STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345372	A. BUILDING ______ B. WING ______	C 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON PINES NURSING AND REHABILITATION CENTER	403 CRESTVIEW AVENUE WILSON, NC 27893

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		7/16/18

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(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

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/12/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 842	Continued From page 1 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (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 staff interviews and record reviews, the facility failed to document a physician ' s order to change a dosing schedule for the administration of a controlled substance medication for 1 of 3 sample residents (Resident #2); and, failed to completely and accurately document the administration of a prescribed medication on the Medication Administration Record (MAR) for 1 of 3 sample residents reviewed (Resident #2). The findings included:	F 842	The process that led to this deficiency was facility failed to document a physician's order to change a dosing schedule for the administration of a controlled substance medication for 1 of 3 sampled residents (resident #2) and failed to completely and accurately document the administration of a prescribed medication on the Medication Administration Record (MAR) for 1 of 3 sampled residents (resident #2)	

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F 842

Continued From page 2

1) Resident #2 was admitted to the facility on 2/1/17 from a hospital. His cumulative diagnoses included a history of constipation, Type 2 diabetes, and dementia.

A review of Resident #2 ' s quarterly Minimum Data Set (MDS) assessment dated 3/14/18 revealed the resident had severely impaired cognitive skills for daily decision making. Section G of the MDS assessment indicated the resident required extensive to total assistance for all of his Activities of Daily Living (ADLs).

A review of the resident ' s medical record revealed Resident #2 underwent a surgical procedure on 5/4/18. A review of the resident ' s physician orders revealed a telephone order was received to initiate 300/30 milligrams (mg) acetaminophen with codeine (a combination medication which included a controlled substance for pain relief) on 5/5/18 as one tablet to be given by mouth every six hours. A review of Resident #2 ' s May 2018 Medication Administration Record (MAR) revealed this medication was scheduled to be given at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM each day, beginning with the 6:00 AM dose on 5/5/18.

Further review of the resident ' s May 2018 MAR revealed a handwritten notation indicated the administration of acetaminophen with codeine given every 6 hours was discontinued after the 6:00 AM dose on 5/9/18. The MAR included a handwritten notation (not dated) which initiated the administration of 300/30 mg acetaminophen with codeine as one tablet by mouth every 6 hours on an as needed basis (versus scheduled dosing). The MAR revealed one dose of 300/30

F 842

On 7/12/18, a 100% audit of all new physician's orders and Medication Administration Records (MARs) for the past 30 days to include resident #2 was completed by the Director of Nursing, Nurse Supervisors, Resource Nurse, Quality assurance Nurses, Minimum Data Set nurse, Staff Facilitator and Treatment Nurses to ensure all medication orders were accurately transcribed to the MAR and provided as ordered. Any omissions noted were addressed immediately by the Director of Nursing, Nurse Supervisors, Quality Assurance Nurses, Minimum Data set nurse, Staff Facilitator and Treatment Nurses to include staff retraining, assessment of residents with omitted medications, to include physician notification and implementation of new orders as applicable.

On 7/12/18, a 100% audit was completed by the Director of Nursing, Nurse Supervisors, Resource Nurse, Quality assurance Nurses, Minimum Data Set nurse, Staff Facilitator and Treatment Nurses of all progress notes x 30 days to ensure all documentation of new orders to include resident #2 were accurately transcribed to the MAR and provided as ordered. All areas of concern were immediately addressed by the Director of Nursing, Nurse Supervisors, Resource Nurse, Quality Assurance Nurses, Minimum Data Set nurse, Staff Facilitator and Treatment Nurses to include staff retraining, assessment of residents with omitted medications, to include physician

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mg acetaminophen with codeine was administered to Resident #2 on 5/15/18, one dose was administered on 5/17/18, and one dose was administered on 5/27/18.

A review of Resident #2 ' s physician ' s orders revealed no order was written to discontinue the scheduled dosing of 300/30 mg acetaminophen with codeine initiated on 5/5/18; and, no order was written to initiate the administration of the acetaminophen with codeine on as needed basis (versus scheduled dosing).

An interview was conducted on 6/28/18 at 12:15 PM with Nurse Supervisor #1 in the presence of the facility ' s Director of Nursing (DON). Nurse Supervisor #1 was identified as having handwritten the change in dosing for Resident #2 ' s acetaminophen with codeine from a scheduled to an as needed basis on the resident ' s MAR. Upon review of the resident ' s records, the Nurse Supervisor stated she recalled talking with the facility ' s Nurse Practitioner (NP) and changing the resident ' s order for the acetaminophen with codeine to be given on as needed basis instead of scheduled dosing. The nurse stated she changed the dosing on Resident #2 ' s MAR, but must have forgotten to write the actual order in the resident ' s medical record. Upon inquiry, the DON stated her expectation was, "for the order to have been written."

2) Resident #2 was admitted to the facility on 2/1/17 from a hospital. His cumulative diagnoses included a history of constipation, Type 2 diabetes, and dementia.

A review of Resident #2 ' s quarterly Minimum Data Set (MDS) assessment dated 3/14/18

F 842

notification and implementation of new orders as applicable.

On 7/12/18 a 100% audit of all MARs x 30 days to include resident #2 was completed by the Director of Nursing, Nurse Supervisors, Resource Nurse, Quality Assurance Nurses, Minimum Data Set nurse, Staff Facilitator and Treatment Nurses to ensure all medications given were completely and accurately documented by nursing staff. All omissions were immediately addressed by the Director of Nursing, Nurse Supervisors, Quality assurance Nurse, Minimum Data set nurse, Staff Facilitator and Treatment Nurses to include staff retraining, assessment of residents with omitted medications, to include physician notification and implementation of new orders as applicable.

On 7/12/18, assessments were completed by the licensed nurses for all residents noted to have medication omissions to determine if any adverse effects were present. The Medical Director was notified of any adverse findings noted during the assessment. The Director of Nursing will utilize a resident census sheet to review all residents with medication omissions and ensure an assessment has been completed and the physician notified of adverse findings.

On 7/11/18, a 100% in-service for all licensed nurses and medication aides was initiated by the Director of Nursing, Staff

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revealed the resident had severely impaired cognitive skills for daily decision making. Section G of the MDS assessment indicated the resident required extensive to total assistance for his Activities of Daily Living (ADLs).

A review of the resident ' s medical record revealed a physician ' s order (based on the physician standing orders) was written on 5/9/18 for the following:
1) Milk of Magnesia (a laxative, frequently abbreviated as MOM) 30 milliliters (ml) by mouth as needed for constipation;
2) If no relief with MOM, add 17 grams Miralax (a laxative) by mouth daily times two doses;
3) If still no relief, may try Fleets enema (a bowel evacuant or laxative) for one dose.

A review of Resident #2 ' s Nursing Notes included a notation dated 5/9/18 at 7:00 PM. This notation reported the resident ' s physician was notified and Milk of Magnesia was administered due to his failure to have a bowel movement in 3 days. However, a review of Resident #2 ' s May 2018 Medication Administration Record (MAR) did not indicate a dose of Milk of Magnesia was administered to the resident on 5/9/18 for relief of the constipation.

An interview was conducted with the facility ' s Director of Nursing (DON) on 6/28/18 at 11:35 AM. Upon inquiry, the DON stated she would have expected the administration of the Milk of Magnesia to Resident #2 on 5/9/18 to have been documented on the resident ' s MAR.

F 842

Facilitator, Quality Assurance Nurses, Nurse Supervisors, Resource Nurse, Minimum Data Set Nurse, and Treatment Nurses in regards to documentation of medications on MAR to ensure all medications are administered as ordered with documentation in the MAR.

To reduce confusion with verbal orders, the following recommendations have been developed:
1) Verbal communication of medication orders should be limited to situations where immediate written, fax, or electronic communication is not feasible.
2) Long term care facilities should promote a culture in which it is acceptable, and strongly encouraged, for nursing staff to question prescribers when there are any questions or disagreements about verbal orders. Questions about verbal orders should be resolved prior to the transcription, dispensing, or administration of the medication.
3) Elements that should be included in a verbal order include:
*Name of patient *room number *drug name
*Dosage form (e.g., tablets, capsules, inhalants)
*Exact strength or concentration
*dose, frequency, and route
*duration of medication therapy
*indication or diagnosis
*full name of prescriber and the name of the individual transmitting the order, if different from the prescriber
*name of individual taking the verbal order and the date and time of the order

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F 842	Continued From page 5	F 842	4) The content of verbal orders should be clearly communicated: *The name of the drug should be confirmed by spelling the drug and the indication back to the prescriber *In order to avoid confusion with spoken numbers, a dose such as 50mg should be repeated as “five zero milligrams” *Instructions for use should be provided without abbreviations. For example, “ 1 tab tid” should be communicated as “give one tablet three times daily” 5) The entire verbal order should be repeated back to the prescriber, or individual transmitting the order, using the principles outlined above. 6) All verbal orders should be reduced immediately to writing, transmitted or fax to the pharmacy, transcribed to the medication administration record (MAR) and countersigned by the prescriber per facility protocol. *All orders on MAR should be signed once medication is given. Check each MAR for signatures prior to moving to the next resident. During shift change while giving report both nurses or med aides should check each MAR for missing signatures so this can be addressed and corrected at that time No licensed nurse or medication aides will be allowed to work until in-service is completed. All newly hired licensed nurses and medication aides will by in-serviced by the Staff Facilitator during	

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F 842	Continued From page 6	F 842	orientation in regards to documentation of medications on MAR. All MARs to include resident #2 will be reviewed by the Director of Nursing and/or Nurse Supervisors, Resource Nurse, Quality assurance Nurse, Minimum Data Set nurse, Staff Facilitator and Treatment Nurses weekly for 8 weeks, then monthly for 1 month, utilizing an MAR Audit Tool to ensure all orders to include verbal orders are written and transcribed accurately to MAR and that all licensed nurses and medication aides completely and accurately document the administration of a prescribed medication on the Medication Administration Record (MAR). All areas of concern will be immediately addressed by the Director of Nursing, Nurse Supervisors, Resource Nurse, Minimum Data Set nurse, Quality Assurance Nurses, Staff Facilitator and Treatment Nurses to include staff retraining and assessment of residents with omitted medications to include physician notification and implementation of new orders as applicable. The DON will review and initial the MAR for completion weekly for twelve weeks. The Administrator will present the findings of the MAR Audit Tool to the Executive QI committee monthly for 3 months. The Executive QI Committee will meet monthly for 3 months and review the MAR Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 842	Continued From page 7	F 842	The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	