

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345437	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2011
NAME OF PROVIDER OR SUPPLIER HIGHLANDS CASHIERS HOSPITAL IN			STREET ADDRESS, CITY, STATE, ZIP CODE 190 HOSPITAL DR HIGHLANDS, NC 28741	
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F 000	INITIAL COMMENTS	F 000	Highlands Cashiers Hospital, Inc. response to this report of survey does not denote agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are filing the POC because it is required by law.	
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on facility policy review and staff interview, the facility failed to include all required components in the abuse policy. The findings are: The facility's policy "Abuse (Suspected) of Patients/Residents" last revised January 2011 did not include how the facility would identify, prevent, and investigate allegations of abuse, neglect and misappropriation of property. In addition, the policy did not include how the facility would protect residents if the alleged abuse, neglect or misappropriation was allegedly inflicted by a nonemployee (i.e. visitor/family). During interview with the Director of Nursing on 12/15/11 at 11:05 AM, she stated she had no additional policies which included these missing policy pieces. She was able to explain and describe how the facility would handle each aspect of the policy that was missing.	F 226	• F 226 Corrective Actions(s) that will be accomplished for those residents found to have been affected by the deficient practice: An audit was conducted and no residents were found to be affected by the deficient practice. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. The Abuse Policy has been updated to include how the facility identifies, prevents, and investigates allegations of abuse, neglect, and misappropriation of property. The Abuse Policy has also been amended to include how the facility protects residents if the alleged abuse, neglect, or misappropriation was allegedly inflicted by a non-employee. All staff in patient care areas received training on changes to the Abuse Policy. Systemic changes to ensure the deficient practice will not occur: The Abuse Policy will be reviewed quarterly for updates or changes and revised as indicated. How facility plans to implement the corrective action and evaluate for it's effectiveness: The updated and amended policy will be the basis for annual mandatory employee abuse education. The updated policy will also be reviewed by all newly hired employees during "New Employee Orientation." The Living Center Social Worker is responsible for scheduling and teaching annual mandatory abuse classes. The Living Center Social Worker is also responsible for providing abuse education to all new hires during new employee orientation. Effectiveness of education will be measured through post tests completed by attendees at the end of abuse classes. Additionally,	1/12/2012
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

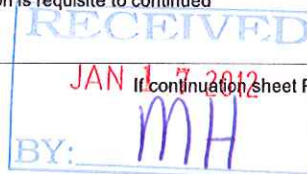
(X6) DATE

C. B. A.

President/CEO

1/12/12

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 241	<p>Continued From page 1</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide feeding assistance in a manner to promote dignity by standing over four (4) of ten (10) sampled residents during feeding. Residents #27, #29, #19 and #14.</p> <p>The findings are:</p> <p>1. Resident #29's diagnoses included Alzheimer's Disease. He was assessed on the most recent Minimum Data Set (MDS), a quarterly dated 10/12/11, as having long and short term memory impairments, decision making difficulties and requiring total assistance with feeding.</p> <p>On 12/12/11 at 11:43 AM Resident #29 was one of seven residents in the assisted dining room. He was seated at one of the U shaped tables (designed for staff to sit inside the U and assist several residents at one time who sit on the outside of the U). Throughout this meal, Nurse Aide #2 stood while feeding Resident #29. NA #2 did not sit during the meal.</p> <p>On 12/14/11 at 2:24 PM a telephone interview was conducted with NA #2. NA #2 stated that she was taught to sit while she feeds residents,</p>	F 241	<p>audits of all reported abuse cases for compliance with the abuse policy will be conducted by an interdisciplinary team comprised of the DON, Human Resources Manager, Social Worker, and Education Specialist. Audits will be reviewed by the QA&A Committee. The QA&A Committee is responsible for reviewing any trends or reoccurring issues and implementing procedure changes to ensure that compliance is achieved and maintained.</p> <p>• F 241 Corrective Actions(s) that will be accomplished for those residents found to have been affected by the deficient practice: Staff have been instructed to sit and remain seated and have been provided appropriate seating to promote dignity and respect while providing feeding assistance for Residents #27, #29, #19, and #14.</p> <p>How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. Nursing Managers have reviewed all resident care plans and assessed all residents for needed assistance with feeding. The nursing staff has been provided portable, height adjustable seating both on the Resident's individual halls and in the Assisted Dining Room to ensure that an appropriate seating height can be reached regardless of the height of the staff member or the height of the resident's chair or bed.</p> <p>Systemic changes to ensure the deficient practice will not occur: The nursing staff has been provided portable, height adjustable seating both on the Resident's individual halls and in the assisted Dining Room to ensure that an appropriate seating height can be reached regardless of the height of the staff member or the height of the resident's chair or bed. All nursing staff has been instructed on the importance of maintaining respect and dignity</p>	1/12/2012

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F 241	<p>Continued From page 2</p> <p>but she is so short that she often has to sit and stand throughout the meal to reach the residents. She stated she was unaware she stood the entire time on 12/12/11. NA #2 stated she had not told the Director of Nursing (DON) that she could not reach the resident in the assisted dining room unless she stood.</p> <p>On 12/15/11 at 10:49 AM the DON stated it was her expectation that staff would position themselves in front or beside the resident while feeding or assisting resident with their meals. She also stated staff should sit as long as they can reach the resident. The DON stated that NA #2 did not share with her that she could not reach the residents when assisting them at the U shaped tables. The DON stated that the staff chairs in the assisted dining room were adjustable. She further stated that if there was any issue with the way residents fit at the tables or not enough room, etc, she would have expected to be notified.</p> <p>2. Resident #27 was assessed on the most recent Minimum Data Set (MDS), a quarterly dated 9/14/11, having severe cognitive impairment and as requiring extensive assistance with eating.</p> <p>On 12/12/11 at 11:43 AM Resident #27 was one of seven residents in the assisted dining room. She was seated at one of the U shaped tables (designed for staff to sit inside the U and assist several residents at one time who sit on the outside of the U). Throughout this meal, Nurse Aide #2 stood while assisting and feeding Resident #27. NA #2 did not attempt to sit during the meal.</p>	F 241	<p>while feeding, as well as the location and use of portable, adjustable seating on every hall and in the dining rooms. New employees will be educated on maintaining dignity and respect in "New Employee Orientation."</p> <p>How facility plans to implement the corrective action and evaluate for it's effectiveness: The Restorative Nurse is responsible for monitoring that dignity and respect are maintained during feeding assistance by bi-weekly observation <i>and</i> audits of the dining rooms and halls during various mealtimes for the next 3 months. Audits are reviewed by the QA&A Committee. The QA&A Committee is responsible for reviewing any trends or reoccurring issues and implementing procedure changes to ensure that compliance is achieved and maintained.</p>	

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F 241	<p>Continued From page 3</p> <p>On 12/14/11 at 2:24 PM a telephone interview was conducted with NA #2. NA #2 stated that she was taught to sit while she feeds residents, but she is so short that she often has to sit and stand throughout the meal to reach the residents. She stated she was unaware she stood the entire time on 12/12/11. NA #2 stated she had not told the Director of Nursing (DON) that she could not reach the resident in the assisted dining room unless she stood.</p> <p>On 12/15/11 at 10:49 AM the DON stated it was her expectation that staff would position themselves in front or beside the resident while feeding or assisting resident with their meals. She also stated staff should sit as long as they can reach the resident. The DON stated that NA #2 did not share with her that she could not reach the residents when assisting them at the U shaped tables. The DON stated that the staff chairs in the assisted dining room were adjustable. She further stated that if there was any issue with the way residents fit at the tables or not enough room, etc, she would have expected to be notified.</p> <p>3. Resident #19 was admitted to the facility with diagnoses including Alzheimer's disease with delusions and agitation and depression. The latest Minimum Data Set (MDS) dated 09/21/11 indicated severe impairment of cognition. The MDS specified Resident #19 was totally dependent on staff assistance when eating.</p> <p>An observation on 12/12/11 at 12:48 PM revealed Resident #19 was lying in bed. The meal tray was</p>	F 241			

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F 241	<p>Continued From page 4</p> <p>observed on the bedside table. Nursing Assistant (NA) #1 was observed standing by the bedside while feeding the resident. NA #1 was observed bending over the resident to assist with the meal</p> <p>In an interview with NA #1 on 12/13/11 at 3:59 PM, NA #1 stated she usually stood at Resident #19's bedside to assist with meals. NA #1 stated no chair was available in the room.</p> <p>An interview with the Director of Nursing (DON) on 12/15/11 at 11:56 AM revealed she expected facility staff to position themselves so they were not standing over a resident when assisting with meals. The DON added facility staff should be seated when feeding residents.</p> <p>4. Resident #14 was admitted with the diagnoses cerebral vascular accident, hypertension and atrial fibrillation. Review of her most recent Minimum Data Set (MDS) dated 09/28/11 revealed she had severe cognitive impairment. The MDS further revealed she required assistance with all activities of daily living but was able to feed herself when her meal was set up. Review of Resident #14's care plan dated 10/05/11 revealed she was at nutritional risk and needed assistance in the restorative dining program.</p> <p>An observation was made on 12/12/11 at 8:25 AM of Nursing Assistant (NA) #4 assisting residents in the restorative dining room. NA #4 was observed standing over Resident #14 feeding her.</p>	F 241			

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F 241	Continued From page 5 An interview was conducted on 12/15/11 at 1:34 PM with NA #4. She reported that she works with residents who need to be in restorative dining, these residents can usually feed themselves but may require prompting or assistance. She reported it was complicated in the restorative dining room because the residents are usually not fed by staff. She further reported that recently she has had to feed Resident #14 as she has had a decline. She reported that normally she would sit down to feed residents.	F 241		
F 286 SS=C	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to make the Minimum Data Set (MDS) assessment accessible to staff for eleven (11) of eleven (11) sampled residents. Residents #52, #48, #53, #73, #38, #7, #69, #27, #37, #33 and #31. The findings are: Review of the medical records of Residents #52,	F 286	• F 286 Corrective Actions(s) that will be accomplished for those residents found to have been affected by the deficient practice: 15 months of the MDS and required CAA's have been made available to the staff for Residents #52, #48, #53, #73, #38, #7, #69, #27, #37, #33, and #31. The MDS's and CAA's are now located behind each Resident's care plan in the hall specific report book. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. 15 months of MDS's and the required CAA's have been printed and filed for each Resident behind their care plan in the report book for their hall. The Unit Coordinator will be responsible for filing the most recent MDS and CAA's and thinning any exceeding the 15 month requirement.	1/12/2012

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F 286	<p>Continued From page 6</p> <p>#48, #53, #73, #38, #7, #69, #27, #37, #33 and #31 revealed the Minimum Data Sets (MDS) were not located in the medical record and not readily accessible to the survey staff.</p> <p>Interview on 12/12/11 at 3:45 PM with the MDS nurse revealed that all MDSs are kept in the computer and that staff did not have access to the MDS as it was password protected and access was given to only those who completed the MDS assessment. She stated that the MDS must be accessible to staff however with the increase in the length of the assessment she printed only the front page and signature sheet for the chart.</p> <p>Interview with Licensed Nurse (LN) # 2 on 12/14/11 at 12:47 PM confirmed that she had no access to the MDS.</p> <p>On 12/14/11 at 12:49 PM the Medical Director reported that he was not familiar with the MDS assessment. If he had access to it he was not aware of it. He only used the paper charts. He would not know who to go to in order to review an MDS assessment.</p> <p>During an interview on 12/15/11 at 10:20 AM the MDS nurse indicated that only the Social Worker (SW), Restorative Nurse and MDS nurse had access to the MDS assessment. The MDS nurse stated that she did not believe the DON (Director of Nursing), Dietary manager or treatment nurse had access to the MDS. She further reported that she inputted data into the MDS assessment for the Dietary Manager and the Treatment Nurse. The MDS nurse stated that she as well as the SW, Restorative nurse, Treatment nurse and</p>	F 286	<p>Systemic changes to ensure the deficient practice will not occur: All nursing staff received training on the location of the MDS and CAA's in the report books for their hall. A memo has been sent to all Attending Physicians and Interdisciplinary Team Members regarding the new location of MDS's and CAA's. The location of the MDS and CAA's will be included in "New Employee Orientation" for all Nursing Staff, Physicians and new Interdisciplinary Team Members.</p> <p>How facility plans to implement the corrective action and evaluate for it's effectiveness: The MDS Nurse is responsible for monitoring that each resident's current MDS and preceding 15 months of assessments are printed and properly filed in the report book designated for each hall. Audits of each report book will be performed weekly for 3 months. Audits are reviewed by the QA&A Committee. The QA&A Committee is responsible for reviewing any trends or reoccurring issues and implementing procedure changes to ensure that compliance is achieved and maintained.</p>	

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F 286	Continued From page 7 Dietary Manager work a Monday to Friday schedule with no weekends and if someone needed to access the MDS on the weekend they would not be able to access this data unless they called for her to come into the building. She stated that she had stopped printing the MDS and the Care Area Assessments (CAAs) two to three months ago. She stated that the charge nurses on the unit did not have access to the MDS assessment. On 12/15/11 at 10:40 AM the Director of Nursing (DON) stated that she definitely had access to the MDS assessment and that the nurses on the unit have access as well, however she was unsure whether the nurses on the unit knew they had access to the MDS, as the MDS appears under the heading RAI (resident assessment instrument) in the computer system and she is sure that her nurses do not know what RAI stands for. An interview with the MDS nurse on 12/15/11 at 2:45 PM she stated that no nurse or other staff member were able to gain access to the MDS assessments and that the MDSs are inaccessible without assistance and that if they were printed they would be accessible. On 12/15/11 at 3:07 PM both LN #1 and LN #2 stated they were unable to log into the computer to access the MDS and they do not have access to the MDS in the computer.	F 286		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		

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F 371	<p>Continued From page 8</p> <p>considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews, the facility failed to label, date, seal and/or discard spoiled food in two (2) of two (2) resident nourishment rooms.</p> <p>The findings are:</p> <p>1. A Resident nourishment room was located on Dogwood. In the resident only refrigerator was the following: *On 12/12/11 at 10:38 AM in a bottom drawer was a poorly wrapped open to air fruit cake with a resident's name but no date on it; a plastic container with lid with a resident's name on it and a date of 11/27/11 full of beans in sauce that smelled sour. In the refrigerator door was a partially used jar of marshmallow cream marked with a resident's name but no date. The jar contained a yellowish separated liquefied substance with chunky pieces in it. *On 12/13/11 at 10:12 AM in a bottom drawer was a poorly wrapped open to air fruit cake with a resident's name but no date on it; a plastic container with lid with a resident's name on it and a date of 11/27/11 full of beans in sauce that smelled sour. In the refrigerator door was a partially used jar of marshmallow cream marked</p>	F 371	<p>• F 371</p> <p>Corrective Actions(s) that will be accomplished for those residents found to have been affected by the deficient practice: An audit was conducted and no residents were found to be affected by the deficient practice.</p> <p>How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. Night shift Nursing Assistants and the Dietary Aide responsible for stocking the refrigerators and freezers are checking the refrigerators and freezers daily for unlabeled, undated, out of date, spoiled, discolored or other wise compromised food items and discarding them as indicated.</p> <p>Systemic changes to ensure the deficient practice will not occur: All Nursing Staff and Dietary Staff received training on the importance of properly dating and labeling resident food, when to discard items, and the schedule for monitoring refrigerators and freezers. Dating and labeling food items was also included on the January Resident Council agenda for discussion and in the quarterly "Family Connection Newsletter." Proper food storage and handling will be included in "New Employee Orientation" for all Nursing Staff and Nutrition Staff.</p> <p>How facility plans to implement the corrective action and evaluate for it's effectiveness: The Director of Nursing is responsible for monitoring the refrigerators and freezers in the Resident Nourishment Rooms for unlabeled, undated, out of date, spoiled, discolored or other wise compromised food. Unlabeled, undated, out of date, spoiled, or discolored items are discarded as indicated. Audits of both refrigerators and freezers will be conducted 3 times weekly for 3 months. Audits are reviewed by the QA&A Committee. The QA&A Committee is responsible for reviewing any trends or reoccurring issues and implementing procedure changes to ensure that</p>	1/12/2012

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F 371	<p>Continued From page 9</p> <p>with a resident's name but no date. The jaw contained a yellowish separated liquefied substance with chunky pieces in it.</p> <p>*On 12/14/11 at 12:24 PM in a bottom drawer was a poorly wrapped open to air fruit cake with a resident's name but no date on it; the plastic container of beans was gone. In the refrigerator door was a partially used jar of marshmallow cream marked with a resident's name but no date. The jaw contained a yellowish separated liquefied substance with chunky pieces in it.</p> <p>On 12/14/11 at 12:23 PM interview with Licensed nurse #3 revealed dietary staff stocks the resident refrigerator daily and throws out items that are outdated.</p> <p>On 12/14/11 at 12:27 PM a Nurse Aide #3 stated she believed dietary staff was responsible for cleaning and stocking the refrigerators in the resident nourishment rooms.</p> <p>On 12/14/11 at 1:01 PM Interview with Dietary Aide #1 revealed the dietary aides stock the resident refrigerator. Dietary aides are to look at the items and make sure there are no out of date items in the refrigerator. These refrigerators are checked daily.</p> <p>On 12/14/11 at 1:13 PM Dietary Aide #3 stated she was assigned to Dogwood on Monday 12/12/11 but was off yesterday. She stated she worked two to three days per week. She stated that dietary staff were responsible for stocking the refrigerators and removing old out of date items. She also stated that she only handles the food that the facility stocks in the refrigerator not any personal food that the resident puts in the</p>	F 371	compliance is achieved and maintained.	

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F 371	<p>Continued From page 10 refrigerator.</p> <p>On 12/14/11 at 2:40 PM interview with the dietary technician revealed that if the food items are out of date, then dietary throws it out while restocking. He then stated that if the item was in Tupperware we would only discard it if it was rotten.</p> <p>On 12/14/11 at 2:41 PM the social worker stated that the nurse aides are responsible for making sure the residents' foods are labeled, dated and discarded timely.</p> <p>During interview on 12/14/11 at 4:15 PM, the Director of Nursing (DON) stated night shift nursing assistants were responsible for ensuring resident foods in the nourishment rooms were labeled, dated and discarded timely.</p> <p>2. A Resident nourishment room was located on Rosewood. In the resident only refrigerator was the following: *On 12/12/11 at 11:14 AM in the freezer was a plastic bag containing a white wrapped item with a resident's name but no date. *On 12/13/11 at 10:10 AM in the freezer was a plastic bag containing a white wrapped item with a resident's name but no date. *On 12/14/11 at 12:20 PM in the freezer was a plastic bag containing a white wrapped item with a resident's name but no date.</p> <p>On 12/14/11 at 12:23 PM interview with Licensed nurse #3 revealed dietary staff stocks the resident refrigerator daily and throws out items that are outdated.</p>	F 371			

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F 371	<p>Continued From page 11</p> <p>On 12/14/11 at 12:27 PM a Nurse Aide #3 stated she believed dietary staff was responsible for cleaning and stocking the refrigerators in the resident nourishment rooms.</p> <p>On 12/14/11 at 1:01 PM Interview with Dietary Aide #1 revealed the dietary aides stock the resident refrigerator. Dietary aides are to look at the items and make sure there are no out of date items are in the refrigerator. These refrigerators are checked daily.</p> <p>On 12/14/11 at 1:04 PM Dietary Aide #2 stated she stocked the refrigerator on Rosewood today and usually stocks it five days a week. She stated who ever is scheduled to stock the resident refrigerators are supposed to make sure things are labeled and dated. She further stated if things are not labeled they should be thrown away. When asked about the plastic bag in the freezer she stated she should have seen the freezer item and thrown it away because it was not dated.</p> <p>On 12/14/11 at 2:40 PM interview with the dietary technician revealed that if the food items are out of date, then dietary throws it out while restocking. He then stated that if the item was in Tupperware we would only discard it if it was rotten.</p> <p>On 12/14/11 at 2:41 PM the social worker stated that the nurse aides are responsible for making sure the residents' foods are labeled, dated and discarded timely.</p> <p>During interview on 12/14/11 at 4:15 PM, the Director of Nursing (DON) stated night shift</p>	F 371			

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F 371	Continued From page 12 nursing assistants were responsible for ensuring resident foods in the nourishment rooms were labeled, dated and discarded timely.	F 371		
F 386 SS=B	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to have physicians sign verbal or telephone orders for seven (7) of eleven (11) sampled residents. (Residents #37, #31, #33, #27, #67, #7, and #38) The findings are: 1. A review of Resident #37's medical record revealed physician verbal or telephone orders dated 09/03/11, 09/07/11, 09/17/11, 09/18/11, 09/22/11 and 10/5/11 did not contain a physician's signature. These orders ranged from initiation of topical treatments, changes in dosages of antibiotics and psychotropic medications, diagnostic testing, and food consistency changes. An interview was conducted on 12/15/11 at 8:39 AM with the Unit Manager. She reported	F 386 • F 386 Corrective Actions(s) that will be accomplished for those residents found to have been affected by the deficient practice: Physician orders for Resident #37, #31, #33, #27, #67, #7, and #38 have all been signed by their attending physicians. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. Any nurse taking a verbal order from a physician indicates that the order is to be signed with a yellow "to be signed" sticker. The chart is placed on a shelf designated for unsigned orders. When the night nurses complete their daily chart reviews they 'flag' any unsigned orders with a yellow "to be signed" sticker and move it to the shelf designated for unsigned orders. On the day or night shift that the Attending Physician is covering their weekly or bi-weekly shift in the Emergency Room (adjacent to the Living Center) the nursing staff delivers the charts to them for signature and retrieves the charts once signed. All H&P's are sent directly from dictation to the Physician's mail box for signature. Once signed, it is filed in the Resident's chart.	1/12/2012	

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F 386	<p>Continued From page 13</p> <p>sometimes the nurses writing the orders would flag the order and sometimes if she noticed the order she would flag it. She further reported the night shift nurses checked each chart for the orders written that day and verified orders were transcribed correctly. The Unit Manager stated the night shift nurses were not responsible for flagging the unsigned orders.</p> <p>An interview was conducted on 12/14/11 at 12:49 PM with the facility's Medical Director. He stated he reviewed his residents' charts monthly or bi-monthly and signed orders. He further reported it was his expectation all facility physicians signed their verbal or telephone orders within a month.</p> <p>An interview was conducted on 12/15/11 at 9:26 AM with the Director of Nursing (DON). She reported the physicians were aware their verbal or telephone orders needed to be signed within five days. Her expectation was orders were signed within five days. She added there is no system in place to ensure physician orders were signed in a timely manner. The DON continued currently there is no system in place to audit charts for unsigned orders.</p> <p>2. A review of Resident #31's medical record revealed verbal or telephone physician orders dated 11/09/11 and 11/10/11 did not contain a physician's signature. These orders ranged from initiation of medications, food consistency changes, diagnostic testing, and initiation of therapies. Further medical record review revealed a history and physical dictated 12/01/11 did not contain a physician's signature.</p> <p>An interview was conducted on 12/15/11 at 8:39</p>	F 386	<p>Systemic changes to ensure the deficient practice will not occur: All nursing staff received training on importance of timely signing of orders and the procedure for "flagging" orders for signature. They also received direction on placement of unsigned charts in the designated area and the schedule for delivery to the Physician. The process for "flagging orders" will be incorporated in "New Employee Orientation" for Nurses. All Attending Physician's received a memo from the Living Center Medical Director and the Director of Nursing regarding the importance of timely signing of orders and the new procedure for 'flagging' orders for signature. They also received direction on location of unsigned charts in the designated area and the schedule for delivery to them for signature. The memo to the Physician also included the requirement for signature on all H&P's and that the H&P would be delivered to their mail box for signature and then they could return it to the Living Center's mail box after signing. All new Attending Physicians will receive instruction on timely dating and signing physician orders.</p> <p>How facility plans to implement the corrective action and evaluate for it's effectiveness: The Director of Nursing monitors 5 Resident medical records 3 times weekly for unsigned orders and H&P's. Any record with orders left unsigned for greater than 5 days is reviewed and signed by the Medical Director. Physician's that routinely fail to sign orders in a timely manner are addressed by the Medical Director. Any continued pattern of non-compliance is reviewed by the Credentialing Committee. The Unit Coordinator has audited every medical record for unsigned H&P's and has returned any unsigned H&P's to the Attending Physician for signature. All new H&P's received are checked by the Unit Coordinator for signature prior</p>		

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F 386	<p>Continued From page 14</p> <p>AM with the Unit Manager. She reported sometimes the nurses writing the orders would flag the order and sometimes if she noticed the order she would flag it. She further reported the night shift nurses checked each chart for the orders written that day and verified orders were transcribed correctly. The Unit Manager stated the night shift nurses were not responsible for flagging the unsigned orders.</p> <p>An interview was conducted on 12/14/11 at 12:49 PM with the facility's Medical Director. He stated he reviewed his residents' charts monthly or bi-monthly and signed orders. He further reported it was his expectation all facility physicians signed their verbal or telephone orders within a month.</p> <p>An interview was conducted on 12/15/11 at 9:26 AM with the Director of Nursing (DON). She reported the physicians were aware their verbal or telephone orders needed to be signed within five days. Her expectation was orders were signed within five days. She added there is no system in place to ensure physician orders were signed in a timely manner. The DON continued currently there is no system in place to audit charts for unsigned orders.</p> <p>3. A review of Resident #33's medical record revealed verbal or telephone physician orders dated 08/18/11, 08/19/11, 08/22/11, 09/12/11 and 10/27/11 were not signed. These orders ranged from initiation of antibiotics and psychotropic medications, wound treatments, diagnostic testing, nutritional supplements, and occupational and physical therapies. Further medical record review revealed a history and physical dictated 08/18/11 did not contain a physician's signature.</p>	F 386	to filing on the medical record. Any unsigned H&P is returned to the Attending Physician for signature. Audits are reviewed by the QA&A Committee. The QA&A Committee is responsible for reviewing any trends or reoccurring issues and implementing procedure changes to ensure that compliance is achieved and maintained.		

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F 386	Continued From page 15 An interview was conducted on 12/15/11 at 8:39 AM with the Unit Manager. She reported sometimes the nurses writing the orders would flag the order and sometimes if she noticed the order she would flag it. She further reported the night shift nurses checked each chart for the orders written that day and verified orders were transcribed correctly. The Unit Manager stated the night shift nurses were not responsible for flagging the unsigned orders. An interview was conducted on 12/14/11 at 12:49 PM with the facility's Medical Director. He stated he reviewed his residents' charts monthly or bi-monthly and signed orders. He further reported it was his expectation all facility physicians signed their verbal or telephone orders within a month. An interview was conducted on 12/15/11 at 9:26 AM with the Director of Nursing (DON). She reported the physicians were aware their verbal or telephone orders needed to be signed within five days. Her expectation was orders were signed within five days. She added there is no system in place to ensure physician orders were signed in a timely manner. The DON continued currently there is no system in place to audit charts for unsigned orders. 4. A review of Resident #27's medical record revealed unsigned physician verbal or telephone orders dated 09/02/11, 09/10/11, and 09/12/11. These orders ranged from imitation of antibiotics, wound treatments, and diagnostic testing. An interview was conducted on 12/15/11 at 8:39 AM with the Unit Manager. She reported	F 386		

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F 386	<p>Continued From page 16</p> <p>sometimes the nurses writing the orders would flag the order and sometimes if she noticed the order she would flag it. She further reported the night shift nurses checked each chart for the orders written that day and verified orders were transcribed correctly. The Unit Manager stated the night shift nurses were not responsible for flagging the unsigned orders.</p> <p>An interview was conducted on 12/14/11 at 12:49 PM with the facility's Medical Director. He stated he reviewed his residents' charts monthly or bi-monthly and signed orders. He further reported it was his expectation all facility physicians signed their verbal or telephone orders within a month.</p> <p>An interview was conducted on 12/15/11 at 9:26 AM with the Director of Nursing (DON). She reported the physicians were aware their verbal or telephone orders needed to be signed within five days. Her expectation was orders were signed within five days. She added there is no system in place to ensure physician orders were signed in a timely manner. The DON continued currently there is no system in place to audit charts for unsigned orders.</p> <p>5. A review of Resident #69's medical record revealed that physician verbal or telephone dated 10/28/11 and 10/30/11 did not contain a physician's signature. These orders ranged from discontinuation of a psychotropic medication, an order for an antidepressant and an order for an antibiotic. Further review of Resident #69's medical record revealed a history and physical dated 08/16/11 was not signed by the physician.</p> <p>An interview was conducted on 12/15/11 at 8:39</p>	F 386		

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F 386	<p>Continued From page 17</p> <p>AM with the Unit Manager. She reported sometimes the nurses writing the orders would flag the order and sometimes if she noticed the order she would flag it. She further reported the night shift nurses checked each chart for the orders written that day and verified orders were transcribed correctly. The Unit Manager stated the night shift nurses were not responsible for flagging the unsigned orders.</p> <p>An interview was conducted on 12/14/11 at 12:49 PM with the facility's Medical Director. He stated he reviewed his residents' charts monthly or bi-monthly and signed orders. He further reported it was his expectation all facility physicians signed their verbal or telephone orders within a month.</p> <p>An interview was conducted on 12/15/11 at 9:26 AM with the Director of Nursing (DON). She reported the physicians were aware their verbal or telephone orders needed to be signed within five days. Her expectation was orders were signed within five days. She added there is no system in place to ensure physician orders were signed in a timely manner. The DON continued currently there is no system in place to audit charts for unsigned orders.</p> <p>6. A review of resident #7's medical record revealed physician verbal and telephone orders dated 09/20/11, 10/05/11, 10/11/11, 11/01/11 and 11/03/11 did not contain a physician's signature. These orders ranged from psychotropic medications, laboratory orders as well as an order to discontinue physical therapy.</p> <p>An interview was conducted on 12/15/11 at 8:39 AM with the Unit Manager. She reported</p>	F 386			

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F 386	<p>Continued From page 18</p> <p>sometimes the nurses writing the orders would flag the order and sometimes if she noticed the order she would flag it. She further reported the night shift nurses checked each chart for the orders written that day and verified orders were transcribed correctly. The Unit Manager stated the night shift nurses were not responsible for flagging the unsigned orders.</p> <p>An interview was conducted on 12/14/11 at 12:49 PM with the facility's Medical Director. He stated he reviewed his residents' charts monthly or bi-monthly and signed orders. He further reported it was his expectation all facility physicians signed their verbal or telephone orders within a month.</p> <p>An interview was conducted on 12/15/11 at 9:26 AM with the Director of Nursing (DON). She reported the physicians were aware their verbal or telephone orders needed to be signed within five days. Her expectation was orders were signed within five days. She added there is no system in place to ensure physician orders were signed in a timely manner. The DON continued currently there is no system in place to audit charts for unsigned orders.</p> <p>7. Review of Resident #38's medical record revealed no physician signature on verbal and telephone physician orders dated 11/02./11, 11/03/11, 11/04/11 and 11/11/11. These unsigned orders ranged from upgrading a diet order, changing antipsychotic medication from a pill form to a liquid form, and orders for antibiotics and labs to be obtained.</p> <p>An interview was conducted on 12/15/11 at 8:39 AM with the Unit Manager. She reported sometimes the nurses writing the orders would</p>	F 386			

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F 386	<p>Continued From page 19</p> <p>flag the order and sometimes if she noticed the order she would flag it. She further reported the night shift nurses checked each chart for the orders written that day and verified orders were transcribed correctly. The Unit Manager stated the night shift nurses were not responsible for flagging the unsigned orders.</p> <p>An interview was conducted on 12/14/11 at 12:49 PM with the facility's Medical Director. He stated he reviewed the charts monthly or bi-monthly and signed orders. He further reported it was his expectation physician verbal or telephone orders were signed within a month.</p> <p>An interview was conducted on 12/15/11 at 9:26 AM with the Director of Nursing (DON). She reported the physicians were aware their verbal or telephone orders needed to be signed within five days. Her expectation was orders were signed within five days. She added there is no system in place to ensure physician orders were signed in a timely manner. The DON continued currently there is no system in place to audit charts for unsigned orders.</p>	F 386			