STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation which was conducted at the time of the annual recertification survey from 10/29/18-11/2/18. Event ID JZUZ11.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a significant change Minimum Data Set (MDS) for a resident with two areas of change, a Stage 4 pressure ulcer and suspected Deep Tissue Injury (sDTI), for 1 of 2 residents reviewed for pressure ulcers. Findings included: Resident #3 was admitted to the facility on 04/16/18 with the following diagnoses: altered mental status secondary to encephalopathy, Alzheimer's disease, dementia without behavioral disturbance, history of stroke with right-sided weakness, expressive language disorder, feeding	F 637	Smoky Mountain Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Smoky Mountain Health and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an	11/30/18

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

Electronically Signed | 11/29/2018

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F 637	Continued From page 1 difficulties, oropharyngeal dysphagia (difficulty swallowing), dehydration, hypertension, urinary retention, abnormal posture, generalized muscle weakness. The following secondary diagnoses were initiated during her stay following her admission to the facility: adult failure to thrive, osteomyelitis (bone infection) of the sacral and sacrococcygeal region of the vertebra, stage 4 pressure ulcer of the sacral region, neurogenic bladder, and contractures of the left and right knees. A review of the Admission Minimum Data Set (MDS), dated 04/23/18, indicated Resident #3's cognition was moderately impaired, needed extensive assistance with two (2) plus person physical assistance for bed mobility and dressing, total dependence with 2 plus person physical assistance for transfers and toileting, and extensive assistance with one (1) person physical assistance for eating. The MDS further indicated Resident #3 was frequently incontinent of bowel and bladder and was at risk of developing pressure ulcers but was not coded for having any pressure ulcers or opioids (pain medications). The MDS revealed the resident was coded for a pressure reducing device for a chair and bed. A review of the Pressure Ulcer Care Area Assessment (CAA), dated 04/29/18, revealed Resident #3 received a pureed diet with nectar thickened liquids with an average meal intake between 50 -100% and the staff fed her. The CAA further revealed she was non-ambulatory. The CAA indicated she was at risk for pressure ulcer development but had no skin breakdown or pressure areas. The MDS further indicated that Resident #3 needed extensive assistance with bed mobility and other activities of daily living	F 637	admission that any deficiency is accurate. Further Smoky Mountain Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The position of Smoky Mountain Health and Rehabilitation Center regarding the process that led to a deficiency was staff failure to follow established policy and procedure. Resident #3 significant change Minimum Data Set (MDS) was completed and submitted 11/29/2018. During Interdisciplinary Team Meetings (IDT), held 5 days per week, all current residents have been reviewed for any significant change identified. On 11/28/18 one resident was identified as a significant change and a significant change MDS was opened 11/28/18. On 11/29/18 the Corporate MDS Consultant in-serviced the facility MDS Nurse on completing a significant change in status assessment per guidelines: reviewed definition of a significant change in status and how to identify/determine if a significant change in status assessment(SCSA) is needed(either a major decline/improvement); and how the IDT will discuss any residents experiencing acute episodes and will monitor for 14 days and document initial	

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F 637	Continued From page 2 (ADL's) and that therapy was working with the resident to reduce right sided weakness. A review of a Skin Referral Form, dated 05/06/18, indicated Resident #3 had broken skin on her coccyx. A review of a Skin Referral Form, dated 05/14/18, indicated Resident #3 was evaluated by the Treatment Nurse and she determined the resident had a Stage 3 pressure ulcer on the cleft of her buttock. The Skin Referral Form further indicated that treatment orders were initiated. A review of a Wound Ulcer Flowsheet, dated 05/17/18, indicated there was a Stage 3 pressure ulcer on the left inner buttock that measured 3.5-centimeter (cm) (length) x 2 cm (width) x 1 cm (depth). A review of a Wound Ulcer Flowsheet, dated 05/23/18, indicated that the pressure ulcer on the left inner buttock was re-classified as an Unstageable pressure ulcer that measured 3.5 cm x 2 cm x 1.4 cm with an increased depth. A review of a Wound Ulcer Flowsheet, dated 05/30/18, indicated that the Unstageable pressure ulcer on Resident #3's left inner buttock measured 3.5 cm x 2 cm x 3 cm. The flowsheet further indicated that the wound had purulent (pus-like) drainage and an odor. The flowsheet revealed that a wound culture was ordered, and the wound was infected. A review of a Wound Ulcer Flowsheet, dated 06/08/18, indicated the pressure ulcer on the left inner buttock was re-classified as a Stage 4 pressure ulcer and measured as 3 cm x 1.3 cm x	F 637	identification of a significant change and will determine if a significant change in status assessment is needed. During IDT meetings held 5 days per week, residents with any significant change will be discussed, identified and monitored for 14 days to determine if a Significant Change in Status Assessment (SCSA)is required per RAI Manual guidelines. An audit tool will be used at the IDT meetings that identifies residents that require a SCSA. This tool will be reviewed 5 days a week x 4 weeks, then weekly x 4, then monthly x 4. The monthly QI committee will review the results of the significant change audit tool monthly for 6 months for identification of actions taken and to determine the need for, and/or the frequency of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or the DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The Director of Nursing is responsible for implementing the plan of correction.	

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F 637	Continued From page 3	F 637		

2.2 cm.

A review of a Wound Ulcer Flowsheet, dated 07/06/18, indicated Resident #3 developed a Suspected Deep Tissue Injury (sDTI) on the left heel which measured 3 cm x 2 cm x 0 cm.

A review of a Wound Ulcer Flowsheet, dated 07/18/18, indicated the Stage 4 pressure ulcer site was named as a Sacral wound instead of left inner buttock that measured 3.5 cm x 2 cm x 2 cm. The flowsheet further indicated no infection was present in the wound.

A review of the Quarterly MDS, dated 07/24/18, revealed Resident #3 had short and long-term memory problems and was severely impaired regarding daily decision making. The MDS further revealed Resident #3 needed total dependence with 2 plus person physical assistance for bed mobility, transfers, dressing, and toileting and total dependence with 1-person physical assistance for eating. The MDS indicated Resident #3 was always incontinent of bowel and had an indwelling Foley catheter. The MDS further indicated the resident was coded for a Stage 4 pressure ulcer, a Suspected Deep tissue injury (sDTI), a pressure reducing device for a chair and bed, nutrition interventions, pressure ulcer care and 1 day of opioids within 7 days.

A review of Resident #3's medical record, from May 2018 to July 2018, indicated that a Significant Change MDS was not implemented following the discovery of the Stage 4 Sacral pressure ulcer and sDTI of the left heel.

A review of a Wound Ulcer Flowsheet, dated 08/20/18, indicated the left heel pressure ulcer

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F 637	Continued From page 4 was re-classified as Unstageable and measured 1 cm x 2 cm x 0 cm. A review of a Wound Ulcer Flowsheet, dated 09/21/18, indicated the left heel wound was re-classified as an Arterial Ulcer that measured 1 cm x 1.4 cm x 0.3 cm. The flowsheet further indicated that specialized boots were put implemented as an intervention. A review of a Wound Ulcer Flowsheet, dated 10/30/18, indicated the Stage 4 Sacral pressure ulcer measured 1 cm x 1.3 cm x 1 cm and no infection was present. The flowsheet further indicated that the left heel arterial ulcer measured 0.8 cm x 0.6 cm x 0.5 cm and no infection was present. On 11/02/18 at 10:28 AM, an interview was conducted with the MDS nurse. She indicated that the 2 areas of change related to the pressure ulcers that developed should have warranted a Significant Change MDS prior to the Quarterly MDS, dated 07/24/18. On 11/02/18 at 01:18 PM, an interview was conducted with the Administrator. She indicated that her expectation was that there should have been a Significant Change MDS for Resident #3 with the development of the 2 pressure ulcers prior to the Quarterly MDS, dated 07/24/18.	F 637		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655		11/29/18

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F 655	Continued From page 5	F 655		

implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

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F 655	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan in the areas of surgical incision and infection within 48 hours of admission to the facility for 1 of 2 newly admitted residents reviewed for baseline care plan (Resident #92). The findings included: Resident #92 was admitted to the facility on 09/10/18 with the following diagnoses: spinal stenosis, decompression of Lumbar (L) 2 and L 5 with posterior lateral fusion surgical repair of L4 through L5 on 08/06/18, wound rupture along the surgical line with a staph infection of the wound after surgery, hypertension, chronic obstructive pulmonary disease (COPD), and stage 3 chronic kidney disease. A review of the hospital discharge orders, dated 09/10/18, revealed an order for Linezolid, an antibiotic, 600 mg (1 tablet) by mouth every 12 hours for 16 doses. A review of a physician order, dated 09/14/18, revealed an order for daily dressing changes to the surgical incision, may cleanse with betadine, cover with absorbent dressing and change as needed. A review of the nursing admission assessment, dated 09/10/18 at 6:22 PM, revealed Resident #92 was alert and oriented to person, place, and time. The admission assessment further revealed there was a mid to lower back surgical incision which measured 4.5 inches long with thick black stitches that were intact. The assessment	F 655	Resident #92 was discharged home on 10/02/2018. On 11/28/18 all new admissions within the last 30 days were reviewed by the Corporate MDS Consultant for complete 48 hour baseline care plans to include infections and/or surgical wounds. On 11/27/18 the DON in-serviced the MDS Nurse on completing baseline care plans on all new admits within 48 hours based on RAI Manual guidelines to include surgical wounds and infections. Using an auditing tool, the DON/ADON will review any new admissions within 48 hours for completed baseline care plan to include surgical wounds and/or infections weekly x 4 weeks, then biweekly x 1 month, then monthly x 4. The monthly QI committee will review the results of the 48 hour baseline care plan auditing tools monthly x 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or the DON will present the finding and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The Director of Nursing is responsible for implementing the plan of correction.	

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F 655	Continued From page 7	F 655		

indicated the dressing had a small amount of serosanguinous drainage noted to the base of the dressing and that the dressing was changed on 09/10/18 at the hospital prior to the resident transferring to the facility.

A review of the skilled/post-acute nursing note, dated 09/11/18 at 4:57 AM, indicated Resident #92's skin was intact and the dressing to her back was intact. The skilled/post-acute nursing note further indicated that the resident was receiving an antibiotic for infection.

A review of the Admission Minimum Data Set (MDS), dated 09/17/18, indicated Resident #92 was cognitively intact, needed limited assistance with two (2) plus person physical assistance for bed mobility, limited assistance with one (1) person physical assistance for transfers and extensive assistance with 1-person physical assistance for dressing and toileting. The MDS revealed that the resident had the following areas coded: an infection following a procedure, a surgical wound with surgical wound care and received 7 days of antibiotics since admission.

A review of the Resident #92's baseline care plan, dated 09/21/18, revealed there was no Focus or Problem related to the surgical incision or the surgical infection.

An interview was conducted with the Treatment Nurse on 11/01/18 at 10:58 AM. She indicated that she oversaw Resident #92's dressing changes. She further indicated the resident's surgical incision had healed well.

An interview was conducted with the MDS nurse on 11/02/18 at 10:40 AM. She stated that the

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F 655	Continued From page 8 Baseline Care Plan should have addressed the surgical Incision and the infection. An interview was conducted with the Director of Nursing (DON) on 11/02/18 at 12: 53 PM. She did not address the issue of the baseline care plan but did state when the facility had the new admission on 09/10/18, Nurse #2 completed the admission assessment on Resident #92. The DON further stated that Nurse #2 checked the resident's dressing, performed a head-to-toe assessment, and sent a skin referral to the treatment nurse. An interview was conducted with the Administrator on 11/02/18 at 01:18 PM. She indicated that her expectation was that the baseline care plan should have addressed the surgical incision and the wound infection.	F 655		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		11/30/18

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F 761	Continued From page 9 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to discard 1 opened and expired Humalog Insulin KwikPen for 1 of 1 residents (Resident #25) and was available for use from 1 of 1 medication storage refrigerators. Findings included: A review of the facility policy, entitled Medication Discard Dates, indicated Humalog KwikPens were to be discarded 28 days once opened. Resident #25 was admitted to the facility on 09/26/18 with a diagnosis of diabetes mellitus. A review of a physician's order, dated 09/27/18, indicated Resident #25 was to receive Humalog KwikPen per sliding scale three times a day. A review of the facility Medication Self-Administration Assessment Form, dated 10/04/18, indicated that Resident #25 could safely self-administer medications. An observation was made on, 10/31/18 at 10:30 AM, of the medication room refrigerator. The observation revealed that a Humalog Insulin KwikPen was opened on 09/27/18 and had an expiration date of 10/25/18. Further observation	F 761	Resident #25 - Humalog Insulin KwikPen was discarded 10/31/18. On 10/31/18 the DON conducted an inspection of the insulin pen kept at bedside of resident #25 for physician ordered self administration and insulin pen was within use date. On 10/31/18 The DON and/or ADON audited all insulin products on each medication cart and in the medication refrigerator for properly dated and expired insulin. The audit revealed no expired insulin. On 11/15/18 the Pharmacy Consultant completed an audit on properly dated, labeled and storage of insulin on medication carets and medication refrigerator. Audit revealed no expired insulin. On 11/27/18 the DON and/or Staff Facilitator started a 100% in-service with Licensed nurses and medication aides on dating all insulin products upon opening and discarding on date indicated. This in-service will be complete by 11/30/18. No Licensed nurses or medication aides	

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F 761	Continued From page 10 of the Humalog Insulin KwikPen revealed that the pen was half empty. An interview was conducted, on 10/31/18 at 10:34 AM, with Nurse #1. She stated Resident #25 was self-medicating her insulin. She further stated that Resident #25 had an assessment to self-medicate in her chart. Nurse #1 indicated that the resident kept the insulin in a locked drawer in her room and that the resident should've had an additional Humalog Insulin Kwikpen in her locked drawer. Nurse #1 further indicated that the nursing staff brought the resident a new insulin pen when she was out. Nurse #1 revealed that the expired insulin pen should have been discarded. An interview was conducted, on 10/31/18 at 10:44 AM, with the Director of Nursing (DON). She stated that the insulin pen should have been taken out of the refrigerator and discarded immediately. An interview was conducted on, 11/01/18 at 07:15 AM, with the Administrator. She stated that the medication should have been discarded immediately.	F 761	will be allowed to work after 11/30/18 until they have received in-servicing on dating all insulin products upon opening and discarding on date indicated. This in-service will be included with orientation for all newly hired licensed nurses and medication aides. Using an auditing tool, the DON/ADON will audit all insulin products in the medication carts and medication refrigerator weekly x 4, then biweekly x 2 months, then monthly x 3. Results of the audits will be reviewed by the monthly QI committee for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or the DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The Director of Nursing is responsible for implementing the plan of correction.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §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	F 842		11/30/18

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(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 842	Continued From page 11	F 842		

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 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

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	345396	A. BUILDING _____ B. WING _____	C 11/02/2018

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F 842	Continued From page 12 (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 medical record review and staff interviews, the facility failed to ensure a comprehensive list of allergies was included in the medical record for 1 of 5 sampled residents with medications reviewed. (Resident #13) The findings included: Resident #13 was admitted to the facility on 09/30/11 with diagnoses which included: end stage renal disease, acute sinusitis, acute pharyngitis, chronic ischemic heart disease, anemia, anxiety, cardiac pacemaker, hyperparathyroidism, hypothyroidism, depression and diabetes. The latest Minimum Data Set was an annual assessment dated 08/31/18 which assessed Resident #13 with no cognitive impairment.	F 842	Resident # 13 had Zithromax added to the comprehensive list of allergies on 11/01/18. On 11/01/18 a clarification order was sent to the pharmacy identifying the Zithromax as an allergy; it was identified on the Medication Administration Record (MAR), on the Treatment Administration Record (TAR) and hard chart front. Zithromax was already identified in the electronic medical record. On 11/27/18 all current residents had an audit of their electronic medical record list of allergies compared to their list of allergies on their MAR, allergies on their TAR and allergies on the hard chart front to reflect each resident's comprehensive list of allergies. On 11/29/18 the DON and MDS Nurse	

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F 842	Continued From page 13 Review of the paper medical record noted a list of drug allergies for Resident #13 which included: Demerol, Morphine Sulfate, Phenergan, Ambien, Lexapro and Levaquin. These allergies were noted on the allergy sticker alert on the outside of the paper chart, on the monthly physician orders, on the monthly medication administration records (MARs), and embedded in physician and nurse practitioner progress notes. The electronic medical record of Resident #13 included the same list of drug allergies in addition to Zithromax. A physician's handwritten order on 10/05/15 noted Z-pack (Zithromax) was ordered for an upper respiratory infection. Nursing progress notes in the electronic medical record of Resident #13 dated 10/06/15 read, "Received order to discontinue Z-pack. Resident states allergy." Review of the entry of the allergy to Zithromax in the electronic medical record of Resident #13 noted it was entered as an allergy on 10/06/15. On 11/01/18 at 9:00 AM, a pharmacist representing the pharmacy (that dispensed medication to the facility where Resident #13 resided) stated they were not aware of the allergy to Zithromax for Resident #13. The pharmacist stated because the allergy to Zithromax was not in their system it would not "flag" the medication if the physician ordered it for Resident #13. The pharmacist stated they provided the monthly physician orders and MARs for the facility and noted the allergies listed on the monthly physician orders and MARs did not include the Zithromax since they were not aware of the allergy. The pharmacist stated the order entry supervisor for the pharmacy was responsible for updating	F 842	started auditing the thinned physician's orders of any current residents that have been in the facility for 3 years for any additional allergies. Any additional allergies noted will have a written physician's order faxed to the pharmacy and will be added to the comprehensive list of allergies on the electronic medical record, the MAR, the TAR and on the front of the hard chart. This will be completed 11/30/18. On 11/27/18 the DON and/or the Staff Facilitator started a 100% in-service with Licensed nurses on maintaining a comprehensive list of allergies on residents to include: interviewing residents on admission; list allergies on the front of the hard chart, list allergies on the MAR and TAR and in the electronic medical record; any new allergies noted are to have a written physician's order faxed to the pharmacy and are to be written on the MAR and TAR, on the front of the hard chart and in the electronic medical record. This in-service will be complete by 11/30/18. No Licensed nurses will be allowed to work after 11/30/18 until they have received in-servicing maintaining a comprehensive list of allergies on each resident as above. This in-service will be included with orientation for all newly hired licensed nurses. Using a comprehensive allergies list auditing tool, the DON/ADON and/or Weekend RN Supervisor will audit all new admissions within 48 hours of admission for a comprehensive list of allergies x 4	

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F 842	Continued From page 14 resident information which included any known allergies. On 11/01/18 at 9:15 AM, the order entry supervisor for the pharmacy stated there were several ways a facility could submit new allergy information to the pharmacy to ensure the pharmacy was aware of all known allergies. The order entry supervisor stated it could be done through a written physician's order or on the copy of the individual resident's paper MAR that was returned to the pharmacy. The order entry supervisor verified not being aware of the allergy to Zithromax for Resident #13. On 11/01/18 at 11:00 AM, the Director of Nursing (DON) stated it was best practice to have all allergies updated and included on the resident's electronic record and paper record; including the allergy sticker and monthly orders and MARs. The DON stated she had just recently started in her position and could not explain what happened. On 11/01/18 at 2:15 PM, the facility consultant pharmacist stated she found the handwritten physician order that was written on 10/06/15 for Resident #13 which read, "discontinue Z-pack-patient states allergy. Keflex 500 milligrams three times a day for 7 days for upper respiratory infection." The pharmacist stated it should have been enough information for the order entry supervisor at the pharmacy to include the Zithromax as an allergy for Resident #13. The pharmacist stated she could not explain what happened but noted the allergy should have been reflected on the allergy sticker, physician monthly order and MAR for Resident #13.	F 842	weeks, then weekly x 4 weeks, then biweekly x 2 months, then monthly x 2. The monthly QI committee will review the results of the comprehensive allergies list auditing tool for 6 months for identification of trends, actions taken, and to determine the need for and/or the frequency of continued monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The Director of Nursing is responsible for implementing the plan of correction.	

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F 842	Continued From page 15 On 11/01/18 at 3:00 PM, the administrator stated she expected the electronic medical record and paper medical record of each resident to be reflective of all known allergies. The administrator stated the allergy to Zithromax should have been included on the allergy alert sticker on the outside of the paper medical record of Resident #13 and on the monthly physician orders and MARs. On 11/01/18 at 5:40 PM, the physician of Resident #13 stated he referred to the monthly physician orders, MAR, allergy sticker alert and information in his progress notes to determine any allergies prior to prescribing medications for residents. The physician stated the pharmacy was a back up to alert him if a resident was allergic to any medications he prescribed. The physician stated he expected allergy information to be up to date in a resident's electronic and paper medical record.	F 842		