STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING ______ B. WING ______	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA NURSING & REHABILITATION-HENDERSON	280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536

(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
E 000	Initial Comments An unannounced Recertification Survey was conducted on 5/13/19 through 5/16/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: IK9Q11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID IK9Q11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to accurately code a resident for discharge (Resident #73) and also failed to code a diagnosis for a resident receiving antipsychotic medication (Resident #64) for 2 of 18 Minimum Data Set (MDS) assessments reviewed for accuracy. The findings included: Resident # 73 was admitted to the facility on 2/8/19 with diagnoses including coronary artery disease, pulmonary edema, chronic obstructive pulmonary disease, anemia, depression and pain. The Discharge Return Not Anticipated MDS assessment with an Assessment Reference Date (ARD) of 2/28/19 had been completed. The assessment indicated Resident #73 had been discharged to an acute hospital.	F 641	F641 Accuracy of Assessments This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1. Residents Affected: Resident # 73 has had a Modification of Assessment Discharge Return Minimum Data Set (MDS) completed for 2/28/19 that reflects a discharge to home. Modified Assessment submitted on	6/10/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/03/2019

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 641 Continued From page 1

A review of the Discharge Summary Note dated 2/28/19 documented Resident # 73 had been discharged home.

During an interview on 5/19/19 at 12:57 PM the MDS nurse stated she had mistook the destination as the same place where Resident #73 had come from. She indicated Resident #73 had been discharged home.

On 5/16/19 at 1:07 PM the Director of Nursing stated she would expect the Resident's discharge destination to be coded correctly on the MDS.

On 5/16/19 at 1:18 PM the Administrator stated he would expect the MDS to be coded correctly.

2. Resident #64 was originally admitted to the facility on 10/15/18 with diagnoses including Hypertension, Type 2 Diabetes Mellitus and Schizoaffective Disorder. According to the most recent Significant Change MDS (Minimum Data Set) dated 4/25/19, Resident #64's cognition was moderately impaired. She required extensive assistance with bed mobility, limited assistance with transfers, total dependence in toileting and bathing and extensive assistance with dressing and personal hygiene.

Review of Resident #64's Medication Administration Record (MAR) revealed she started receiving Risperdal 0.5mg's. twice daily and 1 mg. at bedtime. Review of Section I Diagnoses, of the Significant Change MDS dated 4/25/19 revealed Resident #64 was coded for Non-Alzheimer's Dementia instead of Schizoaffective Disorder.

F 641

5/29/19.
Resident # 64 has had a Modification of Significant Change Assessment completed for 4/25/19 that reflected coding of schizoaffective disorder. Modification Assessment submitted 5/31/19.

2. Residents with Potential to be Affected:

An audit was completed by the Director of Nursing (DON) of Discharge MDS assessments for residents discharged from the facility since 5/16/19 for accurate coding of discharge. Residents with completed discharge Multiple Data Set (MDS) assessments were noted to have accurate discharges coded.

An audit was completed by the DON of the last MDS assessment for residents receiving antipsychotic medications for accurate coding of diagnosis. Any residents noted to have incorrect coding of diagnosis were reported to MDS Coordinator and Modification Discharge assessment will be completed by 6/3/19.

3. Systemic Change:

Upon discharge residents with completed discharge MDS Assessments will be reviewed at the clinical morning meeting to ensure accurate coding of discharge destination on Discharge MDS Assessments. The Interdisciplinary Team (IDT) will review each discharge using the discharge audit tool. The audit tool will be

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F 641	Continued From page 2 Review of Resident #64's care plan dated 4/30/19, Resident #64 used psychotropic medication related to disease process and behavior management. Interventions included Administer medications as ordered. Discuss with family need for ongoing need for use of medication Labs per order. Monitor medications for side effects that may increase risks for falls. Review with IDT for GDR. Monitor/report to medical doctor as needed side effects of medication such as frequent falls, refusal to eat, unsteady gait, tardive dyskinesia, difficulty swallowing, dry mouth, loss of appetite, weight loss, blurred vision, diarrhea and social isolation. During an interview on 5/16/19 at 9:14 AM, the MDS Coordinator stated she did not code Schizoaffective Disorder on the MDS because technically it did not meet the criteria of schizophrenia. She stated she spoke directly to the psychiatrist and although it is a valid diagnosis, it is not in the RAI manual. She stated schizoaffective disorder is not equal to the same thing as schizophrenia. She stated the Psychiatric Nurse indicated schizoaffective disorder was not the same as schizophrenia, but it was a disorder. Review of MDS Section I-I-6000 under Schizophrenia, read, "(e.g., schizoaffective disorder and schizophreniform disorders)." During an interview on 5/16/19 at 1:15 PM, the Director of Nursing (DON) revealed her expectation would be that the diagnosis should be coded according to the RAI manual. During an interview on 5/16/19 at 2:04 PM the Administrator stated his expectation was that information be coded appropriately.	F 641	completed five (5) days per week at clinical morning meeting x 4 weeks; then three (3) days per week times 4 weeks, then weekly times 4 weeks. The Interdisciplinary Team (IDT) team will audit residents on antipsychotic medication for accurate coding of diagnosis on completed MDS assessments using the Antipsychotic Audit tool. The audit tool will be complete five (5) days per week at clinical morning meeting x 4 weeks; then three (3) days per week times 4 weeks, then weekly times 4 weeks. Going forward we will perform random audits at least quarterly. An in-service will be provided to the Interdisciplinary Team (IDT) team which is comprised of the Assistant Director of Nursing, Social Worker, Minimum Data Set (MDS) Coordinator, Staff Development Coordinator, Activities, and Unit Manager. This in-service will be given by the Director of Nursing using the policy and procedure to ensure the alleged deficient practice will not reoccur. Any new hires to the IDT team will be educated upon hire during the orientation process. 4. Monitoring of the change to sustain compliance ongoing: The Director of Nursing will present the results of the audits to the Monthly Quality Assurance Performance Improvement (QAPI) committee meeting for review and discussion of any issues or concerns. The Administrator and the Director of Nursing will monitor the results of the	

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F 641	Continued From page 3	F 641	audits and in-services to ensure we maintain compliance going forward.	
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 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	F 655		6/10/19

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F 655	Continued From page 4 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to include the care for an indwelling urinary catheter in a resident ' s baseline Care Plan for 1 of 1 newly admitted sampled residents (Resident #223). The findings included: Resident #223 was admitted to the facility on 5/10/19 and had a diagnosis of urethral stricture and urinary retention. Review of the hospital discharge orders dated 5/10/19 revealed a urinary catheter was to be left in until the resident followed-up with a urologist. Review of the base line Care Plan dated 5/10/19 revealed there was not a care plan for an indwelling urinary catheter. The resident had not been in the facility long enough for a Minimum Data Set (MDS) Assessment to be completed. On 5/14/19 at 9:09 AM, Resident #223 was observed lying in bed with a urine drainage bag hooked on the left side of the bed frame. During an interview with the resident at this time, the resident was alert and oriented and responded appropriately to questions. The Resident stated he was admitted to the facility from the hospital	F 655	F655 Baseline Care Plans This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1. Resident Affected: Resident # 223 had a care plan for urinary catheter added to his care plan on 5/16/19. 2. Residents with the potential to be affected; An audit was done by the DON of the baseline Care Plans for residents admitted since 5/16/19 has been completed. All of the Residents were noted to have comprehensive/48- hour care plans completed with goals and	

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F 655 Continued From page 5

on Friday (5/10/19) and while in the hospital he had urinary retention and they had to put in a urinary catheter.

On 5/16/19 at 3:25 PM an interview was conducted with the MDS Nurse who stated the nurse that admitted the resident did the base line Care Plan and when they do the 5 day assessment they do a more comprehensive assessment and care plan. The MDS Nurse was observed to review the Care Plan for Resident #223 and stated it was noted the resident was at risk for pain related to a medical procedure (glide wire dilation catheter insertion). The MDS Nurse further stated this was not a Care Plan for an indwelling urinary catheter.

On 5/16/19 at 11:15 AM an interview was conducted with the Director of Nursing (DON) and the nurse (Nurse #2) that signed the base line Care Plan for Resident #223. Nurse #2 stated if the urinary catheter was not in the base line Care Plan then she missed it. Nurse #2 further stated this would be added to the Care Plan today. The DON stated the Base Line Care Plan Evaluation Form was used to identify the things that needed to be included in the base line Care Plan. The DON stated the catheter was checked under the bowel and bladder section on the base line care plan evaluation form and should have been included in the base line Care Plan.

F 655

interventions in place and reviewed by the IDT team including the MDS Nurse, Director of Nursing, Social Worker, Activities, and Dietitian.

3. Systemic Change:

Upon admission residents will be reviewed at the clinical morning meeting to ensure 48-hour baseline Care Plan has been completed with goals and interventions in place. IDT team will review each admission using the 48-hour care plan audit tool. The audit tool will be completed by the DON or her designee five (5) days per week at clinical morning meeting x 4 weeks; then three (3) days per week times 4 weeks, then one (1) day per week times 4 weeks. After these audits, the DON or her designee will randomly audit new admissions on a quarterly basis to determine if we are continuing to complete the baseline Care Plan for new admissions accurately. In-service training will be provided to the IDT team which includes the Assistant Director of Nursing, Social Worker, MDS Coordinator, Staff Development Coordinator (SDC), Activities, and Unit Manager by the Director of Nursing using the policy and procedure to ensure compliance. New IDT team members will be educated by the SDC upon hire during their orientation to ensure compliance.

4. Monitoring of the change to sustain compliance ongoing:

The Director of Nursing or her designee

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F 655	Continued From page 6	F 655	will report the audit findings to the QAPI committee monthly x 3 months. Then moving forward the Quarterly QAPI meeting will have the results of the random audits presented by the Director of Nursing or her designee as well. The Administrator will be responsible for monitoring to ensure all audits are completed timely and that the results are reported to the QAPI committee for discussion, review and any action that may be needed.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		6/10/19

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F 656	Continued From page 7 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to develop a Comprehensive Care Plan for 1 of 1 sampled residents (Resident # 15) reviewed for antidepressants. The findings included: Resident # 15 was admitted to the facility on 10/25/18 with diagnoses including dementia, Alzheimer's, diabetes mellitus, abdominal aortic aneurysm, malignant neoplasm of large intestine and hyperlipidemia. Review of the Care Area Assessment Summary dated 10/25/18 revealed Resident # 15 triggered for antidepressant use. The assessment noted Resident #15 used Remeron daily for appetite stimulation. It is classified as an antidepressant medication. The assessment noted Resident # 15's appetite has been fair to good, medication	F 656	F656 Develop/Implement Comprehensive Care Plan This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1. Resident Affected: Resident # 15 had a comprehensive care plan completed on 5/16/19 which included their use of an antidepressant. The new	

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F 656 Continued From page 8

effective in stimulating appetite.

The Care Plan decision noted Y for yes, however review of Resident #15's care plan revealed he was not care planned for antidepressant use.

During an interview on 5/16/19 at 1:18 PPM the Minimum Data Set Nurse stated the antidepressant medication should have been included in the nutritional care plan as the resident received it for an appetite stimulant.

In an interview on 5/16/19 at 1:07 PM the Director of Nursing stated that she would have expected the antidepressant medication to be care planned.

During an interview on 5/16/19 at 1:18 PM the Administrator stated he would expect the antidepressant medication to be care planned.

F 656

care plan was reviewed by the IDT team members (MDS, Social Worker, DON, Activities Director, and Unit Managers). The resident's representative was informed of the changes in the care plan. The attending physician was notified of the revision to the care plan as well.

2. Residents with the potential to be affected:

An audit of the Care Plan for the residents who are receiving antidepressants was completed on May 30, 2019 by the Director of nursing or Unit Manager. This audit did not identify any other residents who's Comprehensive Care Plan failed to address their antidepressants.

3. Systemic Change:

In-services will be provided between 5/31/19 through 6/7/19 by the Staff Development Coordinator or her designee to the current IDT team (Director of Nursing, MDS, Social Worker, Activities Coordinator, and Nurse Managers) regarding completion of care plans for residents receiving antidepressants. Residents receiving antidepressants will be reviewed at clinical morning meeting using the Antidepressant Audit tool. The IDT team will complete audits three (3) times per week for four weeks, then two (2) times per week times 4 weeks, then weekly x 4 weeks. The results of the audits will be presented to the QAPI committee at the monthly meeting.

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F 656	Continued From page 9	F 656	4. Monitoring of the change to sustain system compliance ongoing: The Director of Nursing or her designee will report the audit findings to the QAPI committee monthly x 3 months. The committee will review and discuss the findings. The Administrator will be responsible for monitoring to ensure all audits are completed timely and that the results are reported to the QAPI committee for discussion, review and any action that may be needed.	
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 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,	F 842		6/10/19

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F 842	Continued From page 10 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 (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	F 842		

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	345344	A. BUILDING ______ B. WING ______	C 05/16/2019

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CONCORDIA NURSING & REHABILITATION-HENDERSON	**280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536**

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F 842	Continued From page 11 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 record review and staff and resident interviews the facility failed to document medications administered for 6 sampled residents (Residents #19, #25, #42, #47, #48, and #63) for 1 of 31 days in January 2019. The findings included: 1. Resident #19 was admitted on 4/4/2013 with diagnoses to include CVA, diabetes (DM), congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). Her quarterly MDS assessment dated 3/14/2019 revealed her cognition was intact. On 5/15/2019 to 5/16/2019 a record review of sampled electronic medical records revealed medications for resident #19 were not documented for the 7:00 AM to 3:00 PM shift on 1/27/2019. On 5/16/2019 at 12:14 PM, an interview was conducted with resident #19 in room 145. The resident stated there had not been a day when she had missed her medications (meds). The resident stated she always received her meds and would tell someone if she did not get them. On 5/16/2019 at 12:46 PM, an interview was conducted with the nurse #1 who worked the 7:00 AM to 3:00 PM shift on 1/27/2019. The nurse stated he did not specifically remember the day in question, but he had given all medications everyday he had worked at the facility. The nurse	F 842	F842 Resident Records-Identifiable Information This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1. Resident Affected: Resident #19, 25, 42, 47, 48 & 63 did not recall missing medications, and a thorough evaluation of medical record and resident assessments completed by the DON and UM's determined that residents suffered no ill effects. 2. Residents with the potential to be affected: Current residents have the potential to be affected. The Licensed Nurse identified as not documenting medication administration on 1/27/19 was in-serviced on 5/16/19 regarding the requirement of verification, completion and timely entry of eMAR documentation. All Licensed Nurses will be given an in-service by the	

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F 842

Continued From page 12

stated the residents on Hall 3 were very vocal and would have spoken up if they had not received their meds. Nurse #1 stated he could not explain why the documentation did not reflect a medication administration for 1/27/2019, but he did not miss a medication pass.

On 5/16/2019 at 12:07 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected the nurses to document medications administered after they were given.

2. Resident #25 was admitted on 4/13/2018 with diagnoses to include CVA, hemiplegia, HTN, and hyperlipidemia (HLD). His quarterly MDS assessment dated 3/26/2019 revealed his cognition was intact.

On 5/15/2019 to 5/16/2019 a record review of sampled electronic medical records revealed medications for Resident #25 were not documented for the 7:00 AM to 3:00 PM shift on 1/27/2019.

On 5/16/2019 at 12:17 PM, an interview was conducted with resident #25 in room 142. The resident stated there had not been a day he had missed his meds. The resident stated he always received his meds and would tell someone if he did not get his meds.

On 5/16/2019 at 12:46 PM, an interview was conducted with the nurse #1 who worked the 7:00 AM to 3:00 PM shift on 1/27/2019. The nurse stated he did not specifically remember the day in question, but he had given all medications everyday he had worked at the facility. The nurse stated the residents on Hall 3 were very vocal and would have spoken up if they had not received

F 842

Staff Development Coordinator, or her designee, regarding timely verification and completion of eMAR documentation.

3. Systemic Changes:

Medication Admin Audit Report will be reviewed at clinical morning meeting for missing eMAR entries. If there are any missing eMAR entries, one of the nurse managers will follow up on the missing entry for either completion and/or notification of such to the attending physician. The IDT team will complete audits five (5) times per week for 4 weeks, then three (3) times per week for four weeks, then two (2) times per week for 4 weeks.

4. Monitoring of the change to sustain system compliance ongoing:

The Director of Nursing or her designee will report the audit findings to the QAPI committee monthly for the next 3 months. The committee will review and discuss the findings. The Administrator will be responsible for monitoring to ensure all audits are completed timely and that the results are reported to the QAPI committee for discussion, review and any action that may be needed.

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F 842	Continued From page 13	F 842		

their meds. Nurse #1 stated he could not explain why the documentation did not reflect a medication administration for 1/27/2019, but he did not miss a medication pass.

On 5/16/2019 at 12:07 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected the nurses to document medications administered after they were given.

3. Resident #42 was admitted on 10/30/2018 with diagnoses to include cerebral vascular accident (CVA), hemiplegia, hypertension (HTN) and peripheral vascular disease (PVD). Her quarterly Minimum Data Set (MDS) assessment dated 3/14/2019 revealed her cognition was intact.

On 5/15/2019 to 5/16/2019 a record review of sampled electronic medical records revealed medications for Resident #42 were not documented for the 7:00 AM to 3:00 PM shift on 1/27/2019.

On 5/16/2019 at 12:14 PM, an interview was conducted with resident #42 in room 145. The resident stated there had not been a day when she had missed her meds. The resident stated she always received her meds and would tell someone if she did not get them.

On 5/16/2019 at 12:46 PM, an interview was conducted with the nurse #1 who worked the 7:00 AM to 3:00 PM shift on 1/27/2019. The nurse stated he did not specifically remember the day in question, but he had given all medications everyday he had worked at the facility. The nurse stated the residents on Hall 3 were very vocal and

F 842 | F 842

Continued From page 14
would have spoken up if they had not received their meds. Nurse #1 stated he could not explain why the documentation did not reflect a medication administration for 1/27/2019, but he did not miss a medication pass.

On 5/16/2019 at 12:07 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected the nurses to document medications administered after they were given.

4. Resident #47 was admitted on 10/10/2018 with diagnoses to include CHF, HTN, DM, and end stage renal disease (ESRD). Her significant change MDS assessment dated 4/15/2019 revealed her cognition was intact.

On 5/15/2019 to 5/16/2019 a record review of sampled electronic medical records revealed medications for Resident #47 were not documented for the 7:00 AM to 3:00 PM shift on 1/27/2019.

On 5/16/2019 at 12:15 PM, an interview was conducted with resident #47 in room 144. The resident stated there had not been a day when she had missed her meds. The resident stated she always received her meds and would tell someone if she did not get them.

On 5/16/2019 at 12:46 PM, an interview was conducted with the nurse #1 who worked the 7:00 AM to 3:00 PM shift on 1/27/2019. The nurse stated he did not specifically remember the day in question, but he had given all medications everyday he had worked at the facility. The nurse stated the residents on Hall 3 were very vocal and would have spoken up if they had not received their meds. Nurse #1 stated he could not explain

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F 842	Continued From page 15	F 842		

why the documentation did not reflect a medication administration for 1/27/2019, but he did not miss a medication pass.

On 5/16/2019 at 12:07 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected the nurses to document medications administered after they were given.

5. Resident #48 was admitted on 1/24/2017 with diagnoses to include CVA, hemiplegia, HTN and cognitive deficit. Her quarterly MDS assessment dated 4/17/2019 revealed her cognition was moderately impaired.

On 5/15/2019 to 5/16/2019 a record review of sampled electronic medical records revealed medications for Resident #48 were not documented for the 7:00 AM to 3:00 PM shift on 1/27/2019.

On 5/16/2019 at 12:15 PM, an interview was conducted with resident #48 in room 144. The resident stated there had not been a day when she had missed her meds. The resident stated she always received her meds and would tell someone if she did not get them.

On 5/16/2019 at 12:46 PM, an interview was conducted with the nurse #1 who worked the 7:00 AM to 3:00 PM shift on 1/27/2019. The nurse stated he did not specifically remember the day in question, but he had given all medications everyday he had worked at the facility. The nurse stated the residents on Hall 3 were very vocal and would have spoken up if they had not received their meds. Nurse #1 stated he could not explain why the documentation did not reflect a

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F 842	Continued From page 16	F 842		

medication administration for 1/27/2019, but he did not miss a medication pass.

On 5/16/2019 at 12:07 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected the nurses to document medications administered after they were given.

6. Resident #63 was admitted on 5/11/2018 with diagnoses to include CVA, hemiplegia, HTN, and epilepsy. Her annual MDS assessment dated 4/25/2019 revealed her cognition to be severely impaired.

On 5/15/2019 to 5/16/2019 a record review of sampled electronic medical records revealed medications for Resident #63 were not documented for the 7:00 AM to 3:00 PM shift on 1/27/2019.

Resident #63 was unable to be interviewed due to her severe cognitive impairment.

On 5/16/2019 at 12:46 PM, an interview was conducted with the nurse #1 who worked the 7:00 AM to 3:00 PM shift on 1/27/2019. The nurse stated he did not specifically remember the day in question, but he had given all medications everyday he had worked at the facility. The nurse stated the residents on Hall 3 were very vocal and would have spoken up if they had not received their meds. Nurse #1 stated he could not explain why the documentation did not reflect a medication administration for 1/27/2019, but he did not miss a medication pass.

On 5/16/2019 at 12:07 PM, an interview was

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F 842	Continued From page 17 conducted with the Director of Nursing (DON) who stated she expected the nurses to document medications administered after they were given.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put into place. This failure was related to non-compliance at the regulatory grouping of 483.21 on two consecutive annual recertification surveys. Two separate deficiencies in the area of base line care plans and comprehensive care plans at the regulatory grouping of 483.21 were cited during the facility ' s 6/14/18 annual recertification survey and were recited again on the current 5/16/19 annual recertification survey. The facility ' s continued failure during the recertification surveys showed a pattern of the facility ' s inability to sustain an effective QAA program. The findings included: 1. This tag is cross referenced to: 483.25: Base line care plan: Based on observation, record review and staff interview the facility failed to include the care for an indwelling urinary catheter in a resident ' s	F 867	F867 QAPI/QAA Improvement Activities This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1. Interventions for residents affected: Resident #223 had a care plan for urinary catheter completed on 5/16/19 Resident # 15 had a care plan completed for antidepressant usage on 5/16/19 The care plans were reviewed by the IDT team members (MDS, Social Worker, DON, Activities Director and Unit Managers). The residents' care plan	6/10/19

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F 867

Continued From page 18

baseline Care Plan for 1 of 1 newly admitted sampled residents (Resident #223).

The facility was cited on the recertification survey dated 6/14/18 due to not developing a base line care plan for a resident with a suprapubic urinary catheter, constipation and dehydration.

On 5/16/19 at 2:22 PM an interview was conducted with the Administrator who stated he was not working at the facility during last year ' s survey. The Administrator further stated the base line Care Plan needed to include the major points of the resident ' s diagnoses. The Administrator continued and stated he could not say why this continued to be a problem but would get the problem corrected moving forward.

2. This tag is cross referenced to:

483.25: Comprehensive care plan:

Based on record review, observations and staff interviews, the facility failed develop a Comprehensive Care Plan for 1 of 1 sampled resident (Resident # 15) reviewed for antidepressants.

The facility was cited on the recertification survey dated 6/14/18 due to the failure to develop a comprehensive care plan for a resident who had pain and received pain medication for multiple diagnoses that could cause pain.

On 5/16/19 at 2:22 PM an interview was conducted with the Administrator who stated he was not working at the facility during last year ' s survey. The Administrator further stated the

F 867

revisions and medical records were discussed with the IDT and no further changes were made to the care plan.

2. Residents with the potential to be affected:
An Ad Hoc Performance Improvement meeting will be held 6/5/19 to discuss and review the care plan accuracy for the other residents of our facility. The PI committee members will consist of the Administrator, DON, MDS, Nurse Managers, SDC, Activities Coordinator and the Social Worker. The team will review corrected care plans for accuracy and completeness for urinary catheter and antidepressant interventions and goals.

3. Systemic Changes

An Ad Hoc Performance Improvement meeting reviewing care plan accuracy will be held for once a week for a period of four (4) weeks; then monthly x 3 months to review and discuss the completion and accuracy of residents' care plans. The Director of Nursing or her designee will perform audits on the Care Plan Process weekly x 4 weeks, and then monthly x 3 months to determine the accuracy of the care plans. Education will be provided to the IDT during the Ad Hoc PI meeting on 6/5/19.

4. Monitoring of the change to sustain system compliance ongoing:

The Director of Nursing or her designee will report the audit findings to the QAPI

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F 867	Continued From page 19 Comprehensive Care Plan needs to include the major points of the resident ' s diagnoses. The Administrator continued and stated he could not say why this continued to be a problem but would get the problem corrected moving forward.	F 867	committee monthly x 3 months. The committee will review and discuss the findings. The Administrator will be responsible for monitoring to ensure all audits are completed timely and that the results are reported to the QAPI committee for discussion, review and any action that may be needed.	