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	345149	A. BUILDING _____ B. WING _____	C 10/08/2015

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BRIAN CTR HEALTH & RETIREMENT	**4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106**

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F 000	INITIAL COMMENTS The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted a recertification and complaint investigation survey on October 4, 2015 through October 8, 2015. During the survey, it was determined that the facility provided substandard quality of care at the immediate jeopardy level at F333. The survey team also identified immediate jeopardy at F428 and F520. The immediate jeopardy began on 8/18/15 and was removed 10/8/15.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156		11/6/15

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

Electronically Signed | 11/12/2015

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F 156	Continued From page 1	F 156		

inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide Notice of Medicare Non-Coverage letter to 3 of 3 residents prior to the 48 hour requirement. (Residents # 9, #13, #80) Findings included: Resident #9 was admitted on 2/4/15 and discharged on 3/20/15. The non-coverage letter was signed on, 3/19/15 coverage ended on 3/18/15. Resident # 13 was admitted on 6/19/15 and discharged on 8/14/15. The non-coverage letter was signed on 8/14/15, coverage ended on 8/13/15. Resident #80 was admitted on 4/8/15 and discharged on 4/8/15. The non-coverage letter was not signed coverage ended on 4/17/15. During interview on 10/8/15 at 12:50 pm, the business office manager indicated she was responsible to get the letters signed. Residents	F 156	F 156 1. Residents #9 was discharged from the facility on 10/1/15, #13 was discharged from the facility on 10/1/15, and #80 was discharged from the facility on 4/21/15. 2. Residents requiring notification of Medicare Non-Coverage have the potential to be affected by this alleged deficient practice. The Business Office Manager completed an audit on 10/26/15 to ensure that all current residents requiring a Medicare Non-Coverage Notice have been notified with-in the required 48 hour timeframe. Opportunities were corrected by the Business Office Manager as identified during this audit.	

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F 156	Continued From page 3 received the non-coverage letters a week before coverage ends. During interview on 10/8/15 at 1:43 pm, the administrator indicated during the morning meeting the resident ' s discharge dates were shared. The business office manager provided the non-coverage letter for signature to the resident or the responsible party up to a week before discharge. The letters were sent via certified mail to responsible parties that weren ' t signed in the facility. The non-coverage letters were required to be provided 48 hours before the end of coverage date. After review of the non-coverage letters for residents #9, #13 and #80 he had no further comment.	F 156	3. The Business Office Manager was re-educated regarding the notification of Medicare Non-Coverage requirements by the District Director of Business Office on 10/12/15. The Business Office Manager will be responsible for completing the Medicare Non-Coverage Letters within the 48 hour timeframe going forward. The Administrator and the Business Office Manager will audit 3 residents discontinuing services for 12 weeks to ensure the notification of Medicare Non-Coverage letters are complete within the 48 hour timeframe. The results of these audits will be documented on the monitoring tool. Opportunities will be corrected by the Business Office Manager daily as identified during these audits. 4. The results of these audits will be reported to the monthly QAPI meeting by the Business Office Manager and the committee will make recommendations for further action as needed.	
F 333 SS=J	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interviews, the facility failed to accurately transcribe a physician's order resulting in a significant medication error for 1 of 3 sampled residents receiving Coumadin (Resident	F 333	F333 1. A Medication Variance Report was completed by the Director of Nursing on 10/6/15 regarding Coumadin for Resident #64. Resident #64 and the Physician	11/6/15

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F 333	Continued From page 4 #64), an oral anticoagulant medication. Immediate Jeopardy began on 8/18/15. At that time, Resident #64 re-entered the facility after a short hospital stay. Upon his return to the facility, Coumadin was omitted during the reconciliation and transcription of orders from the hospital discharge medication list. Resident #64 had been on chronic anticoagulation due to a history of pulmonary embolism. At the time of the survey investigation, the omission of Coumadin had not yet been identified by the facility. Immediate Jeopardy was removed on 10/8/15 at 7:15 PM. The facility remained out of compliance at a lower scope and severity of (D), an isolated deficiency with potential for more than minimal harm, while the facility completed the staff training required. The facility was in the process of monitoring the implementation of their correction action. The findings included: Resident #64 was admitted to the facility on 8/6/15 from an acute care hospital. His cumulative diagnoses included chronic anticoagulation due to a history of pulmonary embolism in 2008 and morbid obesity. A review of the 8/6/15 admission orders for Resident #64 included 14 milligrams (mg) Coumadin given by mouth once daily. A review of Resident #64 ' s medical record included the following Physician ' s Notes which read, in part: 8/10/15 (Authored by the Nurse Practitioner or NP): PLAN: " Pulmonary embolism and infarction, other continue Coumadin as ordered, adjust	F 333	were notified of the Medication Variance Report by the Unit Manager on 10/6/15 and new orders were received for Resident #64 to begin Coumadin 14 mg daily and PT INR ordered for 10/7/15. A Skilled Nursing assessment was completed on 10/6/15 with no change in condition noted. Resident #64 is planning to discharge from the facility on 10/8/15 and Home Health has been arranged by the Director of Nursing to include PT INR monitoring. Resident #64 will receive medication as part of the orders for home health, including teaching and assessments, INR testing and education of resident utilizing own coagulant check machine and verification of accurate usage. 2. 100% of all resident records were audited by the Director of Nursing, Assistant Director of Nursing, and Unit Manager for significant medications as well as all medication transcriptions in order to validate accurate transcription of physician□s orders including hospital admission and readmission orders, 2 residents were identified as currently receiving Coumadin. There were no variances in the auditing process with all audits collected and readily available to be viewed. These resident records were audited by the Director of Nursing, Assistant Director of Nursing, or Unit Manager to validate accurate transcription of orders for Coumadin as well as any significant medication upon admission. The process forthcoming will be a two (2)	

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F 333	Continued From page 5 dosage based on INR (International Normalized Ratio) results, goal 2-3, monitor PT (prothrombin time)/INR weekly. " 8/12/15 (Authored by the Medical Doctor or MD): History of Present Illness (HPI): " Cellulitis: The patient developed painful red rash behind his right knee. He was on Coumadin. He was placed on IV Abs (intravenous antibiotics) and transitioned to POs (oral medications). He is here for rehab (rehabilitation) and continued chronic disease management. PTE (pulmonary thrombotic embolism) in 2008 and placed on lifelong Coumadin. " PLAN: " Personal history of pulmonary embolism. Will monitor. No change in current treatment plan. " A review of the Resident #64 ' s Admission MDS dated 8/13/15 revealed the resident had intact cognitive skills for daily decision making. He required extensive assistance with all Activities of Daily Living (ADLs) with the exception of supervision with eating. The assessment indicated Resident #64 received an anticoagulant on 7 of 7 days during the look back period. A review of the resident ' s 8/13/15 Care Area Assessments included the topic of Circulatory/Heart and a notation which read, ..."History of PE in 2008 on chronic anticoagulation...." Resident #64 ' s Care Plan dated 8/13/15 included an area of focus entitled Bleeding Risk. The Care Plan problem addressed the resident ' s risk for increased bleeding, bruising or injury related to the use of anticoagulant therapy and noted the resident was receiving Coumadin.	F 333	nurse-nurse check of all admission orders as well as readmission orders. The audit was completed on Tuesday 10/6/15. This process will continue the medical record audit weekly by the DON, ADON and/or Unit Manager with two person nurse to nurse check of orders validating accuracy and timeliness. 3. Beginning on 10/6/15 Licensed Nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing or Unit Manager regarding transcription of physician□s orders. No Licensed Nurse shall work after 10/6/15 without receiving this re-education. Beginning on 10/6/15, newly hired Licensed Nurses will be educated, prior to beginning work in the resident care area, by the Director of Nursing, Assistant Director of Nursing as well as pharmacy manager, regarding transcription of physician□s orders. Education regarding transcription of orders will include the review of the physician□s orders received from the hospital by the Physician or Nurse Practitioner to confirm and then these orders will be transcribed by the Charge Nurse to the Medication Administration Record. This will be completed daily with two person nurse check. All transcription orders reviewed in clinical meeting each morning with chart to clinical meeting and validation of two nurse signatures/initials ensuring accuracy and completion.	

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F 333	Continued From page 6 Further review of Resident #64 ' s medical record revealed laboratory results were collected and reported on 8/14/15. The lab work included an INR = 5.35. This value was noted as a critical result. Review of the resident ' s medical record revealed a Physician Orders was received on 8/14/15 which instructed, " DC (discontinue) current Coumadin. PT/INR on 8/15/15. " A review of Resident #64 ' s August 2015 Medication Administration Record (MAR) revealed the Coumadin was highlighted in yellow with a handwritten note which read, " D/C ' d (discontinued) 8/14/15. " Additional laboratory results were collected and reported on 8/15/15 as ordered. The lab work included an INR=5.94. A notation was hand-written on the lab report which read, " Recheck PT/INR on 8/17/15. " On 8/15/15, a Physician Order was received for a PT/INR to be completed on 8/17/15. A review of the Nursing Progress notes written on 8/16/15 at 5:25 PM revealed Resident #64 appeared to experience a change in behavior. The Nurse Practitioner was notified by telephone and a Physician ' s Order was received to send Resident #64 to the hospital Emergency Room (ER) for evaluation and treatment. A review of the Nursing Progress notes for Resident #64 included the following notation: 8/16/15 at 6:15 PM: " EMT (Emergency Medical Team) arrived to the facility to take the Resident	F 333	The Director of Nursing or the Assistant Director of Nursing will be responsible for reviewing these orders daily as part of the medication reconciliation to validate accurate transcription completed by the Charge Nurse. The Director of Nursing, will review at clinical meeting all new admissions as well as re-admissions for accuracy and chart will be brought to the clinical meeting for Nurse to Nurse review and IDT review at clinical meeting. The Director of Nursing, Assistant Director of Nursing, and Unit Manager will be aware of admissions and re-admissions from the hospital through the admission process which includes acceptance of a referral by the Director of Nursing, receipt of discharge orders and discharge summary, including medications from hospital, faxing or giving a copy to the physician and/or nurse practitioner for acceptance and verification of physician and/or nurse practitioner's approval. Upon receipt of orders faxed back to the facility, the orders will be then faxed over to pharmacy to be filled and brought to the facility. The Medication Administration record will be hand written and then checked for accuracy by a second nurse. These audits will be conducted daily for 30 days then 5 times per week for 8 weeks. Audits will be documented on the monitoring tool and opportunities will be corrected immediately by the Director of Nursing or Assistant Director of Nursing as identified during these audits. 4. Measures to ensure that corrections are achieved & sustained include:	

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F 333	Continued From page 7 to the ER and the resident refused to go to the ER. The resident states he feels fine and he hates to go to the hospital. EMT talked with resident and evaluated him. Resident still refuses to go to the ER. Notified resident emergency contact that he refused. " On 8/17/15, laboratory results were collected and reported as ordered by the physician. The resident ' s INR=2.28. A notation hand-written dated 8/18/15 was written on the lab report which read, " Hospital. " A review of the resident ' s Nursing Progress notes included the following, in part: 8/17/15 at 7:00 PM: ... ' Resident ' s sister told the resident that she felt he should go to the ER to be evaluated. The resident told this nurse that he wanted to go to the ER. This nurse called the on-call NP and received NO (new order) to send resident to the ER for eval (evaluation) and treat (treatment) ... " 8/17/15 at 7:30 PM: " Resident left the facility via stretcher and 2 EMT attendants. " Resident #64 was admitted to the hospital on 8/17/15 at 8:35 PM with an altered mental status. He was discharged back to the facility on 8/18/15. A review of the resident ' s 8/18/15 Hospital Records included the following, in part: Assessment and Plan: " 2. History of PE in 2008, on chronic anticoagulation with warfarin (Coumadin) at 14 mg per day based on the previous discharge. We will continue the patient on the Coumadin at 14 mg, check the daily PT/INRs. Today, the INR is 1.83. We will follow up the daily INR on the	F 333	The results of these audits and observations will be presented by the Director of Nursing weekly for 4 weeks, then monthly for 3 months at Facility Quality Assurance Performance Improvement Committee Meeting. During the weekly and monthly QAPI Committee meetings the Director of Nursing will present the information obtained via the audits and observations. The committee will amend the plan based on identified audit trends. These amendments will be implemented immediately following the meeting, to include progressive discipline, re-education and additional monitoring to address opportunities as identified weekly for 4 weeks then monthly for 3 months.	

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patient and increase the dose, or titrate the dose, to an INR of 2-3. "

Resident #64 returned to the facility on 8/18/15. A review of the hospital ' s Discharge Medication list dated 8/18/15 instructed the resident to " Continue these medications which have not changed, " and included 14 mg Coumadin given once daily within this list of medications. The Discharge Medication list was signed by the NP and included a hand-written notation which read: " Check PT/INR weekly. "

A review of Resident #64 ' s August 2015 MAR revealed Coumadin was not included among the medications listed as ordered upon the resident ' s return from the hospital on 8/18/15. The medical record revealed no orders had been transcribed for either the Coumadin or the weekly PT/INR checks on this date.

A review of Resident #64 ' s medical record included the following Physician ' s Notes which read, in part:
9/7/15 (Authored by the MD):
HPI: " PTE in 2008 and placed on lifelong Coumadin. "
Plan: " Personal history of pulmonary embolism: Will monitor. No change in current treatment plan. "

A review of Resident #64 ' s September 2015 and October 2015 MARs revealed Coumadin was not listed as a medication ordered or administered to the resident.

A telephone interview was conducted on 10/6/15 at 8:17 AM with the resident ' s MD at the facility. After a review of the resident ' s history and stay

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at the facility, the physician acknowledged there was a failure to re-initiate Coumadin upon his return from the hospital on 8/18/15. The MD stated the omission was likely due to a transcription error at the facility. Upon inquiry, the MD reported he had thought the resident was still on Coumadin to date and stated, " The doctors before me recommended lifelong Coumadin and I did not mess with it. "

On 10/6/15, a Physician ' s Telephone Order was received from the resident ' s MD to re-initiate 14 mg Coumadin given once daily and to check his INR on 10/7/15.

On 10/6/15 at 10:00 AM, an interview was conducted with Resident #64. During the interview, the resident stated when he came back from the hospital on 8/18/15 there was a problem with some of his medications, including Coumadin. However, he reported the problem had been resolved and all of his medications were re-started. When asked specifically about his Coumadin, the resident stated he had a PE in 2008 and expected to be on Coumadin his entire life. The resident indicated he thought he was currently receiving Coumadin at the facility.

An interview was conducted on 10/6/15 at 10:05 AM with Nurse #2. Nurse #2 assumed responsibilities as a Unit Coordinator for the facility. During the interview, the process followed for obtaining and transcribing re-admission orders for a resident returning to the facility from a hospital was discussed. Nurse #2 reported if the resident returning to the facility had been out to the hospital for less than 24-hours, the staff would not need to do a full admission upon his/her return. However, she stated the hospital may still

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have sent admission orders back to the facility for the resident and the nurse would then need to transcribe those orders. Upon inquiry, the Unit Coordinator stated that the nurse who admitted the resident back to the facility (the hall nurse) would be responsible for completing this task. Upon review of Resident #64 ' s medical record, the Unit Coordinator identified Nurse #6 as the nurse who was on duty at the time the resident came back into the facility on 8/18/15. Upon further inquiry, the Unit Coordinator reviewed Resident #64 ' s chart and acknowledged the signed Discharge Medication list from the hospital dated 8/18/15 was intended to serve as the medication orders for the resident upon return to the facility.

On 10/6/15 at 10:24 AM, Nurse #2 was joined by the Assistant Director of Nursing (ADON). At that time, both nurses reviewed Resident #64 ' s medical records, including his hospital discharge records, Nursing Progress notes, physician orders, and MARs. An interview was conducted with the ADON on 10/6/15 at 10:30 AM. When asked, the ADON stated her expectation would have been for the physician ' s order for Coumadin to have been verified by the nurse when the resident returned to the facility on 8/18/15. She indicated the admission package from the hospital needed to be gone through thoroughly and any new orders transcribed and put on the MAR. The ADON said, " The new order should have been transcribed, " and specifically reported the Coumadin should have been re-initiated upon the resident ' s return to the facility on 8/18/15. When asked what needed to be done now, the ADON stated the facility had received a Physician ' s Order earlier that morning to restart the resident ' s Coumadin (14

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mg given once daily) and for a PT/INR. The ADON indicated she would need to inform the resident of the Coumadin omission which occurred upon his return from the hospital on 8/18/15.

On 10/06/15 at 12:12 PM, the facility ' s Administrator and Director of Nursing (DON) requested an interview to discuss the omission of Coumadin for Resident #64 ' s upon his return from hospital on 8/18/15. During the interview, the Administrator stated, " We realize this is a serious error. We had a system in place but we need to dig deeper now. " Upon inquiry, the Administrator clarified the facility ' s process for resident admissions/re-admissions would need to be adjusted.

A telephone interview was conducted on 10/6/15 at 12:14 PM with Nurse #6. Nurse #6 was the staff nurse assigned to care for Resident #64 when he returned from the hospital on 8/18/15. The nurse reported she " vaguely " recalled accepting Resident #64 back from the hospital on that date and was unable to recall specifics related to the 8/18/15 readmission. Upon inquiry, the nurse discussed the general process employed to accept a resident back from a 24-hour hospital readmission. Nurse #6 reported when a resident came back from the hospital, she would take report from the hospital and review the paper work from EMS (Emergency Medical Service) to be sure there were no new orders for the resident. Upon inquiry, the nurse stated if there was a new medication order, the nurse would need to ensure it was written on the resident ' s MAR.

A follow-up interview was conducted with

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Resident #64 on 10/7/15 at 9:00 AM. During the interview, the resident reported he was angry and disappointed about the situation. He indicated he was afraid the omission of Coumadin back in August and its re-initiation on 10/6/15 would postpone his anticipated discharge. The resident was scheduled to be discharged from the facility on 10/8/15.

An interview was conducted on 10/7/15 at 2:30 PM with the DON. Upon inquiry, the DON reported a breakdown in the facility ' s process occurred after the hospital Discharge Medication list was faxed to the physician ' s office for verification. He indicated the medication list was signed but the order written for Resident #64 ' s Coumadin did not get transcribed into the resident ' s medical record or onto the MAR. During the interview, the DON also discussed the facility ' s process for reviewing or double-checking any new medication orders written for a resident. The DON reported he routinely completed a review of the Nursing 24-Hour Report, made notes on it, and gave it to the Unit Manager or staff nurse to follow-up and audit the chart as an accuracy check. On 8/19/15, the DON reported Nurse #8 was assigned to audit Resident #64 ' s re-admission orders on the chart. Apparently, the omission of Coumadin was not identified during this follow-up audit. He reported Nurse #8 was no longer employed by the facility; and, no contact information was available to reach Nurse #8 for an interview. Upon inquiry, the DON stated his expectation was that the staff would be educated on how to follow through the facility ' s process for accurately obtaining and transcribing medication orders.

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The facility ' s Administrator was notified of the Immediate Jeopardy on 10/6/15 at 3:30 PM. The following credible allegation of compliance was received on 10/8/15 at 3:39 PM:

1. A Medication Variance Report was completed by the Director of Nursing on 10/6/15 regarding Coumadin for Resident #64. Resident #64 and the Physician were notified of the Medication Variance Report by the Unit Manager on 10/6/15 and new orders were received for Resident #64 to begin Coumadin 14 mg daily and PT INR ordered for 10/7/15. A Skilled Nursing assessment was completed on 10/6/15 with no change in condition noted. Resident #64 is planning to discharge from the facility on 10/8/15 and Home Health has been arranged by the Director of Nursing to include PT INR monitoring. Resident #64 will receive medication as part of the orders for home health, including teaching and assessments, INR testing and education of resident utilizing own coagulant check machine and verification of accurate usage.

2. 100% of all resident records were audited by the Director of Nursing, Assistant Director of Nursing, and Unit Manager for significant medications as well as all medication transcriptions in order to validate accurate transcription of physician ' s orders including hospital admission and readmission orders, 2 residents were identified as currently receiving Coumadin. There were no variances in the auditing process with all audits collected and readily available to be viewed. These resident records were audited by the Director of Nursing, Assistant Director of Nursing, or Unit Manager to validate accurate transcription of orders for

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Coumadin as well as any significant medication upon admission. The process forthcoming will be a two (2) nurse-nurse check of all admission orders as well as readmission orders. The audit was completed on Tuesday 10/6/15. This process will continue the medical record audit weekly by the DON, ADON, and/or Unit Manager with two person nurse to nurse check of orders validating accuracy and timeliness.

3. Beginning on 10/6/15 Licensed Nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing or Unit Manager regarding transcription of physician ' s orders. No Licensed Nurse shall work after 10/6/15 without receiving this re-education.

Beginning on 10/6/15, newly hired Licensed Nurses will be educated, prior to beginning work in the resident care area, by the Director of Nursing, Assistance Director of Nursing as well as pharmacy manager, regarding transcription of physician ' s orders.

Education regarding transcription of orders will include the review of the physician ' s orders received from the hospital by the Physician or Nurse Practitioner to confirm and then these orders will be transcribed by the Charge Nurse to the Medication Administration Record. This will be completed daily with two person nurse check. All transcription orders reviewed in clinical meeting each morning with chart to clinical meeting and validation of two nurse signatures/initials ensuring accuracy and completion.

The Director of Nursing or the Assistant Director of Nursing will be responsible for reviewing these

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F 333	Continued From page 15 orders daily as part of the medication reconciliation to validate accurate transcription completed by the Charge Nurse. The Director of Nursing will review at clinical meeting all new admissions as well as re-admissions for accuracy and chart will be brought to the clinical meeting for Nurse to Nurse review and IDT review at clinical meeting. The Director of Nursing, Assistant Director of Nursing, and Unit Manager will be aware of admissions and re-admissions from the hospital through the admission process which includes acceptance of a referral by the Director of Nursing, receipt of discharge orders and discharge summary, including medications from hospital, faxing or giving a copy to the physician and/or nurse practitioner for acceptance and verification of physician and/or nurse practitioner ' s approval. Upon receipt of orders faxed back to the facility, the orders will be then faxed over to pharmacy to be filled and brought to the facility. The Medication Administration record will be hand written and then checked for accuracy by a second nurse. On 10/8/15 at 7:15 PM, the credible allegation of compliance was validated. The survey team confirmed orders for the Coumadin management and monitoring with Home Health were in place; the facility implemented an auditing process to validate accurate transcription of hospital admission and readmission physician orders; and, had educated nursing staff on a two (2) nurse-nurse check of all admission and readmission orders.	F 333		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on	F 356		11/6/15

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F 356	Continued From page 16 a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to indicate the resident census on the daily nursing services staff posting for various dates for 6 months, which included May 2015 through October 8, 2015. The findings included: During the initial tour of the facility on 10/4/15 at	F 356	F 356 1. The Facility Staffing including the Census was posted on 10/7/15 by the Administrator and daily there after. 2. All residents have potential to be	

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F 356	Continued From page 17 3:00pm, the Long Term Care unit ' s daily staff posting was observed located on the wall outside the dining area. The Resident census was noted to be 30 on this floor. Surveyor reviewed documentation for daily nursing staff posting for six months which included May 2015 through October 8, 2015. This review revealed the resident census data were not indicated each day on the daily staff posting as follows: · May 2015 had missing census data 20 of 31 days. · June 2015 had missing census data 16 of 30 days. · July 2015 had missing census data 10 of 31 days. · August 2015 had missing census data 18 of 31 days. · September 2015 had missing data 17 of 30 days and · October 2015 had missing data 1 of 8 days. An interview was conducted with the Assistant Director of Nursing (ADON) on 10/6/15 at 4:00pm, she stated that she was responsible for completing the daily staff posting for the assisted living unit and the long term care units. The ADON further stated that she had received conflicting information regarding whether the resident census data was required or not on the staff posting, and indicated that she had been including the census information, except when she was told that she did not have to. During an interview with the Director of Nursing (DON) on 10/6/15 at 4:55pm, he stated that he began working at the facility on 8/11/15 and had noted fragmentation of the census data. He has made changes to correct the staff posting. The census will be on every staffing sheet forth	F 356	affected by this alleged deficient practice. 3. The Assistant Director of Nursing was re-educated by the Director of Nursing regarding the daily staffing posting requirements and maintenance and filing of these records on 10/12/15. The Assistant Director of Nursing will be responsible for the daily staffing posting. The Administrator or Director of Nursing will audit the daily staffing posting daily for 7 days, then 3 times per week for 3 weeks, then weekly for 8 weeks to ensure the posting is timely and accurately documents the resident census. These audits will be documented on the monitoring tool. Corrections will be made immediately by the Administrator or Director of Nursing as identified during these audits. 4. The results of these audits will be reported to the monthly QAPI meeting by the Administrator and the committee will make recommendations for further action as needed.	

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F 356	Continued From page 18 coming, so that per patient day (PPD) and patient ratio can be identified for quality of care.	F 356		
F 428 SS=J	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, consultant pharmacist and physician interviews, the consultant pharmacist failed to report an irregularity related to medication order transcription and the omission of Coumadin (an oral anticoagulation medication) prescribed for 1 of 3 residents reviewed receiving an anticoagulant (Resident #64). Immediate Jeopardy began on 8/18/15. Resident #64 re-entered the facility on 8/18/15 after a short hospital stay. Upon his return to the facility, Coumadin was omitted during the reconciliation and transcription of orders from the hospital discharge medication list. A Medication Regimen Review (MRR) completed by the consultant pharmacist on 9/11/15 failed to identify the transcription error and omission of Coumadin. Immediate Jeopardy was removed on 10/8/15 at	F 428	F428 1. A Medication Variance Report was completed by the Director of Nursing on 10/6/15 regarding Coumadin for Resident #64. Resident #64 and the Physician were notified of the Medication Variance Report by the Unit Manager on 10/6/15 and new orders were received for resident #64 to begin Coumadin 14 mg daily and PT INR ordered for 10/7/15. A Skilled Nursing assessment was completed on 10/6/15 with no change in condition noted. Resident # is planning to discharge from the facility on 10/8/15 and Home Health has been arranged by the Director of Nursing to include PT INR monitoring. The Pharmacy consultant completed a review on 10/7/15 which outlines the events resulted in the Coumadin	11/6/15

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F 428	Continued From page 19 7:15 PM. The facility remained out of compliance at a lower scope and severity of (D), an isolated deficiency with potential for more than minimal harm. The facility was in the process of monitoring the implementation of their correction action. The findings included: A review of the facility ' s Pharmacy Consultant Agreement (Effective 4/1/2003) included a listing of consultant pharmacist ' s services which included, in part: "Consultant shall perform monthly drug regimen reviews (also known as a Medication Regimen Review) and provide written reports of these reviews to the facility Administrator, Medical Director, Director of Nursing, and all residents' physicians. Such written reports must include a standardized monthly report (a form of which will be provided to consultant). The standardized monthly report will include documentation of compliance with federal regulations and guidelines, the outcome of a drug regimen review (e.g., review of unnecessary drug requirements, psychoactive drug use and compliance, medication laboratory orders, adverse drug reactions, interactions and allergies) and a review of drug interventions which may be or were recommended to physicians." Resident #64 was admitted to the facility on 8/6/15 from an acute care hospital. His cumulative diagnoses included chronic anticoagulation due to a history of pulmonary embolism in 2008 and morbid obesity. A review of the 8/6/15 admission orders for Resident #64 included 14 milligrams (mg)	F 428	medication variance for Resident #64. The review record was faxed to the pharmacy manager at the provider company for his review and was re-faxed back to the facility with the pharmacy manager signature. 2. Current records for residents receiving Coumadin and significant medications will be audited by the Director of Nursing and the Consultant Pharmacist weekly to validate the completion of pharmacist review and recommendations regarding Coumadin and significant medication administration. This audit will be completed on 10/7/15. The Pharmacy Consultant□s report was reviewed for accuracy by the Pharmacy Manager on 10/8/15 via faxsimile. 3. On 10/7/15 the Consultant Pharmacist was be re-educated by the District Director of Clinical Services regarding the requirements of F428, to include the review of residents receiving Coumadin and recommendations for monitoring. The facility investigation revealed that both the nurse and the pharmacy consultant did not discover the transcription error. The medication from the hospital have been compared and reviewed with the current medications with no changes noted. In investigating the process, it was discovered that the nurse as well as the pharmacy consultant had not noted the transcription error. The pharmacy consultant will review medications from the hospital as well as the current medications in the facility.	

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F 428	Continued From page 20 Coumadin given by mouth once daily. A review of Resident #64 ' s medical record included the following Physician ' s Notes which read, in part: 8/10/15 (Authored by the Nurse Practitioner or NP): PLAN: " Pulmonary embolism and infarction, other continue Coumadin as ordered, adjust dosage based on INR (International Normalized Ratio) results, goal 2-3, monitor PT (prothrombin time)/INR weekly. " 8/12/15 (Authored by the Medical Doctor or MD): History of Present Illness (HPI): " Cellulitis: The patient developed painful red rash behind his right knee. He was on Coumadin. He was placed on IV Abs (intravenous antibiotics) and transitioned to POs (oral medications). He is here for rehab (rehabilitation) and continued chronic disease management. PTE (pulmonary thrombotic embolism) in 2008 and placed on lifelong Coumadin. " PLAN: " Personal history of pulmonary embolism. Will monitor. No change in current treatment plan. " Further review of the resident ' s medical record revealed the facility ' s consultant pharmacist completed an initial Medication Regimen Review (MRR) on 8/13/15. The review included a notation to check Resident #64 ' s INR. Further review of Resident #64 ' s medical record revealed laboratory results were collected and reported on 8/14/15. The lab work included an INR = 5.35. This value was noted as a critical result.	F 428	Beginning on 10/7/15, newly hired Pharmacy Consultants will be educated prior to beginning work in the resident care area, by the Director of Nursing and the pharmacy manager regarding the requirement of F428, to include the review of residents receiving Coumadin and recommendations for monitoring current medications and hospital information. The new pharmacy consultants will be educated by the facility Director of Nursing and/or designee as well as the pharmacy manager at the pharmacy provider office which will include review of hospital information. The Director of Nursing will be responsible to ensure the Pharmacy Manager reviews the Pharmacy Consultants recommendations for residents receiving Coumadin and significant medications weekly. These audits will be conducted weekly for 4 weeks, then monthly for 3 months. The Director of Nursing will fax weekly consulting pharmacy review and or recommendations to the pharmacy manager for review who will initial each pharmacy recommendation and review. Starting the week of October 12 and continuing weekly, it has been agreed and necessary that the pharmacy consultant visit the facility weekly until safe practice has been resolved and demonstrated. Audits will be documented on the monitoring tool and opportunities will be corrected immediately by the Director of Nursing or Assistant Director of Nursing as identified during these audits	

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F 428	Continued From page 21 Review of the resident ' s medical record revealed a Physician Orders was received on 8/14/15 which instructed, " DC (discontinue) current Coumadin. PT/INR on 8/15/15. " A review of Resident #64 ' s August 2015 Medication Administration Record (MAR) revealed the Coumadin was highlighted in yellow with a handwritten note which read, " D/C ' d (discontinued) 8/14/15. " Additional laboratory results were collected and reported on 8/15/15 as ordered. The lab work included an INR=5.94. A notation was hand-written on the lab report which read, " Recheck PT/INR on 8/17/15. " On 8/15/15, a Physician Order was received for a PT/INR to be completed on 8/17/15. On 8/17/15, laboratory results were collected and reported as ordered by the physician. The resident ' s INR=2.28. A notation hand-written dated 8/18/15 was written on the lab report which read, " Hospital. " Resident #64 was admitted to the hospital on 8/17/15 at 8:35 PM with an altered mental status. He was discharged back to the facility on 8/18/15. A review of the resident ' s 8/18/15 Hospital Records included the following, in part: Assessment and Plan: " 2. History of PE in 2008, on chronic anticoagulation with warfarin (Coumadin) at 14 mg per day based on the previous discharge. We will continue the patient on the Coumadin at 14 mg, check the daily PT/INRs. Today, the INR is 1.83. We will follow up the daily INR on the	F 428	4. Measures to ensure that corrections are achieved & sustained include: The results of these audits and observations will be presented by the Director of Nursing weekly for 4 weeks, then monthly for 3 months at Facility Quality Assurance Performance Improvement Committee Meeting. During the weekly and monthly QAPI Committee meetings the Director of Nursing will present the information obtained via the audits and observations. The committee will amend the plan based on identified audit trends. These amendments will be implemented immediately following the meeting, to include progressive discipline, re-education and additional monitoring to address opportunities as identified weekly for 4 weeks then monthly for 3 months.	

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patient and increase the dose, or titrate the dose, to an INR of 2-3. "

Resident #64 returned to the facility on 8/18/15. A review of the hospital ' s Discharge Medication list dated 8/18/15 instructed the resident to " Continue these medications which have not changed, " and included 14 mg Coumadin given once daily within this list of medications. The Discharge Medication list was signed by the NP and included a hand-written notation which read: " Check PT/INR weekly. "

A review of Resident #64 ' s August 2015 MAR revealed Coumadin was not included among the medications listed as ordered upon the resident ' s return from the hospital on 8/18/15. The medical record revealed no orders had been transcribed for either the Coumadin or the weekly PT/INR checks on this date.

A review of Resident #64 ' s medical record included the following Physician ' s Notes which read, in part:
9/7/15 (Authored by the MD):
HPI: " PTE in 2008 and placed on lifelong Coumadin. "
Plan: " Personal history of pulmonary embolism: Will monitor. No change in current treatment plan. "

Further review of the resident ' s medical record revealed the consultant pharmacist completed an MRR on 9/11/15. The pharmacist ' s MRR indicated the resident was readmitted to the facility on 8/18/15. The omission of Coumadin from the resident ' s medication regimen was not addressed with the text of the review.

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BRIAN CTR HEALTH & RETIREMENT	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

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A review of Resident #64 ' s September 2015 and October 2015 MARs revealed Coumadin was not listed as a medication ordered or administered to the resident.

A telephone interview was conducted on 10/6/15 at 8:17 AM with the resident ' s MD at the facility. After a review of the resident ' s history and stay at the facility, the physician acknowledged there was a failure to re-initiate Coumadin upon his return from the hospital on 8/18/15. The MD stated the omission was likely due to a transcription error at the facility. Upon inquiry, the MD reported he had thought the resident was still on Coumadin to date and stated, " The doctors before me recommended lifelong Coumadin and I did not mess with it. "

On 10/6/15, a Physician ' s Telephone Order was received from the resident ' s MD to re-initiate 14 mg Coumadin given once daily and to check his INR on 10/7/15.

An interview was conducted on 10/6/15 at 3:15 PM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON reported the facility ' s consultant pharmacist did not make a Consultation Report with concerns or recommendations specific to Resident #64 in either August 2015 or September 2015.

A telephone interview was conducted with the facility ' s consultant pharmacist on 10/6/15 at 3:58 PM. During the interview, the consultant pharmacist confirmed she had reviewed Resident #64 ' s pharmacy records for the months of August, September and October 2015. She reported the records showed Resident #64 had orders for Coumadin through 8/17/15; and, the

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Coumadin had not been re-ordered for the resident after 8/17/15. Upon inquiry, the pharmacist indicated she did not have a record of having made any recommendations specific to Resident #64 during her August 2015 or September 2015 consultation visits. The pharmacist indicated she apparently had missed the Coumadin transcription error at the time of her September 2015 review.

A follow-up interview was conducted with the consultant pharmacist on 10/07/2015 at 10:08 AM. During the interview, the pharmacist stated she reviewed Resident #64 ' s medical record to identify how she had missed the Coumadin transcription error and omission of the medication at the time of her 9/11/15 review. The consultant reported she must have assumed the medications listed as " continued " on the 8/18/15 hospital Discharge Medication list were continued at the facility and indicated she apparently focused on the medications noted as " changed. " She concluded the Coumadin may have been overlooked since it was not listed as a medication change for the resident.

An interview was conducted on 10/7/15 at 2:30 PM with the DON. Upon inquiry, he indicated his expectation as a DON was for the pharmacy (and consultant pharmacist) to help the facility put a process in place to promote the accuracy of medications administered to its residents. The DON stated he expected the pharmacy and pharmacist, " To be our check and balance system and second set of eyes. "

The facility ' s Administrator was notified of the Immediate Jeopardy on 10/6/15 at 3:30 PM. The following credible allegation of compliance was

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F 428	Continued From page 25 received on 10/8/15 at 3:39 PM: 1. A Medication Variance Report was completed by the Director of Nursing on 10/6/15 regarding Coumadin for Resident #64. Resident #64 and the Physician were notified of the Medication Variance Report by the Unit Manager on 10/6/15 and new orders were received for Resident #64 to begin Coumadin 14 mg daily and PT INR ordered for 10/7/15. A Skilled Nursing assessment was completed on 10/6/15 with no change in condition noted. The Pharmacy consultant completed a review on 10/7/15 which outlines the events resulted in the Coumadin medication variance for Resident #64. The review record was faxed to the pharmacy manager at the provider company for his review and was re-faxed back to the facility with the pharmacy manager signature. 2. Current records for residents receiving Coumadin and significant medications will be audited by the Director of Nursing and the Consultant Pharmacist weekly to validate the completion of pharmacist review and recommendations regarding Coumadin and significant medication administration. This audit will be completed on 10/7/15. The Pharmacy Consultant ' s report was reviewed for accuracy by the Pharmacy Manager on 10/8/15 via faxsimile. 3. On 10/7/15 the Consultant Pharmacist was be re-educated by the District Director of Clinical Services regarding the requirements of F428, to include the review of residents receiving Coumadin and recommendations for monitoring. The facility investigation revealed that both the nurse and the pharmacy consultant did not	F 428		

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discover the transcription error. The medication from the hospital have been compared and reviewed with the current medications with no changes noted. In investigating the process, it was discovered that the nurse as well as the pharmacy consultant had not noted the transcription error. The pharmacy consultant will review medications from the hospital as well as the current medications in the facility.

Beginning on 10/7/15, all newly hired Pharmacy Consultants will be educated prior to beginning work in the resident care area, by the Director of Nursing and the pharmacy manager regarding the requirement of F428, to include the review of residents receiving Coumadin and recommendations for monitoring current medications and hospital information. The new pharmacy consultants will be educated by the facility Director of Nursing and/or designee as well as the pharmacy manager at the pharmacy provider office which will include review of hospital information.

The Director of Nursing will be responsible to ensure the Pharmacy Manager reviews the Pharmacy Consultants recommendations for residents receiving Coumadin and significant medications weekly. The pharmacy consultant will being completing weekly reviews until the deficient practice is resolved. The Director of Nursing will fax weekly consulting pharmacy review and or recommendations to the pharmacy manager for review who will initial each pharmacy recommendation and review. Starting the week of October 12 and continuing weekly, it has been agreed and necessary that the pharmacy consultant visit the facility weekly until safe practice has been resolved and demonstrated.

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F 428	Continued From page 27 On 10/8/15 at 7:15 PM, the credible allegation of compliance was validated. The survey team confirmed Resident #64 ' s Pharmacist MRR dated 10/7/15 was reviewed and signed by the Pharmacy Manager; and, the facility and consultant pharmacist implemented an auditing process to validate completion of pharmacist reviews and recommendations regarding Coumadin and signification medication orders for residents within the facility. .	F 428		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520		11/6/15

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F 520	Continued From page 28 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, physician interview, and staff interviews the facility's Quality Assessment and Assurance Committee failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 11/6/14 and the complaint investigation dated 5/20/15 in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies on significant medication errors (F333) from the recertification survey of 11/6/14 and, again, on the current recertification survey. The facility also had a pattern of repeat deficiencies on the posting of nurse staffing information (F356) from the recertification survey of 11/6/14, a complaint investigation survey of 5/20/15, and again, on the current recertification survey. The findings include: Example 1) This tag is cross referenced to F333: Residents Are Free of Any Significant Medication Errors. Based on record review, staff interviews, and physician interviews, the facility failed to accurately transcribe a physician's order resulting in a significant medication error for 1 of 3 sampled residents receiving Coumadin (Resident #64), an oral anticoagulant medication. Immediate Jeopardy began on 8/18/15. Resident #64 re-entered the facility on 8/18/15 after a short hospital stay. Upon his return to the facility,	F 520	F-520 1. On 10/7/15, the District Director of Clinical Services conducted re-education for the Administrator on the facility□s Quality Assurance and Performance Improvement Program including meeting schedules, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity. All members of the Quality Assurance and Performance Improvement Committee submit data related to each department and participate in the identification of areas in need of improvement. 2. On 10/6/15, the Administrator and the Quality Assurance Committee were retrained on the Quality Assurance and Performance improvement program. This training was completed by the District Nursing Consultant. On 11/6/15, the Administrator and the Quality Assurance Committee were retrained on the Quality Assurance & Performance Improvement Program. This training was completed by Casey Connor, Quality Advisor of Alliant Quality. The Quality Assurance committee consists of: Administrator Director of Nursing Dietary Manager	

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F 520	Continued From page 29 Coumadin was omitted during the reconciliation and transcription of orders from the hospital discharge medication list. Resident #64 had been on chronic anticoagulation due to a history of pulmonary embolism. At the time of the survey investigation, the omission of Coumadin had not yet been identified by the facility. Immediate Jeopardy was removed on 10/8/15 at 7:15 PM. The facility remained out of compliance at a lower scope and severity of (D), an isolated deficiency with potential for more than minimal harm, while the facility completed the staff training required. The facility was in the process of monitoring the implementation of their correction action. During the recertification survey of 11/6/14, the facility was cited for F333 for failing to administer digoxin (an antiarrhythmic medication) to a resident as ordered by the physician; and, failing to administer the correct dosage of haloperidol (an antipsychotic medication) to a resident in accordance with the physician ' s orders. On the current recertification survey, the facility was recited for failing to transcribe a physician ' s order for Coumadin, resulting in the omission of this medication for a resident. An interview was conducted on 10/8/15 at 5:37 PM with the facility ' s Administrator. The Administrator reported he assumed responsibility as the Quality Assessment and Assurance (QAA) contact person. He noted there has been a change of staff over the past few months and indicated that he started in his position approximately 3 months ago. The Administrator reported shortly after starting his position, a complaint investigation survey on 7/8/15 identified facility non-compliance for pressure sores (F314), complete and accurate records (F514), and QAA	F 520	Rehabilitation Manager Maintenance or Environmental Representative Activities Director Social Services Director Human Resource Designee Business Office Director Resident Care Management Director Medical Director 3. The Administrator and the Director of Nursing will present the results of all audits of transcription of physician□s orders, audits of Coumadin care plans, and audits of Consultant Pharmacist reviews of residents receiving Coumadin to the Quality Assurance & Performance Improvement committee weekly for four (4) weeks and then monthly thereafter. The next Quality Assurance & Performance Improvement meetings will be conducted weekly for four weeks, then monthly with oversight by District Director of Clinical Services for three months 4. Measures to ensure that corrections are achieved & sustained include: The results of these audits and observations will be presented by the Director of Nursing weekly for 4 weeks, then monthly for 3 months at Facility Quality Assurance Performance Improvement Committee Meeting. During the weekly and monthly QAPI Committee meetings the Director of Nursing will present the information obtained via the audits and observations. The committee will amend the plan based on identified audit trends. These amendments will be implemented	

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F 520	Continued From page 30 (F520). In response to this complaint investigation survey, the frequency of QAA committee meetings had been increased from monthly to weekly. This was expected to continue until the Plan of Correction and compliance was ensured for the issues identified at that time. However, upon inquiry, the Administrator reported he was not aware of continuous QAA involvement specifically focused on the issue of significant medication errors at the facility. The facility ' s Administrator was notified of the Immediate Jeopardy on 10/6/15 at 3:30 PM. The following credible allegation of compliance was received on 10/8/15 at 3:39 PM. 1. On 10/7/15, the District Director of Clinical Services conducted re-education for the Administrator on the facility ' s Quality Assurance and Performance Improvement Program including meeting schedules, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity. All members of the Quality Assurance and Performance Improvement Committee submit data related to each department and participate in the identification of areas in need of improvement. 2. On 10/7/15, the Administrator and the Quality Assurance Committee were retrained on the Quality Assurance & Performance Improvement Program. This training was completed by the District Director of Clinical Services and the District Director of Operations. . The Quality Assurance committee consists of: · Administrator	F 520	immediately following the meeting, to include progressive discipline, re-education and additional monitoring to address opportunities as identified weekly for 4 weeks then monthly for 3 months.	

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F 520	Continued From page 31 · Director of Nursing · Dietary Manager · Rehabilitation Manager · Maintenance or Environmental Representative · Activities Director · Social Services Director · Human Resource Designee · Business Office Director · Resident Care Management Director · Medical Director 3. The Administrator and the Director of Nursing will present the results of all audits of transcription of physician ' s orders, audits of Coumadin care plans, and audits of Consultant Pharmacist reviews of residents receiving Coumadin to the Quality Assurance & Performance Improvement committee weekly for four (4) weeks and then monthly thereafter. The next Quality Assurance & Performance Improvement meetings will be conducted weekly for four weeks, then monthly with oversight by District Director of Clinical Services for three months. On 10/8/15 at 7:15 PM, the credible allegation of compliance was validated. The survey team confirmed the facility ' s Quality Assurance Committee completed re-education and re-training on the facility ' s Quality Assurance and Performance Improvement Program, including meeting schedules, identification of trends, submission of data, and initiation of quality improvement plans related to the identified areas. Example 2) This tag is cross referenced to: F356 Nurse staffing information. Based on observations and staff interviews, the facility failed to indicate the	F 520		

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resident census on the daily nursing services staff posting for various dates for 6 months, which included May 2015 through October 8, 2015. This tag was cited at a Scope/Severity of C (a widespread deficiency that constitutes no actual harm with potential for no more than minimal harm).
During the recertification survey of 11/6/14, the facility was cited for F356 for failing to post accurate nurse staffing information. On a complaint investigation survey of 5/20/15, the facility was recited for failing to include census information on the posted nurse staffing information. On the current recertification survey, the facility was again recited for failing to include the resident census data on the daily posting of nurse staffing information.

An interview was conducted on 10/8/15 at 5:37 PM with the facility ' s Administrator. The Administrator reported he assumed responsibility as the Quality Assessment and Assurance (QAA) contact person. He noted there has been a change of staff over the past few months and indicated that he started in his position approximately 3 months ago. The Administrator reported shortly after starting his position, a complaint investigation survey on 7/8/15 identified facility non-compliance for pressure sores (F314), complete and accurate records (F514), and QAA (F520). In response to this complaint investigation survey, the frequency of QAA committee meetings had been increased from monthly to weekly. This was expected to continue until the Plan of Correction and compliance was ensured for the issues identified at that time. However, upon inquiry, the Administrator reported he was not aware of continuous QAA involvement specifically focused

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F 520	Continued From page 33 on the issue of significant medication errors at the facility.	F 520		