DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING ______ B. WING ______	C 05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	**400 PELT DRIVE FAYETTEVILLE, NC 28301**

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F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility allowed residents' medical information to be transmitted in texting format from staff members' private cell phones to the physician and physician assistant's personal cell phones for 7 out of 7 residents (Resident #1, #2,	F 164	Nurse #1 with resident identifying information on his personal cell phone was instructed to delete the information immediately and was in-serviced on the policy for cell phone usage while in the facility, located in the personnel handbook	6/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/27/2014

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 164	Continued From page 1 #3, #4, #5, #6 and #7). Findings included: Review the of the facility policy for personal electronic devices page 28 in part read "personal devices to include cell phones are to be shut off during working hours - cells phone should not be used in resident areas. Taking photos of facility property is strictly prohibited. Transmitting of any confidential information is strictly prohibited." 1a. Observation on 5/7/14 at 2:07 pm was made of Nurse #1's personal cell phone accompanied by the director of nursing (DON) revealed transmitted texted messages that read "Resident #1's first/last name, has a change in status: she has jerking and fine motor skills seem unable to feed self and slightly confusion during conversation. Blood glucose 84, 128/84, 84, 80, 97.5, oxygen saturation 95 on room air" dated 3/14/14 at 9:02 am to the physician. At 9:04 am, a text message read "I apologize this is (name of the facility), (name of the hall) Nurse #1. "A reply back from the physician's cell phone dated 3/14/14 at 9:12 am read "complete blood count, complete metabolic count and urine let me know if still jerking in 10 min." b. Observation on 5/7/14 at 2:08 pm, Nurse #1's personal cell phone accompanied by the DON revealed a transmitted texted message from Nurse #1's personal cell phone sent to the physician's cell phone that in part read "Resident #2's first/last name, INR (international normalized ratio) 1.5 on 10 mg (milligrams) of coumadin; previously INR 0.9 on 3/19/14 received 7.5 mg Monday/Wednesday dated 3/22/14 at 10:24 am, name of facility, name of hall resident resided on, at 10:25 am."	F 164	and the secure methods of relaying resident information by the Director of Nursing on 05/07/14. A Directed Plan of Correction was imposed by Centers for Medicare & Medicaid Services (CMS). All licensed nursing staff were called by the Director of Nursing and asked if they had resident identifying information on their cell phones. All licensed nursing staff were instructed to delete any resident identifying information immediately, and were informed they were violating company policy, by the Director of Nursing on 05/07/14. All previously employed licensed nursing staff and certified nursing assistants, going back to 2012, were sent a letter explaining the violation and the steps taken to correct the violation, as well as instructing the previous employees to check their personal electronic devices for protected health information of residents, notify the facility immediately if protected health information is found and to delete it immediately. All Staff in-serviced on the policy regarding cell phone use while in the facility and secure methods of relaying resident information by the Director of Nursing and the Assistant Director of Nursing, on 05/07/14. No staff member will be allowed to work until the completion of the in-service on cell phone usage in the facility and secure methods of relaying resident information. A Directed Plan of Correction was imposed by Centers for Medicare & Medicaid Services (CMS).	

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F 164	Continued From page 2 c. Observation on 5/7/14 at 2:09 pm, Nurse #1's personal cell phone accompanied by the DON revealed a transmitted texted message (picture of physician discharge medications orders) that in part read "Resident #3's first/last name, age, patient #, sex, attending doctor, medical record number, atrovent 0.5mg (2 milliliters). d. Observation on 5/7/14 at 2:10 pm, Nurse #1's personal cell phone accompanied by the DON revealed transmitted texted messages that in part that read "Resident #4's first/last name, has been on cipro 500 mg since 3/5 with no stop date for ulcerative colitis, name of the facility, dated 3/15/14 at 10:26 am." Reply back was texted on 3/15/14 at 10:28 am from the physician read "I will check it might come this pm." In an interview on 5/7/14 at 2:15 pm, Nurse #1 accompanied by the director of nursing, acknowledged that all the residents' information reviewed on his personal cell phone had been transmitted by text message to the physician's personal cell phone. He stated that he had also texted messaged pictures of labs including residents' first/last name, date of birth and diagnoses with a picture taken of the resident's information on his personal phone, and then texted messaged to the physician. Nurse #1 added that this expedited the process in communicating with the physician versus using the facility scanner to scan residents' medical information. When questioned did his personal cell phone have encryption software installed on it, Nurse #1 replied not to his knowledge. In an interview on 5/7/14 at 2:20 pm with the director of nursing about staff 's use of their personal cell phone taking pictures and text	F 164	Physicians were educated to the secure methods of relaying resident information by the Administrator via telephone verbally on 05/07/14. Secure methods of relaying information are e-mail, fax, face to face, or on the telephone verbally. A follow-up letter referencing the secured methods of relaying resident information was mailed to each physician on 05/15/14. During orientation and on annual review, it will be stressed to all staff, by the Administrator, regarding the privacy of resident information and secure means of communicating such information to include the facility policy on cell phone usage. Any new physician in the facility will be educated, by the Administrator, to the fact that no resident information will be communicated via text messaging. Compliance with the policy will be through random audits of 10 percent of staff members 5 times per week for 4 weeks, then 10 percent of staff members 1 time per month for 2 months, then 10 percent of staff members 1 time per quarter for 3 quarters, and as needed. Compliance with the plan will be discussed during morning administration meeting 5 times per week for 1 month, then 1 time per month for 2 months, then 1 time per quarter for 3 quarters, and as needed The plan and its outcomes will be reviewed by the QAPI(Quality Assurance and Process Improvement) committee during the monthly QA (Quality Assurance)meeting. Any deviations of the plan will be examined using a RCA (Root Cause Analysis) approach to the issue	

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F 164	Continued From page 3 messaging residents' identifying medical information to the physician via staff personal cell phones, she stated that she first became aware of this practice upon hire in December 2013. She acknowledged that "Yes" the facility nursing staff do text message medical related information to the physician via their personal cell phones. She further indicated that she was informed that this was okay by the former director of nursing. The DON further acknowledged that she too have texted messaged labs, medication related information, which included residents' first/last name on the facility issued cell phone to the physician. The DON indicated that this expedited the process in communication with the physician; versus using the facility scanner to scan residents' medical information. She added that this was the physician's preferred method of communication concerning residents' care. When questioned did the facility cell phone have encryption software installed on it, the DON responded she was not sure, but would find out. The DON did not indicate how long she retained residents' medical information on the facility's cell phone, or what method was used to destroy the information contained in the cell phone. In an interview on 5/7/14 at 2:50 pm with the administrator and DON, the administrator when questioned regarding staff transmission of resident identifying medical information via text messages, which included pictures of the residents' medical record from the staff 's personal or facility cell phone indicated that her expectation was that this practice would stop immediately. When questioned did the facility cell phone used by administrative staff have encryption software installed on it, the administrator indicated "no."	F 164	and amendments to the plan as needed. The review, outcomes,recommendations, and monitoring will be included in the facility QAPI (Quality Assurance and Process Improvement) meeting minutes. Any changes to the plan will be documented in the QAPI (Quality Assurance and Process Improvement) meeting minutes, and appropriate staff re-in-serviced to changes in the plan, monthly x 3 months, quarterly x 3 quarters, and as needed	

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F 164	Continued From page 4	F 164		

2a. Observation on 5/7/14 at 3:10 pm, Nurse #2's personal cell phone accompanied by Nurse #3 revealed transmitted texted messages that in part read "Resident #5's first/last name, physician discharge medication orders (picture) that included: patient identification number, date of birth, age, physician name, discharge medication (albuterol sulfate 0.5 ml)."

b. Observation on 5/7/14 at 3:11 pm, Nurse #2's personal cell phone accompanied by Nurse #3 revealed a transmitted texted message of an INR tracking form (picture) that in part read "Resident #6's first/last name, previous INR 2.4 date 5/3/14, INR 1.8 dated 5/5/14."

c. Observation on 5/7/14 at 3:12 pm, Nurse #2's personal cell phone accompanied by Nurse #3 revealed a transmitted texted message of an INR tracking form (picture) that in part read "Resident #7's first/last name, 5/1/14 previous INR 2.1 current coumadin dose 10 mg."

In an interview on 5/7/14 at 3:15 pm, Nurse #2 accompanied by Nurse #3, acknowledged that all the residents' information (Resident #5, #6, #7) reviewed on her personal cell phone had been transmitted through text message to the physician assistant's (PA) personal cell phone. Nurse #2 indicated that this was the PA's preferred method of communication regarding concerns with the residents. Nurse #2 further added that in the past she had also sent pictures via text of residents' lab values (no specific residents was indicated) which included residents' identifying information, along with the labs values. She stated that she usually deleted the pictures and any resident related information from her cell phone before

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F 164	Continued From page 5 she exited the facility to go home, but was not sure why she still had residents' medical information retained in her cell phone. She stated, "Oh my, I thought I had deleted this (Resident #7) information from out of my phone. I'm not sure why it is still present now in my phone picture gallery. I am not sure how it got there because I deleted it." When questioned did here personal cell phone have encryption software installed on it, she said no. Nurse #2 concluded that the DON and the quality assurance nurse were aware (no specific date indicated) that she communicated with the PA in this manner, and that she had not been instructed by either to do otherwise. Nurse #3 stated that she had not communicated residents' medical information to the PA via text message due to resident privacy/confidentiality concerns. Nurse #3 added that any concerns related to residents while under her care, she either called the PA using the facility's telephone, and/or scanned residents' medical information via the facility's scanner. In an interview on 5/7/14 at 3:20 pm, the director of nursing was informed concerning Nurse #2's practice of communicating to the physician assistant via her personal cell phone by text messaging residents' identifying information which included pictures of resident's medical information obtained from the medical record to the PA. The DON indicated that her expectation currently was for the facility staff not to communicate resident medical information via transmission of text message on the staff personal or facility cell phones to the physician or PA.	F 164		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		5/29/14

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F 282	Continued From page 6	F 282		

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to follow the care plan to recheck the blood sugar of a resident that was out of range for 1 of 3 residents' care plans reviewed for hypoglycemia associated with diabetes (Resident #1). Findings included:

Resident #1 was readmitted into the facility on 11/10/10. Diagnoses included diabetes and dementia. The 5 day minimum data set completed on 3/28/14 indicated Resident #1's cognitive pattern was moderately impaired. Insulin injections were indicated as received as seven. The care plan dated 8/1/13 with a of goal date through 7/1/14 stated "at risk for hypoglycemia associated with diabetes, provide recheck for blood sugars if out of normal range."

A review of the facility's protocol for Resident #1 signed by the physician on 6/13/13 in part read " Blood glucose monitoring: Hypoglycemic: blood glucose less than or equal to 60: If resident is asymptomatic (alert and in usual state of mind) give orange juice by mouth. Recheck blood glucose in 30 minutes, if blood glucose still less than 60 administer glucagon 1 milligram emergency kit (or equivalent) intramuscular from stat kit and notify physician."

A review of text communication by Nurse #1

Provider's Plan of Correction:

Nurse #1 was given a verbal disciplinary action by the Director of Nursing on 05/10/14, for failing to follow facility policy on care of a resident with diabetes mellitus.
Nurse #1 was in-serviced by the Director of Nursing, on 05/10/14, on the facility policy, care of a resident with diabetes mellitus.
The facility has determined that all residents with diagnosis of diabetes mellitus have the potential to be affected, after review of the medication administration records,by the Director of Nursing on 05/13/14.
An audit of all medication administration records of residents with diagnosis of diabetes mellitus and an order for accuchecks was completed by the Director of Nursing on 05/13/14
All licensed nursing staff were in-serviced by the Director of Nursing,on 05/09/14, on the facility policy, care of a resident with diabetes mellitus. No licensed nurse will be allowed to work until in-service on care of a resident with diabetes mellitus.
All newly hired nurses will be in-serviced during orientation by the Director of Nursing, on the facility policy, care of a resident with diabetes mellitus.

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F 282	Continued From page 7 (accompanied by the director of nursing) via his personal cell phone to the physician on 3/14/14 at 2:26 pm in part read "critical for glucose level please advise, accu check at this time 54, with on jerking s/s is jerking on right shoulder, but talking the same with eyes open and conversation. I gave her med pass (like an ensure supplement) to elevate glucose." Further review of the medical record for 3/14/14 reflected no re-evaluation of Resident #1's blood sugar by Nurse #1 or other facility nursing staff, upon identifying the blood sugar was 54 at 2:26 pm. In an interview on 5/7/14 at 5:15 pm, Nurse #1 when questioned did he reevaluate Resident #1's blood sugar on 3/14/14 after checking at 2:26 pm, which resulted 54, stated that he could not answer the question, however, the resident was alert and confused upon emergency medical services arrival. He elaborated that normally such follow-up information would be reflected in his nurse's note. He concluded that he could not attest to what Resident #1's blood sugar was after he checked it at 2:26 pm, or what other interventions he provided prior to emergency medial services arrival into the facility. In an interview on 5/8/14 at 10:23 am, the director of nursing stated she expected Nurse #1 to have followed the care plan as written to recheck the blood sugar (bs) if the bs was out of range.	F 282	All licensed nurses will be in-serviced annually, by the Director of Nursing on the facility policy, care of a resident with diabetes mellitus. Accucheck results will be monitored by the Director of Nursing 5 times a week times 4 weeks, then weekly times 4 weeks,then monthly times 3 months, then quarterly x 3 quarters and as needed. Compliance with the plan will be discussed during morning meeting by the administrator 5 times per week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months, then quarterly x 3 quarters, and as needed. The plan and its outcomes will be reviewed by the QAPI (Quality Assurance and Process Improvement)committee during the monthly QA (Quality Assurance) meeting. Any deviations of the plan will be examined using a RCA (Root Cause Analysis) approach to the issue and amendments to the plan as needed. This review, outcomes, recommendations, and monitoring will be included in the facility QAPI (Quality Assurance and Process Improvement) meeting minutes. Any changes to the plan will be documented in the QAPI (Quality Assurance and Process Improvement) meeting minutes, and appropriate staff re-in-serviced to changes to the plan, monthly x 3 months, quarterly x 3 quarters, and as needed.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		5/29/14

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F 309	Continued From page 8 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the nursing staff failed to follow the facility's hypoglycemia protocol to recheck the blood sugar of a resident that was hypoglycemic for 1 of 3 residents reviewed for diabetes (Resident #1). Findings included: Resident #1 was admitted into the facility on 11/10/10. Diagnoses included diabetes and dementia. The 5 day minimum data set completed on 3/28/14 indicated Resident #1's cognitive pattern was moderately impaired. Insulin injections were indicated as received as seven. The care plan dated 8/1/13 with a of goal date through 7/1/14 stated "at risk for hypoglycemia associated with diabetes, provide recheck for blood sugars if out of normal range." A review of the facility's protocol for Resident #1 signed by the physician on 6/13/13 in part read "Blood glucose monitoring: Hypoglycemic: blood glucose less than or equal to 60: If resident is asymptomatic (alert and in usual state of mind) give orange juice by mouth. Recheck blood glucose in 30 minutes, if blood glucose still less than 60 administer glucagon 1 milligram emergency kit (or equivalent) intramuscular from stat kit and notify physician."	F 309	Nurse #1 was given a verbal disciplinary action by the Director of Nursing on 05/10/14, for failing to follow facility policy on care of a resident with diabetes mellitus. Nurse #1 was in-serviced by the Director of Nursing, on 05/10/14, on the facility policy, care of a resident with diabetes mellitus. The facility has determined that all residents with diagnosis of diabetes mellitus have the potential to be affected,after a review of the medication administration records, by the Director of Nursing on 05/13/14. An audit of all medication administration records of residents with diagnosis of diabetes mellitus and an order for accuchecks was completed by the Director of Nursing on 05/13/14 All licensed nursing staff were in-serviced by the Director of Nursing,on 05/09/14, on the facility policy, care of a resident with diabetes mellitus. No licensed nurse will be allowed to work until in-service on care of a resident with diabetes mellitus. All newly hired nurses will be in-serviced during orientation by the Director of	

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Continued From page 9

A review of the physician orders for March 14, 2014 revealed the following ordered medications related to diabetes signed as approved by the physician on 3/5/14:

· Glucotrol XL (extended release) 5 mg (milligram) at 6:30 am and 4:30 pm.
· Lantus solostar 30 units subcutaneous at bed time (9:00 pm) - Lantus is a long acting insulin which lowers the blood glucose (sugar) within 4 to 6 hours after being injected. Within 10 - 18 hours after injection is when the strongest effect is achieved.

A review of the nurses note dated 3/14/14 at 9:14 am, written by Nurse #1 in part read "at 8:15 am, Resident #1 observed jerking on right side during morning conversation; slightly confusion observed alert and oriented to self and able to recognize nurse by name but sluggish and pausing while talking often, unable to feed self with hand shaking; staff one to one with feeding. Physician notified at 9:00 am: new order for complete blood count, completed metabolic panel, and urinalysis and culture/sensitivity.

A review of the medication administration record dated 3/14/14 at 9:15 am; Nurse #1 indicated Resident #1 blood glucose was 84.

A review of the nurse's note dated 3/14/14 in part read "at 10:56 am, the physician was notified and updated that resident resting with eyes closed and breathing within normal limits and no further episodes of jerking and resident consumed greater than 50% of breakfast with staff assisting. At 12:20 pm, the responsible party was notified of resident's current condition and physician's new

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Nursing, on the facility policy, care of a resident with diabetes mellitus.
All licensed nurses will be in-serviced annually, by the Director of Nursing on the facility policy, care of a resident with diabetes mellitus.
Accucheck results will be monitored by the Director of Nursing 5 times a week times 4 weeks, then weekly times 4 weeks,then monthly times 3 months, then quarterly x 3 quarters and as needed.
Compliance with the plan will be discussed during morning meeting by the administrator 5 times per week times 4 weeks, then weekly times 4 weeks, then monthly times 3 months, then quarterly x 3 quarters, and as needed.
The plan and its outcomes will be reviewed by the QAPI (Quality Assurance and Process Improvement)committee during the monthly QA (Quality Assurance) meeting. Any deviations of the plan will be examined using a RCA (Root Cause Analysis) approach to the issue and amendments to the plan as needed. This review, outcomes, recommendations, and monitoring will be included in the facility QAPI (Quality Assurance and Process Improvement) meeting minutes.
Any changes to the plan will be documented in the QAPI (Quality Assurance and Process Improvement) meeting minutes, and appropriate staff re-in-serviced to changes to the plan, monthly x 3 months, quarterly x 3 quarters, and as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING ______ B. WING ______	C 05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	**400 PELT DRIVE FAYETTEVILLE, NC 28301**

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F 309	Continued From page 10	F 309		

order received and some of the lab being obtained and sent to be processed. At 4:10 pm, lab results received and physician notified: new order to send to (name of hospital), resident remain alert and oriented x2; no respiratory distress noted."

A review of the lab report dated 3/14/14 collected at 10:22 am in part read "glucose 46 (critical) [reference range 74-106], result comments: critical value called at 3/14/14 at 1:51: pm and read back by Nurse #1 at 1:56 pm.

A review of a saved text message by Nurse #1 (accompanied by the director of nursing) in his personal cell phone to the physician on 3/14/14 at 2:26 pm in part read "critical for glucose level please advise, accu check at this time 54, with on jerking s/s is jerking on right shoulder, but talking the same with eyes open and conversation. I gave her med pass (like an ensure supplement) to elevate glucose."

A review of the nurse's notes and medication administration record for 3/14/14 revealed no recheck of Resident #1's blood sugar or any follow-up intervention after Nurse #1 at 2:26 pm assessed the resident's blood sugar of 54. At 4:10 pm, Nurse #1 nurse's note indicated "lab result faxed and physician notified: new order to send to (name of hospital), resident remains alert and oriented x2; no respiratory distress noted."

A review of the emergency room report dated 3/14/14 at 5:40 pm revealed Resident #1 accu check (blood sugar) was noted at 64 (origin of blood sugar obtained by emergency medical services field assessment). Clinical impression was indicated as "hypoglycemia."

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F 309	Continued From page 11 In an interview on 5/7/14 at 5:15 pm, Nurse #1 when questioned did he reevaluate Resident #1's blood sugar per facility protocol on 3/14/14 after checking at 2:26 pm, which resulted 54, stated that he could not answer the question, however, the resident was alert and confused upon emergency medical services arrival. He elaborated that normally such follow-up information would be reflected in his nurse's note. He concluded that he could not attest to what Resident #1's blood sugar was after he checked it at 2:26 pm, or what other interventions he provided prior to emergency medial services arrival into the facility. In an interview on 5/8/14 at 10:23 am, the director of nursing stated that she expected Resident #1's blood sugar to have been rechecked per the facility protocol by Nurse #1 within 30 minutes when the blood sugar was assessed at 54 (2:26 pm), with any interventions provided to be reflected in the medical record.	F 309		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520		6/18/14

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F 520	Continued From page 12 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to identify and implement a plan of correction as part of the facility's quality assurance that prevented the facility staff from transmitting residents' medical information in texting format from staff members' personal cell phones to the physician and physician assistant's personal cell phones for 7 out of 7 residents (Resident #1, #2, #3, #4, #5, #6, #7). Findings included: A review of the facility's quality management program policy dated June 2, 2013, revealed as part of the facility's quality and assurance performance improvement, the facility would use a systematic approach that in part read "1) find a process to improve, 2) organize a team that knows the process." Cross reference F 164. Based on record review, observations and staff interviews, the facility allowed residents' medical information to be transmitted in texting format from staff members'	F 520	Nurse #1 with resident identifying information on his personal cell phone was instructed to delete the information immediately and was in-serviced on the policy for cell phone usage while in the facility, located in the personnel handbook and the secure methods of relaying resident information by the Director of Nursing on 05/07/14. A Directed Plan of Correction was imposed by Centers For Medicare & Medicaid Services (CMS). All licensed nursing staff were called by the Director of Nursing and asked if they had resident identifying information on their cell phones. All licensed nursing staff were instructed to delete any resident identifying information immediately, and were informed they were violating company policy, by the Director of Nursing on 05/07/14. All previously employed licensed nursing staff and certified nursing assistants,	

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F 520	Continued From page 13 private cell phones to the physician and physician assistant's personal cell phones for 7 out of 7 residents (Resident #1, #2, #3, #4, #5, #6 and #7). Refer to F 164 on the CMS-2567 (statement of deficiencies) for the details of this particular federal deficiency and investigation. In an interview on 5/7/14 at 2:50 pm, the administrator, accompanied by the director of nursing and the quality assurance nurse; the administrator when questioned regarding her awareness that the facility staff was communicating residents' medical information from their personal cell phones through text messaging (including pictures of medical information that identified specific residents) to the physician and physician assistant (PA) personal cell phones, the administrator stated that she was aware of the practice that anything that the facility scanned goes directly to the physician's personal cell phone. When questioned how often the quality assurance (QA) committee met she said "monthly", which included the director of nursing and the quality assurance nurse in each meeting. The DON added that the physician is present quarterly in the QA meetings. The administrator acknowledged that to date, there had been no prior discussion, nor had they self identified as part of their quality assurance that the facility staff were sending residents' medical information which included residents' name, diagnoses, medications and lab information, to the physician and PA's personal cell phone, from the staff 's personal and facility cell phone in text format. The quality assurance nurse when questioned indicated that she did not have any quality assurance documents to support identifying this concern, nor had she initiated a facility plan of	F 520	going back to 2012, were sent a letter explaining the violation and the steps taken to correct the violation, as well as instructing the previous employees to check their personal electronic devices for protected health information of residents, notify the facility immediately if protected health information is found and to delete it immediately. All Staff in-serviced on the policy regarding cell phone use while in the facility and secure methods of relaying resident information by the Director of Nursing and the Assistant Director of Nursing, on 05/07/14. No staff member will be allowed to work until the completion of the in-service on cell phone usage in the facility and secure methods of relaying resident information. A Directed Plan of Correction was imposed by Centers For Medicare & Medicaid Services (CMS). Physicians were educated to the secure methods of relaying resident information by the Administrator via telephone verbally on 05/07/14. Secure methods of relaying information are e-mail, fax, face to face, or on the telephone verbally. A follow-up letter referencing the secured methods of relaying resident information was mailed to each physician on 05/15/14. During orientation and on annual review, it will be stressed to all staff, by the Administrator, regarding the privacy of resident information and secure means of communicating such information to include the facility policy on cell phone usage. Any new physician in the facility will be educated, by the Administrator, to	

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F 520	Continued From page 14 correction until made aware of the concerns today. The administrator concluded that her expectation was that this practice would stop immediately. In an interview on 5/7/14 at 3:15 pm, Nurse #2 accompanied by Nurse #3, acknowledged that she had transmitted residents' medical information to the physician assistant from her personal cell phone to his cell phone. Nurse #2 indicated that this was the PA's preferred method of communication regarding concerns with residents. Nurse #2 further added that in the past she had also sent pictures via text of residents' lab values (no specific residents was indicated) which included resident identifying information, along with the labs values. Nurse #2 concluded that the DON and the quality assurance nurse were aware that she communicated with the PA in this manner prior to 5/7/14, and that she was not instructed by either to do otherwise. When questioned how long had it been since she notified the administration staff, she said it had been several weeks.	F 520	the fact that no resident information will be communicated via text messaging. Compliance with the policy will be through random audits of 10 percent of staff members 5 times per week for 4 weeks, then 10 percent of staff members 1 time per month for 2 months, then 10 percent of staff members 1 time per quarter for 3 quarters, and as needed. Compliance with the plan will be discussed during morning administration meeting 5 times per week for 1 month, then 1 time per month for 2 months, then 1 time per quarter for 3 quarters, and as needed The plan and its outcomes will be reviewed by the QAPI(Quality Assurance and Process Improvement) committee during the monthly QA (Quality Assurance)meeting. Any deviations of the plan will be examined using a RCA (Root Cause Analysis) approach to the issue and amendments to the plan as needed. The review, outcomes,recommendations, and monitoring will be included in the facility QAPI (Quality Assurance and Process Improvement) meeting minutes. Any changes to the plan will be documented in the QAPI (Quality Assurance and Process Improvement) meeting minutes, and appropriate staff re-in-serviced to changes in the plan, monthly x 3 months, quarterly x 3 quarters, and as needed	