STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345571	A. BUILDING _____ B. WING _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA BAY HEALTHCARE CTR OF WILMINGTON LLC	630 CAROLINA BAY DRIVE WILMINGTON, NC 28403

(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 suvey was conducted on 06/03/19 through 06/06/19. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID# DPKP11.	E 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 staff interview and record review the facility failed to complete an accurate Minimum Data Set (MDS) assessment for 2 of 14 residents (#6 and #9) whose medical records were reviewed. Findings included: 1. Resident #6 was admitted to the facility on 10/09/18 with diagnoses that included heart failure, anemia, atrial fibrillation, kidney and ureter disorder and hypotension. Review of the quarterly MDS assessment dated 04/20/19 completed for Resident #6 documented her weight as 64 pounds and indicated she had a qualifying weight gain during the assessment time frame indicated. Review of the weights recorded by the facility for Resident #6 revealed on 10/19/18 the resident weighed 149.1 pounds and on 04/02/19 she weighed 144.6 pounds. She had not weighed 64 pounds and had not gained weight.	F 641	F641 Accuracy of Assessments The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. For resident #6, the specific deficiency was corrected by modifying the Minimum Data Set assessment with an Assessment Reference Date of 04/20/19 and correcting the coding for K0200B (weight) to reflect resident's actual weight at the time of the Assessment Reference Date of 145 pounds and K0310 (weight gain) to reflect that resident had NOT had	6/28/19

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

Electronically Signed | 06/27/2019

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F 641	Continued From page 1 2. Resident #9 was admitted to the facility on 04/10/18 with diagnoses that included hypertension, osteoarthritis, chronic obstructive pulmonary disease, anemia, malignant neoplasm of bronchus and lung, left shin wound and Stage 2 pressure ulcer left foot, 5th digit. Review of the annual MDS assessment for Resident #9 dated 04/24/19 documented she had a weight loss during the assessment period. Review of weights recorded for Resident #9 revealed that she had not had a qualifying weight loss in the preceding six months. In an interview conducted with Nurse #9, MDS Coordinator, on 06/05/19 at 4:00 PM she stated Resident #6 had not weighed 64 pounds and had not gained weight as documented in the assessment. Nor had Resident #9 had a qualifying weight loss during the assessment time frame of her assessment. She confirmed the MDS assessments had been coded in error. She commented she would create and transmit assessment modifications to correct the errors. In an interview with the Director of Nursing on 06/05/19 at 4:45 PM she commented that she expected all residents to have an accurate MDS assessment completed.	F 641	significant weight gain during the specified assessment time frame. Corrected Minimum Data Set assessment was re-submitted to State Database in Batch #386. For resident #9, the specific deficiency was corrected on by modifying the Minimum Data Set assessment with an Assessment Reference Date of 04/24/19. Corrections were made to K0300 (weight loss) in order to accurately reflect that resident had NOT had significant weight loss during the specified assessment time frame. This correction was made by the Minimum Data Set Nurse and was re-submitted to the State Database in Batch #391. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of Minimum Data Set assessments that have been completed during the past 30 days for current residents will be completed in order to validate accurate coding of K0200B (current weight); K0310 (significant weight gain) and K0300 (significant weight loss). Any coding errors that are identified during this audit will be corrected immediately. This audit will be conducted by the Minimum Data Set nurse and Dietary Manager and will be completed no later than 06/28/2019. Systemic Changes	

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F 641	Continued From page 2	F 641	On 06/24/19, the Regional Minimum Data Set Consultant completed an in service training for the facility Minimum Data Set Coordinator and Dietary Manager that included the importance of thoroughly reviewing the medical record prior to completion of Section K0300 (significant weight loss); K0310 (significant weight gain) and K0200B (current weight) of the Minimum Data Set assessment. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators and new Dietary Managers. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will begin auditing the coding of Sections K0200B (weight); K0300 (significant weight loss) and K0310 (significant weight gain) of the Minimum Data Set Assessment using the quality assurance survey tool entitled “Accurate Coding of Section K (weight, weight gain and weight loss) Audit Tool” to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of	

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F 641	Continued From page 3	F 641	Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 06/28/2019	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 observation, record review, and staff interviews the facility failed to provide a diet as ordered for 1 of 1 sampled residents (Resident #2) who should have received large protein portion meals. Findings included: Resident #2 was admitted to the facility on 03/26/19 with diagnoses of congestive heart failure (CHF), diabetes, and hypertension. Review of the admission Minimum Data Set (MDS) dated 04/02/19 revealed Resident #2 was moderately cognitively impaired and did not reject care. Resident #2 needed supervision and set up	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 1. Corrective action	6/28/19

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F 658	Continued From page 4 help with meals. Review of Resident #2's meal card revealed a large protein portion was to be included with all meals. In an observation on 06/04/19 at 12:30 PM Resident #2 was seated at a table in the dining room. A staff member was seen removing the meal plate. The plate contained vegetable lasagna and brussels sprouts. There was no protein seen with Resident #2's meal. In an interview on 06/04/19 at 12:35 PM the Dietary Manager stated that Resident #2 received a large portion of vegetable lasagna. She indicated that the vegetable lasagna did not contain any protein and that Resident #2 should have received a large portion of chicken with the meal and had not. In an interview on 06/05/19 at 3:05 PM Nursing Assistant (NA) #1 stated that Resident #2 was supposed to receive double protein meals. She indicated that she had been instructed to encourage Resident #2 to eat the protein that was provided with the meals. In an interview on 06/06/19 at 9:24 AM the Administrator indicated the Dietary Manager worked closely with the residents to choose their diets. She indicated that if a special diet, such as large protein portions, was ordered then that was to be included in addition to their regular diet order.	F 658	On 6/4/19 the Dietary Services Director revised tray card to ensure that resident's diet order was accurate. Resident to receive large portion of chicken when a vegetarian or limited protein entrée is on menu. The Vegetarian Lasagna menu option has been changed to Chicken Parmesan to ensure adequate protein is provided. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. All dietary staff was in-serviced on 6/4/2019 regarding accuracy of tray cards and meals served. A chart audit/tray card audit was completed by the Consultant Dietitian on 6/11/19. Orders/ Tray Cards were corrected on 6/12/19. Another traycard audit was conducted on 6/18/19; there were no discrepancies. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff by the Dietary Services Director. Topics included: • Accuracy of tray preparation. • Tray card accuracy. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring	

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F 658	Continued From page 5	F 658	procedure. The Dietary Services staff and Nursing staff will monitor accuracy of completed trays served to residents daily. Using Dietary Audit Tool: Meal Service/ Diet Order Accuracy, the Dietary Services Director will audit meal accuracy 5 times weekly x 4 weeks then weekly x 2 months and then monthly for 3 additional months. The Dietary Services Director or designee will complete weekly chart audit x 6 months comparing diet orders in PCC – EMR vs diet order on PCC Tray Cards. Corrections will be made as necessary and documentation of findings will be reported on the Dietary Audit Tool: Meal Service/ Diet Order Accuracy. Reports will be presented to the weekly Quality Assurance committee. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Services Director.	
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.	F 761		6/28/19

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F 761	Continued From page 6 §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. §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 and staff interviews the facility failed to keep unattended medications secured by leaving them out on an overbed table for 1 of 14 resident rooms (Room #34). Findings included: In an observation on 06/03/19 at 12:30 PM a round, dark pink tablet was seen in a medication cup on the overbed table in room #34. In an interview on 06/06/19 at 12:42 PM Nurse #7 stated she had provided medications to the resident in room #34 at about 10:30 AM. She stated she thought the resident had taken all the medications and did not realize that she had left a medication in the cup on the overbed table. Nurse #7 indicated it was her responsibility to make sure medications were not left unsecured in resident's rooms.	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 1. A corrective action for the resident involved. For room #34, on 6/26/2019 nurse #4 was counseled by the Director of Nursing regarding securing medications during a medication pass.	

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F 761	Continued From page 7 In an observation on 06/04/19 at 4:21 PM a round, dark pink tablet was again seen in a medication cup on the overbed table in room #34. In an interview on 06/04/19 at 4:25 PM Nurse #4 stated that medications should never be left on a resident's overbed table. She indicated that anyone could take medications that were left out. In an interview on 06/04/19 at 2:16 PM the Director of Nursing (DON) stated that medications should not be left out on resident overbed tables. She indicated that medications should always be secured and not left where other residents, staff, or visitors could get them.	F 761	For room #34, on 6/26/2019 the nurse #7 was counseled by the Director of Nursing regarding securing medications during a medication pass. Room #34 discharged on 06/11/2019. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 6/25/2019, the RN Supervisor completed an audit of all current resident rooms to identify any unsecured mediations in order to remove or secure per the self-administration policy. Beginning on 6/25/2019, the Director of Nursing or SDC completed a medication pass observation to all full-time, part-time, and PRN nurses to observe for staff ensuring medications were taken by the resident when administered and not left at the bedside. This audit will be completed by 6/28/2019. 3. Systemic changes In-service education was provided to all full time, part time, and as needed nurses,. Topics included: • Principles of medication administration • Self-administration of medication policy	

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F 761	Continued From page 8	F 761	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Staff Development Coordinator or designee will monitor medication pass for unsecured medications by observation weekly x 2 weeks then monthly x 3 months using the medication pass Quality Assurance monitor. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Completion date: 06/28/2019	
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.	F 842		6/28/19

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(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 by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or

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F 842	Continued From page 10 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 record review and staff interviews the facility failed to maintain complete and accurately documented medical records for 3 of 14 Residents (Resident #2, Resident #11, and Resident #9) whose medical records were reviewed. Findings included: 1. Resident #2 was admitted to the facility on 03/26/19 with diagnoses of congestive heart failure (CHF), diabetes, and hypertension. Review of the admission Minimum Data Set (MDS) dated 04/02/19 revealed Resident #2 was moderately cognitively impaired and did not reject care.	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F842 1. A corrective action for the resident involved	

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F 842	Continued From page 11 Review of the physician orders revealed daily weights had been ordered every night shift for Resident #2 on 04/15/19 for CHF monitoring. Review of the Weight Summary sheet for 04/26/19 revealed no weight documentation for Resident #2. Review of the Medication Administration Record (MAR) for 04/26/19 revealed the daily weight order was coded as a "7" which indicated Resident #2 was sleeping. There was no current weight recorded in Resident #2's 04/26/19 nursing notes. Review of the Weight Summary sheet for 04/29/19 revealed no weight documented for Resident #2. Review of the MAR for 04/29/19 revealed the daily weight order was coded as a "9" which indicated other/see nurse notes. There was no nursing note for 04/29/19 to indicate a weight or why the weight was not obtained for Resident #2. Review of the Weight Summary sheet for 05/07/19 revealed no weight documentation for Resident #2. Review of the MAR for 05/07/19 revealed no documentation of a weight for Resident #2. There was no nursing note for 05/07/19 to indicate a weight or why the weight was not obtained for Resident #2. Review of the Weight Summary sheet for 05/10/19 revealed no weight documentation for Resident #2. Review of the MAR for 05/10/19 revealed no documentation of a weight for Resident #2. There was no nursing note for 05/10/19 to indicate a weight or why the weight was not obtained for Resident #2. Review of the Weight Summary sheet for	F 842	1. On 6/25/2019, the MD changed the weight frequency for resident #2 to weekly. A weight was obtained by the night RN on 06/24/2019. 2 A. On 06/06/2019, the order for resident #11 to receive Oxycodone 1 hour prior to wound vac application was discontinued by the hall nurse. 2 B. On 06/06/2019, education began for the involved nurses #2, #3, #4, #5, #6, and #7 received education from the nurse consultant or Director of Nursing regarding documentation of medications including narcotics. This education was completed on 6/28/2019. 3. For resident #9, on 06/05/2019, the duplicate order for the Vitamin C was discontinued by the hall nurse. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 6/24/2019, the charge nurse audited all current physician orders to identify ordered weigh frequency and audited to ensure all current residents are weighed per MD orders. This process will be completed by 6/28/2019. Beginning on 6/25/2019, the charge nurse and nurse supervisor audited all current physician orders for duplicate orders and orders that are no longer active (such as one time orders or orders no longer applicable) and discontinued those orders as applicable. This process will be completed by 6/28/2019. Beginning on 6/25/2019, the Director of Nursing or SDC completed a medication pass observation to all full-time, part-time,	

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F 842	Continued From page 12 05/11/19 revealed no weight documentation for Resident #2. Review of the MAR for 05/11/19 revealed no documentation of a weight for Resident #2. There was no nursing note for 05/11/19 to indicate a weight or why the weight was not obtained for Resident #2. Review of the Weight Summary sheet for 05/12/19 revealed no weight documentation for Resident #2. Review of the MAR for 05/12/19 revealed no documentation of a weight for Resident #2. There was no nursing note for 05/12/19 to indicate a weight or why the weight was not obtained for Resident #2. Review of the Weight Summary sheet for 05/13/19 revealed no weight documentation for Resident #2. Review of the MAR for 05/13/19 revealed no documentation of a weight for Resident #2. There was no nursing note for 05/13/19 to indicate a weight or why the weight was not obtained for Resident #2. Review of the Weight Summary sheet for 05/17/19 revealed no weight documented for Resident #2. Review of the MAR for 05/17/19 revealed the daily weight order was coded as a "2" which indicated that Resident #2 had refused to be weighed at that time. There was no nursing note for 05/17/19 to indicate that a weight had been attempted at any other time during the day. Review of the Weight Summary sheet for 05/20/19 revealed no weight documentation for Resident #2. Review of the MAR for 05/20/19 revealed no documentation of a weight for Resident #2. There was no nursing note for 05/20/19 to indicate a weight or why the weight was not obtained for Resident #2.	F 842	and PRN nurses to observe for documenting medications after they were given including as needed narcotic medications and documenting daily weights on the MAR after obtained. This audit will be completed by 6/28/2019. 3. Systemic Changes On 6/28/2019, the Staff Development Coordinator provided an in-service education to all full-time, part-time, and PRN nurses, medication aides, and medication techs. Topics included: • Obtaining and documenting weights per MD order • Discontinuing orders that are no longer active or one time orders • Documentation of narcotics and all medications This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and medication tech's as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the documentation of weights, narcotics, and discontinuing MD orders once completed or no longer active. In addition to this, 4 nurses will be audited for skills check on administering and documenting medications during the medication pass. The Quality Assurance	

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F 842	Continued From page 13 Review of the Weight Summary sheet for 05/21/19 revealed no weight documentation for Resident #2. Review of the MAR for 05/21/19 revealed no documentation of a weight for Resident #2. There was no nursing note for 05/21/19 to indicate a weight or why the weight was not obtained for Resident #2. Review of the Weight Summary sheet for 05/27/19 revealed no weight documentation for Resident #2. Review of the MAR for 05/27/19 revealed no documentation of a weight for Resident #2. There was a nursing note for 05/27/19 that the daily weight was attempted on night shift but had not been obtained. Review of the Weight Summary sheet for 06/01/19 revealed no weight documented for Resident #2. Review of the MAR for 06/01/19 revealed the daily weight order was coded as a "9" which indicated other/see nurse notes. There was no nursing note for 06/01/19 to indicate a weight or why the weight was not obtained for Resident #2. In an interview on 06/06/19 at 8:40 AM Nurse #1 indicated that the order for daily weights would pop up on the computer screen for the night shift nurse to obtain. Once the weight was obtained the weight would be recorded on the MAR. She stated that unless the night shift nurse informed her that the weight was not obtained she would not know it was still needed. In a telephone interview on 06/06/19 at 9:01 AM Nurse #2 stated he provided a list of residents needing weights to the aides. He indicated it was their responsibility to obtain the weights and to	F 842	documentation tool will be completed weekly for 8 weeks then monthly for 4 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Completion date: 6/28/2019	

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inform him of the results and then he would enter the information on the MAR.

In an interview on 06/06/19 at 9:24 AM the Director of Nursing (DON) indicated that if a resident had an order for daily weights it was the responsibility of the nurse to make sure the weight was obtained and then documented in the medical record.

2. A. Resident #11 was admitted to the facility on 04/24/19 with diagnoses of a non-displaced fracture, hypertension and anemia.
Review of the admission MDS dated 05/09/19 revealed Resident #11 was cognitively intact and received opioid pain medication. Resident #11 did not reject care.

Review of the physician orders revealed Resident #11's wound vacuum had been discontinued on 05/30/19 and that oxycodone 5 mg (milligrams) by mouth as needed for pain every six hours had been discontinued on 05/31/19.

Review of Resident #11's June 2019 MAR revealed an order to give a prn (as needed) dose of oxycodone one hour prior to the wound vacuum dressing changes on Monday, Wednesday, and Friday. The order was checked off as completed on 06/03/19 and 06/05/19.

Review of the Narcotic Count Sheet revealed no oxycodone had been given to Resident #11 on 06/03/19 or 06/05/19.

In an interview on 06/06/19 at 11:00 AM Nurse #1, who was assigned to Resident #11 on 06/05/19, stated that a check mark on the MAR meant the order had been completed. She

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indicated that although she had placed a checkmark on the order she had not given any oxycodone to Resident #11. Nurse #1 stated she had placed the checkmark to indicate that Resident #11 could have received oxycodone and not that she gave oxycodone. Nurse #1 indicated that the order to administer oxycodone prior to the wound vacuum dressing changes should have been discontinued when the wound vacuum treatment was discontinued to avoid confusion.

In an interview on 06/06/19 at 3:02 PM the DON indicated that the nurses should discontinue orders that were no longer applicable and that they should not check them as completed when they were not done.

2. B. Resident #11 was admitted to the facility on 04/24/19 with diagnoses of a non-displaced fracture, hypertension and anemia.

Review of the admission MDS dated 05/09/19 revealed Resident #11 was cognitively intact and received opioid pain medication. Resident #11 did not reject care.

Review of Resident #11's Narcotic Count Sheet revealed two tablets of oxycodone 5 mg were removed on 05/05/19 at 12:25 PM.
Review of the 05/05/19 MAR revealed no documentation that the medication had been administered.

Review of Resident #11's Narcotic Count Sheet revealed two tablets of oxycodone 5 mg were removed on 05/06/19 at 9:30 AM. Review of the 05/06/19 MAR revealed no documentation that the medication had been administered.

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Review of Resident #11's Narcotic Count Sheet revealed one tablet of 5 mg oxycodone was removed on 05/18/19 at 10:00 AM. Review of the 05/18/19 MAR revealed no documentation that the medication had been administered.

Review of Resident #11's Narcotic Count Sheet revealed one tablet of 5 mg oxycodone was removed on 05/20/19 at 9:15 AM. Review of the 05/20/19 MAR revealed no documentation that the medication had been administered.

Review of Resident #11's Narcotic Count Sheet revealed one tablet of 5 mg oxycodone was removed on 05/21/19 at 1:00 PM. Review of the 05/21/19 MAR revealed no documentation that the medication had been administered.

Review of Resident #11's Narcotic Count Sheet revealed 2 tablets of 5 mg oxycodone were removed on 05/25/19 at 9:45 PM. Review of the 05/25/19 MAR revealed no documentation that the medication had been administered.

Review of Resident #11's Narcotic Count Sheet revealed 2 tablets of 5 mg oxycodone were removed on 05/26/19 at 5:45 AM. Review of the 05/26/19 MAR revealed no documentation that the medication had been administered.

In an interview on 06/06/19 at 2:05 PM Nurse #2, who was assigned to Resident #11 on 05/25/19, stated he administered oxycodone to Resident #11. He verified that he had not documented the administration of the medication on the MAR.

In an interview on 06/06/19 at 2:06 PM Nurse #3, who was assigned to Resident #11 on 05/18/19, stated she administered the medication to

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Resident #11. She verified that she had not documented the administration of the oxycodone on the MAR.

In an interview on 06/06/19 at 2:22 PM Nurse #4, who was assigned to Resident #11 on 05/06/19, stated she had signed out and administered the oxycodone to Resident #11. She verified that she did not document the administration of the medication on the MAR.

In an interview on 06/06/19 at 2:27 PM Nurse #5, who was assigned to Resident #11 on 05/26/19, verified that she had not documented the administration of the oxycodone on the MAR but that she had administered the medication.

In an interview on 06/06/19 at 2:33 PM Nurse #6, who was assigned to Resident #11 on 05/22/19 (not on 05/21/19), stated that she had written the incorrect date of 05/21/19 instead of 05/22/19 when she removed the oxycodone for administration to Resident #11 at 1:00 PM. Nurse #6 verified that she did not document the administration of the oxycodone on the 05/22/19 MAR.

In an interview on 06/06/19 at 2:45 PM Nurse #7, who was assigned to Resident #11 on 05/20/19, indicated that she had administered oxycodone to Resident #11 on that date. She verified that she had not documented the administration on the MAR.

In an interview on 06/06/19 at 3:02 PM the DON stated that any medication that was administered to a resident needed to be documented on the MAR.

3. Resident #9 was admitted to the facility on

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04/10/18 with diagnoses that included hypertension, osteoarthritis, chronic obstructive pulmonary disease, anemia, malignant neoplasm of bronchus and lung, left shin wound and Stage 2 pressure ulcer left foot, 5th digit.

Review of the physician's orders for May and June 2019 revealed an order for Ascorbic Acid 500 milligrams (mg) give one tablet one time a day for nutritional supplement.

Review of the MAR's for May and June 2019 revealed the above order was duplicated on the MAR's in error and signed off as given twice at the same time each day on 5/24/19, 5/25, 5/26, 5/27, 5/28, 5/29, 5/30, 5/31, 6/1, 6/2, 6/3, and 6/4/19 at 9:00 AM.

In an interview conducted on 06/05/19 at 8:40 AM with Nurse #6 she revealed that she had signed the MAR twice by mistake for the same dose of Ascorbic Acid 500 mg. She stated when she administered medication she double checked the medication when she pulled the bubble pack and then poured the medication in the cup, administered it, then returned to the cart to sign off the medications taken by a resident. She commented that she had not noticed that she had been signing off the Ascorbic Acid order twice when she had only given it once. She corrected the medical record to reflect only one Ascorbic Acid order for 9:00 AM as ordered.

In an interview with Nurse #4 on 06/05/19 at 10:45 AM she stated she had started doing wound care at the facility about a month previous. She commented she initiated the wound care protocol for residents who had wounds which included Ascorbic Acid 500 mg daily. She thought

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F 842	Continued From page 19 she had checked the MAR's to be sure none of the orders had been duplicated but apparently missed it on the MAR for Resident #9 and two orders for Ascorbic Acid were then recorded on the MAR. She explained Resident #9 already had an order for Ascorbic Acid then the wound care protocol added the order again and that was how the duplication occurred. She confirmed the resident was to only receive one dose of Ascorbic Acid 500 mg daily. In an interview with Nurse #8 on 06/05/19 at 11:00 AM she revealed that she cared for Resident #9. She confirmed that she had not noticed that she had signed the MAR for two doses of Ascorbic Acid daily. She stated she had only ever given the resident one dose of Ascorbic Acid each morning but signed it off twice in error. She stated she poured the medications, administered them, then returned to the MAR and signed them off as given. She had not noticed the Ascorbic Acid was on the MAR twice, she simply clicked off the 0900 medications on the screen. She reported that she had been taking care of Resident #9 for a while and was certain she had only given her one tablet each morning. In an interview with the Director of Nurse on 06/05/19 at 11:30 AM she revealed that she expected the physician orders to be transcribed into the MAR correctly and administered as ordered. She confirmed this order duplication had occurred due to the initiation of the standing physician orders for wound care that included an order that was already present on the resident's MAR.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		6/28/19

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F 867	Continued From page 20 §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 facility's quality assurance (QA) program failed to prevent the reoccurrence of deficient practice related to the maintenance of complete and accurately documented medical records which resulted in a repeat deficiency at F842. The re-citing of F842 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F842: Resident Records - Identifiable Information: Based on record review and staff interviews the facility failed to maintain complete and accurately documented medical records for 3 of 14 Residents (Resident #2, Resident #11, and Resident #9) whose medical records were reviewed. Findings included: Review of the facility's survey history revealed F842 was cited during the facility's 06/08/18 annual recertification/complaint investigation survey for incomplete and inaccurately documented medical records. The facility was re-cited during the current 06/06/19 annual recertification/complaint investigation survey for the same issue of incomplete and inaccurately documented medical records.	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. A corrective action for the resident involved 1. 1. On 6/25/2019, the MD changed the weight frequency for resident #2 to weekly. A weight was obtained by the night RN on 6/24/2019. 2 A. On 06/06/2019, the order for resident #11 to receive Oxycodone 1 hour prior to wound vac application was discontinued by the hall nurse. 2 B. On 06/06/2019, education began for the involved nurses #2, #3, #4, #5, #6, and #7 received education from the nurse consultant or Director of Nursing regarding documentation of medications including narcotics. This education was completed on 6/28/2019.	

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F 867	Continued From page 21 In an interview on 06/06/19 at 3:22 PM the Administrator indicated that there had been a large staff turn-over and this may have contributed to a decreased focus on documentation. She indicated that a longer period in QA may have allowed the facility to monitor and audit documentation and provide education to the nurses as needed.	F 867	3. For resident #9, on 06/05/2019, the duplicate order for the Vitamin C was discontinued by the hall nurse. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 6/24/2019, the charge nurse audited all current physician orders to identify ordered daily weights and audited to ensure all current residents with daily weight orders are weighed daily. This process will be completed by 6/28/2019. Beginning on 6/25/2019, the charge nurse and nurse supervisor audited all current physician orders for duplicate orders and orders that are no longer active (such as one time orders or orders no longer applicable) and discontinued those orders as applicable. This process will be completed by 6/28/2019. Beginning on 6/25/2019, the Director of Nursing or SDC completed a medication pass observation to all full-time, part-time, and PRN nurses and medication Tech□s to observe for documenting medications after they were given including as needed narcotic medications and documenting daily weights on the MAR after obtained. This audit will be completed by 6/28/2019. 3. Systemic Changes On 6/26/2019, the Nurse Consultant provided an in-service education to the Administrator and Director of Nursing Service. Topics included: " Preventing repeat survey tags " Quality assurance monitoring for F tag 842 This information has been integrated into	

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F 867	Continued From page 22	F 867	the standard orientation training and in the required in-service refresher courses for administrator and Director of Nursing as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor completion of ongoing audits for F tag 842 until the next survey cycle. Any negative findings will immediately be addressed and reviewed with the facility QA nurse consultant for interventions or additional training. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Completion date: 6/28/2019	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		6/28/19

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	345571	A. BUILDING _____ B. WING _____	06/06/2019

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F 880	Continued From page 23	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 24 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, Nurse Practitioner interview and staff interview the facility failed to maintain infection control for 1 of 2 residents observed for wound care (Resident #9) whose Stage 2 pressure ulcer on her left foot, 5th digit, was cleansed with a 4 x 4 that had been used to cleanse a wound on her shin that was infected with and being treated for a Staphylococcus Aureus infection. Findings included: During an observation of wound care on 06/06/19 at 9:45 AM, Nurse #4 used a saline soaked 4 x 4 gauze pad to cleanse a Staphylococcus Aureus infected wound on Resident #9's left shin then	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F880 1. A corrective action for the resident involved. On 6/24/2019, the Director of Nursing	

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F 880	Continued From page 25 immediately used the same 4 x 4 gauze pad to cleanse the Stage 2 pressure ulcer on her left foot 5th digit. In an interview with the facility Nurse Practitioner #1 on 06/06/19 at 11:40 AM he commented that the same gauze pad used to cleanse an infected wound on the resident's shin should not have been used to cleanse the wound on her toe that was not infected. In an interview with the Director of Nursing on 06/06/19 at 11:45 AM she stated that she intended to re-educate Nurse #4 concerning wound care. She stated that she would not expect a nurse to use the same cleansing gauze pad between wounds especially if one wound was infected.	F 880	educated nurse #4 on preventing cross contamination of wounds during wound care. 2. Corrective action for residents with the potential to be affected Residents with wounds have the potential to be affected. On 6/27/2019, the RN supervisor observed all full time, part time, and as needed nurses for skills check for correct technique during wound care to prevent cross contamination. 3. Systemic Changes: On 6/28/2019, the Staff Development Coordinator provided an in-service education to all full-time, part-time, and PRN nurses. Topics included: • Preventing cross contamination of wounds • Clean dressing change policy This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Staff Development Coordinator or designee will monitor Preventing cross contamination. The Quality Assurance tool will be completed weekly for 2 weeks then monthly for 3 months. Monitoring will include auditing wound care for cross contamination. Reports will be presented	

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F 880	Continued From page 26	F 880	to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Completion date: 6/28/2019	