brownish drainage noted on the towel where the right heel had been positioned. Resident #18 had 2 open wounds on his right foot and no dressings were in place. NA #2 continued with bathing while NA #3 assisted. His legs were contracted so the aides were not able to spread his legs to wash inside. NA #2 washed his perineal area and scrotum as best she could. She removed the soft brown stool from his rectum, inner buttocks and scrotum. A clean gown was placed. The soiled bed pad was removed and a clean one placed underneath Resident #18. Resident #18's back, legs and feet were not washed. The aides repositioned him and covered him with the bed linens. After mouth care was completed at approximately 11:20 AM, both aides were questioned about washing the left hand. Neither aide was able to report the last time the left hand had been washed because they had been on different assignments. NA #3 stated she had washed his left hand the last time she worked with him which was over the weekend. NA #2 was not sure when she had washed the left hand. NA #3 removed the carrot shaped protector from his left hand and began to wash it. As she opened the hand, a very foul odor was detected. NA #3 washed his left hand and dry skin was observed flaking off the hand onto the bed linens. NA #2 stated she would send the protective device to the laundry and ask what could be placed in the left hand while the carrot shaped protector was being laundered. NA #2 was questioned as to washing his feet so she washed his left foot but she never washed the right foot which had been covered with the urine soiled towel. She stated when she came on duty this morning NA #4 had reported to her that she had removed the dressings from his right foot around 3:00 AM this morning when she provided incontinent care. She stated NA #4 told her that the dressing had become soiled with feces and urine so she had placed a clean towel around the foot. She stated when she provided personal care at approximately 7:10 AM the pad and the towel were both soaked with urine and she had placed a clean towel around the right foot. NA #2 also reported that the facility had a no brief policy so she was constantly having to check on him to provide care as he was not wearing a brief. NA #2 added that she had not been back in to change Resident #18 since her first check earlier today. The Director of Nurses (DON) was interviewed on 11/19/15 at 5:00 PM. She stated all body parts were to be washed during a bath. She stated that included hands and feet. She stated showers were provided based on rotation sheets and if the resident was not scheduled for a shower a complete bed bath was to be given.
F 0315 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0315 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Based on physician interview, staff interview, and record review the facility failed to collect urine for a urinalysis for ten days and failed to initiate antibiotic treatment as ordered by the physican for fifteen days after nursing faxed the physician describing painful signs and symptoms for 1 of 1 sampled residents (Resident #287) who experienced a urinary tract infection [MEDICAL CONDITION]. Findings included: Resident #287 was admitted to the facility on [DATE], readmitted to the facility on [DATE], and discharged to the hospital on [DATE]. The resident's documented [DIAGNOSES REDACTED]. On 06/24/14 the resident's care plan identified, I have occasional episodes of incontinence as a problem. The resident's care plan was last reviewed on 03/23/15, and there were no revisions regarding this problem. Interventions to this problem included, Observe me for acute behavioral changes that may indicate UTI. The resident's 03/16/15 quarterly minimum data set (MDS) documented her cognition was severely impaired, there were no signs of [MEDICAL CONDITION], the resident was having trouble sleeping, the resident was feeling tired, the resident was experiencing poor appetite, the resident was having trouble concentrating, there was no evidence of [MEDICAL CONDITION], the resident exhibited no behaviors, the resident did not reject care, and the resident was not wandering. The resident required extensive assist with her activities of daily living except she was totally dependent on staff for bathing. The resident was frequently incontinent of bowel and bladder, and had two or more falls since her last MDS with one resulting in non-major injury. A 04/09/15 (Sunday) physician progress notes [REDACTED].#287's health status. The note documented a routine visit with the resident being alert, but not oriented to time or place. [MEDICAL CONDITION] was noted in the hands and feet, the resident was unable to follow commands, there was evidence of advancing multi-infarct dementia with recent TIA ([MEDICAL CONDITION]), the resident was continuing a DNR (do not resuscitate) status, and there was to be a continuation of comfort measures. A 04/21/15 fax to Resident #287's primary physician from Nurse #1 documented, Rsdt (resident) had 2 falls on 11 - 7 shift last night. Rsdt is being very combative, hallucinating. Urine is cloudy with (symbol used) gray tint. Strong odor & c/o (and complaints of) pain when urinating. Family is present @ (at) current & request she gets a UA/C & S ASAP (urinalysis/culture and sensitivity as soon as possible). Current symptoms before & had UTI. Please advise! The fax documented the resident's 04/21/15 10: 00 AM vital signs were blood pressure of 144/86, pulse 78, respirations 18, temperature 98.1, and oxygen saturation 95% on room air. Also handwritten on the facility's copy was, Temp (temperature) 99.9 urine collected.: This handwritten entry was undated. On 04/21/15 Combative behavior during care AEB (as evidenced by) striking out at and pulling away from staff; at risk of injury to self/others and undue stress r/t (in regard to) increased confusion was newly identified as a problem in the resident's care plan. Interventions to this problem included, monitor and document my behavior Q (every) shift, report significant changes to physician, administer medications as ordered by physician, monitor effectiveness of resident drug regime. On 05/01/15 the primary physician faxed a reply which documented, If still symptomatic (i.e. having dysuria), obtain in and out cath for U/A, C & S only if pyuria. 05/02/15 vital signs documented Resident #287's temperature was 99.9 degrees Fahrenheit (with all prior temperatures in April 2015 on 04/06/15, 04/13/15, 04/20/15, and 04/27/15 being within normal range). Lab results documented urine was collected on 05/02/15 with the C & S available on 05/04/15 which showed greater than 100,000 colony-forming units (CFU) of Escherichia coli bacteria. A 05/05/15 4:44 PM progress note documented, Rsdt slept majority of the day and consumed 0% of food and about 60 cc (cubic centimeters) of liquids throughout the day. Family also stated resdt was in pain and PRN (as needed) pain medication administered and had minimal effect A 05/05/15 physician order [REDACTED]. A 05/06/15 fax to Resident #287's primary physician by Nurse #1 documented, Rsdt family requesting a CBC & BMP (complete blood count and basic metabolic panel) on rsdt. Rsdt currently not consuming food or liquids. A 05/06/15 physician order [REDACTED]. A 05/06/15 12:42 AM progress note documented, Resident remained in bed throughout 3 - 11 shift. Respirations even and unlabored. Skin warm and dry to touch. Total care provided by staff, resident fed by staff member consuming 100% of dinner intake. ABT (antibiotic in progress for UTI, no adverse reactions note. No complaints voiced, no distress noted. Resident #287's Medication Administration Record [REDACTED]. A 05/07/15 12:11 AM progress note documented, Resident in bed resting entire shift with family members at bedside most of shift. Received total care, fed by family members, appetite good consuming greater than 75% of dinner intake. The resident's MAR indicated [REDACTED]. A 05/07/15 12:09 PM progress note documented, Resdt in bed all morning very lethargic with family @ bedside. Did not consume any breakfast, scant amounts of liquids .ABT in progress with no adverse reactions noted. A 05/08/15 1:57 PM progress note documented the resident's blood pressure was 126/82, pulse was 92, respirations were 20, temperature was 97.7, and oxygen saturation was 95% on room air. A 05/08/15 physician order [REDACTED]. The resident's MAR indicated [REDACTED]. A 05/08/15 hospital history and physical documented, .was brought in from nursing home for evaluation of change in mentation. The patient is lethargic. She opens her eyes spontaneously to verbal commands. She tries to communicate, but no meaningful information can be obtained Apparently the patient has complaints of abdominal pain and was diagnosed with [REDACTED]. She was started on [MEDICATION NAME], but the patient continued to get worse. The patient can usually talk and answer questions, but for the last 2 days, the ___ (family member designation) states the patient has not been able to communicate at all. Also, the patient's intake has decreased significantly, which has complicated things. She also states the patient's urine has smelled very foul and is very dark in color. The patient apparently used to use a wheelchair to ambulate, but for the last few weeks the patient's functional status has also declined tremendously. No report of fever, chills, nausea, vomiting, diarrhea, chest pain, shortness of breath, lightheadedness, dizziness, or rash Results from the CBC were faxed to the facility on [DATE] with the white blood cells elevated at 22.8 (the normal range being 4.5 - 12.5). A hospital final summary documented Resident #287 passed away in the hospital on [DATE]. Death [DIAGNOSES REDACTED]. At 2:25 PM on 11/18/15 Nurse #1 stated she personally observed the signs and symptoms Resident #287 was experiencing when she faxed the physician on 04/21/15. She also reported the resident's family informed her that they recognized these as the signs and symptoms experienced by the resident when she had UTIs in the past. According to Nurse #1, the resident continued to experience all these signs and symptoms, and she placed three follow-up phone calls to the physician's office on multiple days (there was no documentation of these phone calls in the resident's medical record). She commented she was not able to talk to the physician during these follow-up calls, but his nurses told her that the physician was aware of her concerns about Resident #287 and he would be back in touch. Nurse #1 stated this lag in physician response was not an isolated incident, reporting it was not uncommon to have to wait a week or longer for feedback and orders from Resident #287's physician. At 2:50 PM on 11/18/15 nursing assistant (NA) #5 stated for a couple of weeks before Resident #287 went out to hospital on [DATE] the resident had some hallucinations, moaned, reported she wanted to get out of the facility, and more frequently tried to do unsafe things like get up unassisted. During this same time period the NA commented the resident would say she had to go to the bathroom, and then be unable to urinate, complaining of feeling pressure. According to the NA, she also recalled the resident having brown/gray stains in her brief for a couple of weeks, but she felt this might not have been unusual for the resident. The NA also reported she thought she remembered the resident having cloudy urine, an isolated elevation in temperature, and some complaints of abdominal pain 2 - 5 day before the 05/08/15 hospitalization . She commented she was told by family members that the resident had a past history of UTIs, and her family was concerned that she was going through the same thing again. At 4:30 PM on 11/18/15 Nurse #5 stated for a couple of weeks before her 05/08/15 hospitalization Resident #287 seemed more confused, was less able to do things for herself, and was falling more frequently. She reported she was unsure about any

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F 0315 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) changes in the resident's urination during this time period. However, she commented she recalled the family having concerns saying they thought the resident was exhibiting signs and symptoms of a UTI, and they were getting more aggravated because the resident's doctor was not responding. Nurse #5 commented delays of a week or longer were not uncommon after faxing physicians about changes in resident condition or about concerns with resident health. She explained that about all you could do about the delay was call the physician office and talk to nurses who would say they had already passed the information on to the physician. At 3:06 PM on 11/19/15 NA #6 stated because the resident was last in the facility so long ago about all she could remember was in her last couple of weeks in the facility Resident #287 seemed more weak, was more confused, and the resident was able to go to the bathroom less. She reported Resident #287 did not have frequent UTIs, but had enough in the past that the family stated they could tell when the resident had a UTI from the symptoms she exhibited. At 3:35 PM on 11/19/15 the director of nursing (DON) stated there were two ways to communicate changes in resident condition to the primary physician. She explained if the change seemed urgent nurses could page physicians or physician assistants, and if the change was not urgent and a reply within 1 - 2 days was acceptable then a communication form could be faxed or placed in the physician communication book. She reported staff usually called Resident #287's primary physician since he only had 2 or 3 residents in the building. She commented he was not in the building much more than once a month when he attended quality assurance (QA) meetings. According to the DON, there was a folder at the nurse's station where communication forms that had been faxed to physicians were kept. She stated she expected the nursing staff to check the folder the next day after the initial fax to make sure a response had been obtained. If there was no response, she reported the nurse was supposed to call the physician office. If the nurse was unable to get a response from the physician after the phone call, then the nurse was supposed to take the matter to the unit or clinical coordinator who would then take over the responsibility of obtaining a response. The DON stated waiting almost two weeks to get antibiotic orders for someone exhibiting definitive symptoms of a UTI was too long. She commented in that amount of time the resident should have already completed antibiotic therapy and been free of painful UTI symptoms. At 8:42 AM on 11/20/15, during a telephone conversation with Resident #287's primary physician, he stated when residents experienced changes in condition the best way the nursing staff could reach him was on his cellular phone. He commenting faxing was acceptable also if the problem was not urgent. The physician reported he had some conversations with the former DON before 05/01/15, and they did not think Resident #287 was exhibiting definitive signs and symptoms of a UTI until the resident had an elevated temperature on 05/02/15. (However, there was no documentation of such conversations in the resident's paper or electronic medical record). He stated definitive signs and symptoms of a UTI included elevated temperature, pelvic/abdominal/flank pain, and painful urination. According to the physician, he also stopped by to see Resident #287 while visiting two other residents in the facility on 05/03/15 (Sunday), and Resident #287 seemed at baseline and in no acute distress. (However, there was not a physician progress notes [REDACTED].
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** Based on observation and staff interview the facility failed to sanitize kitchenware when dish machine final rinse temperatures did not reach 180 degrees Fahrenheit, failed to maintain the temperature of tuna salad made with mayonnaise at or below 41 degrees Fahrenheit during operation of the trayline, failed to air dry kitchenware before stacking it on top of one another in storage, failed to use sanitizing solutions to sanitize food preparation surfaces and meal carts, failed to clean kitchen equipment and filters, and failed to label and date opened food items. Finding included: 1. Between 9:30 AM and 9:52 AM on 11/18/15 15 racks of kitchenware were run through the facility's dish machine. The wash and final rinse gauges were not monitored by the dietary employees operating the dish machine, and these employees were unsure whether the dish machine sanitized kitchenware via heat or chemical sanitization. The final rinse temperatures ranged between 142 and 148 degrees Fahrenheit. At 9:55 AM on 11/18/15 the facility's maintenance manager (MM) stated the dish machine sanitized by heat alone, and final rinse temperatures should be at least 180 degrees Fahrenheit. During a follow-up interview with the MM at 10:56 AM on 11/18/15, he stated in response to a work order the thermostat and contacters were replaced in the dish machine booster system about a week and a half ago. He reported on 11/16/15 there were still problems with the dish machine temperatures so a contracted service technician recalibrated the thermostat in the booster system. The MM commented he did not regularly monitor dish machine temperatures, but did respond to work orders that concerned problems with the dish machine. At 4:22 PM on 11/18/15 the kitchen manager (KM) stated he expected the dietary staff operating the dish machine to monitor the wash and final rinse gauges. He reported if the final rinse gauge did not reach 180 degrees Fahrenheit as racks of kitchenware were run through, he expected the racks to be rerun until the target temperature was reached or exceeded. If this temperature could not be reached the KM commented the dietary staff was to notify the MM or a member of the dietary management team. At 10:04 AM on 11/19/15 a dietary employee, whose responsibilities sometimes included dish machine operation, stated the dietary staff was in-serviced and instructed that the employee retrieving sanitized kitchenware from the dish machine was supposed to monitor the final rinse gauge. If the gauge did not register at least 180 degrees Fahrenheit, the employee reported the reset button was to be activated and the kitchenware was to be run back through. According to the employee, if a temperature of at least 180 degrees was not reachable then the MM was to be notified immediately. 2. At 11:37 AM on 11/18/15 the cook took the food temperatures before the trayline began operation. Temperatures on hot foods were obtained, but no temperatures were taken on cold food items. At 11:50 AM on 11/18/15 after two tuna fish sandwiches were placed on resident trays, a calibrated thermometer was used to check the tuna fish filling. The sandwiches were being stored in a tray pan which was placed on top of another tray pan filled with ice. When placed in the filling, the thermometer registered 56 degrees Fahrenheit. At this time the dietary employee who prepared/assembled the tuna salad reported it contained tuna fish, mayonnaise, relish, mustard, onion, and boiled egg. She stated she finished preparing the salad at about 10:00 AM on 11/18/15, and the tuna fish sandwiches had been in the reach-in refrigerator since. At 11:55 AM on 11/18/15 a large bowl of left over/back-up tuna salad (from which the filling for the sandwiches had been obtained) was removed from the reach-in refrigerator. The calibrated thermometer used to check the tuna salad temperature registered 56 degrees Fahrenheit. At this time the kitchen manager (KM) stated he preferred cold salads to be assembled on the same day they were to be served so they would be as fresh as possible. At 9:13 AM on 11/19/15 the KM stated he was rethinking his stance on the time table for preparing cold salads made with mayonnaise in order to make sure they would be at or below 41 degrees Fahrenheit during operation of the trayline. He reported sandwiches containing fillings made with mayonnaise were to be stored in the refrigerator before serving, and kept above an ice bath while resident trays were being prepared. At 10:04 AM on 11/19/15 a dietary employee, whose responsibilities included food preparation, stated she did not believe preparing salads made with mayonnaise on the same day they were served was allowing them to cool down enough before serving. She reported on 11/18/15 she used chilled ingredients in preparing the tuna salad, and refrigerated the sandwiches as soon as they were assembled. She commented that if tuna salad did not reach 41 degrees Fahrenheit for a couple of hours there was a potential for making residents sick. 3. At 9:00 AM on 11/18/15 10 of 12 tray pans, stacked on top of one another in storage, had moisture trapped inside of them. At this time the kitchen manager (KM) stated he thought some of the tray pans had been stacked in storage last night and a few had been added this morning. At 9:13 AM on 11/19/15 the KM stated employees were in-serviced previously that kitchenware should be free of food particles and dry before stacking it on top on one another in a storage area. He reported part of the problem was that there was not a lot of room to air dry kitchenware. The KM also commented trapped moisture could grow bacteria which had the potential of making residents sick. At 10:04 AM on 11/19/15 a dietary employee stated all dietary staff had attended in-services during which staff were instructed that kitchenware had to be clean and dry before placing it in storage. 4. At 8:45 AM on 11/18/15 a dietary employee was straining tuna fish over the meat sink. At 8:52 AM on 11/18/15 mayonnaise, onion, and boiled egg were added to a large bowl containing tuna fish. At this time the

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F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) employee making the tuna salad stated she would be using a spray bottle to sanitize the meat sink when she completed the salad preparation. At 9:06 AM on 11/18/15 a cloth from a green bucket was used to wipe down the food preparation table where the tuna salad was assembled. At 9:12 AM on 11/18/15 the cook was observed wiping down a food preparation cart/table and the steam table ledges with a cloth from a green bucket. Between 9:30 AM and 9:52 AM on 11/18/15 three meal carts which had been on the halls and in the dining room were emptied. A dietary employee wiped down the inside and outside of the carts with a cloth which she obtained from a tub of dish washing solution where dirty utensils were soaking. At 10:00 AM on 11/18/15 the kitchen manager (KM) stated the green buckets in the kitchen contained a dishwashing solution. He reported he was unsure whether the three sanitizer bottles in the kitchen contained bleach or quaternary sanitizing solution. He was also unsure about when the spray bottles had been made up. Strips used to check the strength of both bleach-based and quarternary solutions failed to register when placed in the solutions inside 2 of the 3 spray bottles (including the spray bottle utilized in the area where the tuna fish salad was prepared). At 9:13 AM on 11/19/15 the KM stated every work station should have a red bucket and a spray bottle containing quarternary sanitizing solution. He reported all food preparation surfaces in the kitchen should be sanitized between completing preparation tasks. The KM commented strips should be used after making up the bottles and buckets to make sure the solutions registered 150 - 200 parts per million of sanitizer. According to the KM, the spray bottles and red buckets should be changed out twice daily. He stated a quarternary sanitizing solution was supposed to be used for wiping down meal carts which returned from the halls and dining room where germs and bacteria could have been picked up. At 10:04 AM on 11/19/15 a dietary employee stated she did not recall being instructed to wipe down meal carts with a sanitizing solution. However, she reported red buckets and spray bottles were made up twice daily, and contained quarternary solution dispensed from the three-compartment sink system. She stated work surfaces were supposed to be sanitized after completing each food preparation task. 5. During initial tour of the kitchen, beginning at 9:50 AM on 11/16/15, the filters on the ice machine were coated in a thick film of grease and dust. In addition, a thick film of grease and patches of dust were observed on the seven filter sections above the stove/oven system. The inside top of the microwave oven was also covered with dried food particles. During a follow-up tour of the kitchen at 8:50 AM on 11/18/15 the inside top of the microwave oven was covered with dried food particles. At 4:22 PM on 11/18/15 the kitchen manager (KM) stated the maintenance department was responsible for cleaning the ice machine filters and the hood system. However, he reported employees in the dietary department cleaned both types of filters if they became greasy and dirty between the scheduled maintenance times. The KM commented dirty filters on the ice machine could contaminate the ice and effect the proper functioning of the ice machine. He also remarked dusty filters above the stove could contaminate the food cooking below them, and greasy filters posed a fire hazard. According to the KM, the inside bottom, sides, and top of the microwave were supposed to be cleaned at least daily to prevent dried food from falling into fresh food which was being heated. At 9:28 AM on 11/19/15 the maintenance manager (MM) stated he was responsible for making sure the hood system was deep cleaned every six months, but he thought dietary employees cleaned the filters in the stove system at least every month and as needed to prevent a build up of grease and dust which could cause fires and contaminate food. The MM reported he cleaned kitchen filters/vents monthly, but he thought dietary slid out the ice machine filters weekly and as needed to keep them clean to prevent contamination to ice and promote optimal functioning of the machine. At 10:04 AM on 11/19/15 a dietary employee stated the facility had a cleaning schedule with some tasks to be done daily, some weekly, and some monthly. However, she stated the dietary employees mainly cleaned up as they went, and would either notify maintenance or clean filters themselves if they became dirty and greasy. She reported employees using the microwave were supposed to wipe it down after use or at least by the end of their shift. She commented dried food could fall off the inside top of the microwave and contaminate food which was heating. 6. During initial tour, beginning at 9:50 AM on 11/16/15, bags of potato cakes and sliced eggplant in the reach-in freezer were opened but without labels and open dates. In the reach-in refrigerator gallon containers of Tuscan Caesar dressing, mayonnaise, French dressing, blue cheese dressing, ranch dressing, barbecue sauce, Italian dressing, and honey mustard dressing were opened but without labels and open dates. In the dry storage room a 5-pound box of cornbread mix, two 5-pound bags of cake mix, a bag of croutons, and a bag of vanilla wafers were opened but without labels and open dates. In the walk-in freezer bags of corn on the cob and sliced eggplant were opened but without labels and dates. At this time the kitchen manager (KM) stated he was not aware that food items should be dated when opened. He reported, however, he was making sure the staff wrote on containers of food the dates when they were received into the facility. At 10:04 AM on 11/19/15 a dietary employee stated prior to the survey the only dates recorded on food items were the receipt dates when the foods arrived in the facility. However, she reported it made sense to also document an open date to make sure those foods which were opened earliest were used up first so everything would stay as fresh as possible.
F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, pharmacy staff interview, physician interviews and record review, the facility failed to follow established procedures for the acquisition of narcotic medications for 9 of 37 residents (Resident #46, #45, #121, #33, #160, #270, #56, #21 and #177) receiving controlled substances. Findings included: 1. A review of the facility policy titled Medication Ordering and Receiving from Pharmacy-Emergency Pharmacy Services and Emergency Kits (dated as effective June 9, 2015) included a section titled, Procedures: E. Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency box or automated dispensing system (ADS), from the provider pharmacy or a back-up pharmacy that is determined by the provider pharmacy. Resident # 46 was admitted to the facility on [DATE]. A review of the resident ' s medical record revealed medication orders included the following: Klonopin 0.5 milligrams (mg) to be given twice daily to treat schizophrenia originally ordered 9/26/15. A review of Resident #46 ' s Controlled Drug Record revealed her Klonopin was signed out by a nurse and noted as borrowed for (Resident #29) . In an interview on 11/18/15 at 2:05 PM, the consultant pharmacist stated she was not aware that the nurses were borrowing narcotics. She stated she primarily does the medication reviews and leaves the medication carts and ADS issues to either the pharmacy technician or the nurse consultant. In another interview on 11/18/15 at 2:17 PM, the pharmacist recalled the ADS crashed on 11/5/15 and she was aware it went off line a few days before. When the system went offline, the pharmacy could not see what needed reordering or what is being used from the ADS. It does not limit the staff ' s ability to get medications out of the ADS according to the pharmacist. She recalled the pharmacy calling the facility and leaving multiple messages for the director of nursing (DON) and the unit manager (UM) to reset the ADS because the pharmacy was unable to view the inventory. She stated the pharmacy called the provider of the ADS and made them aware of offline concerns on 11/4/15 but then the ADS crashed. The pharmacy ordered a replacement ADS that arrived at the facility on 11/7/15 but the facility did have backup pharmacy services in the interim. In an interview on 11/18/15 at 2:45 PM, the DON stated there had been problems recently with the ADS and she had to repeatedly reset the machine but it was replaced the first part of November and she thought it was working better. The DON stated once an admission was verified, the orders were faxed to the facility pharmacy and when the resident arrived with the original paper prescription it would be placed in the pharmacy tote to be delivered to the pharmacy. The DON verified the pharmacy delivered medications to the facility around midnight and cut off time to get medications the same night was

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She stated she could call the physician and get orders for an alternate medication in some instance but not for some medications used for her residents. Nurse #4 stated anytime a medication was unavailable the physician should be notified and she felt some nurses did not reorder the narcotics timely enough since the physician only came in on the weekends. She stated when the nurse saw the medication get into the blue area on the punch card, that was when normally a nurse should start trying to obtain another written prescription but if a nurse waited until a medication was in the blue area, it would be too late to get a new prescriptions and have the refill available for the resident. Nurse #4 stated she had worked at the facility for approximately 2 weeks but she had already identified the issue but did not report it because she was told it had been an ongoing problem and management was aware. In a telephone interview on 11/19/15 at 9:48 AM, the long term care unit physician stated he came to the facility on Saturdays and Sundays. He stated staff normally anticipate a need for a narcotic refill and put the order in his box the week before he comes. If a resident needed a medication during week, he could write prescription at his office and fax it to the pharmacy. He stated he had never had any issue with resident ' s getting their narcotics as ordered. In an interview on 11/19/15 at 10:25 AM, the rehabilitation unit physician assistant (PA) stated the facility had an ADS that should only be used in emergencies and if staff notified him timely when a resident ' s narcotic medications were in the blue area on the punch card, there should be ample time to get a refill. The PA stated he was at the facility at minimum 2-3 times weekly and verified that he could email the pharmacy prescriptions if he was made aware of a need. In a telephone interview on 11/19/15 at 11:08 AM, the pharmacy technician stated the ADS was internet based but it could be accessed at facility the whether or not it was online. She acknowledged the pharmacy could not log in to refill the ADS unless it was online. The pharmacy technician she was at the facility on 10/28/15 and reset the machine but on 11/5/15, she was made aware of crashed all together. The pharmacy technician stated she was not aware the facility was borrowing narcotics but she normally does not review the Control Drug Records but rather checked that medication carts for expired medications during her monthly visits. In a telephone interview on 11/19/15 at 11:15 AM, the pharmacy nurse consultant stated during her monthly facility visit, she spot checks the medication carts for expired medications. She stated she was unaware that the facility was having any narcotic borrowing issues and was not made aware until yesterday, the ADS had to be replaced earlier this month. The pharmacy nurse consultant stated she was uncertain who was responsible for the review of the Control Drug Records to ensure there was no evidence of narcotic borrowing. She acknowledged she had reviewed the Control Drug Records in the past but if she noted any problems, it would have been addressed in her monthly visit report given to the facility. A review of the Medication Room Compliance Report dated 8/21/15, 9/15/15 and 10/28/15 completed by the pharmacy nurse consultant and the pharmacy technician did not reference a review of the Control Drug Record sheets. In an observation on 11/19/15 at 2:45 PM, the UM was attempting to retrieve a onetime dose of supplemental potassium for a resident from the ADS. The UM attempted three times but the ADS never would open to allow retrieve the potassium from the ADS. After the third attempt, she went and got the consultant pharmacist who was in the facility for assistance. The pharmacist was asked to follow up with the outcome of the ADS malfunction. In an interview on 11/19/15 at 4:50 PM, the DON stated the pharmacist was no longer at the facility and she was unsure of the outcome of the ADS malfunction earlier witnessed. It was the expectation of the DON that the facility not borrow narcotic medications under any circumstance but rather utilize the backup pharmacy or the ADS. 2. A review of the facility policy titled Medication Ordering and Receiving from Pharmacy-Emergency Pharmacy Services and Emergency Kits (dated as effective June 9, 2015) included a section titled, Procedures: E. Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency box or automated dispensing system (ADS), from the provider pharmacy or a back-up pharmacy that is determined by the provider pharmacy. Resident # 45 was admitted to the facility on ,[DATE]. A review of the resident ' s medical record revealed medication orders included the following: Xanax 0.25 milligrams (mg) to be given every 6 hours as needed for anxiety originally ordered 10/1/15. A review of Resident #45 ' s Controlled Drug Record revealed her Xanax was signed out by a nurse and noted as borrowed for (Resident #29) . In an interview on 11/18/15 at 2:05 PM, the consultant pharmacist stated she was not aware that the nurses were borrowing narcotics. She stated she primarily does the medication reviews and leaves the medication carts and ADS issues to either the pharmacy technician or the nurse consultant. In an interview on 11/18/15 at 2:05 PM, Nurse # 7 stated she was aware it was against the facility policy but she acknowledge her signature on the Control Drug Record and borrowing narcotics in the past. Nurse #7 stated the facility has had a problem for awhile getting prescriptions from the physician before the residents ran out of narcotics. She stated everyone has the same problem and everyone knows about it. Nurse #7 stated there was ongoing issues with the facility ADS. She stated there was problems accessing it and it was never restocked. In another interview on 11/18/15 at 2:17 PM, the pharmacist recalled the ADS crashed on 11/5/15 and she was aware it went off line a few days before. When the system went offline, the pharmacy could not see what needed reordering or what is being used from the ADS. It does not limit the staff ' s ability to get medications out of the ADS according to the pharmacist. She recalled the pharmacy calling the facility and leaving multiple messages for the director of nursing (DON) and the unit manager (UM) to reset the ADS because the pharmacy was unable to view the inventory. She stated the pharmacy called the provider of the ADS and made them aware of offline concerns on 11/4/15 but then the ADS crashed. The pharmacy ordered a replacement ADS that arrived at the facility on 11/7/15 but the facility did have backup pharmacy services in the interim. In an interview on 11/18/15 at 2:45 PM, the DON stated there had been problems recently with the ADS and she had to repeatedly reset the machine but it was replaced the first part of November and she thought it was working better. The DON stated once an admission was verified, the orders were faxed to the facility pharmacy and when the resident arrived with the original paper prescription it would be placed in the pharmacy tote to be delivered to the pharmacy. The DON verified the pharmacy delivered medications to the facility around midnight and cut off time to get medications the same night was 5:00 PM. She also stated the facility utilized a backup pharmacy in the event that a medication was needed prior to the arrival of the ordered medication at midnight. In a telephone interview on 11/19/15 at 9:48 AM, the long term care unit physician stated he came to the facility on Saturdays and Sundays. He stated staff normally anticipate a need for a narcotic refill and put the order in his box the week before he comes. If a resident needed a medication during week, he could write prescription at his office and fax it to the pharmacy. He stated he had never had any issue with resident ' s getting their narcotics as ordered. In an interview on 11/19/15 at 10:25 AM, the rehabilitation unit physician assistant (PA) stated the facility had an ADS that should only be used in emergencies and if staff notified him timely when a resident ' s narcotic medications were in the blue area on the punch card, there should be ample time to get a refill. The PA stated he was at the facility at minimum 2-3 times weekly and verified that he could email the pharmacy prescriptions if he was made aware of a need. In a telephone interview on 11/19/15 at 11:08 AM, the pharmacy technician stated the ADS was internet based but it could be accessed at facility the whether online or offline. She acknowledged the pharmacy could not log in to refill the ADS unless it was online. The pharmacy technician she was at the facility on 10/28/15 and reset the machine but on 11/5/15, she was made aware of crashed all together. The pharmacy technician stated she was not aware the facility was borrowing narcotics but she normally does not review the Control Drug Records but rather checked that medication carts for expired medications during her monthly visits. In a telephone interview on 11/19/15 at 11:15 AM, the pharmacy nurse consultant stated during her monthly facility visit, she spot checks the medication carts for expired medications. She stated she was unaware that the facility was having any narcotic borrowing issues and was not made aware until yesterday, the ADS had to be replaced earlier this month. The

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After the third attempt, she went and got the consultant pharmacist who was in the facility for assistance. The pharmacist was asked to follow up with the outcome of the ADS malfunction. In an interview on 11/19/15 at 4:50 PM, the DON stated the pharmacist was no longer at the facility and she was unsure of the outcome of the ADS malfunction earlier witnessed. It was the expectation of the DON that the facility not borrow narcotic medications under any circumstance but rather utilize the backup pharmacy or the ADS. 3. A review of the facility policy titled Medication Ordering and Receiving from Pharmacy-Emergency Pharmacy Services and Emergency Kits (dated as effective June 9, 2015) included a section titled, Procedures: E. Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency box or automated dispensing system (ADS), from the provider pharmacy or a back-up pharmacy that is determined by the provider pharmacy. Resident # 121 was admitted to the facility on [DATE]. A review of the resident ' s medical record revealed medication orders included the following: Klonopin 0.5 mg to be given every three times daily for anxiety originally ordered 5/1/15. A review of Resident #121 ' s Controlled Drug Record revealed her Klonopin was signed out by a nurse and noted as borrowed for (Resident #46) . In an interview on 11/18/15 at 2:05 PM, the consultant pharmacist stated she was not aware that the nurses were borrowing narcotics. She stated she primarily does the medication reviews and leaves the medication carts and ADS issues to either the pharmacy technician or the nurse consultant. In an interview on 11/18/15 at 2:05 PM, Nurse # 7 stated she was aware it was against the facility policy but she acknowledge her signature on the Control Drug Record and borrowing narcotics in the past. Nurse #7 stated the facility has had a problem for awhile getting prescriptions from the physician before the residents ran out of narcotics. She stated everyone has the same problem and everyone knows about it. Nurse #7 stated there was ongoing issues with the facility ADS. She stated there was problems accessing it and it was never restocked. In another interview on 11/18/15 at 2:17 PM, the pharmacist recalled the ADS crashed on 11/5/15 and she was aware it went off line a few days before. When the system went offline, the pharmacy could not see what needed reordering or what is being used from the ADS. It does not limit the staff ' s ability to get medications out of the ADS according to the pharmacist. She recalled the pharmacy calling the facility and leaving multiple messages for the director of nursing (DON) and the unit manager (UM) to reset the ADS because the pharmacy was unable to view the inventory. She stated the pharmacy called the provider of the ADS and made them aware of offline concerns on 11/4/15 but then the ADS crashed. The pharmacy ordered a replacement ADS that arrived at the facility on 11/7/15 but the facility did have backup pharmacy services in the interim. In an interview on 11/18/15 at 2:45 PM, the DON stated there had been problems recently with the ADS and she had to repeatedly reset the machine but it was replaced the first part of November and she thought it was working better. The DON stated once an admission was verified, the orders were faxed to the facility pharmacy and when the resident arrived with the original paper prescription it would be placed in the pharmacy tote to be delivered to the pharmacy. The DON verified the pharmacy delivered medications to the facility around midnight and cut off time to get medications the same night was 5:00 PM. She also stated the facility utilized a backup pharmacy in the event that a medication was needed prior to the arrival of the ordered medication at midnight. In a telephone interview on 11/19/15 at 9:48 AM, the long term care unit physician stated he came to the facility on Saturdays and Sundays. He stated staff normally anticipate a need for a narcotic refill and put the order in his box the week before he comes. If a resident needed a medication during week, he could write prescription at his office and fax it to the pharmacy. He stated he had never had any issue with resident ' s getting their narcotics as ordered. In an interview on 11/19/15 at 10:25 AM, the rehabilitation unit physician assistant (PA) stated the facility had an ADS that should only be used in emergencies and if staff notified him timely when a resident ' s narcotic medications were in the blue area on the punch card, there should be ample time to get a refill. The PA stated he was at the facility at minimum 2-3 times weekly and verified that he could email the pharmacy prescriptions if he was made aware of a need. In a telephone interview on 11/19/15 at 11:08 AM, the pharmacy technician stated the ADS was internet based but it could be accessed at facility the whether or not it was online. She acknowledged the pharmacy could not log in to refill the ADS unless it was online. The pharmacy technician she was at the facility on 10/28/15 and reset the machine but on 11/5/15, she was made aware of crashed all together. The pharmacy technician stated she was not aware the facility was borrowing narcotics but she normally does not review the Control Drug Records but rather checked that medication carts for expired medications during her monthly visits. In a telephone interview on 11/19/15 at 11:15 AM, the pharmacy nurse consultant stated during her monthly facility visit, she spot checks the medication carts for expired medications. She stated she was unaware that the facility was having any narcotic borrowing issues and was not made aware until yesterday, the ADS had to be replaced earlier this month. The pharmacy nurse consultant stated she was uncertain who was responsible for the review of the Control Drug Records to ensure there was no evidence of narcotic borrowing. She acknowledged she had reviewed the Control Drug Records in the past but if she noted any problems, it would have been addressed in her monthly visit report given to the facility. A review of the Medication Room Compliance Report dated 8/21/15, 9/15/15 and 10/28/15 completed by the pharmacy nurse consultant and the pharmacy technician did not reference a review of the Control Drug Record sheets. In an observation on 11/19/15 at 2:45 PM, the UM was attempting to retrieve a onetime dose of supplemental potassium for a resident from the ADS. The UM attempted three times but the ADS never would open to allow retrieve the potassium from the ADS. After the third attempt, she went and got the consultant pharmacist who was in the facility for assistance. The pharmacist was asked to follow up with the outcome of the ADS malfunction. In an interview on 11/19/15 at 4:50 PM, the DON stated the pharmacist was no longer at the facility and she was unsure of the outcome of the ADS malfunction earlier witnessed. It was the expectation of the DON that the facility not borrow narcotic medications under any circumstance but rather utilize the backup pharmacy or the ADS. 4. A review of the facility policy titled Medication Ordering and Receiving from Pharmacy-Emergency Pharmacy Services and Emergency Kits (dated as effective June 9, 2015) included a section titled, Procedures: E. Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency box or automated dispensing system (ADS), from the provider pharmacy or a back-up pharmacy that is determined by the provider pharmacy. Resident # 33 was admitted to the facility on [DATE]. A review of the resident ' s medical record revealed medication orders included the following: Klonopin 0.5mg twice daily as need for anxiety originally ordered 10/15/15. A review of Resident #33 ' s Controlled Drug Record revealed her Xanax was signed out by a nurse and noted as borrowed for (Resident #46) . In an interview on 11/18/15 at 2:05 PM, the consultant pharmacist stated she was not aware that the nurses were borrowing narcotics. She stated she primarily does the medication reviews and leaves the medication carts and ADS issues to either the pharmacy technician or the nurse consultant. In another interview on 11/18/15 at 2:17 PM, the pharmacist recalled the ADS crashed on 11/5/15 and she was aware it went off line a few days before. When the system went offline, the pharmacy could not see what needed reordering or what is being used from the ADS. It does not limit the staff ' s ability to get medications out of the ADS according to the pharmacist. She recalled the pharmacy calling the facility and leaving multiple messages for the director of nursing (DON) and the unit manager (UM) to reset the ADS because the pharmacy was unable to view the inventory. She stated the pharmacy called the provider of the ADS and made them aware of offline concerns on 11/4/15 but then the ADS crashed. The pharmacy ordered a replacement ADS that arrived at the facility on 11/7/15 but the facility did have backup pharmacy services in the interim. In an interview on 11/18/15 at 2:45 PM, the DON stated there had been problems recently with the ADS and she had to repeatedly reset the machine but it was replaced the first part of November and she thought it was working better. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE REHAB AND HC CTR AT VILLAGE GR	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) stated once an admission was verified, the orders were faxed to the facility pharmacy and when the resident arrived with the original paper prescription it would be placed in the pharmacy tote to be delivered to the pharmacy. The DON verified the pharmacy delivered medications to the facility around midnight and cut off time to get medications the same night was 5:00 PM. She also stated the facility utilized a backup pharmacy in the event that a medication was needed prior to the arrival of the ordered medication at midnight. In an interview on 11/18/15 at 4:40 PM, Nurse #4 identified her signature of the Control Drug Record as having borrowed Klonopin from Resident #46 for Resident #29. She acknowledged she had borrowed control substances on other occasions as well. Nurse #4 stated she was aware of the facility policy against borrowing controlled medications but the physician only came on the weekends and wrote prescriptions for refills and she was left with little option. Nurse #4 stated she was aware there were issues with the ADS and she could not use the backup pharmacy without a physician signed prescription. She stated she could call the physician and get orders for an alternate medication in some instance but not for some medications used for her residents. Nurse #4 stated anytime a medication was unavailable the physician should be notified and she felt some nurses did not reorder the narcotics timely enough since the physician only came in on the weekends. She stated when the nurse saw the medication get into the blue area on the punch card, that was when normally a nurse should start trying to obtain another written prescription but if a nurse waited until a medication was in the blue area, it would be too late to get a new prescriptions and have the refill available for the resident. Nurse #4 stated she had worked at the facility for approximately 2 weeks but she had already identified the issue but did not report it because she was told it had been an ongoing problem and management was aware. In a telephone interview on 11/19/15 at 9:48 AM, the long term care unit physician stated he came to the facility on Saturdays and Sundays. He stated staff normally anticipate a need for a narcotic refill and put the order in his box the week before he comes. If a resident needed a medication during week, he could write prescription at his office and fax it to the pharmacy. He stated he had never had any issue with resident ' s getting their narcotics as ordered. In an interview on 11/19/15 at 10:25 AM, the rehabilitation unit physician assistant (PA) stated the facility had an ADS that should only be used in emergencies and if staff notified him timely when a resident ' s narcotic medications were in the blue area on the punch card, there should be ample time to get a refill. The PA stated he was at the facility at minimum 2-3 times weekly and verified that he could email the pharmacy prescriptions if he was made aware of a need. In a telephone interview on 11/19/15 at 11:08 AM, the pharmacy technician stated the ADS was internet based but it could be accessed at facility the whether or not it was online. She acknowledged the pharmacy could not log in to refill the ADS unless it was online. The pharmacy technician she was at the facility on 10/28/15 and reset the machine but on 11/5/15, she was made aware of crashed all together. The pharmacy technician stated she was not aware the facility was borrowing narcotics but she normally does not review the Control Drug Records but rather checked that medication carts for expired medications during her monthly visits. In a telephone interview on 11/19/15 at 11:15 AM, the pharmacy nurse consultant stated during her monthly facility visit, she spot checks the medication carts for expired medications. She stated she was unaware that the facility was having any narcotic borrowing issues and was not made aware until yesterday, the ADS had to be replaced earlier this month. The pharmacy nurse consultant stated she was uncertain who was responsible for the review of the Control Drug Records to ensure there was no evidence of narcotic borrowing. She acknowledged she had reviewed the Control Drug Records in the past but if she noted any problems, it would have been addressed in her monthly visit report given to the facility. A review of the Medication Room Compliance Report dated 8/21/15, 9/15/15 and 10/28/15 completed by the pharmacy nurse consultant and the pharmacy technician did not reference a review of the Control Drug Record sheets. In an observation on 11/19/15 at 2:45 PM, the UM was attempting to retrieve a onetime dose of supplemental potassium for a resident from the ADS. The UM attempted three times but the ADS never would open to allow retrieve the potassium from the ADS. After the third attempt, she went and got the consultant pharmacist who was in the facility for assistance. The pharmacist was asked to follow up with the outcome of the ADS malfunction. In an interview on 11/19/15 at 4:50 PM, the DON stated the pharmacist was no longer at the facility and she was unsure of the outcome of the ADS malfunction earlier witnessed. It was the expectation of the DON that the facility not borrow narcotic medications under any circumstance but rather utilize the backup pharmacy or the ADS. 5. A review of the facility policy titled Medication Ordering and Receiving from Pharmacy-Emergency Pharmacy Services and Emergency Kits (dated as effective June 9, 2015) included a section titled, Procedures: E. Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency box or automated dispensing system (ADS), from the provider pharmacy or a back-up pharmacy that is determined by the provider pharmacy. Resident # 159 was admitted to the facility on [DATE] A review of the resident ' s medical record revealed medication orders included the following: Klonopin 0.5 milligrams (mg) to be given twice daily for anxiety originally ordered 9/24/15. A review of Resident #159 ' s Controlled Drug Record revealed her Klonopin was signed out by a nurse and noted as borrowed for (Resident #210) . In an interview on 11/18/15 at 2:05 PM, the consultant pharmacist stated she was not aware that the nurses were borrowing narcotics. She stated she primarily does the medication reviews and leaves the medication carts and ADS issues to either the pharmacy technician or the nurse consultant. In another interview on 11/18/15 at 2:17 PM, the pharmacist recalled the ADS crashed on 11/5/15 and she was aware it went off line a few days before. When the system went offline, the pharmacy could not see what needed reordering or what is being used from the ADS. It does not limit the staff ' s ability to get medications out of the ADS according to the pharmacist. She recalled the pharmacy calling the facility and leaving multiple messages for the director of nursing (DON) and the unit manager (UM) to reset the ADS because the pharmacy was unable to view the inventory. She stated the pharmacy called the provider of the ADS and made them aware of offline concerns on 11/4/15 but then the ADS crashed. The pharmacy ordered a replacement ADS that arrived at the facility on 11/7/15 but the facility did have backup pharmacy services in the interim. In an interview on 11/18/15 at 2:45 PM, the DON stated there had been problems recently with the ADS and she had to repeatedly reset the machine but it was replaced the first part of November and she thought it was working better. The DON stated once an admission was verified, the orders were faxed to the facility pharmacy and when the resident arrived with the original paper prescription it would be placed in the pharmacy tote to be delivered to the pharmacy. The DON verified the pharmacy delivered medications to the facility around midnight and cut off time to get medications the same night was 5:00 PM. She also stated the facility utilized a backup pharmacy in the event that a medication was needed prior to the arrival of the ordered medication at midnight. In an interview on 11/18/15 at 4:40 PM, Nurse #4 identified her signature of the Control Drug Record as having borrowed Klonopin from Resident #46 for Resident #29. She acknowledged she had borrowed control substances on other occasions as well. Nurse #4 stated she was aware of the facility policy against borrowing controlled medications but the physician only came on the weekends and wrote prescriptions for refills and she was left with little option. Nurse #4 stated she was aware there were issues with the ADS and she could not use the backup pharmacy without a physician signed prescription. She stated she could call the physician an