STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345576	A. BUILDING ______ B. WING ______	C 04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HEALTH & REHAB CENTER	**1716 LEGION ROAD CHAPEL HILL, NC 27517**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 04/25/23 through 04/28/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QXPF11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 04/24/23 through 04/28/23. Event ID# QXPF11. The following intakes were investigated NC00195314, NC00198426, NC00191058, NC00195218, NC00194773, NC00195386, and NC00201473. 0 of the 11 complaint allegations resulted in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 553		5/26/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/19/2023

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

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F 553	Continued From page 1 right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to invite a cognitively intact resident to participate in the planning of the resident's care for 1 of 3 residents reviewed for participation in care plan meetings. (Resident #12) Resident #12 was admitted on 12/3/18. Review of the electronic medical record for Resident #12 revealed a form titled," Care Plan Attendance Sheet" dated 11/11/2022 contained the Residents name, Responsible Party's (RP) name and the people who had attended the meeting. The Social Worker and the Unit Manager reviewed the plan of care with Resident #12's family member. Resident #12 did not attend the meeting. The medical record included no evidence that Resident #12 was invited to participate in the care plan meeting conducted on 11/11/2022. Review of the most recent Minimum Data Set	F 553	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. F553 RIGHT TO PARTICIPATE IN PLANNING CARE Corrective Action: Resident #12 Care plan meeting scheduled for Resident invited to care planning meeting by Parkview on 4/18/2023/ via verbal invitation. Identification of other residents who may be affected by alleged deficient practice: All current cognitively intact residents,	

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F 553	Continued From page 2 (MDS) dated 2/1/23 revealed Resident #12 was cognitively intact. Record review for Resident #12 revealed no evidence of any care plan meetings conducted after 11/11/2022 and no evidence that the resident was incorporated into his care planning process. An interview on 4/25/23 at 3:35 PM with Resident #12, revealed he had never attended a care plan meeting or had been asked to attend one. Resident #12 stated that he wanted to go to his care planning meetings. During an interview on 4/27/23 at 9:26 AM, Social Worker #1 (SW) explained that all residents with a cognitive score between 13-15 were cognitively intact and should have been invited to care plan meetings. SW #1 said the invitations to care plan meetings were provided to the resident and the responsible party after the MDS nurse set the assessment date. SW #1 said herself and SW #2 were responsible for distributing the care plan meeting invitations. Resident #12 was set for a meeting in February 2023 following completion of the 2/1/23 MDS assessment. There was no invitation letter sent for this care plan meeting and no care plan meeting occurred for Resident #12. SW #1 was not sure why Resident #12 had not received invitations to the care plan meetings. SW#1 further explained that care plan meetings were done upon admission and on a quarterly basis, following the completion of the quarterly MDS assessments. An interview with the Director of Nursing (DON) on 4/28/23 at 2:13 PM, revealed Resident #12 should have been invited and involved in their	F 553	have the potential to be affected by the alleged practice. A 100% audit of all current residents who are cognitively intact residents (BIMS score 13-15) will be completed in order to validate whether they have been invited to participate in the planning of their care during the past 90 days. This audit will be completed by the facility Social Worker and Administrator by May 24, 2023 All residents identified as not having been invited to participate in their care planning conference will receive an invitation to a scheduled care conference. This will be completed for all affected residents no later than May 26, 2023. Systemic Changes: On 5/18/2023 The Minimum Data Set (MDS) Coordinator and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the Director of Nursing. The education focused on: The resident has the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The	

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F 553	Continued From page 3 care plan meetings. The DON revealed care plan meetings needed to be documented in the record to include everyone in attendance. The delivery of a care plan letter to a resident and/or family member, as well as a declination to attend a meeting, needed to be documented. The DON further explained all residents needed to at least be invited to participate in the care planning process.	F 553	right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will interview 5 cognitively intact residents to ensure that they have been invited to participate in the planning of their care. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or	

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F 553	Continued From page 4	F 553	Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F 636		5/26/23

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F 636	Continued From page 5 (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD), which was the last day of the assessment period) for 2 out of	F 636	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	

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Continued From page 6

12 sampled residents (Resident #19, and #52).

Findings include:

1. Resident #19 was admitted to the facility on 10/28/22. A review of Resident #19's 5-day/admission MDS assessment with an ARD of 11/4/22 was signed as completed on 11/14/22.

An interview with MDS Coordinator on 4/27/23 at 9:31 AM, revealed she did not sign the MDS assessments as completed. The MDS Coordinator reported that the Corporate MDS Nurse Consultant signed the assessments after she filled them out and was unable to say why the assessments were signed as completed late.

A telephone interview on 4/28/23 at 9:07 AM, with the Corporate MDS Nurse revealed she signed the completed assessments, both remotely and in the facility. She did not know which assessments were signed late.

Interview with Administrator on 4/28/23 at 2:15 PM, indicated all MDS assessments should be completed in a timely manner. She went on to explain the facility MDS Nurse was a Licensed Practical Nurse, the corporate MDS nurses were Registered Nurses, and they signed the completed assessments.

2. Resident #52 was admitted to the facility on 11/16/22. A review of Resident #52's admission MDS assessment with an ARD of 11/23/22 was signed as completed on 12/8/22.

An interview with MDS Coordinator on 4/27/23 at 9:31 AM, revealed she did not sign the MDS assessments as completed. The MDS

F 636

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.

F636 – Comprehensive Assessment and Timing
Corrective actions have been taken for all affected residents as follows:
¿ Resident #19: Assessment with ARD 11/4/22 was completed on 11/14/2022 by the facility Minimum Data Set nurse.
¿ Resident #52: Assessment with ARD of 11/23/22 was completed on 12/8/22 by the facility Minimum Data Set nurse.

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 all current residents was completed in order to identify any resident with a comprehensive assessment that has not been completed within the required timeframe. This audit will be completed by the facility MDS team and Administrator no later than 5/24/23.

Any comprehensive MDS identified by the audit as being late, will be completed and submitted to the state database. All comprehensive MDS assessments will be up to date no later than 5/26/2023

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Coordinator reported that the Corporate MDS Nurse Consultant signed the assessments after she filled them out and was unable to say why the assessments were signed as completed late.

A telephone interview on 4/28/23 at 9:07 AM, with the Corporate MDS Nurse revealed she signed the completed assessments, both remotely and in the facility. She did not know which assessments were signed late.

Interview with Administrator on 4/28/23 at 2:15 PM, indicated all MDS assessments should be completed in a timely manner. She went on to explain the facility MDS Nurse was a Licensed Practical Nurse, the corporate MDS nurses were Registered Nurses, and they signed the completed assessments.

F 636

Systemic Changes

On 5/18//23, the Administrator completed an in-service training for the facility Minimum Data Set Coordinator that included the importance of ensuring that each resident receive a comprehensive assessment according to the rules stated in Chapter 2 of the RAI (resident assessment instrument) Manual.

OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission Assessment, Annual Assessment, and Significant Change in Status Assessment, and Significant Correction to Prior Comprehensive Assessment.

The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day one if:

- this is the resident's first time in this facility, OR
- the resident has been admitted to this facility and was discharged return not anticipated, OR
- the resident has been admitted to this

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facility and was discharged return anticipated and did not return within 30 days of discharge.

The ARD (item A2300) must be set no later than day 14, counting the date of admission as day 1. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. For example, if a resident is admitted at 8:30 a.m. on Wednesday (day 1), a completed RAI is required by the end of the day Tuesday (day 14).
The MDS completion date (item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than. The CAA(s) completion date (item V0200B2) must be no later than day 14.
The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).
The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA or an SCPA has been completed since the most recent comprehensive assessment was completed. The ARD (item A2300) must be set within 366 days after the ARD of the previous OBRA comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA (ARD of previous OBRA Quarterly assessment + 92

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F 636	Continued From page 9	F 636	calendar days). The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be earlier than or the same as the CAA(s) completion date, but not later than. The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be the same as the MDS completion date, but not earlier than. The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days). The Significant Change Status Assessment is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change. The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for an SCSA are met (determination date + 14 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This information has been integrated into	

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F 636	Continued From page 10	F 636	the standard orientation training for new Minimum Data Set Coordinators. The administrator will ensure that all assessments are being completed timely by nurse at center or remotely. The RN MDS nurse will ensure assessments are locked once completed to ensure assessments are transmitted timely. RN MDS nurse will notify Corporate when assessments are completed and ready for transmission. Transmission will be completed daily. 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/Administrator or designee will begin auditing the facility's compliance with ensuring that comprehensive Minimum Data Set assessments are scheduled and completed within required timeframes as stated in Chapter 2 of the RAI (resident assessment instrument) Manual using the quality assurance survey tool entitled "Comprehensive Assessments and Timing 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 or until substantial compliance is achieved and maintained. Reports will be presented to the weekly Quality Assurance committee	

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F 636	Continued From page 11	F 636	by the Director of 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.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by	F 640		5/26/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HEALTH & REHAB CENTER	**1716 LEGION ROAD CHAPEL HILL, NC 27517**

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CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to transmit Minimum Data Set (MDS) assessments to the Centers for Medicare & Medicaid Services (CMS) within the regulatory timeframe for 2 of 12 residents reviewed (Resident #11 and #19).

1.Resident #11 was admitted to the facility on 10/24/22.

A review of Resident #11's most recent admission MDS assessments with an Assessment

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.

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Reference Date (ARD) of 10/28/22 revealed it was signed as completed on 11/6/22. The assessment was transmitted to CMS on 12/8/2022.

An interview with the Corporate MDS Consultant on 4/28/23 at 9:07 AM, revealed she completed facility MDS assessments. The corporate billing office transmitted the assessments. She was unaware the assessments were transmitted late.

During an interview on 4/28/23 at 10:42 AM, the Director of Receivables from the Corporate Billing department revealed the MDS assessments were transmitted every morning by a support person from the billing department. All completed MDS assessments were transmitted Monday through Friday. Any assessments that were in the queue were transmitted.

An Interview on 4/28/23 at 2:13 PM, with the Director of Nursing (DON) revealed MDS assessments needed to be transmitted in a timely manner per regulations.

2.Resident #19 was originally admitted on 8/30/22, discharged and subsequently readmitted on 10/28/22.

a. A review of Resident #19's initial admission /5-day MDS assessment with an ARD of 9/6/22, revealed it was signed as completed on 9/12/22. The assessment was transmitted to CMS on 10/13/22.

b. A review of Resident #19's most recent admission/5-day MDS assessment with an ARD of 11/4/22, revealed it was signed as completed on 11/14/22. The assessment was transmitted to

F 640

F-640 Encoding/Transmitting Resident Assessments
Corrective action for affected residents:
Resident #11: Specific deficiency for this resident was corrected by the Minimum Data Set assessment with an Assessment Reference Date of 10/28/2022 being completed on 11/6/2022 by the facility Minimum Data Set Nurse. Assessment was submitted/accepted by state database on 12/8/2022.
Resident #19: Specific deficiency for this resident was corrected by the Minimum Data Set assessment with an Assessment Reference Date of 9/6/ 2022 being completed on 9/12/2022 y the facility Minimum Data Set Nurse. Assessment was submitted/accepted by state database on 10/13/2023.
Corrective action for residents with the potential to be affected by the alleged deficient practice:

A 100% audit of all residents who have had an MDS assessment completed within the past 30 days will be completed in order to validate that the MDS was transmitted to the state database within the required timeframe. This audit will be completed by the facility MDS team and Administrator no later than 5/26/2022. All resident MDS assessments will be up to date including being transmitted to the state database by the required due date no later than 5/26/2023.

Systemic Changes

On 5/18/23, the Administrator provided

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CMS on 12/8/22.

An interview with the Corporate MDS Consultant on 4/28/23 at 9:07 AM, revealed she completed facility MDS assessments. The corporate billing office transmitted the assessments. She was unaware the assessments were transmitted late.

During an interview on 4/28/23 at 10:42 AM, the Director of Receivables from the Corporate Billing department revealed the MDS assessments were transmitted every morning by a support person from the billing department. All completed MDS assessments were transmitted Monday through Friday. Any assessments that were in the queue were transmitted.

An Interview on 4/28/23 at 2:13 PM with the Director of Nursing (DON) revealed MDS assessments needed to be transmitted in a timely manner per regulations. He was aware that there were late assessments.

F 640

education to the Minimum Data Set Coordinator on the importance of scheduling and completing all Minimum Data Set assessments according to regulated timeframes per chapter 2 of the Resident Assessment Instrument manual. The education also included requirements for encoding Minimum Data Set data: Within 7 days after completing a resident’s Minimum Data Set assessment or tracking record, the provider must encode the Minimum Data Set data (i.e., enter the information into the facility Minimum Data Set software).
The encoding requirements are as follows:

- For a comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive), encoding must occur within 7 days after the Care Plan Completion Date (V0200C2 + 7 days).
- For a Quarterly, Significant Correction to Prior Quarterly, Discharge, or Prospective Payment System assessment, encoding must occur within 7 days after the Minimum Data Set Completion Date (Z0500B + 7 days).
- For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records).

The administrator will ensure that all assessments are being completed timely by nurse at center or remotely. The RN MDS nurse will ensure assessments are

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F 640	Continued From page 15	F 640	locked once completed to ensure assessments are transmitted timely. RN MDS nurse will notify Corporate when assessments are completed and ready for transmission. Transmission will be completed daily. 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, Administrator or designee will review 5 random residents who have had any of the following Minimum Data Set types (Admission, Quarterly, Annual, Significant Change, 5 day or Discharge Tracking) completed during the past 30 days in order to validate whether or not the assessment was completed within the required timeframes according to Chapter 2 of the Resident Assessment Instrument manual using the Quality Assurance Tool titled “Encoding/Transmitting MDS Within Required Timeframe.” This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Management, Dietary Manager and the Administrator	

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F 640	Continued From page 16	F 640	The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication error rate of 10.34% (3 errors out of 29 opportunities) for Resident #235 and Resident #62. The findings included: 1a. A medication administration for Resident #235 was observed on 4/27/23 at 9:26 AM, Nurse #1 administered a simethicone 125 milligram (mg) tablet orally. Review of physician orders 4/14/23 revealed Resident #235 was prescribed simethicone tablet chewable 80 mg by mouth four times a day for heartburn. An interview on 4/27/23 at 2:25 PM, Nurse #1 stated she gave the 125 mg simethicone dose, even though the order was for 80 mg. The 125 mg was the standard dosage provided in the medication cart for the over-the-counter	F 759	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. F759 Free of Medication Error Rate 5 percent or More Based on observation, record review, and staff, responsible party, resident interviews the facility failed to maintain the medication error rate at 5% or below for Resident #235 and # 62. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident # 235, on 4/27/2023 nurse # 1 was educated by the Director of Nurses	5/26/23

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medication. She further revealed she could have contacted Central Supply to obtain 80 mg simethicone tablets.

The physician interview on 4/27/23 at 3:18 pm, revealed she was not aware that simethicone 125 mg had been administered to Resident #235 instead of 80 mg. She further revealed that 125 mg simethicone was an acceptable dosage for Resident #235.

During an interview on 4/27/23 at 3:27 PM, the Central Supply Secretary revealed the facility's over-the-counter medications were supplied by a vendor. She stated she ordered over-the-counter medication as ordered by the physician. The nurse documented the prescribed over-the-counter medication and dose on a form located at the nurse's station. The vender filled and delivered orders every Tuesday. She indicated she obtained the medication from the vender, the facility pharmacy, or a local pharmacy.

An interview on 4/28/23 at 3:15 PM, the Director of Nursing (DON) revealed each nursing station had a form that the nurses filled out for prescribed over-the-counter medication. He further revealed there was a back-up pharmacy to fill over-the-counter medication orders for new prescriptions. He revealed the nurse should have notified the physician when there was a discrepancy between the physician order dose and the dose that was available on the cart during medication pass.

1b. During the medication administration observed on 4/27/23 at 9:26 AM for Resident #235, Nurse #1 did not administer nasal spray

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on the correct
procedure for administering ordered medications to include following the six rights of medication
administration to assure medications are administered as ordered by the physician. The nurse was also
educated on notification of the physician if a medication is not available as ordered and how to utilize
the backup pharmacy to assure medications are administered as ordered. The nurse was observed on
5/01/23 by the Director of Nurses and complied with facility policy on medication administration and
was able to verbalize process to follow for assuring medications were available to be administered as
ordered.
For resident # 62, on 4/27/23 nurse # 2 was educated by the Director of Nurses on the correct
procedure for administering ordered medications to include following the six rights of medication
administration to assure medications are administered as ordered by the physician and notification of
the physician of new complaints of pain. The nurse was observed on 5 / 11 /23 by the Director of Nurses
and complied with facility policy on medication administration and was able to verbalize process for pain
assessment and notification of the physician.
2. Corrective action for residents with the potential to be affected by the alleged

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sodium chloride nasal solution 0.65% (saline), one spray in each nostril.

Review of the physician orders 4/14/23 revealed Resident #235 was prescribed sodium chloride nasal solution 0.65 % (saline) 1 spray in each nostril three times a day for epistaxis (nosebleeds).

Nurse #1 was interviewed on 4/27/23 at 2:25 PM, and revealed the nasal spray was not given because she overlooked and missed the order for the nasal spray for morning medication pass.

2. A medication administration was observed on 4/27/23 at 4:35 PM, for Resident #62. Nurse #2 administered 2 grams of diclofenac sodium topical gel 1% to the back of the left hand.

Review of the physician orders revealed two orders for diclofenac sodium external topical gel 1%:
a) order dated 3/27/23 for diclofenac sodium external topical gel 1%, 2 grams applied for bilateral shoulder pain three times a day, and
b) order dated 3/29/23 for diclofenac sodium gel 1%, 2 grams applied to the lower back four times a day for lower back pain.

On 4/27/23 at 5:43 PM, Nurse #2 stated there were orders for diclofenac sodium topical gel 1%, 2 grams for Resident #62's back and shoulder areas. She continued Resident #62 denied pain to his back but indicated his left hand and wrist had pain. She indicated she would contact the physician for an order to include left hand and wrist treatment for pain.

An interview on 4/28/23 at 3:15 PM, the DON

F 759

deficient
practice.
On 5/8/2023 the Director of Nurses/Assistant Director of Nurses observed administration of medications by nurse #1 and nurse # 2 to assure compliance with the administration of ordered medications
following the facility medication administration process.
Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 5 /1/2023 the Director of Nursing/Assistant Director of Nurses began education of all full time, part time, per-diem nurses/agency nurses and medication aides. Education will be focused on medication
administration as ordered by physicians or mid-level practitioners to include following the six rights of
medication administration, following physician orders and applying medications as ordered to the
correct body site.
The pharmacy consultant will complete medication administration pass observations with licensed nurses/medication aides and report the findings to the Director of Nurses to assure compliance is
sustained.
This information has been integrated into the standard orientation training and in the required in□service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not

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F 759	Continued From page 19 revealed when a resident told the nurse about a pain in a new area, the nurse should have completed an assessment, notified the physician, and obtained a new order for the right patient, right location, right dose, right time, and documented what was done.	F 759	receive scheduled in□service training by 5/25/2023 will not be allowed to work until training has been completed. 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 Nurses or Assistant Director of Nurses will randomly observe medication pass for adherence to orders by physicians or mid-level practitioners. This will be done on random shifts including weekends. The Director of Nurses or Assistant Director of Nurses will complete the Quality Assurance audit tool for adherence to the facility medication administration policy and process weekly x 2 then monthly x 3. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	