| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345518 | A. BUILDING _____ B. WING _____ | 10/01/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| INN AT QUAIL HAVEN VILLAGE | 155 BLAKE BOULEVARD PINEHURST, NC 28374 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 250 SS=D | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review and staff interview, the facility failed to obtain psychiatric services for one of one resident who had a diagnosis of paranoid schizophrenia and exhibited behaviors (Resident #26). The findings included:<br><br>Resident #26 was originally admitted to the facility 6/5/08. Cumulative diagnoses included: paranoid schizophrenia and major depressive disorder.<br><br>An Annual Minimum Data Set dated 7/8/15 indicated Resident #26 was cognitively intact. No mood or behaviors were indicated as having occurred during the assessment period.<br><br>Resident #26's current care plan was reviewed and revealed Resident #26 was on antipsychotic medications related to depression and schizophrenia. Interventions included, in part, mental health consult as needed. Monitor, document behaviors and report to physician as needed.<br><br>A review of the medical record for Resident #26 revealed a nursing note dated 6/23/15 at 9:03 PM that stated Resident #26 told the nurse that she had been worried about her two daughters | F 250 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>Corrective Action for Resident Affected<br>On 10/7/15, Social Worker obtained order for Resident #26 to receive consult by psychiatrist at Carolina Behavioral Center on October 21, 2015.<br><br>Corrective Action for Residents Potentially Affected<br>All residents have the potential to be affected by this practice. On 10-08-15, Social Worker began auditing all current residents for psychiatric treatment referrals and completed the audit on 10-23-15. This audit was completed by reviewing progress notes for the past 30 | 10/26/15 |

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

Electronically Signed | 10/16/2015

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| F 250 | Continued From page 1<br>because she had been hearing voices from the television telling her that they were dead and also to kill herself. Resident#26 stated that the nursing staff had been walking by and saying they were sorry to hear about her daughters. Resident #26 was reassured that none of that was true. Resident #26 also stated that she had been hearing the voices on and off for about a month but just did not want to tell anybody. Continue to monitor and follow up with physician about medication adjustment.<br><br>A nursing note dated 6/24/15 at 4:20AM stated there were no behaviors, talk of voices or death in the family on that shift. No further nursing documentation was noted that indicated monitoring continued to occur.<br><br>A review of the social services notes for June and July 2015 revealed no documentation that further evaluation/ psychiatric services had been requested or done. A social work note dated 7/9/15 stated outpatient psychiatric services as needed.<br><br>A review of the physician progress notes for June through September was completed and revealed no documentation that the physician and/or nurse practitioner had been notified of the incident on 6/23/15.<br><br>An interview was conducted during stage 1 with Resident #26. She was cognitively intact, pleasant and made no references to hearing voices or having thoughts of killing herself. Resident #26 stated she was happy at the facility, attended activities and enjoyed watching/ talking to people. | F 250 | days, reviewing diagnosis list for psychiatric diagnosis including Schizophrenia, and reviewing behavior documentation in PCC. During the audit, three residents were identified as needing referrals for psychiatric and/or psychological treatment, Social Worker contacted attending physician to obtain referral to local psychiatric and/or psychological service providers. These appointments were scheduled and completed on 10-14-15.<br><br>Systemic Changes<br>On 10-05-15, Social Worker was in-serviced the Director of Nursing on how to audit residents taking anti-psychotic medications by running a Psychotropic Medication report, how to review for behavior documentation in progress notes and eMAR/Point of Care documentation, and how to review resident diagnosis to identify residents for referral needs to psychiatric and/or psychological services. When residents are identified, Social Worker will contact the attending physician to obtain referral to local psychiatric and/or psychological service providers.<br>On 10-07-15, All full time, part time and PRN RN's, LPN's, Social Worker and CNA's were in-serviced by the DON about residents exhibiting unusual behaviors such as Resident expresses feeling of worthlessness, hopelessness or helplessness, outbursts of anger, mood swings, and drastic changes in behavior, experienced a recent significant loss, direct and indirect statements such as, "I | |

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| F 250 | Continued From page 2<br>An interview was conducted with the social worker on 9/30/15 at 10:38 AM. She stated she had never been informed of the incident on 6/23/15 when Resident #26 heard voices and spoke of her daughters being killed and that Resident #26 heard voices telling her to kill herself. She stated, if she had been aware of the situation, she would have visited the resident and informed the physician 09/30/2015 10:40:53 AM Wendy, DN stated the incident would be documented on the 24 hr. report and taken to meeting the next morning.<br><br>On 9/30/2015 at 11:53 AM, a telephone interview was conducted with Nurse #1. She stated she provided care for Resident #26 on 6/23/15. Nurse #1 said she knew Resident #26 had a diagnosis of schizophrenia and, other than 6.23.15, had never said anything like that to her. Nurse #1 said she told Resident #26 there were no voices coming out of the television and asked Resident #26 if she was thinking about killing herself. Resident #26 stated no bur that was what the television was telling her. Nurse #1 stated she just wrote a nursing note and passed the information on to the 3rd shift nurse. She told the nursing assistants to "watch" Resident #26. Nurse #1 stated she also left a note for the assistant director of nursing to contact the physician the next day. Nurse #1 stated she did not call the physician, Director of Nursing or anyone at the time of the incident.<br><br>On 9/30/15 at 2:45PM, a telephone interview was conducted with the Nurse Practitioner. She stated she was not aware of the incident of Resident #26 hearing voices and talking of killing herself and stated the nursing staff should have informed her at the time of the incident. | F 250 | wish I were dead," "I'm going to kill myself," "I'm useless," and "I can't go on living like this," or they are hearing voices to harm themselves and appropriate documentation. Upon a resident exhibiting unusual behavior, nurses will document under the Progress Note "Behavior" and the CNA's will document behaviors in Point of Care under PRN Behavior reporting. In addition to this, in-serviced were how staff should respond when behaviors such as above were noted. Provide a quiet, calm atmosphere to decrease anxiety/agitation. Express care and concern while allowing resident to express emotions. Assess resident environment for safety and remove and store objects which could be used for self-harm. Assess resident for physical problems or drug reactions. Check for new medication orders which occurred prior to noted changes in resident/patient. Vital signs, O2 Sats, FSBS (if Diabetic) as needed. Notify Physician and obtain an order for a psychological evaluation. (Utilize the Interact II Guidelines). If the resident makes a suicide gesture or discusses detailed plan, immediately call the MD. Start One to One sitters and notify the DON. Notify and involve family/significant other. Request a family member sit with the resident if possible. Monitor resident closely.<br><br>Any Social Worker, RN, LPN or CNA who did not receive in-service training by 10/21/15 will not be allowed to work until training has been completed. This information has been integrated into the | |

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| F 250 | Continued From page 3<br><br>On 9/30/15 at 5:31 PM, the Director of Nursing stated nursing staff should follow the care path for "Change in Behavior" that stated, in part "Evaluate symptoms and signs for immediate notification that included suicidal ideation and notify physician/ nurse practitioner and/or physician assistant." She stated she expected nursing staff to immediately contact the physician as well as the Director of Nursing immediately when the incident occurs and this should have been done on 6/23/15. | F 250 | standard orientation training for all Social Workers, nurses and CNA's and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br><br>Quality Assurance<br>The Director of Nursing will monitor weekly eight residents by interviewing the residents for psychological concerns, by reviewing the progress notes, and behavior documentation in PCC for the past 30 days to assess for referral needs for psychiatric services. This will be done weekly for one month then monthly times two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, Medical Records, Dietary Manager and the Administrator. | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the | F 278 | | 10/15/15 |

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| F 278 | Continued From page 4<br>assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) for PASRR (Preadmission Screening Resident Review) (Resident #26), medications (Resident #4), falls (Resident #30) and for dentures (Resident #65) for four of fifteen sampled residents. The findings included:<br><br>1. Resident #26 was admitted to the facility 6/5/2008. Cumulative diagnoses included: paranoid schizophrenia and major depressive disorder.<br><br>A review of Resident #26's medical record revealed she was admitted with a level 2 PASRR. | F 278 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>Corrective Action for Resident Affected<br>On 9/30/15, Resident #4, #26, and #30 MDS assessments were reviewed by the | |

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| F 278 | Continued From page 5<br>An Annual MDS dated 7/8/15 was reviewed and stated "No" to question A1500 which asked if Resident #26 was PASRR level 2.<br><br>On 9/29/15 at 4:18PM, an interview was conducted with the social worker. She stated she had been the social worker at the facility for eight years and was told, when she first came to the facility,that Resident #26 was a level 1 PASRR. The social worker stated the facility monitored Resident #26's behaviors in case her behaviors increased to a point that Resident #26 would need to be reassessed. Resident #26 had no significant changes and the social worker stated she was not aware that Resident #26 was a PASRR level 2. The social worker said she called the Division of Medical Assistance today and learned Resident #26 was a PASRR level 2.<br><br>On 9/29/15 at 4:48PM, the MDS Coordinator stated she completed the section A for PASSR and did not know that Resident #26 was a PASRR level 2. She said, if she had known, she would have answered "yes" to question A1500.<br><br>2. Resident #4 was admitted to the facility 10/31/09 and last readmitted on 2/20/13. Cumulative diagnoses included: Alzheimer's disease, schizophrenia and bipolar disorder.<br><br>A Quarterly Minimum Data Set (MDS) dated 9/15/15 indicated Resident #4 received the following medications during the assessment look-back period of seven days--7 days of injections, 7 days of insulin injections, and 7 days of antipsychotic medication.<br><br>A review of the physician's orders for September 2015 revealed, in part, the following medications: | F 278 | MDS coordinator and MDS consultant. All identified issues were recorded correctly on the MDS and a modification was completed by 09/30/15. Resident #65 MDS assessment was reviewed by the MDS Coordinator and all identified issues were recorded correctly and a modification was completed on 10/14/15.<br><br>Corrective Action for Resident Potentially Affected<br>All residents have the potential to be affected by this practice. On 10/11/15, 100% of current resident assessments were reviewed by MDS coordinator for coding accuracy of PASRR, Medications, Dentures, and Falls. No other assessments were identified as erroneous or non-compliant.<br><br>Systemic Changes<br>On 09/29/15, the MDS Coordinator was rein-serviced by the MDS Consultant on accurate coding of the following MDS items to include:<br><br>Section N Medications: MDS Coordinator will refer to the medication administration record for the specified 7 day look back period of the MDS to ensure accurate coding of section N.<br><br>Section L Dentures: MDS Coordinator will physically assess the resident during the 7 day look back period for use/non-use of dental appliances to ensure accurate coding of section L.<br><br>Section J Falls: MDS Coordinator will | |

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| F 278 | Continued From page 6<br>Cymbalta (antidepressant) 60 milligrams daily<br>Lantus insulin 40 units subcutaneous daily<br>Zyprexa (antipsychotic) 15 milligrams every night.<br><br>A review of the September Medication Administration Record for the look-back period of 9/9/15 through 9/15/15 revealed Resident #4 received 7 days of antidepressant medication. The medication was not coded on the MDS.<br><br>On 9/29/15 at 4:57 PM, the MDS Coordinator stated she was the person who completed section N for medications on the MDS. She stated she used the MAR to determine what medications should be coded on the MDS and Cymbalta, the antidepressant medication, should have been coded for 7 days. She indicated she did not know why she did not include that medication on the MDS.<br><br>3. Resident#65 was admitted to facility 6/8/15. Cumulative diagnoses include: acute renal failure on chronic kidney disease stage III, atrial fibrillation, moderate protein-calorie malnutrition, Diabetes Mellitus type II, hypertension, vascular dementia, debility, history of tremor, and history of malignant melanoma.<br>An admission Minimum Data Set (MDS) dated 6/15/15 indicated the resident had no dental problems; his missing teeth/edentulous status was not coded. The Care area assessment (CAA) did not include any documentation of his edentulous status and/or his dentures. His initial care plan of 6/15/15 did not include his dental status.<br>A significant change of status MDS Assessment date 9/8/15 indicated the resident is not coded for | F 278 | review PCC Risk Management reports during resident review period to identify past falls.<br><br>On 09-29-15, Social Worker was in-serviced by the MDS Consultant on obtaining and maintaining proper and accurate PASRR level for all residents and completing the Section A01500 to A01550 on MDS assessments. Social Worker will notify MDS Coordinator of PASRR level changes on all current residents.<br><br>This information has been integrated into the standard orientation training for MDS Coordinators and Social Worker and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br><br>Quality Assurance<br>The MDS Consultant will audit up to three residents MDS for accuracy of section A, N, J, and L. This will be done weekly for one month then monthly for two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate.<br>Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, Medical Records, Dietary Manager and the Administrator. | |

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| F 278 | Continued From page 7<br>being edentulous and/or having dentures. A revised care plan dated 9/18/15 did not include a dental status.<br><br>9/30/15 8:27am an interview with the MDS Coordinator was conducted. The MDS Coordinator stated that she " did not remember if the resident has dentures, but if he did he would not be a good candidate for keeping him because I do not know how we could get them in and out. I don ' t think he would let us put them in, and if he did I would be afraid of a choking issue with him " . The MDS Coordinator verified that she had completed the MDS dated 6/15/15 and 9/8/15, to include section L. She stated that she was the " only one who updates the care plans " . | F 278 | | |

4. Resident #30 was admitted to the facility on 9/3/15 with multiple diagnoses including hip replacement. The 5 day Minimum Data Set (MDS) assessment dated 9/9/15 indicated that Resident had no falls since admission/entry or reentry.

The nurse's notes and incident report were reviewed. The notes and incident report indicated that Resident #30 was found on the floor on 9/5/15 at 11:00 PM. He received new skin tear to the right elbow and a small pink abrasion to the right forehead.

On 9/30/15 at 2:30 PM, MDS Nurse was interviewed. She reviewed the records and

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| F 278 | Continued From page 8<br>agreed that Resident #30 had a fall on 9/5/15 and should have been coded on the 5 day assessment but it was not. | F 278 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to correctly transcribe a laxative/stool softener (medication used to relieve constipation) ordered by the physician, to the Medication Administration Record (MAR) for 1 of 5 sampled residents (Resident #65) reviewed for unnecessary medications. Finding included:<br><br>Resident #65 was admitted to the facility on 6/8/15 with multiple diagnoses including constipation. The significant change in status Minimum Data Set (MDS) assessment dated 9/8/15 indicated that Resident #65 had severe cognitive impairment.<br>Review of the physician's orders revealed that on 8/31/15, Resident #65 had an order for Senokot S (a combination drug of laxative and stool softener) two tablets by mouth at bedtime for bowel regimen.<br>The MAR for September, 2015 was reviewed. The medications listed on the electronic MAR included Senna or Senokot (a laxative drug) and not Senna S or Senokot S as ordered.<br>On 9/30/15 at 4:30 PM, administrative staff #1 was interviewed regarding the transcription error. She indicated that she would review the records | F 281 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>Corrective Action for Resident Affected<br>On 9/29/15, the hall nurse contacted the MD regarding a written telephone order for Senokot-S as it had been transcribed into PCC incorrectly as Senokot (no S). MD clarified and approved order for Senokot (no S) as its use had been effective.<br><br>Corrective Action for Resident Potentially Affected<br>All residents have the potential to be affected by this practice. Beginning on | 10/26/15 |

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| F 281 | Continued From page 9<br>and would get back with me.<br>On 10/1/15 at 8:30 AM, administrative staff #1 was again interviewed. She stated that she was able to talk to the nurse who transcribed the order for the Senokot S on 9/30/15. She indicated that the nurse admitted that she transcribed the Senokot S incorrectly to the MAR. Administrative staff #1 stated that the physician was informed of the error on 9/30/15 and a clarification order was written. She added that she educated the nurse to check the electronic physician order three times before hitting the enter button on the computer. | F 281 | 10/06/15, all current resident orders for the past 30 days will be audited by hall nurse and charge nurse to ensure orders were correctly transcribed into PCC. This audit will be completed by 10/23/15.<br><br>Systemic Changes<br>On 10/06/15, RN supervisor and DON in-serviced all RN's, LPN's full-time, part-time and PRN. Nurses must complete in-service prior to returning to work.<br><br>Procedure for Processing Telephone and Verbal Orders:<br>Nurses will use QA log to document any telephone orders. They will enter them into the computer. Communication method should be "telephone". Complete the entire order and save. If the physician is different than the one listed. Use the magnifying glass to find the other physician. If the physician is not listed use the attending physician and type the doctor who gave the order in additional directions. Save the orders. Print the telephone order sheets. They will still fax to pharmacy. The order sheet will be put in Medical Records for physician signature and filing. Put the duplicate in the chart (or notebook) and put the original in Medical Records box for signatures.<br><br>Procedure for Processing Provider Written Orders:<br>There will be an order notebook at each hall. All patients will be written on one sheet. The yellow copy will be maintained for QA purposes. The white copy will be | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| INN AT QUAIL HAVEN VILLAGE | 155 BLAKE BOULEVARD PINEHURST, NC 28374 |

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| F 281 | Continued From page 10 | F 281 | faxed to pharmacy and used to key in the orders. When keying in the order make sure to use communication method of "prescriber written". Once keyed into the system the nurse will not print the telephone order sheet. The white copy will be given to Medical Records for putting it in the correct patient's chart. The only orders that will not be keyed in by nursing will be the therapy orders. They will continue to write them for now. Orders for admission and readmission will also be processed by nursing.<br><br>Any RN or LPN who did not receive in-service training by 10/21/15 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all RN's and LPN's and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br><br>Quality Assurance<br>The Director of Nursing will audit a combination of ten verbal and written orders for accuracy into PCC. This will be done weekly for one month then monthly times two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, | |

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| F 281 | Continued From page 11 | F 281 | Medical Records, Dietary Manager and the Administrator. | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to obtain ordered laboratory work for thyroid function studies for one of six residents reviewed for unnecessary medications (Resident #26).. The findings included: | F 329 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State | 10/26/15 |

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| F 329 | Continued From page 12<br><br>Resident #26 was admitted to facility 6/5/2008. Cumulative diagnoses included hypothyroidism.<br><br>A review of the physician's orders for September 2015 revealed an order for Synthroid (medication for treatment for hypothyroidism) 50 micrograms by mouth daily. The physician orders also stated to obtain a free T4, TSH annually every May.<br><br>A review of Resident #26's medical record revealed no laboratory results for freeT4, TSH for 2015.<br><br>On 9/30/15 at 10:22AM, Administrative staff #1 stated the lab work for the free T4,TSH was not done in May due to the fact medical records was going from paper to electronic and it was written in an incorrect way so it did not trigger on the nurse dashboard to obtain the lab. She stated the last lab work for free T4, TSH was completed on 6/13/14 and the results were T4-8.23 and TSH-3.25 (both within normal limits). Administrative staff #1 stated she expected nursing staff to obtain lab work as ordered by the physician.<br><br>On 9/30/15 at 2:45PM, an interview was conducted with the Nurse Practitioner. She stated she was not aware the lab work for the thyroid studies had not been done. She stated she expected staff to follow physician orders and obtain labs when ordered. | F 329 | Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>Corrective Action for Resident Affected<br>On 09/30/15, Director of Nurses reviewed lab orders for Resident #26. Identified missing lab results for Free T4 & TSH, order noted to be completed in May annually. The hall nurse obtained a new MD order for Free T4 & TSH annually in October. The lab was ordered on 09-30-15 and results were received on 10-01-15.<br><br>On 10/5/15, Resident #26 medical record was audited by Medical Records to ensure all labs ordered by MD since January 2015 were reconciled. No other labs found to be missing.<br><br>Corrective Action for Resident Potentially Affected<br>All residents have the potential to be affected by this practice. On 10/09/15, Medical Records began auditing 100% of current resident charts back to January 2015 for missing lab results. This was completed on 10/12/15. One resident was identified as having labs ordered and completed, but no lab results received prior to resident discharge on 10/19/15; hall nurse notified MD on 10/21/15.<br><br>On 9/30/15, floor nurse and charge nurse | |

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| F 329 | Continued From page 13 | F 329 | audited 100% of all current, active residents' lab orders in PCC back to September 2015 to ensure proper input. No other concerns were identified.<br><br>Systemic Changes<br>On 10/6/15, RN supervisor in-serviced all full time, part time and PRN RN's and LPN's on:<br><br>How to complete monthly MAR checks and identifying necessary labs.<br>How to process labs identified on monthly MAR check and how to process labs slips and adding it to the lab calendar.<br>How to input lab orders into PCC so that lab work ordered is triggered on MAR for nurse on duty.<br>Procedure for night shift nurses for reviewing all lab orders and to ensure lab slips are completed for labs the following day.<br>Procedure for ADON/charge nurse to collect orders and take it to the clinical meeting where they will be reviewed for compliance or follow-up<br>On 10/5/15, Medical Records in-serviced by Director of Nursing on how to complete 100% audits on all current medical records using the monthly orders and Lab Orders Report in PCC.<br><br>Any RN or LPN who did not receive in-service training by 10/21/15 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all RN's, LPN's, and Medical Records and will be reviewed by the | |

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| F 329 | Continued From page 14 | F 329 | Quality Assurance Process to verify that the change has been sustained.<br><br>Quality Assurance<br>Medical Records will be responsible for auditing (10) medical records listed on PCC monthly orders tab against lab orders report to ensure that all labs ordered were drawn and results were on file. This will be done weekly for one month then monthly times two months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy, Medical Records, Dietary Manager and the Administrator. | |