STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	**155 BLAKE BOULEVARD PINEHURST, NC 28374**

(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 10/28/19 through 10/31/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #43B311.	E 000		
F 000	INITIAL COMMENTS On 10/28/19 through 10/31/19 an unannounced recertification and complaint survey entry was conducted. There was 1 intake with 5 allegations. All 5 allegations were unsubstantiated for insufficient evidence. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. See Event ID #43B311.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		11/19/19

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

Electronically Signed | 11/19/2019

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that the resident's elected advance directive matched with the physician's order in the electronic health record (EHR) and hard chart for 1 (Resident #24) of 1 sampled resident reviewed for advance directive. Findings included: Resident #24 was originally admitted to the facility on 5/25/18 and was discharged to the community on 6/19/18. The facility's advance directive form signed on 5/28/18 revealed that the resident elected to be Full Code. Resident #24 was readmitted to the facility on 8/16/19 with multiple diagnoses including	F 578	The statements made on this Plan of Correction are not an admission to nor do they 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 date or dates indicated. F578 For the residents involved the following corrective action has been accomplished by: On October 29, 2019, the resident's	

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F 578	Continued From page 2	F 578		

dementia and right femur fracture. The admission Minimum Data Set (MDS) assessment dated 8/23/19 indicated that Resident #24 had moderate cognitive impairment. The facility's advance directive form signed by the power of attorney (POA) on 8/16/19 revealed that the resident was a Do Not Resuscitate (DNR).

Resident #24's EHRs and the hard chart were reviewed. The current physician's order indicated that the resident was a Full code. The physician's progress note dated 10/24/19 indicated that the resident was a DNR. The care plan dated 8/19/19 indicated that the resident was a DNR.

On 10/30/19 at 12:50 PM, the MDS Nurse was interviewed. She verified that Resident #24 had a physician order for a full code and her care plan indicated that she was a DNR. The MDS Nurse stated that it looked like the resident was a Full Code on admission and was discharged to the hospital and when she was readmitted, her code status had changed to a DNR. She indicated that when the resident was readmitted, the code status should have been clarified by the admitting nurse.

On 10/30/19 at 12:52 PM, Nurse #1, assigned to Resident #24, was interviewed. The Nurse stated that he normally looked at the physician's order for the resident's code status in EHR or hard chart. He added that the nurses had a list of resident's code status in a clip board. Nurse #1 verified that Resident #24 was a Full Code on the list. The Nurse further indicated that on admission/readmission, the admission staff member provided the responsible party (RP) a facility's advance directive form to elect and to sign for the resident's code status. The form was elected advanced directive was corrected by the Nursing Supervisor so that the physician's order in the electronic health record (EHR) matched the hard chart.
Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:
On October 30, 2019, the Director of Nursing (DON) audited 100% of current residents to ensure their elected advance directive matched with the physician's order in the EHR and the hard chart. Any issues noted were corrected at that time. For results of the audit please see exhibit (Exhibit One).
Measures put in place or systematic changes made to ensure the alleged deficient practice does not occur:
The Admission Audit form was amended to include checking for the elected advance directive for all admissions and readmissions to ensure the physician's order in the EHR and the hard chart match (Exhibit Two). On November 14, 2019, the DON educated all nurses, fulltime and part time on the appropriate use of the Admission Audit form and advanced directive orders (Exhibit Three).
The facility has implemented a Quality Assurance Monitor:
The Director of Nursing will begin weekly observation. She will audit five recent new or readmitted residents using the Advance Directive Quality Assurance (QA) Monitor (Exhibit Four). The monitor will be completed weekly for three months and reported to the Monthly Quality of Life Team at the Monthly Quality of Life

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F 578	Continued From page 3 scanned into the EHR and the physician's order was written based on the elected code status. Nurse #1 stated that he didn't know why the elected code status (DNR) did not match with the physician's order (Full Code). On 10/31/19 at 11:45 AM, the Director of Nursing (DON) was interviewed. The DON expected the staff to verify code status on readmission and to ensure the physician order for code status in the EHR and hard copy matched with the code status elected by the resident/RP.	F 578	Meeting. For any month with less than 100% compliance, the monitor will be extended an additional month and corrective action will be implemented by the Monthly Quality of Life Team at that time.	
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 review, observation, and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of hospice, life expectancy, and wander alarm (Resident #11), pressure ulcer (Resident #32), and positioning and mobility (Resident #26) for 3 of 14 residents reviewed. Findings included: 1a. Resident #11 was admitted to the facility on 4/8/19 with diagnoses of Parkinson's and dementia. The resident's quarterly MDS dated 8/6/19 documented the resident had unclear speech and was rarely understood or understands and his cognition was unable to be determined. The active diagnoses were non-Alzheimer's dementia, Parkinson's, and malignant melanoma of lower	F 641	The statements made on this Plan of Correction are not an admission to nor do they 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 date or dates indicated. F641 For the residents involved, corrective action has been accomplished by: On October 30, 2019, the Minimum Data Set (MDS) for Resident # 11 was updated	11/19/19

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F 641	Continued From page 4 extremity. Section "J. 1400 life expectancy" was answered "no," Section "O. 100 k hospice services" was coded "no," and Section "P. 200 e wander alarm" was coded "no." There was a physician order dated 4/24/19 for hospice consult documented for the resident. The care plan documented that hospice was provided by outside private hospice services initiated on 4/29/19. On 10/31/19 at 11:15 am an interview was conducted with the MDS Coordinator who stated that after review of the resident's admission MDS dated 8/6/19, the MDS was incorrectly coded in Section "O. 100 k hospice services" which was human error and would be corrected. The Director of Nursing (DON) was interviewed on 10/31/19 at 11:45 am who stated that she expected the MDS to be accurately coded. 1b. Resident #11 was admitted to the facility on 4/8/19 with diagnoses of Parkinson's and dementia. The resident's quarterly MDS dated 8/6/19 documented the resident had unclear speech and was rarely understood or understands and his cognition was unable to be determined. The active diagnoses were non-Alzheimer's dementia, Parkinson's, and malignant melanoma of lower extremity. Section "J. 1400 life expectancy" was answered "no," Section "O. 100 k hospice services" was coded "no," and Section "P. 200 e wander alarm" was coded "no." There was a physician order dated 4/24/19 for	F 641	to reflect his wander alarm, Hospice designation, and life expectancy by the Minimum Data Set (MDS) Nurse. On October 30, 2019, the MDS Nurse corrected the MDS for Resident #32 to accurately reflect a pressure ulcer that was present on admission. On date October 30, 2019 the MDS Nurse corrected the current MDS for Resident #26, to accurately reflect bilateral upper extremity contractures. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: By November 18, 2019, the facility Director of Nursing completed a 100 % audit of all current residents with Hospice, wander alerts, wounds and contractures to ensure accurate coding on their current MDS. For results, please see exhibit (Exhibit Five). Any discrepancies noted were corrected at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On November 15, 2019 the Regional Minimum Data Set/Quality Assurance Consultant completed an in- service training for MDS Nurse on how to accurately code hospice, life expectancy, wander alarms, pressure ulcers and contractures on the MDS. Education information was taken directly from the Resident Assessment Instrument (RAI). Education was provided on: Section P0200, Section O0100, Section M, and Section G0400 and specifically the process of accurately coding Minimum	

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F 641	Continued From page 5 hospice consult documented for the resident. The care plan documented that hospice was provided by outside private hospice services initiated on 4/29/19. On 10/31/19 at 11:15 am an interview was conducted with the MDS Coordinator who stated that after review of the resident's admission MDS dated 8/6/19, the MDS was incorrectly coded in Section "J. 1400 life expectancy" which was human error and would be corrected. The Director of Nursing (DON) was interviewed on 10/31/19 at 11:45 am who stated that she expected the MDS to be accurately coded. 1c. Resident #11 was admitted to the facility on 4/8/19 with diagnoses of Parkinson's and dementia. The resident's quarterly MDS dated 8/6/19 documented the resident had unclear speech and was rarely understood or understands and his cognition was unable to be determined. The active diagnoses were non-Alzheimer's dementia, Parkinson's, and malignant melanoma of lower extremity. Section "J. 1400 life expectancy" was answered "no," Section "O. 100 k hospice services" was coded "no," and Section "P. 200 e wander alarm" was coded "no." The resident had a physician order for wander guard order dated/placed 5/8/19 and to check each day, twice a day. The resident's care plan documented it was updated 6/27/19 at risk for elopement related to exit seeking behaviors. Intervention was for	F 641	Data Set (Exhibit Six). The facility has implemented a quality assurance monitor: The following QA Tools will be completed by the DON weekly for four weeks and monthly for three months: Accurate Coding of MDS Section O0100, MDS Coding Accuracy (Section P-Alarms) Audit Tool, Accurate Coding of Section M0300 (Ulcer Present upon Admission) Audit Tool and Accurate MDS Coding of G0400 (Function al Limitation in Range of Motion) Audit Tool (Exhibit Seven). The Director of Nursing will audit five current residents' most recent MDS for accuracy in coding of hospice, life expectancy, wander alarms, pressure ulcers and contractures. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. For each month with less than 100% compliance, the monitor will be extended. Any corrective action required will be made by the Quality of Life Team at that time.	

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wander guard placement and check. The resident was receiving hospice services.

Review of documentation for wander guard check/assessment in place and properly functioning twice a day for the past 60 days (from 9/1/19 to 10/29/19) was present signed by the Nursing Assistant.

On 10/30/19 at 8:30 am an observation was done of the resident while sitting up in his bed and his wander guard was in place.

On 10/31/19 at 11:15 am an interview was conducted with the MDS Coordinator who stated that after review of the resident's admission MDS dated 8/6/19, the MDS was incorrectly coded in Section "P. 200 e wander alarm" which was human error and would be corrected.

The Director of Nursing (DON) was interviewed on 10/31/19 at 11:45 am who stated that she expected the MDS to be accurately coded.

2. Resident #32 was admitted to the facility on 10/2/19 with diagnoses of displaced right femur fracture, fall, and pressure ulcer of the left buttocks stage 3.

A review of the resident's admission Minimum Data Set dated 10/9/19 revealed the resident was admitted from the hospital on 10/2/19. The resident had minimal difficulty hearing and her cognition was intact. The active diagnoses were fracture and other trauma and pressure ulcer of the left buttock stage 3. The pressure ulcer was coded as not present on admission.

The initial care plan dated 10/21/19 documented

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goals and interventions for at risk for fall and actual pressure ulcer.

A physician order for pressure ulcer care was initiated upon admission dated 10/2/19.

A review of the resident's treatment administration record from 10/2/19 to 10/28/19 revealed documentation that the resident received pressure ulcer care to her sacrum that was present on admission.

On 10/31/19 at 11:15 am an interview was conducted with the MDS Coordinator who stated that after review of the resident's admission MDS dated 10/9/19, the MDS was incorrectly coded in Section "M. pressure ulcer present on admission" which was human error and would be corrected.

The DON was interviewed on 10/31/19 at 11:45 am who stated that she expected the MDS to be accurately coded.

3. Resident # 26 was admitted to the facility on 6/28/18 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 9/20/19 indicated that Resident #26 had impairment in range of motion on one side of upper extremity.

Resident #26 had a physician order dated 9/24/18 to apply upper extremity splint at night.

Resident #26's care plan dated 9/20/19 was reviewed. One of the care plan problems was alteration in musculoskeletal status related to contractures of bilateral upper extremities.

The physician progress note dated 10/15/19 revealed that Resident #26's bilateral upper

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F 641	Continued From page 8 extremities had claw hands with braces in place. On 10/29/19 at 8:35 AM and on 10/30/19 at 4:30 PM, Resident #26 was observed. Her bilateral hands were noted to be contracted. On 10/31/19 at 9:05 AM, the MDS Nurse was interviewed. The MDS Nurse verified that Resident #26's bilateral hands were contracted. She stated that the quarterly MDS dated 9/20/19 was coded incorrectly and she would make a correction to the MDS to reflect the limitation in range of motion to both upper extremities. On 10/31/19 at 11:45 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be coded accurately.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		11/19/19

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F 657	Continued From page 9 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to review and revise care plans in the areas of fall risk interventions (Resident #12), infections (Resident #19), and discharge planning (Resident #19) for 2 of 14 sampled residents. The findings included: 1. Resident #12 was admitted to the facility on 7/20/18 and most recently readmitted on 12/20/18 with diagnoses that included dementia and a history of falling. The quarterly Minimum Data Set (MDS) assessment dated 8/12/19 indicated Resident #12 ' s cognition was severely impaired. She required the extensive assistance of 1 with bed mobility, transfers, locomotion on/off unit, and personal hygiene. Resident #12 was not steady on her feet, she utilized a wheelchair and walker, and she was frequently incontinent of bladder and bowel. She was coded with 2 or more falls without injury. Resident #12 ' s care plan included the focus area of an actual fall with risk for further falls.	F 657	The statements made on this Plan of Correction are not an admission to nor do they 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 date or dates indicated. F657 For the residents involved, corrective action has been accomplished by: On October 29, 2019, the MDS Nurse corrected the care plan for Resident #12 to accurately reflect current fall risk interventions. On October 30, 2019, the MDS Nurse corrected the care plan for Resident #19 to accurately reflect infections and discharge planning. Corrective action has been accomplished on all residents with the potential to be	

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F 657	Continued From page 10 The interventions included, in part, removal of bed side commode (BSC). This intervention was initiated on 8/6/19 and was active as of 10/29/19. An observation was conducted of Resident #12 ' s room on 10/29/19 at 3:46 PM. A BSC was observed next to her bed. An interview was conducted with Nursing Assistant (NA) #1 on 10/29/19 at 3:47 PM. She stated that Resident #12 had a BSC in place as a fall risk intervention. An interview was conducted with the Director of Nursing (DON) on 10/29/19 at 3:48 PM. She confirmed that Resident #12 had a BSC in place as a fall risk intervention. She reported that they had a trial removal of the BSC for a short period of time to see if that reduced Resident #12 ' s falls, but it was decided this was an effective intervention and it was put back in place. The DON wasn ' t able to recall when the intervention of the BSC was put back into place, but she thought it wasn ' t long after it was removed (8/6/19). An interview was conducted with the MDS Nurse on 10/30/19 at 12:09 PM. The care plan related to falls for Resident #12 was reviewed with the MDS Nurse. She revealed the intervention of the removal of the BSC should have been revised when the BSC was put back in place. A follow up interview was conducted with the DON on 10/31/19 at 11:45 AM. She indicated that she expected care plans to be reviewed and revised to reflect the current status of the resident.	F 657	affected by the alleged deficient practice by: On November 13, 2019, the Director on Nursing audited the care plans of all current residents for accurate discharge planning in the resident□s care plan, fall interventions and infection control (contact precautions). For results of the audit, please see exhibit (Exhibit Eight). Any issues noted were corrected at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On November 15, 2019, the Regional Minimum Data Set/Quality Assurance Consultant completed an in- service training for the MDS Nurse on how to accurately care plan risk interventions, infections and discharge planning. (Exhibit Nine). The facility has implemented a quality assurance monitor: The Director of Nursing will complete the Care Plan Update and Revision Quality Assurance Monitor weekly for four weeks and monthly for three months (Exhibit Ten). The Director of Nursing will evaluate the care plans of three current residents to ensure accuracy with fall interventions, discharge planning and infections. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. For each month with less than 100% compliance, the monitor will be extended. Any corrective action required will be made by the Quality of Life Team at that time.	

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	345518	A. BUILDING _____ B. WING _____	C 10/31/2019

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INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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F 657	Continued From page 11	F 657		

2. Resident #19 was admitted to the facility on 8/16/19 with diagnoses that included dementia and heart failure.
The admission Minimum Data Set (MDS) assessment dated 8/23/19 indicated Resident #19 ' s cognition was severely impaired.

2a. A physician ' s order for Resident #19 dated 8/22/19 indicated contact precautions due to shingles for 7 days. This order had an end date of 8/29/19.

A physician ' s order for Resident #19 dated 8/22/19 indicated Valacyclovir HCl (antiviral medication) 1 gram (gm) three times daily for shingles for 7 days. This order had an end date of 8/30/19.

A review of Resident #19 ' s care plan indicated the focus area of contact isolation related to shingles was initiated on 8/29/19 and continued to be an active focus area as of 10/29/19.

A review of Resident #19 ' s physician ' s orders and Medication Administration Records (MARs) from 8/29/19 through 10/29/19 indicated Resident #19 was removed from contact precautions and completed his antiviral medication on 8/29/19. He had no further episodes of shingles requiring contact isolation.

An interview was conducted with the MDS Nurse on 10/30/19 at 12:09 PM. The care plan related to contact isolation for shingles for Resident #19 was reviewed with the MDS Nurse. She revealed that this focus area should have been resolved/removed from the care plan when the contact isolation was discontinued. She stated

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F 657	Continued From page 12 that this was an error. An interview was conducted with the Director of Nursing on 10/31/19 at 11:45 AM. She indicated that she expected care plans to be reviewed and revised to reflect the current status of the resident. 2b. A nursing note dated 9/9/19 completed by the Director of Nursing (DON) indicated Resident #19 ' s last day of therapy was 9/9/19 and he was staying at the facility for long term care. A review of Resident #19 ' s care plan, initiated on 8/29/19, indicated the focus area of a planned discharge to the community once his current treatment plan was completed. This focus area conducted to be active as of 10/29/19. An interview was conducted with the MDS Nurse on 10/30/19 at 12:09 PM. The care plan related to planned discharge to the community for Resident #19 was reviewed with the MDS Nurse. She revealed that this focus area should have been revised when Resident #19 converted from a short term stay to a long-term resident. She stated that she missed this change and she probably would ' ve realized it when his quarterly review came up toward the end of November 2019. An interview was conducted with the DON on 10/31/19 at 11:45 AM. She indicated that she expected care plans to be reviewed and revised to reflect the current status of the resident.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		11/19/19

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F 695	Continued From page 13 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, Physician' s Assistant interview, and staff interview, the facility failed to provide nasal saline spray as ordered for 1 of 1 residents (Resident #37) reviewed for respiratory care. The findings included: Resident #37 was admitted to the facility on 5/23/16 and most recently readmitted on 1/7/19 with diagnoses that included dementia, heart disease, and chronic kidney disease. The quarterly Minimum Data Set (MDS) assessment dated 4/16/19 indicated Resident #37 had short term and long-term memory problems and severely impaired decision making. She had no behaviors and no rejection of care. A Physician ' s Assistant (PA) note dated 7/15/19 indicated Resident #37 was seen at staff ' s request related to a wet productive cough and green mucus. The physician indicated his treatment plan included, in part, nasal saline spray for Resident #37. A hard copy physician ' s order entry sheet dated 7/15/19 completed by the PA indicated nasal	F 695	The statements made on this Plan of Correction are not an admission to nor do they 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 date or dates indicated. F695 For the residents involved, corrective action has been accomplished by: At the time of the survey, the nasal saline ordered was completed for Resident #37. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On November 18, 2019 the Director on Nursing audited all current residents for medication compliance using the Not Administered Med Pass Last Twenty-Four Hour Report. The report was used to	

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F 695	Continued From page 14 saline spray 4 times daily for 5 days for Resident #37. An electronic physician ' s order dated 7/15/19 entered by Nurse #2 indicated nasal saline spray 5 times daily for cough for 5 days for Resident #37. This was once a day more than the hard copy order written by the PA. A review of the July 2019 Medication Administration Record (MAR) and the corresponding MAR notes revealed the following information related to the administration of the nasal saline spray (NSS) for Resident #37: - 7/16/19 at 04:00 PM: Nurse #2 administered NSS - 7/16/19 at 08:00 PM: Nurse #6 administered NSS - 7/17/19 at 12:00 AM: Nurse #6 administered NSS - 7/17/19 at 08:00 AM: Nurse #3 had not administered NSS - 7/17/19 at 12:00 PM: Nurse #3 had not administered NSS; 1:18 PM note: " ...awaiting arrival" - 7/17/19 at 04:00 PM: Nurse #3 had not administered NSS; 4:34 PM note: " ...Ordered and awaiting arrival" - 7/17/19 at 08:00 PM: Nurse #4 administered NSS - 7/18/19 at 12:00 AM: Nurse #4 had not administered NSS; 7/17/19 at 11:57 PM note: " ...not received from pharmacy yet" - 7/18/19 at 08:00 AM: Nurse #2 administered NSS - 7/18/19 at 12:00 PM: Nurse #2 had not administered NSS; 2:27 PM note: " ...arriving tomorrow from pharmacy ..." - 7/18/19 at 04:00 PM: Nurse #2 had not	F 695	identify any missed administrations. Please see exhibit for results (Exhibit Eleven). Any issues noted were correct at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On October 30, 2019 the Staff Development Coordinator began in-servicing all nurses and medication aides, part-time and fulltime, on the expectation of following physician orders and how to document any issues (Exhibit Twelve). All nurses, fulltime and part time and all medication aides were in-serviced. The facility has implemented a quality assurance monitor: The Director of Nursing will complete the Missed Medication Quality Assurance Monitor weekly for four weeks and monthly for three months (Exhibit Thirteen). The Director of Nursing will evaluate three residents to ensure medication administration is correct. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. For each month with less than 100% compliance, the monitor will be extended. Any corrective action required will be made by the Quality of Life Team at that time.	

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administered NSS; 4:23 PM note: " ...on order...will receive from pharmacy tomorrow"
- 7/18/19 at 08:00 PM: Nurse #5 administered NSS
- 7/19/19 at 12:00 AM, 08:00 AM, 12:00 PM, 04:00 PM, 08:00 PM: NSS administered
- 7/20/19 at 12:00 AM, 08:00 AM, 12:00 PM, 04:00 PM, 08:00 PM: NSS administered
- 7/21/19 at 12:00 AM, 08:00 AM, 12:00 PM: NSS administered

A PA note dated 7/19/19 indicated Resident #37 was seen at staff ' s request about green phlegm she had coughed up. The PA revealed that review of the record showed Resident #37 had not been getting all of her medications that were ordered on 7/15/19. She was not receiving her NSS. The resident was noted to continue to have upper respiratory congestion and he recommended completing her previous orders.

An interview was conducted with the Director of Nursing (DON) on 10/30/19 at 3:03 PM. The July 2019 MAR and the corresponding MAR notes related to Resident #37 ' s NSS were reviewed with the DON. The DON stated that NSS was a stock medication that would not have needed to be ordered from the pharmacy. She explained that Nurse #2 was new to the facility when she entered the electronic order on 7/15/19 and she probably had not realized the NSS was a stock medication. The DON reported that this was probably the case with some of the other nurses, Nurse #3 and Nurse #4, who also indicated the NSS was on order from the pharmacy. The DON stated that she believed Nurse #6, who was a contracted nurse, had inadvertently taken the NSS home with her which was why they initially

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had the NSS for administration.

An interview was conducted with Nurse #2 on 10/31/19 at 11:10 AM. The hard copy physician ' s order entry sheet dated 7/15/19 completed by the PA that indicated NSS 4 times a day for 5 days was reviewed with Nurse #2. The electronic order dated 7/15/19 completed by Nurse #2 that indicated NSS 5 times a day for 5 days was reviewed with Nurse #2. She revealed this was a transcription error on her part as she was new to the facility at that time and was learning the electronic medical records system. The MAR that indicated Nurse #2 had administered the NSS on 7/16/19 at 4:00 PM and 7/18/19 at 8:00 AM was reviewed. The MAR and corresponding notes that indicated Nurse #2 had not administered the NSS on 7/18/19 at 12:00 PM or 4:00 PM as she was waiting for it to arrive from the pharmacy were reviewed. Nurse #2 revealed she believed the 7/16/19 at 4:00 PM and 7/1819 at 8:00 AM were errors. She explained that she had not known the NSS was a stock medication, so she thought it was being delivered from the pharmacy and had not arrived at the facility yet.

A phone interview was conducted with Nurse #3 on 10/30/19 at 3:55 PM. Nurse #3 was unable to recall any information related to Resident #37 ' s NSS order from July 2019. She stated that she knew that NSS was normally a stock medication and had not needed to be ordered from the pharmacy. She was unable to explain why her notes indicated the NSS was ordered and she was awaiting its arrival.

A phone interview was conducted with Nurse #4 on 10/30/19 at 3:58 PM. The MAR and corresponding notes that indicated Nurse #4 had

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F 695	Continued From page 17	F 695		

administered NSS to Resident #37 on 7/17/19 at 8:00 PM and then that the NSS was not administered on 7/18/19 at 12:00 AM as it was "not received from the pharmacy yet" were reviewed with Nurse #4. Nurse #4 stated that she believed the 7/17/19 at 8:00 PM administration of the NSS was documented in error.

A phone interview was conducted with Nurse #6 on 10/30/19 at 4:00 PM. Nurse #6 was unable to recall any information related to Resident #37 ' s NSS order from July 2019. She denied ever taking a resident ' s NSS home with her.

An interview was conducted with the PA on 10/31/19 at 9:10 AM. The hard copy physician ' s order entry sheet dated 7/15/19 that indicated NSS 4 times a day for 5 days was reviewed. The electronic order dated 7/15/19 completed by Nurse #2 that indicated NSS 5 times a day for 5 days was reviewed. The PA reported that he believed this was a harmless transcription error by Nurse #2. The 7/19/19 PA note that indicated the NSS was not administered as ordered was reviewed. He stated that he had noticed that there were missed doses of the NSS for Resident #37 when he reviewed her record. He reported that this had no negative consequences for Resident #37. The PA indicated that he expected the nurses to transcribe his orders correctly and to administer medications as ordered.

A follow up interview was conducted with the DON on 10/31/19 at 11:45 AM. The DON indicated that she expected the nurses to transcribe physician ' s orders correctly, administer medications as ordered, and correctly document the administration of medications.

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F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 732		11/19/19

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F 732	Continued From page 19 by: Based on record review, observation and staff interview, the facility failed to post daily the total number and the actual hours worked per shift of the Registered Nurse (RN) and Licensed Practical Nurse (LPN) directly responsible for the resident care and failed to post the nurse staffing information daily in a prominent place readily accessible to residents and visitors for 4 of 4 days observed. Findings included: On 10/28/19 at 4:30 PM, 10/29/19 at 3:10 PM, 10/30/19 at 10:10 AM and 10/31/19 at 8:10 AM, the daily nurse staffing information was observed posted at the nurse's station of the 500/600 hall. The nurse staffing information form included the name of the facility, the census, the actual number and actual hours worked per shift of the unlicensed nursing staff (nursing assistant). The form did not include the total number and the actual hours worked per shift of the RN and LPN. On 10/31/19 at 8:15 AM, Nurse #2, nurse assigned on 500/600 hall, was interviewed. The Nurse stated that the morning shift nurse on 500/600 hall, was responsible for completing and posting the nurse staffing information daily. Nurse #2 verified that the nurse staffing information form did not include the total number and the actual hours worked for the RN and LPN. On 10/31/19 at 8:20 AM, Nurse #1, assigned on 300/400 hall, was interviewed. He stated that the nurse staffing information was only posted on one hall (500/600 hall) and not on 300/400 hall. Nurse #1 indicated that about 2 years ago, the staffing information was posted on each hall but	F 732	The statements made on this Plan of Correction are not an admission to nor do they 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 date or dates indicated. F732 For the residents involved, corrective action has been accomplished by: On November 15, 2019, the nursing staff began using a new form that reflects specifically Registered Nurse (RN) and Licensed Practical Nurse (LPN) hours (Exhibit Fourteen). Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: The new Daily Nursing Staffing Posting will begin being posted with the survey results on November 19, 2019. On November 18, 2019, the Director on Nursing posted at all three visitor designated entrances the new location of the Daily Nursing Staffing Posting which is located with the survey results. This notification will remain posted for a minimum of one week.	

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F 732	Continued From page 20 that had changed. The Nurse further indicated that residents and families of residents on 300/400 hall had no access to the daily nurse staffing information. On 10/31/19 at 11:40 AM, the Director of Nursing (DON) was interviewed. The DON stated that the nurse staffing information form was a corporate form and she would check with the corporate to ensure the regulation regarding the total number and actual hours worked for the RN and LPN was followed. The DON further indicated that in the past, the nurse staffing information was posted on each hall, however, the daily posting information, completed by the nurses, did not match, so it was decided to just post it on one hall. The DON stated that the facility had 4 entrance/exit doors and it was hard to find a location accessible to all residents and visitors.	F 732	Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On November 18, 2019, the Staff Development Coordinator educated all nurses, fulltime and part time and the Scheduler on the proper completion of the new Posted Nurse Staffing Information and where to post the form daily (Exhibit Fifteen). The facility has implemented a quality assurance monitor: The Director of Nursing will complete the Daily Nursing Staffing Sheet Quality Assurance Monitor weekly for four weeks and monthly for three months (Exhibit Sixteen). The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. For each month with less than 100% compliance, the monitor will be extended. Any corrective action required will be made by the Quality of Life Team at that time.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		11/19/19

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F 812	Continued From page 21 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to discard expired food items in 2 of 2 reach-in refrigerators and 1 of 1 walk-in refrigerator. Findings include: On 10/28/19 at 9:40 am an initial tour of the kitchen was conducted with the Dietary Manager (DM) present. An observation of the walk-in refrigerator revealed there was a large plastic container (approximately a gallon) with plastic wrap semi-adhered that contained cooked vegetables and an expiration label dated 10/27/19. The reach-in, glass front refrigerator was observed and there was sliced ham in a plastic zip lock bag and sliced turkey in a plastic zip lock bag and both items (approximately a pound each) had an expiration tag dated 10/22/19. In a plastic container were several cut lemons that were starting to turn brown/wilted and cocktail sauce (labeled) in a metal container with plastic wrap cover and both items had an expiration tag dated 10/22/19. In the metal door reach-in refrigerator was a large plastic container (approximately a gallon) with plastic wrap cover was chocolate pudding with an expiration tag dated 10/27/19. The Dietary manager was present, informed and identified each food item as expired.	F 812	The statements made on this Plan of Correction are not an admission to nor do they 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 date or dates indicated. F812 For the residents involved, corrective action has been accomplished by: On October 29, 2019, the expired food items were discarded by the Food Service Director. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On October 29, 2019, the Food Service Director audited all refrigerators to ensure that no other expired food items were present. For results, please see the	

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F 812	Continued From page 22 On 10/28/19 at 9:55 am the DM was interviewed and commented that cooked vegetables would be discarded after 4 days. DM stated the cooked vegetables in the walk-in refrigerator were expired and would be discarded. After the observation of the two reach in refrigerators, the DM stated she would discard all the identified expired food items during observation. The Administrator was interviewed on 10/31/19 at 11:40 am and informed regarding the expired food items identified on 10/28/19 and interview with the DM. The Administrator stated she expected the kitchen staff to discard expired food items by their labeled expiration date.	F 812	exhibit (Exhibit Seventeen). Any issues noted were corrected at that time. Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On November 19, 2019, the Food Service Director educated all fulltime and part time dietary staff on how to properly label food and when to discard the food (Exhibit Eighteen). The facility has implemented a quality assurance monitor: The Food Service Director will complete the QA Label and Dating Inspection Report Quality Assurance Monitor weekly for four weeks and monthly for three months (Exhibit Nineteen). The Food Service Director will inspect all refrigerated storage for proper labeling and expired foods. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. For each month with less than 100% compliance, the monitor will be extended. Any corrective action required will be made by the Quality of Life Team at that time.	
F 842 SS=B	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	F 842		11/19/19

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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 unauthorized use.

§483.70(i)(4) Medical records must be retained for-

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F 842	Continued From page 24 (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 interview, the facility failed to have complete and accurate medical records for Residents #8, #19, and #37 for 3 of 14 sampled residents. The findings included: 1. Resident #19 was admitted to the facility on 8/16/19 with diagnoses that included dementia and heart failure. The admission Minimum Data Set (MDS) assessment dated 8/23/19 indicated Resident #19' s cognition was severely impaired. A physician ' s order for Resident #19 dated 8/22/19 indicated contact precautions due to shingles for 7 days. This order had an end date of 8/29/19.	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 date or dates indicated. F842 For the residents involved, corrective action has been accomplished by: 1. On November 14, 2019, the Director of Nursing made a Medical Record	

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F 842	Continued From page 25 A physician ' s order for Resident #19 dated 8/22/19 indicated Valacyclovir HCl (antiviral medication) 1 gram (gm) three times daily for shingles for 7 days. This order had an end date of 8/30/19. A review of Resident #19 ' s physician ' s orders and Medication Administration Records (MARs) from 8/29/19 through 10/29/19 indicated Resident #19 was removed from contact precautions and completed his antiviral medication on 8/29/19. He had no further episodes of shingles requiring contact isolation. Nursing notes dated 8/30/19 through 9/8/19 completed by Nurse #2, Nurse #5, Nurse #7, Nurse #8, and Nurse #9 inaccurately indicated Resident #19 was on contact precautions for shingles and was receiving antiviral medication. An interview was conducted with Nurse #9 on 10/30/19 at 10:15 AM. The inaccurate notes that indicated Resident #19 was on contact precautions for shingles and was receiving antiviral medication after the contact precautions and antiviral medication had been discontinued were reviewed with Nurse #9. She confirmed the notes were inaccurate. She indicated that the notes pulled forward like a template and she and the other nurses failed to revise the section of the notes related to the contact precautions, shingles, and antiviral medication. A phone interview was conducted with Nurse #7 on 10/30/19 at 11:15 AM. The inaccurate notes that indicated Resident #19 was on contact precautions for shingles and was receiving antiviral medication after the contact precautions and antiviral medication had been discontinued	F 842	Correction for Resident #19 to reflect accurate Contact Precaution Status. 2. On November 14, 2019, the Director of Nursing made a Health Status Note to reflect that Resident #37 did not receive nasal saline as ordered on July 17th and 18th and that the primary physician is aware and no new orders received. 3. On November 19, 2019, the Director of Nursing made a Medical Correction note to reflect that Dr. Alexander's office contacted the Responsible Party for Resident # 8 and he declined the recommended extractions. 3b. On November 19, 2019, the Director of Nursing made a Medical Correction note to reflect that the MD and PA notes for Resident #8 regarding his Lasix were incorrect and should have accurately reflected the MD order of Lasix 40mg in the morning and 20mg at 2pm daily. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On November 19, 2019, the Director on Nursing audited all current residents' medication administration records, nursing notes, physician progress notes, and most recent dental consultant reports for the past fourteen days for accuracy and completion. For results, please see the exhibit (Exhibit Twenty). Any corrections needed were made at that time. Measures put into place or systematic	

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F 842	Continued From page 26 were reviewed with Nurse #7. She confirmed the notes were inaccurate. She explained that the previous notes were able to be copied and used as a template and they were supposed to revise any areas that had changed from the previous note. She stated that not revising the notes was an error. A phone interview was conducted with Nurse #5 on 10/30/19 at 11:44 AM. The inaccurate notes that indicated Resident #19 was on contact precautions for shingles and was receiving antiviral medication after the contact precautions and antiviral medication had been discontinued were reviewed with Nurse #5. She confirmed the notes were inaccurate. She explained that the previous notes were able to be copied and used as a template and they were supposed to revise any areas that had changed from the previous note. She stated that not revising the notes was an error. A phone interview was conducted with Nurse #8 on 10/30/19 at 11:02 AM. The inaccurate notes that indicated Resident #19 was on contact precautions for shingles and was receiving antiviral medication after the contact precautions and antiviral medication had been discontinued were reviewed with Nurse #8. She stated that if the contact precautions and antiviral medication had been discontinued then these notes were inaccurate. A phone interview was conducted with Nurse #2 on 10/30/19 at 11:09 AM. The inaccurate notes that indicated Resident #19 was on contact precautions for shingles and was receiving antiviral medication after the contact precautions and antiviral medication had been discontinued	F 842	changes made to ensure the alleged deficient practice does not occur: On November 15-19, 2019, the Staff Development Coordinator and Director of Nursing educated all nurses, fulltime and part time and the MD and PA on the proper documentation of Contact Precautions, Medication Administration, follow up of consultations and monitoring of physician documentation (Exhibit Twenty-one). The facility has implemented a quality assurance monitor: The Director of Nursing will complete the Accurate Documentation Quality Assurance Monitor weekly for four weeks and monthly for three months (Exhibit Twenty-two). The Director of Nursing will evaluate five residents to ensure proper documentation nursing, MD and PA notes and proper documentation of consultant follow up. The results will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting. For each month with less than 100% compliance, the monitor will be extended. Any corrective action required will be made by the Quality of Life Team at that time.	

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were reviewed with Nurse #2. She stated that if the contact precautions and antiviral medication had been discontinued then these notes were inaccurate. She reported she was still learning the electronic medical records system.

An interview was conducted with the Director of Nursing on 10/31/19 at 11:45 AM. She indicated that she expected the nursing notes to be accurate and to be revised as needed to reflect any changes with the resident and/or their treatment regimen.

2. Resident #37 was admitted to the facility on 5/23/16 and most recently readmitted on 1/7/19 with diagnoses that included dementia, heart disease, and chronic kidney disease.

The quarterly Minimum Data Set (MDS) assessment dated 4/16/19 indicated Resident #37 had short term and long-term memory problems and severely impaired decision making.

An electronic physician ' s order dated 7/15/19 entered by Nurse #2 indicated nasal saline spray 5 times daily for cough for 5 days for Resident #37.

A review of the July 2019 Medication Administration Record (MAR) and the corresponding MAR notes revealed the following information related to the administration of the nasal saline spray (NSS) for Resident #37:
- 7/16/19 at 04:00 PM: Nurse #2 administered NSS
- 7/16/19 at 08:00 PM: Nurse #6 administered NSS
- 7/17/19 at 12:00 AM: Nurse #6 administered

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F 842	Continued From page 28 NSS - 7/17/19 at 08:00 AM: Nurse #3 had not administered NSS - 7/17/19 at 12:00 PM: Nurse #3 had not administered NSS; 1:18 PM note: " ...awaiting arrival" - 7/17/19 at 04:00 PM: Nurse #3 had not administered NSS; 4:34 PM note: " ...Ordered and awaiting arrival" - 7/17/19 at 08:00 PM: Nurse #4 administered NSS - 7/18/19 at 12:00 AM: Nurse #4 had not administered NSS; 7/17/19 at 11:57 PM note: " ...not received from pharmacy yet" - 7/18/19 at 08:00 AM: Nurse #2 administered NSS - 7/18/19 at 12:00 PM: Nurse #2 had not administered NSS; 2:27 PM note: " ...arriving tomorrow from pharmacy ..." - 7/18/19 at 04:00 PM: Nurse #2 had not administered NSS; 4:23 PM note: " ...on order ...will receive from pharmacy tomorrow An interview was conducted with Nurse #2 on 10/31/19 at 11:10 AM. The MAR that indicated Nurse #2 had administered the NSS on 7/16/19 at 4:00 PM and 7/18/19 at 8:00 AM was reviewed. The MAR and corresponding notes that indicated Nurse #2 had not administered the NSS on 7/18/19 at 12:00 PM or 4:00 PM as she was waiting for it to arrive from the pharmacy were reviewed. Nurse #2 revealed she believed the 7/16/19 at 4:00 PM and 7/18/19 at 8:00 AM were errors. She explained that she had not known the NSS was a stock medication, so she thought it was being delivered from the pharmacy and had not arrived at the facility yet.	F 842		

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A phone interview was conducted with Nurse #4 on 10/30/19 at 3:58 PM. The MAR and corresponding notes that indicated Nurse #4 had administered NSS to Resident #37 on 7/17/19 at 8:00 PM and then that the NSS was not administered on 7/18/19 at 12:00 AM as it was "not received from the pharmacy yet" were reviewed with Nurse #4. Nurse #4 stated that she believed the 7/17/19 at 8:00 PM administration of the NSS was documented in error.

An interview was conducted with the Director of Nursing on 10/31/19 at 11:45 AM. She indicated that she expected the MAR to be accurate.

3. Resident #8 was admitted to the facility on 7/16/15 and most recently readmitted on 7/25/16 with diagnoses that included Alzheimer ' s Disease and heart failure. The annual Minimum Data Set (MDS) assessment dated 8/3/19 indicated Resident #8 ' s cognition was severely impaired. He was assessed with obvious or likely cavity or broken natural teeth. Resident #8 was administered diuretic medication on 7 of 7 days during the MDS review period.

3a. A dental consultation progress note dated 5/14/19 indicated extractions were recommended for 3 of Resident #8 ' s teeth. The dental provider indicated Resident #8 ' s family member needed to be spoken with related to the recommended extractions.

A review of the medical record from 5/15/19 through 10/30/19 revealed no further information related to Resident #8 ' s 5/14/19 dental consultation and the recommended extractions.

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An interview was conducted with the Director of Nursing (DON) on 10/30/19 at 9:45 AM. The 5/14/19 dental consultation note for Resident #8 was reviewed with the DON. She stated she had to look into this further to provide more information.

An email exchange from the DON to the dental provider on 10/30/19 at 9:55 AM requested follow up information on the 5/14/19 dental consultation for Resident #8. A return email from the dental provider to the DON on 10/30/19 at 10:22 AM indicated Resident #8 ' s family had declined the extractions at that time and the next dental visit would be in November 2019 pending the family ' s approval.

An interview was conducted with the Director of Nursing on 10/31/19 at 11:45 AM. She indicated that she expected information related to dental consultation recommendations to be included in the resident ' s medical record.

3b. A physician ' s order dated 11/8/17 for Resident #8 indicated Lasix (diuretic medication) 40 milligrams (mg) in the morning and 20 mg in the evening.

A review of the physician ' s order summaries and Medication Administration Records (MARs) from December 2018 through October 2019 indicated Resident #8 ' s Lasix order initiated 11/8/17 remained an active order.

A review of Physician Assistant (PA) notes dated 12/21/18, 2/6/19, 3/20/19, 3/28/19, 5/13/19, 5/28/19, 6/18/19, 6/25/19, and 7/2/19 inaccurately indicated that Resident #8 was on Lasix 20 mg per day rather than the ordered 40 mg in the

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morning and 20 mg in the evening.

A physician note dated 8/21/19 inaccurately indicated Resident #8 was on Lasix 20 mg per day rather than the ordered 40 mg in the morning and 20 mg in the evening.

An interview was conducted with the PA on 10/31/19 at 9:10 AM. The 9 inaccurate PA notes and 1 inaccurate physician note from December 2018 through August 2019 for Resident #8 were reviewed with the PA. The PA revealed that his notes pulled forward like a template and he was unable to edit the note without creating an entirely new note. He explained that if there was an error in one note it was likely repeated in several notes if the error was not identified. He further explained the physician normally used his notes as a template as well which also would have caused an error in the physician notes. He stated that ideally, he would expect all of his notes to be accurate.

An interview was conducted with the Director of Nursing on 10/31/19 at 11:45 AM. She indicated that she expected the PA and physician notes to be accurate and to be revised as needed to reflect any changes with the resident and/or their treatment regimen.