STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

(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
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		10/25/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/23/2017

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F 166	Continued From page 1	F 166		

conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interview, the facility failed to investigate and resolve grievances for 1 of 1 residents reviewed for grievances (Resident #108). The findings included: The facility's grievance policy, with a revision date of March 2017, was reviewed. The policy read, in part, "Grievances and/or complaints may be submitted orally or in writing by the resident or the person filing the grievance or complaint on behalf of the resident. They may also be verbalized to any staff member, who will be responsible for documenting the grievance/concern on the appropriate form." Resident #108 was admitted to the facility on 12/8/16 with diagnoses that included muscle weakness, difficulty walking, unsteadiness on feet, and abnormalities of gait and mobility. The Admission Minimum Data Set (MDS) assessment dated 12/16/16 indicated Resident #108's cognition was severely impaired. He was assessed as requiring the extensive assistance of two or more staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #108 was not steady on his feet and was only able to stabilize with staff assistance.	F 166	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. IMMEDIATE ACTION TAKEN On 10/12/2017, Executive Director interviewed resident #108□s responsible party to determine if the alleged noncompliance remain to be an issue. Resident #108 responsible party stated that there have been not further issues. Alleged verbal grievance was documented in the facility grievance form and addressed per facility grievance policy. IDENTIFICATION OF OTHERS	

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F 166	Continued From page 3 The Care Area Assessment (CAA) related to urinary incontinence indicated Resident #108 had triggered for this area due to incontinence and the need for staff assist/provision for toileting. The quarterly MDS assessment dated 9/8/17 indicated Resident #108 had severely impaired decision making and problems with short term and long term memory. He was assessed as requiring the extensive assistance of two or more staff with bed mobility, transfers, and dressing and one staff for toileting and personal hygiene. Resident #108 was not steady on his feet and was only able to stabilize with staff assistance. The plan of care for Resident #108 included the problem area of the risk for Urinary Tract Infections (UTIs) secondary to incontinence of bowel and bladder with the need for staff provision for elimination care and hygiene. This area was initiated on 12/19/16 and last reviewed on 9/12/17. A family interview was conducted with Resident #108's Responsible Party (RP) on 10/2/17 at 11:13 AM. She indicated she had verbally reported two concerns to Nurse #5 related to toileting/incontinent care for Resident #108. She stated these concerns were reported in the past month or two. She indicated one concern was a Nursing Assistance (NA), name unknown, had taken Resident #108 to the bathroom and had left him there unattended. She reported the second concern was an NA, name also unknown, had placed a dirty brief in Resident #108's closet after she had completed incontinence care for him. Resident #108's RP stated she had not written a formal grievance/concern form related to either	F 166	On 10/12/2017, 10/13/2017, 10/16/2017, 2017, and 10/20 the Admissions Coordinator, Director Social services and the Executive Director interviewed 100% of all interview able residents to determine any concerns related to care and services at the facility. Any resident who was not able to be interviewed due to cognitive deficit a responsible party or interested family member was interviewed. Findings of this audit were documented in a Grievance audit tool maintained in the facility compliance binder. ten other grievances identified and resolved per grievance policy SYSTEMIC CHANGES Effective 10/25/2017 all grievances voiced by resident, or resident representative will be documented per facility policy Executive Director, Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), Director of Social Services and Nurse Supervisor will complete 100% education for all active staff, to include full time, part time and as needed employees, on the facility grievance policy. This education will be completed by 10/25/2017. Any Staff member not educated by 10/25/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new employees and will provided effective 10/25/2017. MONITORING PROCESS Effective 10/25/2017, Executive Director,	

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F 166	Continued From page 4 incident. She additionally stated she believed the NA no longer worked at the facility. A review of the facility grievance log from 4/1/17 through 10/2/17 revealed no grievances were filed by or on behalf of Resident #108. A phone interview was conducted with Nurse #5 on 10/4/17 at 2:45 PM. She stated she was familiar with Resident #108 and indicated he required assistance with toileting and incontinent care. She confirmed Resident #108's RP had verbally reported two concerns to her in the past several months related to toileting/incontinent care. She stated Resident #108's RP informed her an NA, name unknown, left Resident #108 in the bathroom unattended. She indicated she had asked all of the NAs who were working at the time the concern was reported and she was unable to corroborate the information. Nurse #5 stated Resident #108's RP also informed her an NA, name unknown, had placed a dirty brief in Resident #108's closet after she had completed incontinent care for him. She indicated she immediately went to Resident #108's closet and had not located a dirty brief. She stated she also had asked all of the NAs who were working at the time the concern was reported and she was unable to corroborate the information. Nurse #5 revealed she had not completed a grievance form for either of these concerns reported by Resident #108's RP. An interview was conducted with the Director of Nursing (DON) on 10/4/17 at 2:54 PM. She stated she expected the grievance policy to be followed and for verbal concerns voiced to staff to be written up by that staff member and investigated per the grievance policy.	F 166	Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Admissions Coordinator, Nursing Supervisor and/or Director of Social Services will interview 5 residents daily (Monday □ Friday) to determine their satisfaction with care. Any issues voiced will be documented in the facility grievance form and addressed per facility grievance policy. Findings from this monitoring process will be documented on a daily resident interview tool Executive Director will review the completion of daily resident interview report daily (M-F) X2 weeks, weekly x 2 weeks, then monthly x 3 months. Effective 10/25/2017, Executive Director and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 6 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Effective 10/25/17, the center Executive Director and the Director of health services will be ultimately responsible to ensure implementation of this plan of correction for alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interview, the facility failed to assess a resident for safe self-administration of medication and to care plan the determination who will be responsible for the storage and documentation of administration of medication for 1 (Resident #43) of 1sampled resident observed who self-administer. Findings included: Resident #43 was admitted to the facility on 7/6/17 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). The admission Minimum Data Set (MDS) assessment dated 7/13/17 indicated that Resident #43's cognition was intact. Resident #43 had a doctor's order dated 7/6/17 for Symbicort (used to treat COPD) 80 - 4.5 microgram (mcg) inhaler - inhale 2 puffs into lungs twice a day and on 9/1/17, there was an order to keep the inhaler at bedside. On 10/4/17 at 8:30 AM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to prepare and to administer the resident's medications except Symbicort. When questioned, Nurse #2 stated that Resident #43 self-administer the Symbicort and it was kept at bedside.	F 176	IMMEDIATE ACTION TAKEN On 10/4/2017 Licensed nurse #1 completed self-medication administration review in electronic medical records for resident #43. Resident #43 Symbicort inhalers, Proair inhaler and nose spray remained at the bedside for resident to self- administer. On 10/4/2017 Director of nursing discussed with resident #43 about her rights to self-administer medication. Resident state she prefers for the rest of her medication to be administered by facility staff. On 10/05/17 MDS nurse #1 developed a care plan that addresses how the facility will handle storage and documentation of medication that resident self-administer. IDENTIFICATION OF OTHERS: All residents with medication or treatment orders have the potential to be affected. Audit was completed on 100% of active residents on 10/5/2017 and 10/6/2017 by licensed nurse #1 to determine if any other resident is currently self-administering their medication. One other resident was identified as a result of the audit. Resident self-medication administration assessment was	10/25/17

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F 176	Continued From page 6 On 10/4/17 at 8:32 AM, Resident #43's bedside was observed. A used Symbicort inhaler was observed inside a plastic container that was kept on top of the over the bed table. On 10/4/17 at 8:33 AM, Resident #43 was interviewed. She stated that she had been administering the Symbicort to herself. She had to inhale 2 puffs two times a day. She added that she would take the Symbicort after she ate breakfast. Resident #43's medical records including electronic records were reviewed and revealed that there was no assessment of resident's ability to safely self-administer medication and there was no care plan to determine who will be responsible for the storage and documentation of the administration of the medication. On 10/4/17 at 9:40 AM, MDS Nurse #1 and MDS Nurse #2 were interviewed. They stated that they were not aware that Resident #43 was self-administering medication. MDS Nurse #1 stated that the Director of Nursing (DON) or the Staff Development Coordinator (SDC) was responsible for assessing residents for safe self-administration of medication. On 104/17 at 9:54 AM the DON and SDC were interviewed. They stated that they were not aware of any form used to assess residents for safe self-administration of medication. On 10/4/17 at 9:58 AM Nurse #2 was interviewed. She stated that as long as there was a doctor's order to keep the medication at bedside, the resident could self-administer the medication.	F 176	completed on 10/06/2017 by licensed nurse #1. Resident will continue to self-administer her medication. On 10/5/17 MDS nurse #1 developed a care plan that addresses the storage and documentation. Audit was completed on 100% of active residents by licensed nurse #1 on 10/5/17, 10/6/17 and 10/9/17 by the Director of Nursing, Staff Development Coordinator, Nursing Supervisor and licensed nurse #2 to identify if every resident had a Self-Administration assessment completed within the past quarter. The results indicated that no resident had an assessment completed within the past quarter. Self-Administrations assessments were completed on all residents on 10/5, 10/6 and 10/7 using the “Self-Administrator of Medications Determination” tool. SYSTEMIC CHANGES Effective 10/10/2017, the “Self-Administrator of Medication Determination” tool will be completed for all residents upon admission, readmission, quarterly and with significant changes by the facility licensed nurses. This review will be documented in individual resident electronic medical records. Effective 10/25/2017 the new “Admission Checklist” tool will be implemented. This form will enhance the process of checking accuracy of each resident assessment on a daily basis. Admitting nurse on duty will	

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F 176	Continued From page 7 She added that she initialed on the Medication Administration Record (MAR) that Symbicort was administered as scheduled (8 AM). On 10/4/17 at 3:00 PM, the DON was interviewed. She stated that a doctor's order to keep the medication at bedside would indicate that the resident could self-administer the medication. The DON further stated that she called the corporate office and a "Self - Administration of Medication Determination" form was faxed to the facility. On 10/4/17 at 3:30 PM, a Self-Administration of Medication Determination form was completed for Resident #43.	F 176	be responsible to complete the admission checklist upon admission/re-admission of a resident in the facility. (Readmission for this purpose indicates any resident who return to the facility after 72 hours of discharge). Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and/or Nurse Supervisor will complete 100% education for all licensed nurses, to include full time, part time and as needed staff, on the new revised admission checklist and the requirements to complete Self-Administrator of Medications Determination" tool. This education will be completed by 10/25/2017. Any licensed nurse not educated by 10/25/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed nurses effective 10/25/2017. MONITORING PROCESS Effective 10/25/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor the completion of self-medication administration determination (assessment) daily (M-F) by reviewing new admission records from prior day. The audit will ensure each resident admitted has a completed assessment. Any issues identified during this monitoring process will be addressed	

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F 176	Continued From page 8	F 176	promptly. Findings from this audit will be documented on a new admission checklist and filed in a daily clinical meeting binder after proper follow ups are done. Director of Nursing will review the completion of new admission checklist daily (M-F) x 2 weeks, weekly x 2 more weeks, then monthly x 3 months, or until the pattern of compliance is maintained. Effective 10/25/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Effective 10/25/17, the center Executive Director and the Director of health services will be ultimately responsible to ensure implementation of this plan of correction for alleged noncompliance to ensure the facility remains in substantial compliance.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		10/25/17

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F 278	Continued From page 9 (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of behaviors for 3 (Residents #13, #35, #110) of 5 residents reviewed for unnecessary medications and in the area of vision for 1 (Resident #31) of 3 residents reviewed for vision. The findings included: 1. Resident #13 was most recently admitted to the facility on 2/24/17 with multiple diagnoses that	F 278	F278 IMMEDIATE ACTION TAKEN The MDS assessment for resident #13, ARD 9/7/17, #35, ARD 7/22/17 and #110, ARD 9/14/17 were modified on 10/4/2017 to reflect documented behaviors on the look back period per RAI guidelines. That modification was done by the social worker. The corrected MDS was also transmitted and accepted on 10/19/17 and	

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F 278	Continued From page 10 included major depressive disorder, anxiety disorder, delusional disorder, mood disorder, and dementia. The quarterly Minimum Data Set (MDS) assessment dated 9/7/17 indicated Resident #13 had severely impaired decision making, inattention, disorganized thinking, and problems with short term and long term memory. Section E, the Behavior Section, indicated Resident #13 had no behaviors during the seven day MDS look back period (9/1/17 through 9/7/17). Section E was completed by the Social Worker (SW). A review of the Medication Administration Record (MAR) during the seven day look back of the 9/7/17 quarterly MDS (9/1/17 through 9/7/17) for Resident #13 revealed grabbing behaviors on four days (9/1, 9/2, 9/3, and 9/4) and kicking behaviors on two days (9/3 and 9/4). An interview was conducted with the SW on 10/3/17 at 3:05 PM. She stated she was responsible for completing Section E, the Behavior Section, of the MDS assessments. She indicated she completed this section of the MDS by reviewing nursing notes and completing observations of the resident. She revealed she had not reviewed the MARs to code the behavior section of the MDS. Section E of the 9/7/17 quarterly MDS for Resident #13 that indicated he had no behaviors during the seven day look back period (9/1/17 through 9/7/17) was reviewed with the SW. The MAR for Resident #13 that indicated he had physical behaviors on 4 of 7 days (grabbing behaviors on 9/1, 9/2, 9/3, 9/4 and kicking behaviors on 9/3, 9/4) during the MDS look back period was reviewed with the SW. The SW revealed this 9/7/17 MDS for Resident #13	F 278	10/20/17. The MDS assessment for resident #31, ARD 05/24/2017 Section V Care area Assessment (CAA) was modified on 10/06/2017 for a triggered vision CAA to reflect the correct visual devise used by this resident. Modified CAAs indicated resident #31 wears glasses as indicated on section B1200. That modification was done by MDS nurse #1. The corrected MDS was also transmitted and accepted on 10/16/17. MDS nurse #1, MDS nurse #2, and the facility Social Worker met with the MDS consultant from the contracted facility management and consulting company on 10/12/17 to review this alleged noncompliance and to identify the root cause. The root cause analysis concluded that, the MDS nurse #1 and MDS nurse #2 were unable to remove the prepopulated information in section V of MDS 3.0, even when such information does not reflect resident's assessment. Likewise it was identified that Social worker did not code the behaviors documented in Electronic Medication Administration due to unawareness of how to pull such records. It is evident that the resident behaviors and vision devices were assessed as the plan of care reflect the use of such is in place. This determination was made on 10/12/17. IDENTIFICATION OF OTHERS:	

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F 278	Continued From page 11 was coded inaccurately for physical behaviors because she had not reviewed the behaviors documented on the MAR. A follow up interview was conducted with the SW on 10/4/17 at 2:55 PM. She stated she had made the correction/modification to the behavior section of Resident #13's 9/7/17 MDS. An interview was conducted with the Director of Nursing on 10/4/17 at 3:00 PM. She reported her expectation was for the MDS to be coded accurately. 2. Resident #35 was admitted to facility on 9/29/14 with multiple diagnoses that included Alzheimer's, anxiety disorder, major depressive disorder, and delusional disorder. The quarterly Minimum Data Set (MDS) assessment dated 7/22/17 indicated Resident #35's cognition was severely impaired. She was assessed with physical behaviors, verbal behaviors, and other behaviors on one to three days during the seven day MDS review period (7/16/17 through 7/22/17). A review of the Medication Administration Record (MAR) during the seven day look back of the 7/22/17 quarterly MDS (7/16/17 through 7/22/17) for Resident #35 revealed the following: - Physical behaviors on five of seven days: grabbing behaviors (7/16, 7/18, 7/19, 7/21), hitting behaviors (7/18), pushing behaviors (7/18, 7/19), and kicking behaviors (7/22) - Other behaviors on five of seven days: disruptive sounds (7/16), pacing behaviors (7/18, 7/19, 7/20, 7/21) and rummaging behaviors (7/18, 7/19, 7/21)	F 278	100% audit for all active residents' most recent MDS assessment was completed on 10/19/2017 by the Social Worker and MDS Coordinator #1 and MDS Coordinator #2 to determine if any other resident with documented behaviors in the look back period was coded appropriately per RAI guidelines in section E of MDS 3.0. The results of the audit indicated 16 other residents with documented behaviors identified to be coded inaccurately per RAI guidelines in section E of MDS 3.0. The identified inaccurate MDS assessments were modified on 10/4/2017 to reflect documented behaviors on the look back period per RAI guidelines. That modification was done by the social worker. The modified MDS assessments were transmitted and accepted on 10/20/17. 100% audit for all active residents most recent comprehensive assessment was completed on 10/06/2017 and 10/11/2017 by the MDS Coordinator #1 and MDS Coordinator #2 to determine if any other resident who trigger as using visual appliances on section B1200 of MDS 3.0 had a correct visual CAA completed accurately per RAI guidelines. The results of the audit indicated 15 other residents who triggers as using visual appliances in section B1200 identified to have CAAs completed inaccurately per RAI guidelines in section V of MDS 3.0.	

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F 278	Continued From page 12 An interview was conducted with the SW on 10/3/17 at 3:05 PM. She stated she was responsible for completing Section E, the Behavior Section, of the MDS assessments. She indicated she completed this section of the MDS by reviewing nursing notes and completing observations of the resident. She revealed she had not reviewed the MARs to code the behavior section of the MDS. Section E of the 7/22/17 quarterly MDS for Resident #35 that indicated she had physical behaviors and other behaviors on one to three days during the seven day look back period (7/16/17 through 7/22/17) was reviewed with the SW. The MAR for Resident #35 that indicated she had physical behaviors and other behaviors on 5 of 7 days during the MDS look back period was reviewed with the SW. The SW revealed this 7/22/17 MDS for Resident #35 was coded inaccurately for physical behaviors and other behaviors because she had not reviewed the behaviors documented on the MAR. A follow up interview was conducted with the SW on 10/4/17 at 2:55 PM. She stated she had made the correction/modification to the behavior section of Resident #35's 7/22/17 MDS. An interview was conducted with the Director of Nursing on 10/4/17 at 3:00 PM. She reported her expectation was for the MDS to be coded accurately. 3. Resident #110 was admitted to the facility on 10/5/16 with multiple diagnoses including dementia with behaviors. The annual Minimum Data Set (MDS) assessment dated 9/14/17 was reviewed. The assessment indicated that Resident #110 had severe cognitive impairment	F 278	15 identified inaccurate vision CAAs in Section V Care area Assessment (CAA) were modified on 10/11/2017 to reflect the correct visual devise used by this resident. Modified CAAs indicated the appropriate visual device coded in section B1200 of MDS. The modifications were done by MDS nurse #1, and MDS nurse #2. SYSTEMIC CHANGES Effective 10/25/2017, social worker will review behaviors documented in electronic Medication Administration Records (eMAR) through “behavior types” report located in the facility used licensed Electronic Health records software to ensure all documented behaviors from eMAR on a look back period are coded accurately per RAI guidelines. On 10/12/17, 10/14/17 and 10/16/17 MDS consultant conducted re-education on accurate coding of MDS using Resident Assessment Instruments (RAI) guidelines. This education covers coding requirements and supportive documentation for each item coded in MDS, specifically related to section E and accurate completion of Care Area Assessment when triggered. Effective 10/25/2017, Education on the Accurate coding of MDS will be added to new hires orientation education for MDS nurses, Director of Social Services, Activities Director, and the C Dietary Manager (DM). This education will also be	

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F 278	Continued From page 13 and she had not exhibited any physical behaviors. The behavior monitoring documented on the Medication Administration Record (MAR) during the assessment period was reviewed. The documentation revealed that Resident #110 had exhibited grabbing and or kicking behavior on 9/9/17 at 9:35 AM and 5:17 PM, 9/10/17 at 4:16 PM, 9/11/17 at 8:22 AM and 9/14/17 at 6:31 PM. On 10/3/17 at 4:42 PM, the Social Worker (SW) was interviewed. She stated that she was responsible for coding the behavior section of the MDS assessment. She stated that she reviewed the nurse's notes for behaviors but not the MAR. On 10/4/17 at 2:55 PM, the SW stated that she had made correction/modification on the behavior section of the MDS assessment for Resident #110. On 10/4/17 at 3:00 PM, the Director of Nursing (DON) was interviewed. She stated that she expected the MDS assessments to be accurate. 4. a. Resident #31 was admitted to the facility 6/17/16. Cumulative diagnoses included Alzheimer's disease and glaucoma (eye disease that can damage the optic nerve and vision loss). An Annual Minimum Data Set (MDS) dated 5/24/17 indicated Resident #31 was moderately impaired in vision with limited vision and was not able to see newspaper headlines but could identify objects. The MDS indicated Resident #31 had corrective lenses. A Care Area Assessment (CAA) dated 5/31/17 stated, in part, that Resident #31 triggered for visual function due to a diagnosis of glaucoma.	F 278	provided annually for MDS nurses, Director of Social Services, Activities Director, and the Dietary Manager (CDM). MONITORING PROCESS Effective 10/25/2017, prior to submission, MDS Nurse #1 and/or MDS nurse #2 will review section E of MDS assessment completed by the social worker to ensure that all documented behaviors on eMARs is coded accurately per RAI guideline. These reviews will take place Monday through Friday, prior to submission for 2 weeks on all completed comprehensive MDS assessments, 50% of all completed comprehensive MDS assessments weekly for 2 weeks, then 25% of all completed MDS assessments monthly for 3 months or until the pattern of compliance is achieved. Effective 10/25/2017, prior to submission, MDS Nurse #1 will review Vision Care area Assessments (CAAs) completed by MDS nurse #2 (and vice versa) to ensure that an appropriate visual device used by a resident if any, as coded in section B1200 id reflect in Vision CAAs per RAI guideline. These reviews will take place Monday through Friday, prior to submission for 2 weeks on all completed comprehensive MDS assessments, 50% of all completed comprehensive MDS assessments weekly for 2 weeks, then 25% of all completed MDS assessments monthly for 3 months or until the pattern of compliance is achieved.	

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F 278	Continued From page 14 Eyeglasses were worn. The CAA use of visual appliances had the following checked: reading glasses, distance glasses, contact lenses and magnifying glass. A care plan dated 6/28/16 and last reviewed 9/13/17 stated Resident #31 had a diagnosis of glaucoma. Approaches included, in part, to monitor and report symptoms of change of status related to her eyes or vision. On 10/03/2017 at 12:01 PM, Resident #31 was observed sitting in her wheelchair near the nursing station. Resident #31 was wearing eye glasses. On 10/03/2017 at 2:33 PM, an interview was conducted with NA #1 who stated Resident #31 wore glasses. She stated she put Resident #31's eyeglasses on when she provided care for her. On 10/04/2017 at 9:44 AM, an interview was conducted with MDS Nurse #1. She stated she obtained her information about vision from observation, during staff interviews and reviewing the weekly nursing summaries. MDS Nurse #1 stated the CAA area for use of visual appliances was automatically populated and contained checks for reading glasses, distance glasses, contact lenses and magnifying glasses and the checks could not be removed. She stated she documented in her comments that Resident #31 had eyeglasses. On 10/4/17 at 3:01 PM, an interview was conducted with the Director of Nursing who stated she expected the MDS and CAA to be accurate. 4. b. Resident #31 was admitted to the facility	F 278	Effective 10/25/17, MDS nurse #1, MDS nurse #2, and/or Director of Social Services, will bring the results of this audit to the monthly QAPI meeting and present the findings. This will continue for a period of 3 months. The QAPI team will make adjustments to this plan as deemed necessary to ensure compliance. Effective 10/25/17, the center Executive Director and the Director of health services will be ultimately responsible to ensure implementation of this plan of correction for alleged noncompliance to ensure the facility remains in substantial compliance	

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6/17/16. Cumulative diagnoses included Alzheimer's disease and glaucoma (eye disease that can damage the optic nerve and vision loss).

A Quarterly MDS dated 8/17/17 indicated Resident #31 was moderately impaired in vision with limited vision and was not able to see newspaper headlines but could identify objects. The MDS indicated Resident #31 did not have corrective lenses.

On 10/4/17 at 9:44 AM, an interview was conducted with Nurse #1 who had completed the vision section of the MDS dated 8/17/17. She stated Resident #31 did not have her glasses at the time of the assessment. She stated she would check her noted and see if Resident #31 had refused to wear her glasses or if the glasses had not been available at the time. Nurse #1 reviewed her noted as stated she did not have any documentation as to why or where Resident #31's glasses were at the time of the assessment.

On 10/4/17 at 3:01 PM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate.

4. c. Resident #31 was admitted to the facility 6/17/16. Cumulative diagnoses included Alzheimer's disease and glaucoma (eye disease that can damage the optic nerve and vision loss).

A Quarterly MDS dated 9/11/17 indicated Resident #31 was moderately impaired in vision with limited vision and was not able to see newspaper headlines but could identify objects. The MDS indicated Resident #31 did not have

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F 278	Continued From page 16 corrective lenses. On 10/4/17 at 9:44 AM, an interview was conducted with MDS Nurse #2 who stated she completed the vision section of the MDS dated 9/11/17. She stated, at the time, Resident #31's glasses were not on her or available. She stated she did not know if the glasses were lost at that time and did not ask anyone about the glasses. On 10/4/17 at 3:01 PM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate.	F 278		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and Consultant Pharmacist and staff interview, the facility failed to administer Lantus insulin (used to treat Diabetes Mellitus) as ordered by the physician for 1 (Resident #91) of 1 sampled resident reviewed who was receiving Lantus insulin. Findings included: Resident #91 was admitted to the facility on 6/7/17 with multiple diagnoses including Diabetes Mellitus. The quarterly Minimum Data Set (MDS) assessment dated 9/7/17 indicated that Resident #91 had severe cognitive impairment and he had	F 281	IMMEDIATE ACTION TAKEN Staff Development Coordinator (SDC) obtained a clarification order from physician on 10/04/2017 for resident #91. Lantus at bedtime was clarified to Levemir at bedtime. SDC transcribed the clarified order appropriately on resident's Medication administration record. Resident responsible party notified by the staff development coordinator on 10/4/2017 of the new order.	10/25/17

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F 281	Continued From page 17 received injection and insulin during the last 7 days. Resident #91 had a physician order dated 6/7/17 for Lantus insulin 12 units subcutaneous (SQ) at bedtime for Diabetes Mellitus. On 10/4/17 at 11:45 AM, the medication cart where Resident #91 resided was observed. There was a used Levemir insulin pen (used to treat Diabetes Mellitus) with Resident #91's name on it but there was no Lantus insulin noted. On 10/4/17 at 2:21 PM, the Consultant Pharmacist was interviewed. She stated that Levemir was not the same as Lantus insulin and she expected the nurse to write an order to give Levemir instead of Lantus. On 10/4/17 at 3:00 PM, the Director of Nursing (DON) was interviewed. She expected the nurse to write an order to give Levemir instead of Lantus and she expected the nurses to make sure medication administered matched with the doctor's order. On 10/4/17 at 3:40 PM, Nurse #3 was interviewed. She stated that she was assigned to Resident #91 on second shift. She acknowledged that she was giving Levemir instead of Lantus as ordered because the pharmacy indicated that Levemir and Lantus were interchangeable. Nurse #3 added that she questioned the physician if she could give Levemir instead of Lantus but the physician did not reply so she continued to give the Levemir instead of Lantus.	F 281	IDENTIFICATION OF OTHERS All residents with medication or treatment orders have the potential to be affected. On 10/4/2017, Staff Development Coordinator and Assistant director of Nursing audited all residents with insulin orders to determine if correct order was entered into the resident's electronic medical record. As a result of the audit, two other resident were identified without appropriate order. On 10/4/2017 Staff development coordinator corrected the identified incorrect order; residents' family and physician were notified. It is evident that resident's insulins identified as incorrect were therapeutically substituted as approved by the facility Medical Director; however the facility did not transcribe the substituted order in resident's electronic Medication Administration Records. 100% audit of current medications for all current residents was completed by the Facility's pharmacy personnel, Director of Nursing, Staff Development Coordinator and Nursing Supervisor on 10/20/2017 to identify any other resident with medication or treatment orders that was therapeutically substituted but not transcribed to reflect the substitution in resident's medication and/or treatment administration records. This audit was completed on 10/12/17, 10/13/17, 10/16/17, 10/17, 10/18/18 and 10/20/17. No other resident identified with	

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therapeutically substituted medication not transcribed in medical records

SYSTEMIC CHANGES
Effective 10/25/2017, the new 24-hour chart check will be implemented. The 24-Hour chart check is the process of checking all orders received in the most recent 24 hours to ensure accurate and proper transcriptions. If any medication or treatment order is not transcribed as ordered, night shift nurse, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Nursing Supervisor will ensure it is transcribed correctly on the electronic Medication Administration Record or electronic Treatment Administration Records. 24-Hour chart check form will be located in a binder titled 24 Hour report at each nurse's station.

Effective 10/20/2017, the center nursing administrative team, which includes DON, ADON, and/or SDC, initiated a process for reviewing all new physician orders or change of orders daily (Monday through Friday) and will address any discrepancy in a promptly. The assigned nurse administrative team member will compare orders written in the physician order forms to orders transcribed on the Medication Administration Record (MAR). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor.

Effective 10/25/2017, week end

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F 281	Continued From page 19	F 281	Registered Nurse supervisor and/or designated licensed nurse will review, all new orders or change of orders every Saturday & Sunday and will address any discrepancy in a timely manner. The assigned nurse administrative team member will compare orders written in the physician order forms to orders transcribed on the Medication Administration Record (MAR). Any identified issues will be addressed promptly and appropriate actions will be implemented as appropriate by the Registered Nurse supervisor, and reported to the center's DON timely. On 10/12/2017, Regional Clinical director conducted an education with the center DON and SDC about the process of reviewing new physician orders or changes of orders daily (Monday through Friday). This education emphasized on how to identify a root cause when an order is not transcribed appropriately and actions to be taken to address any discrepancies in a timely manner. Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses, to include full time, part time and as needed staff, on the new 24-hour chart check form and medication administration and transcription. This education will be completed by 10/25/2017. Any licensed nurse not educated by 10/25/2017 will not be allowed to work until educated. This education will also be added on new hires	

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F 281	Continued From page 20	F 281	orientation process for all new Licensed nurses effective 10/25/2017. MONITORING PROCESS Effective 10/25/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor proper transcription of physician orders by conducting clinical meeting daily (M-F), review of physician orders written from prior clinical meeting, any admission/discharges occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting. The audit and discussion will ensure physician orders are transcribed correctly to the MARs/TARs. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done. Director of Nursing will review the completion of daily clinical report daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 10/25/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility	

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F 281	Continued From page 21	F 281	remains in substantial compliance. Effective 10/25/17, the center Executive Director and the Director of health services will be ultimately responsible to ensure implementation of this plan of correction for alleged noncompliance to ensure the facility remains in substantial compliance.	
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--	F 329		10/25/17

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F 329	Continued From page 22 (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain the Magnesium level and Basic Metabolic Panel (BMP) as ordered by the physician for 2 (Residents #110 & #43) of 5 sampled residents reviewed. Findings included: 1. Resident 110 was admitted to the facility on 10/5/16 with multiple diagnoses including Hypertension and Atrial Fibrillation. The annual Minimum Data Set (MDS) assessment dated 9/14/17 indicated that Resident #110 had severe cognitive impairment. Resident #110 had a physician's order dated 10/5/16 for Magnesium Oxide (used to treat low level of Magnesium in the body) 400 milligrams (mgs) 1 tablet by mouth twice a day. Resident #110 had a physician's order dated 10/26/16 for Magnesium level to be drawn in 1 week. Resident #110's medical records including electronic records were reviewed and there was no Magnesium level report noted.	F 329	IMMEDIATE ACTION Resident #43 Basic Metabolic Panel (BMP obtained on 10/05/2017 by the Staff Development Coordinator, blood was sent to the Licensed Laboratory, results received and communicated to MD on 10/06/2017 by Licensed nurse #2 Resident #110). Magnesium level was also obtained on 10/05/2017 by the Staff Development Coordinator, blood sent to the Licensed Laboratory, results received and communicated to MD on 10/06/17 by licensed nurse #2. No Critical laboratory findings noted. Results for both laboratory tests are filed in each resident medical records IDENTIFICATION OF OTHERS All residents who take medication that requires laboratory test monitoring has a potential to be affected.	

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F 329	Continued From page 23 On 10/4/17 at 11:36 AM, the Staff Development Coordinator (SDC) was interviewed. She stated that she could not find a Magnesium level report in the resident's medical records. The SDC also indicated that she had called the laboratory and the laboratory did not have a Magnesium level report on their file. She added that the order for the Magnesium level was missed. On 10/4/17 at 3:00 PM, the Director of Nursing (DON) was interviewed. The DON stated that orders written on the laboratory reports were considered doctor's order. She indicated that she expected the nurse to transcribe the order for the Magnesium level. The DON indicated that the order for the Magnesium level was missed. 2. Resident #43 was admitted to the facility on 7/6/17 with multiple diagnoses including Congestive Heart Failure (CHF). The admission Minimum Data Set (MDS) assessment dated 7/13/17 indicated that Resident #43's cognition was intact and she had received a diuretic medication during the last 7 days. Resident #43 had a physician's order for Lasix (diuretic) 20 milligrams by mouth daily for CHF. A BMP report dated 8/24/17 for Resident #43 was reviewed. The report revealed a low Sodium level of 130. The reference range was 137-146 melliequivalent per liter (meq/L). The report also indicated that the Sodium level had improved from 128 on 8/21/17 and 127 on 8/4/17.	F 329	100% of resident lab orders were audited for the past three months by the Director of Nursing on 10/6/17 and 10/9/17. These lab orders were then compared to each resident's chart to identify if a corresponding lab result is present. As a result of this audit, it was found that no other residents were found to have ordered labs documented on laboratory results that weren't completed as indicated. Findings of this audit is documented on the "lab order audit form". 100% of resident ordered laboratory test results for the last three months reviewed to identify any if there is any follow up ordered laboratory test documented on any result. This audit was completed for all results for all active residents by the Director of Nursing, Staff Development Coordinator, Nurse Supervisor and/or Licensed nurse #1. As a result of this audit, it was found that two other residents were found to have missing labs. Orders were received for a TSH for resident 1386 and an iron study for resident 1652. These results were received on 10/11/17 and 10/12/17, reported to the attending physician and placed in the resident charts. Findings of this audit will be documented on the "lab results audit form". 100% audit for all required routine laboratory tests necessary for monitoring of medication usage for current residents was completed by the Licensed Pharmacist, Director of Nursing and Assistant Director of nursing on 10/13/17,	

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F 329	Continued From page 24 Resident #43 had a physician's order dated 8/24/17 to recheck BMP in 1 week. Review of Resident #43's medical records including electronic records revealed no BMP report after 8/24/17. On 10/4/17 at 11:38 AM, the Staff Development Coordinator (SDC) was interviewed. She stated that she could not find a BMP report dated September 2017 in the resident's medical records. The SDC also indicated that she had called the laboratory and the laboratory did not have a BMP report on their file for September 2017. She added that the order for the BMP was missed. On 10/4/17 at 3:00 PM, the Director of Nursing (DON) was interviewed. The DON stated that orders written on the laboratory reports were considered doctor's order. She indicated that she expected the nurse to transcribe the order for the BMP. The DON stated that the order for the BMP was missed.	F 329	10/16/17, and 10/17/17 to identify any other laboratory test necessary for medication monitoring that was either not ordered or obtained. 25 other residents identified with medication that require a routine laboratory test for monitoring of medication but was either not ordered or obtained. All identified needed laboratory tests ordered and will be completed on 10/20/17, 10/23/2017 and 10/24/2017. Results of those laboratory tests will be communicated to the attending physician promptly. Findings of this audit is documented on the “Routine lab audit form”. SYSTEMIC CHANGES Effective 10/25/2017, a new laboratory process will be implemented in the facility. This process will ensure all ordered laboratory tests are transcribed, obtained, and results reported to residents attending physician in a timely manner. This lab process will involve three steps approach to ensure compliance. The first step will be completed by a licensed nurse responsible to care for the resident (nurse on duty). Nurse on duty will transcribe any ordered laboratory test to both the facility electronic medical records and on the daily laboratory log effective 10/25/2017. The second step will be completed by a licensed nurse responsible to care for the resident during night (Night shift nurse).	

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F 329	Continued From page 25	F 329	Night shift nurse will complete a 24 hours chart check and ensure all orders to include laboratory tests were transcribed appropriately. If any laboratory test was not transcribed as ordered, night shift nurse will ensure it is transcribed. Laboratory tests will be obtained by the DON, ADON, SDC and/or designated licensed nurse on the date ordered to be completed and results will be returned to the facility via facsimile. The third step will involve the nurse on duty on the evening shift, Effective 10/25/2017, the evening shift nurse on duty will be responsible to ensure all ordered laboratory tests are resulted and communicated to MD in a timely manner. Evening shift nurse will indicate on a daily laboratory log form when the test result are not back during evening shift on that day. Nurse in all shifts are responsible to report laboratory results to physician promptly as they receive the laboratory results. Evening shift nurses are the gatekeepers of this process. New standing orders lab protocol re-implemented in the facility effective 10/20/2017. This laboratory protocol will be used to identify type of laboratory tests recommended with different therapeutic medication classes to ensure adequate monitoring. When a resident is admitted, the required laboratory tests necessary for medication monitoring per lab protocol will be ordered ad entered in facility electronic medical records.	

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F 329	Continued From page 26	F 329	Effective 10/25/17, At the beginning of each month, the Director of Nursing, Assistant Director of Nursing, staff development, Nursing manager and/or designated licensed nurse will review the routine laboratory report obtained from Facility electronic health records software and ensure completion per order. On 10/20/2017, Regional clinical director completed an education to the Director of Nursing, Staff Development Coordinator, and Licensed nurse #1on the new laboratory process in the facility. Director of nursing, staff Development Coordinator and/or Nurse Manager will complete 100% education for all licensed nurses, to include full time, part time and as needed staff, on the new laboratory process. This education will be completed by 10/25/2017. Any licensed nurse not educated by 10/25/2017 will not be allowed to work until educated. The new laboratory process will be added to new hire orientation process for all licensed nurses effectively 10/25/2017, and will also be provided annually. MONITORING PROCESS Effective 10/25/2017; Director of Nursing, Staff development Coordinator, Nursing Manager and/or designated licensed nurse will review physician orders for the prior day, for proper transcription and follow through. Director of Nursing, Staff development Coordinator, Nursing	

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F 329	Continued From page 27	F 329	supervisor and/or Designated Licensed nurse will follow up to ensure any laboratory tests noted were obtained as ordered. This monitoring process will be done daily (Monday - Friday) for 2 weeks, Weekly x 2 more weeks then monthly x 3 months or until the pattern of compliance is maintained. The result of this monitoring process will be documented on “Daily laboratory monitoring tool and will be maintained in the facility compliance binder. Effective 10/25/2017; Medical record Clerk will review laboratory log for the prior day(s) and compare with laboratory tests obtained on that date, to ensure all ordered laboratory tests were completed, resulted and followed through appropriately. Any discrepancies noted will be reported to the Director of nursing and/or the Administrator promptly. This monitoring will be done daily (Monday - Friday) x 2 weeks, Weekly x 2 more weeks then monthly x 3 months or until the pattern of compliance is maintained. Effective 10/25/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 329	Continued From page 28	F 329	Effective 10/25/17, the center Executive Director and the Director of health services will be ultimately responsible to ensure implementation of this plan of correction for alleged noncompliance to ensure the facility remains in substantial compliance	
F 428 SS=E	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the	F 428		10/25/17

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F 428	Continued From page 29 attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and Consultant Pharmacist and staff interview, the Consultant Pharmacist failed to address the missing Magnesium level, failed to have an accurate drug regimen review and failed to identify a failed gradual dose reduction (GDR) for antipsychotic medication for 2 (Residents #110 & #35) of 5 sampled residents reviewed for unnecessary medications. Findings included: 1a. Resident #110 was admitted to the facility on 10/5/16 with multiple diagnose including Dementia with behaviors, Hypertension and Atrial Fibrillation. The annual Minimum Data Set (MDS) assessment dated 9/14/17 indicated that Resident #110 had severe cognitive impairment.	F 428	IMMEDIATE ACTION 1a. Drug Regimen Review documentation for resident #110 dated 8/5/2017 and 9/10/17 reviewed and clarified by the Licensed Pharmacist to correct the data entry error, and to reflect the correct medication resident was taking at the time of the review. It is concluded based on root cause analysis process that those errors happened at the time when licensed pharmacist was transferring individual resident Drug Regimen Review from one electronic health record software to another using copying and pasting functionality. The clarified documentation is located in resident #110 medical record.	

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F 428	Continued From page 30 Resident #110's physician's orders included Seroquel (antipsychotic), Prozac and Remeron (antidepressant), Depakote (used to treat behaviors), Eliquis (anticoagulant), Metoprolol (antihypertensive), Magnesium Oxide (Magnesium supplement), Digoxin and Cardizem(use to treat Atrial Fibrillation) and Simvastatin (antihyperlipidemia). Review of Resident #110's drug regimen review (DRR) was conducted. The DRR notes dated 8/5/17 revealed "continue Remeron 30 daily (appetite) and Ativan 0.5 every 6 hours PRN (as needed) anxiety and agitation, Zoloft 100 milligrams (mgs) daily (dose increased in September), last psych eval note 4/27, dementia with behavioral disturbances, fair, Zyprexa for mood, depression improved with Zoloft and Remeron, no acute, continue to monitor. Noted on Omeprazole 20 daily, no adverse drug reactions, attempt gradual dose reduction (GDR) Zoloft, Medical Doctor (MD) note." The DRR notes dated 9/10/17 indicated "Prozac 20 mgs by mouth daily for depression) decreases 10/25) and then increased back 3/23. Klonopin 0.5 mgs twice a day PRN (as needed) anxiety/depression (changed from scheduled dosing 11/8) noted some incidences of yelling out "help me." " On Seroquel 12.5 twice a day added in April for sundowning. Will request GDR in October." On 10/4/17 at 2:21 PM, the Consultant Pharmacist was interviewed. She was informed that her DRR notes dated 8/5/17 and 9/10/17 indicated that Resident #110 was on Ativan, Zoloft, Zyprexa, Omeprazole and Klonopin. The Consultant Pharmacist stated that she had to	F 428	This clarification was conducted on 10/12/2017 b. Magnesium level was also obtained on 10/05/2017 by the Staff Development Coordinator, blood sent to the Licensed Laboratory, results received and communicated to MD on 10/06/17 by licensed nurse #2. No Critical laboratory findings noted. Results for both laboratory tests are filed in each resident medical records. 2. Resident #35 failed Gradual Dose Reduction for Seroquel in December 2016 is now documented in Licensed Pharmacist from July 2017 to current. Director Clinical Services of the Pharmacy Vender that provides services to the facility was notified of this alleged noncompliance by the facility executive Director on 10/12/2017. Pharmacy clinical Director addressed the involved licensed pharmacy who omitted failed GDR for resident #35 per pharmacy personnel policy. No further action taken for this alleged non-compliance. IDENTIFICATION OF OTHERS All residents has a potential to be affected. 100% audit of DRR documentation for all active residents was completed by the Licensed Pharmacist to ensure completion and accuracy. This audit covered all DRR documented in the last 3	

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F 428	Continued From page 31 document her notes on her tablet during the DRR review and then she had to cut and paste her notes to the facility's computer. She added that she might have cut and paste the wrong information to the resident's records, She acknowledged that Resident #110 was not on Ativan, Zoloft, Zyprexa or Omeprazole. She also stated that Resident #110 might have been on Klonopin months ago but she would check the records. b. Resident #110 was admitted to the facility on 10/5/16 with multiple diagnose including Dementia with behaviors, Hypertension and Atrial Fibrillation. The annual Minimum Data Set (MDS) assessment dated 9/14/17 indicated that Resident #110 had severe cognitive impairment. Resident #110 had a physician's order dated 10/5/16 for Magnesium Oxide (used to treat low level of Magnesium in the body) 400 milligrams (mgs) 1 tablet by mouth twice a day. Resident #110 had a physician's order dated 10/26/16 for Magnesium level to be drawn in 1 week. Resident #110's medical records including electronic records were reviewed and there was no Magnesium level report noted. Review of Resident #110's drug regimen reviews (DRR) was conducted. The DRR notes revealed that the Consultant Pharmacist had conducted a DRR on 11/9/16, 12/5/16, 2/3/17, 3/5/17 and 4/5/17. The notes indicated "Magnesium level in 1 week - follow for labs (laboratory)." The DRR notes dated 5/3/17 indicated "Magnesium level in	F 428	months. This audit was aimed to identify any in-accurate DRR documentation and/or any missing failed GDR documentation. No other resident identified as having incorrect or missing DRR. This audit was completed on 10/12/2017. Findings of this audit is located in the facility compliance binder. 100% of resident lab orders were audited for the past three months by the Director of Nursing on 10/6/17 and 10/9/17. These lab orders were then compared to each resident's chart to identify if a corresponding lab result is present. As a result of this audit, it was found that no other residents were found to have ordered labs documented on laboratory results that weren't completed as indicated. Findings of this audit is documented on the "lab order audit form". 100% of resident ordered laboratory test results for the last three months reviewed to identify any if there is any follow up ordered laboratory test documented on any result. This audit was completed for all results for all active residents by the Director of Nursing, Staff Development Coordinator, Nurse Supervisor and/or Licensed nurse #1. As a result of this audit, it was found that two other residents were found to have missing labs. Orders were received for a TSH for resident 1386 and an iron study for resident 1652. These results were received on 10/11/17 and 10/12/17, reported to the attending physician and placed in the resident charts. Findings of this audit will be	

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F 428	Continued From page 32 1 week - follow for labs NN (nursing)." From June 2017 through September 2017, the missing Magnesium level was not addressed on the DRR notes. On 10/4/17 at 2:21 PM, the Consultant Pharmacist was interviewed. She stated that she had addressed on her notes to follow up for the Magnesium level as ordered from November 2016 through April 2017. On May 2017, she addressed the missing Magnesium level with Nursing. She acknowledged that she failed to follow up with the Director of Nursing the missing Magnesium level after May 2017. 2. Resident #35 was admitted to the facility on 9/29/14 with diagnoses that included anxiety disorder, major depressive disorder, and delusional disorder. A physician's order for Resident #35 dated 11/2/16 indicated a Gradual Dose Reduction (GDR) of Seroquel (antipsychotic medication). Resident #35's previous order (prior to 11/2/16) for Seroquel was 100 milligrams (mg) twice daily. This was decreased for Resident #35 on 11/2/16 to 75 mg in the morning with the bedtime dose remaining at 100 mg. Resident #35's monthly Drug Regimen Review (DRR) was completed by the Consultant Pharmacist on 11/9/16. Resident #35 was noted with a GDR of Seroquel this month (November 2016) with physician's orders for 75 mg in the morning and 100 mg at bedtime. Resident #35's monthly DRR was completed by the Consultant Pharmacist on 12/5/16. The DRR read, in part, "Seroquel 75 mg [in the morning]	F 428	documented on the “lab results audit form”. 100% audit for all required routine laboratory tests necessary for monitoring of medication usage for current residents was completed by the Licensed Pharmacist, Director of Nursing and Assistant Director of nursing on 10/13/17, 10/16/17, and 10/17/17 to identify any other laboratory test necessary for medication monitoring that was either not ordered or obtained. 25 other residents identified with medication that require a routine laboratory test for monitoring of medication but was either not ordered or obtained. All identified needed laboratory tests ordered and will be completed on 10/20/17, 10/23/2017 and 10/24/2017. Results of those laboratory tests will be communicated to the attending physician promptly. Findings of this audit is documented on the “Routine lab audit form”. SYSTEMIC CHANGES Effective 10/25/2017, Licensed pharmacist will document monthly DRR to include any failed GDR in resident’s electronic medical records and also will provide a hard copy of all DRR monthly to the facility Executive Director and/or Director of nursing to be filed in resident’s medical records. Effective 10/25/2017, licensed pharmacy will provide the list of outstanding and/or	

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and 100 mg [at bedtime]...GDR in November [2016] will continue to watch."

A physician's order dated 12/9/16 indicated an increase in the morning dose of Seroquel to 100 mg from 75 mg for Resident #35 starting on 12/10/16. The evening dose of Seroquel remained at 100 mg for Resident #35. Resident #35 was noted to have failed the GDR for Seroquel.

There was no monthly DRR in the medical record for Resident #35 from 12/6/16 through 2/4/17.

Resident #35's monthly DRRs were completed by the Consultant Pharmacist on 2/5/17, 3/5/17, 4/5/17, 5/3/17, and 6/5/17. The DRR for all dates listed read, in part, "Seroquel 75 mg [in the morning] and 100 mg [at bedtime]...GDR in November [2016] will continue to watch." There was no documentation by the Consultant Pharmacist of Resident #35's failed GDR of Seroquel in December 2016 on the DRRs dated February 2017 through June 2017.

Resident #35's monthly DRR was completed by the Consultant Pharmacist on 7/9/17. The DRR read, in part, "Seroquel 100 mg [twice daily]...GDR in November [2016] and then increased back to current dose in [December 2016]."

The quarterly Minimum Data Set (MDS) assessment dated 7/22/17 indicated Resident #35's cognition was severely impaired. She was administered antipsychotic medication on 7 of 7 days during the MDS review period.

A review of the current physician orders for

past due laboratory tests needed for medication monitoring. This list will be provided to the Executive Director and/or Director of nursing for proper follow through.

Effective 10/25/2017, a new laboratory process will be implemented in the facility. This process will ensure all ordered laboratory tests are transcribed, obtained, and results reported to residents attending physician in a timely manner. This lab process will involve three steps approach to ensure compliance.

The first step will be completed by a licensed nurse responsible to care for the resident (nurse on duty). Nurse on duty will transcribe any ordered laboratory test to both the facility electronic medical records and on the daily laboratory log effective 10/25/2017.

The second step will be completed by a licensed nurse responsible to care for the resident during night (Night shift nurse). Night shift nurse will complete a 24 hours chart check and ensure all orders to include laboratory tests were transcribed appropriately. If any laboratory test was not transcribed as ordered, night shift nurse will ensure it is transcribed. Laboratory tests will be obtained by the DON, ADON, SDC and/or designated licensed nurse on the date ordered to be completed and results will be returned to the facility via facsimile.

The third step will involve the nurse on

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F 428	Continued From page 34 Resident #35 was conducted on 10/4/17. The physician's orders indicated Resident #35 remained on Seroquel 100 mg twice daily since 12/10/16. An interview was conducted with the Consultant Pharmacist on 10/4/17 at 10:50 AM. She stated she completed a DRR for residents once per month. She indicated her normal process was to duplicate her note from the previous month and then adjust the note as needed. The physician's order dated 11/2/16 that indicated a Seroquel GDR for Resident #35 was reviewed with the Consultant Pharmacist. The physician's order dated 12/9/16 that indicated the Seroquel GDR for Resident #35 had failed was reviewed with the Consultant Pharmacist. The monthly DRR's from February 2017 through June 2017 that had not identified the failed GDR of Seroquel for Resident #35 were reviewed with the Consultant Pharmacist. The Consultant Pharmacist stated she was unable to explain why she had not identified the failed GDR of Seroquel that occurred in December 2016 for Resident #35 until her DRR in July 2017. She indicated the DRR should be thorough and was to accurately reflect the physician's orders. She revealed she had made a mistake. She explained that when the GDR of Seroquel failed in December 2016 she had not accurately adjusted Resident #35's DRR until July 2017. An interview was conducted with the Administrator on 10/4/17 at 12:00 PM. He stated he expected the Consultant Pharmacist's monthly DRR to be thorough and accurate. He additionally indicated he expected the Consultant Pharmacist to identify a failed GDR of an antipsychotic medication during the monthly DRR.	F 428	duty on the evening shift, Effective 10/25/2017, the evening shift nurse on duty will be responsible to ensure all ordered laboratory tests are resulted and communicated to MD in a timely manner. Evening shift nurse will indicate on a daily laboratory log form when the test result are not back during evening shift on that day. Nurse in all shifts are responsible to report laboratory results to physician promptly as they receive the laboratory results. Evening shift nurses are the gatekeepers of this process. New standing orders lab protocol re-implemented in the facility effective 10/20/2017. This laboratory protocol will be used to identify type of laboratory tests recommended with different therapeutic medication classes to ensure adequate monitoring. When a resident is admitted, the required laboratory tests necessary for medication monitoring per lab protocol will be ordered ad entered in facility electronic medical records. Effective 10/25/17, At the beginning of each month, the Director of Nursing, Assistant Director of Nursing, staff development, Nursing manager and/or designated licensed nurse will review the routine laboratory report obtained from Facility electronic health records software and ensure completion per order. On 10/20/2017, Regional clinical director completed an education to the Director of Nursing, Staff Development Coordinator, and Licensed nurse #1on the new	

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F 428	Continued From page 35	F 428	laboratory process in the facility. Director of nursing, staff Development Coordinator and/or Nurse Manager will complete 100% education for all licensed nurses, to include full time, part time and as needed staff, on the new laboratory process. This education will be completed by 10/25/2017. Any licensed nurse not educated by 10/25/2017 will not be allowed to work until educated. The new laboratory process will be added to new hire orientation process for all licensed nurses effectively 10/25/2017, and will also be provided annually. MONITORING PROCESS Effective 10/25/2017, the facility medical record clerk, and/or Executive Director will review the facility monthly DRR to ensure completion. Any identified omission will be reported to the licensed pharmacist immediately. This audit will be completed monthly for 3 months or until the pattern of compliance is maintained. This monitoring process will be documented on “Medical Records audit tool” Effective 10/25/2017, Pharmacy Clinical Director and/or designated Licensed Pharmacy will review the facility monthly DRR documentation to ensure completion and accuracy. This audit will focus to ensure documentation are accurate to include but not limited to failed GDR is any. This monitoring process will take place monthly within 10 business days of	

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the Licensed pharmacist visit for 3 months or until the pattern of compliance is maintained.

Effective 10/25/2017; Director of Nursing, Staff development Coordinator, Nursing Manager and/or designated licensed nurse will review physician orders for the prior day, for proper transcription and follow through. Director of Nursing, Staff development Coordinator, Nursing supervisor and/or Designated Licensed nurse will follow up to ensure any laboratory tests noted were obtained as ordered. This monitoring process will be done daily (Monday - Friday) for 2 weeks, Weekly x 2 more weeks then monthly x 3 months or until the pattern of compliance is maintained. The result of this monitoring process will be documented on “Daily laboratory monitoring tool and will be maintained in the facility compliance binder.

Effective 10/25/2017; Medical record Clerk will review laboratory log for the prior day(s) and compare with laboratory tests obtained on that date, to ensure all ordered laboratory tests were completed, resulted and followed through appropriately. Any discrepancies noted will be reported to the Director of nursing and/or the Administrator promptly. This monitoring will be done daily (Monday - Friday) x 2 weeks, Weekly x 2 more weeks then monthly x 3 months or until the pattern of compliance is maintained.

Effective 10/25/2017, Director of Nursing

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F 428	Continued From page 37	F 428	will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Effective 10/25/17, the center Executive Director and the Director of health services will be ultimately responsible to ensure implementation of this plan of correction for alleged noncompliance to ensure the facility remains in substantial compliance.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain-	F 514		10/25/17

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F 514	Continued From page 38 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, Consultant Pharmacist interview, and staff interview, the facility failed to have complete and accurate monthly Drug Regimen Reviews (DRRs) and Medication Administration Records (MARs) for 3 of 5 residents (Residents #13, #35, and #78) reviewed for unnecessary medications. The findings included: 1. Resident #13 was most recently admitted to the facility on 2/24/17 with multiple diagnoses that included major depressive disorder, anxiety disorder, delusional disorder, mood disorder, and dementia. A review of the Consultant Pharmacist's monthly Drug Regimen Reviews (DRRs) for Resident #13 indicated there was no DRR between the dates of 2/24/17 and 5/2/17 in the medical record. An interview was conducted with the Consultant	F 514	F514 IMMEDIATE ACTION TAKEN 1. Resident #13 DRR documentation for 2/24/17 and 5/2/2017 retrieved from consultant Pharmacist Electronic Health Records Software and placed in resident's medical records on 10/5/2017 by the licensed pharmacist. Executive Director audited resident 13's medical record on 10/19/17 to ensure the past three months DRRs are present. Results of audit revealed all three months are present. 2. Resident #35 DRR documentation for 12/16/16 and 2/4/2017 retrieved from consultant Pharmacist Electronic Health Records Software and placed in resident's medical records on 10/5/2017 by the licensed pharmacist. Executive Director audited resident 35's medical record on 10/19/17 to ensure the past three months MRRs are present. Results of audit	

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F 514	Continued From page 39 Pharmacist on 10/4/17 at 10:50 AM. She stated she completed a DRR for residents once per month. She indicated she completed the DRR on her own electronic system and then cut and pasted her documentation into the facility's electronic medical records system. The facility's medical record for Resident #13 that indicated there was no DRR for Resident #13 between the dates of 2/24/17 and 5/2/17 was reviewed with the Consultant Pharmacist. The Consultant Pharmacist stated she must have not copied and pasted Resident #13's March 2017 DRR or April 2017 DRR from her electronic system into the facility's electronic medical records system. An interview was conducted with the Administrator on 10/4/17 at 12:00 PM. He stated he expected the Consultant Pharmacist's monthly DRR to be located in the facility's medical record. 2. Resident #35 was admitted to the facility on 9/29/14 with diagnoses that included anxiety disorder, major depressive disorder, and delusional disorder. A review of the Consultant Pharmacist's monthly Drug Regimen Reviews (DRR) for Resident #35 from 11/1/16 through 10/3/17 indicated there was no DRR for Resident #35 between the dates of 12/6/16 and 2/4/17. An interview was conducted with the Consultant Pharmacist on 10/4/17 at 10:50 AM. She stated she completed a DRR for residents once per month. She indicated she completed the DRR on her own electronic system and then cut and pasted her documentation into the facility's electronic medical records system. The facility's medical record for Resident #35 that indicated	F 514	revealed all three months are present. 3. Staff Development Coordinator (SDC) obtained a clarification order from physician on 10/04/2017 for resident #91. Lantus at bedtime was clarified to Levemir at bedtime. SDC transcribed the clarified order appropriately on resident's Medication administration record. Resident responsible party notified by the staff development coordinator on 10/4/2017 of the new order. IDENTIFICATION OF OTHERS 100% audit of DRR documentation for all active residents was completed by the Medical records Clerk and the Executive Director to ensure completion of medical records. This audit covered all DRR documented in the last 3 months. No other resident identified as having missing DRR. This audit was completed on 10/12/2017. Findings of this audit is located in the facility compliance binder. On 10/4/2017, Staff Development Coordinator and Assistant director of Nursing audited all residents with insulin orders to determine if correct order was entered into the resident's electronic medical record. As a result of the audit, two other resident were identified without appropriate order. On 10/4/2017 Staff development coordinator corrected the identified incorrect order; residents' family and physician were notified. It is evident that resident's insulins identified as incorrect were therapeutically substituted as approved by the facility Medical	

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F 514	Continued From page 40 there was no DRR for Resident #35 between the dates of 12/6/16 and 2/4/17 was reviewed with the Consultant Pharmacist. The Consultant Pharmacist stated she must have not copied and pasted Resident #35's January 2017 DRR from her electronic system into the facility's electronic medical records system. An interview was conducted with the Administrator on 10/4/17 at 12:00 PM. He stated he expected the Consultant Pharmacist's monthly DRR to be located in the facility's medical record. 3. Resident #78 was admitted to the facility on 8/18/17. Cumulative diagnoses included diabetes and long term use of insulin. A Significant Change Minimum Data Set dated 9/14/17 indicated Resident #78 was cognitively intact. Diagnoses included diabetes. Medications administered during the assessment period included 7 days of injections and 7 days of insulin. A review of physician orders dated 8/18/17 revealed an order for Lantus insulin 25 units subcutaneous twice daily. A review of physician orders for September and October 2017 revealed the order remained for Lantus insulin 25 units subcutaneous twice daily. On 10/3/17 at 4:29 PM, Nurse #4 was observed during medication pass. She prepared Levemir 25 units and administered Levemir 25 units subcutaneously to Resident #78. An observation of the medication revealed the pharmacy had dispensed the Levemir 100 units/ milliliter vial on 9/13/17 for Resident #78. A review of the electronic Medication	F 514	Director; however the facility did not transcribe the substituted order in resident's electronic Medication Administration Records. 100% audit of current medications for all current residents was completed by the Facility's pharmacy personnel, Director of Nursing, Staff Development Coordinator and Nursing Supervisor on 10/20/2017 to identify any other resident with medication or treatment orders that was therapeutically substituted but not transcribed to reflect the substitution in resident's medication and/or treatment administration records. This audit was completed on 10/12/17, 10/13/17, 10/16/17, 10/17, 10/18/18 and 10/20/17. No other resident identified with therapeutically substituted medication not transcribed in medical records SYSTEMIC CHANGES Effective 10/25/2017, Licensed pharmacist will document monthly DRR to include any failed GDR in resident's electronic medical records and also will provide a hard copy of all DRR monthly to the facility Executive Director and/or Director of nursing to be filed in resident's medical records. Effective 10/25/2017, the new 24-hour chart check will be implemented. The 24-Hour chart check is the process of checking all orders received in the most recent 24 hours to ensure accurate and proper transcriptions. If any medication or	

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F 514	Continued From page 41 Administration Record (MAR) revealed documentation that Resident #78 had received Lantus insulin 25 units subcutaneously by Nurse #4. On 10/3/17 at 4:29 PM, an interview was conducted with Nurse #4 who stated she had administered the Levemir as ordered. She reviewed the Medication Administration Record (MAR) and physician orders and indicated both stated Lantus 25 units subcutaneous twice daily. Nurse #4 stated the pharmacy must have substituted the Lantus with Levemir insulin. On 10/4/17 at 3:00 PM, the Director of Nursing (DON) was interviewed. She expected the nurse to write an order to give Levemir instead of Lantus and she expected the nurses to make sure medication administered matched with the doctor's order. On 10/4/17 at 3:03 PM, an interview was conducted with the Pharmacy Consultant who stated she expected nursing staff to make sure the physician order matches the medication that was administered.	F 514	treatment order is not transcribed as ordered, night shift nurse, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Nursing Supervisor will ensure it is transcribed correctly on the electronic Medication Administration Record or electronic Treatment Administration Records. 24-Hour chart check form will be located in a binder titled 24 Hour report at each nurse's station. Effective 10/20/2017, the center nursing administrative team, which includes DON, ADON, and/or SDC, initiated a process for reviewing all new physician orders or change of orders daily (Monday through Friday) and will address any discrepancy in a promptly. The assigned nurse administrative team member will compare orders written in the physician order forms to orders transcribed on the Medication Administration Record (MAR). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. Effective 10/25/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review, all new orders or change of orders every Saturday & Sunday and will address any discrepancy in a timely manner. The assigned nurse administrative team member will compare orders written in the physician order forms to orders transcribed on the Medication Administration Record (MAR). Any	

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F 514	Continued From page 42	F 514	identified issues will be addressed promptly and appropriate actions will be implemented as appropriate by the Registered Nurse supervisor, and reported to the center's DON timely. On 10/12/2017, Regional Clinical director conducted an education with the center DON and SDC about the process of reviewing new physician orders or changes of orders daily (Monday through Friday). This education emphasized on how to identify a root cause when an order is not transcribed appropriately and actions to be taken to address any discrepancies in a timely manner. Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses, to include full time, part time and as needed staff, on the new 24-hour chart check form and medication administration and transcription. This education will be completed by 10/25/2017. Any licensed nurse not educated by 10/25/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed nurses effective 10/25/2017. MONITORING PROCESS Effective 10/25/2017, the facility medical record clerk, and/or Executive Director will review the facility monthly DRR to ensure completion. Any identified omission will be reported to the licensed pharmacist immediately. This audit will be completed	

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F 514	Continued From page 43	F 514	monthly for 3 months or until the pattern of compliance is maintained. This monitoring process will be documented on "Medical Records audit tool" Effective 10/25/2017, Pharmacy Clinical Director and/or designated Licensed Pharmacy will review the facility monthly DRR documentation to ensure completion and accuracy. This audit will focus to ensure documentation are accurate to include but not limited to failed GDR is any. This monitoring process will take place monthly within 10 business days of the Licensed pharmacist visit for 3 months or until the pattern of compliance is maintained. Effective 10/25/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor proper transcription of physician orders by conducting clinical meeting daily (M-F), review of physician orders written from prior clinical meeting, any admission/discharges occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting. The audit and discussion will ensure physician orders are transcribed correctly to the MARs/TARs. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done. Director of Nursing will review the completion of daily clinical	

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F 514	Continued From page 44	F 514	report daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 10/25/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Effective 10/25/17, the center Executive Director and the Director of health services will be ultimately responsible to ensure implementation of this plan of correction for alleged noncompliance to ensure the facility remains in substantial compliance.	
F 526 SS=D	483.70(o)(1)-(4) Hospice (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident	F 526		10/25/17

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in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:

(i) Ensure that the hospice services meet professional standards and principles that apply to
individuals providing services in the facility, and to the timeliness of the services.

(ii) Have a written agreement with the hospice that is signed by an authorized representative of the
hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:

(A) The services the hospice will provide.

(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.

(C) The services the LTC facility will continue to provide based on each resident's plan of care.

(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.

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(E) A provision that the LTC facility immediately notifies the hospice about the following:

(1) A significant change in the resident's physical, mental, social, or emotional status.

(2) Clinical complications that suggest a need to alter the plan of care.

(3) A need to transfer the resident from the facility for any condition.

(4) The resident's death.

(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.

(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal

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F 526	Continued From page 47 illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. (3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.	F 526		

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The designated interdisciplinary team member is responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.

(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

(iv) Obtaining the following information from the hospice:

(A) The most recent hospice plan of care specific to each patient.

(B) Hospice election form.

(C) Physician certification and recertification of the terminal illness specific to each patient.

(D) Names and contact information for hospice personnel involved in hospice care of each patient.

(E) Instructions on how to access the hospice's 24-hour on-call system.

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F 526	Continued From page 49 (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. (4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by: Based on record review, observation and facility and hospice staff interview, the facility failed to designate a member of the facility's interdisciplinary team to coordinate the care provided between the facility and hospice staff and to have the most recent plan of care, including the hospice medication information and all the hospice notes pertaining to the care and services provided by the hospice staff to the hospice resident for I (Resident #72) of 1 sampled resident who was receiving hospice services. Findings included: Resident #72 was admitted to the facility on 8/31/16 with multiple diagnoses including	F 526	IMMEDIATE ACTION Most recent plan of care, hospice medication information, certification of terminal illness, hospice contact information and visit notes were placed in resident #72's Hospice Notebook by the Social Worker on 10/5/2017. IDENTIFICATION OF OTHERS On 10/6/17, 10/9/17, 10/10/17 and 10/11/17 the Social Worker audited 100% of active hospice residents in the facility to ensure the appropriate documentation is present in the resident's chart. There were no further issues noted as a result of the audit. Findings of this audit is documented and maintained in the facility	

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F 526	Continued From page 50 Dementia with behaviors and unspecified psychosis. The annual Minimum Data Set (MDS) assessment dated 8/22/17 indicated that Resident #72 had severe cognitive impairment and he was receiving hospice services while a resident at the facility. Resident #72's care plan dated 8/24/17 was reviewed. One of the care plan problems was "I have chosen to receive Hospice care related to my diagnosis of cerebrovascular accident with right sided weakness (hemiplegia)." The goal was "I will remain comfortable throughout Hospice care as evidenced by report of improved comfort following interventions for pain management x (times) 3 months (within 45-60 minutes of intervention)." The approaches "to coordinate my care with my Hospice Team, my family and physician, coordinate with the Hospice Team to assure I experience as little pain as possible, provide activities of daily living (ADL) related to my right sided weakness." On 10/3/17 at 12:05 PM and 2:27 PM - Resident #72 was observed. He was up in wheelchair and he had no signs or symptoms of pain or discomfort. Resident #72's medical records including the electronic records were reviewed. The hospice section of the records contained hospice information including hospice election form and hospice communication log forms. The communication log forms revealed that a Nurse had visited the resident on 2/3/17, 2/6/17, 2/9/17, 4/3/17, 4/7/17, 4/10/17, 4/28/17, 5/10/17, 7/27/17, 8/21/17 and 9/28/17. The records did not contain the most recent hospice plan of care, hospice medication information, hospice certification and	F 526	compliance binder SYSTEMIC CHANGES Effective 10/20/2017, the facility designated the Director of Social Services of the center to coordinate the care provided between the facility and Hospice staff. Effective 10/20/2017, facility will utilize “hospice binder, located at the nurses station. Most recent resident’s plan of care to include hospice medication information, most recent hospice notes pertaining to the care and services provided by the Hospice agency to the resident. Effectively 10/25/2017 a monthly hospice audit tool will be utilized to ensure all appropriate documentation is present in the resident’s Hospice Notebook. This form will be maintained in each Hospice resident’s notebook located in the facility. On 10/6/17, the Administrator in-serviced the Social worker on the “monthly hospice audit” tool. 100% education will be provided by the Director of Nursing, Staff Development coordinator and/or nursing manager to all licensed nurses including full time, part-time and as needed staff regarding documentation and communication with the hospice agencies utilized by the facility. Education of nursing staff will be complete by 10/25/17. Any Licensed nurse who has not received education by 10/25/2017 will not be allowed to continue working until educated. MONITORING PROCESS. Effective 10/25/2017; Social Worker or	

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F 526	Continued From page 51 recertification and complete hospice visit notes. On 10/3/17 at 3:45 PM, the Social Worker (SW) was interviewed. She stated that she coordinated the care provided to hospice residents between the hospice and the facility staff. The SW further stated that the hospice agency providing hospice care and services to Resident #72 stated that a hospice plan of care was not needed. She also stated that the Hospice Aide visited weekly and the SW had no scheduled visit, she visited anytime. The SW revealed that the Hospice staff had their notes in their tablet and she didn't know if their notes were sent to the facility. On 10/3/17 at 3:52 PM, Nurse #6 was interviewed. She stated that the Hospice Nurse for Resident #72 visited every 1-2 weeks and she documented her notes on her tablet. She didn't know if the hospice notes were sent to the facility or not. Nurse #6 also indicated that she had not seen a Hospice Aide or SW visited Resident #72. On 10/4/17 at 9:05 AM, the SW provided copies of the most recent plan of care of Resident #72, Hospice certification and recertification, Hospice medication information and hospice visit notes dated 9/6/17, 9/11/17, 9/22/17 and 9/28/17. She indicated that she had called the office of the hospice agency and the office faxed these information to the facility. She reported that she had talked with the Hospice Nurse who informed her that she would asked their office as to why their notes were not sent to the facility. The SW further stated that the hospice agency indicated that a hospice plan of care was not needed for the resident. She added that she was informed that only a Nurse was assigned to visit Resident #72 once a week on Wednesdays and no	F 526	Administrator will audit the hospice notebook weekly for 4 weeks then monthly for three months or until the pattern of compliance is maintained. Findings of this audit will be documented in monthly Hospice Audit Tool. Effective 10/25/2017; the Executive Director, Director of Nursing and/or Social worker will report findings of this monitoring process to facility Quality Assurance Performance improvement Committee monthly for 3 months, or until the pattern of compliance is maintained. The QAPI committee will recommend any additional monitoring needs or alteration of this requirement as it deem it appropriate Effective 10/25/17, the center Executive Director and the Director of health services will be ultimately responsible to ensure implementation of this plan of correction for alleged noncompliance to ensure the facility remains in substantial compliance	

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Hospice Aide, SW or Chaplain.

On 10/4/17 at 3:00 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected a hospice resident to have a hospice plan of care and to have their hospice notes filed in the resident's medical records. She added that she didn't have a good communication with this hospice agency and they didn't have a hospice care plan meeting.

On 10/5/17 at 8:50 AM, the Hospice Nurse was interviewed She stated that she was the hospice designee for Resident #72. She came to visit once a week and as needed and she documented her visit notes on her tablet. She also revealed that a Hospice Aide visited Resident #72 twice a week and she also had documented her notes on her tablet. The Hospice Nurse reported that there was no SW or Chaplain scheduled to visit the resident per family request. She stated that hospice plan of care (POC) should include the frequency of visit of each discipline and the medication information and the POC should be kept in resident's medical records and a copy in their office. The Hospice Nurse further indicated that Resident #72 was recertified for hospice services every 60 days and the hospice notes can be printed and sent to the facility. She stated that she didn't know who the facility designee was for hospice care, when she came to visit, she talked to the resident's Nurse, Aide, SW or the Physician Assistant (PA).