STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING _____ B. WING _____	C 02/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/CH	5939 REDDMAN ROAD CHARLOTTE, NC 28212

(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
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		3/3/18

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

Electronically Signed | 03/02/2018

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 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and Medical Doctor interviews the facility failed to notify the medical provider of an elevated Sodium (NA) level and of a STAT lab that was not obtained as ordered for 1 of 1 resident sampled for laboratory services (Resident #2). The findings included: Resident #2 admitted to the facility on 01/17/18. His diagnoses included: heart failure, diabetes mellitus, dementia, and others. Review of the most recent comprehensive minimum data set (MDS) dated 01/24/18 revealed that Resident #2 was severely cognitively impaired for daily decision making and required extensive assistance of one staff member with activities of daily living. Review of a laboratory value dated 01/24/18 revealed that Resident #2's NA level was 153 (normal range 135-146) which indicated an abnormal high value. Review of a physician's order dated 01/26/18 at 3:07 PM read, STAT (now) basic metabolic panel	F 580	This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan Does not constitute admission or Agreement by the provider of the truth of The facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility policy is to notify Physician and family promptly of any changes in condition. 1.Corrective action was accomplished for the alleged deficient practice for Resident #2, the facility failed to notify the medical provider of an abnormal high sodium level, and of a STAT lab that was not obtained as ordered. Resident #2 is no longer in the facility. 2. Current residents who use laboratory services have the potential to be affected	

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F 580	Continued From page 2 (BMP) for hypernatremia (high NA level). Call provider with results. Discontinue Lasix (diuretic). Diagnoses increased NA and creatinine level. The order was signed by the Nurse Practitioner (NP). Review of Resident #2 medical record on 02/07/18 revealed no laboratory results for the STAT BMP that was ordered on 01/26/18. An interview was conducted with the Medical Doctor (MD) on 02/07/18 at 2:14 PM. The MD stated that on 01/26/18 the NP had called to consult about Resident #2's NA level that at the time was 153. The MD explained that was an abnormal high level and we had to determine if the NA level was still high and if so how high was it. The MD instructed the NP to write an order for a STAT BMP and to call the results to the provider so that the course of treatment could be determined. The MD went on to explain that when she arrived at the facility on 01/27/18 which was her next scheduled day at the facility she asked the staff where the STAT BMP was because it has not been called to the provider. The staff stated that the BMP was unable to be obtained and they were going to wait until Monday 01/29/18 to get it. The MD stated that when a STAT lab was ordered she expected the lab to be drawn in a reasonable time frame and the results called to the provider. She added if the staff was unable to obtain the STAT BMP they should have also contacted the MD or NP for further orders. An interview was conducted with the NP on 02/07/18 at 2:33 PM. The NP stated that on 01/26/18 she was reviewing laboratory values and discovered that on 01/24/18 Resident #2's NA level was 153 which was an abnormal high	F 580	by this alleged deficient practice. An audit of labs ordered for the past 30 days starting 1/9/18 has been completed to ensure that abnormal lab values and labs not obtained were reported to Medical Director or NP. 3. The Director of Nursing or designee will re-educate Licensed nurses on the policy for obtaining and reporting Labs to the Medical Director or NP by 3/3/2018. The DON or designee will bring lab logs to Clinical Morning Meeting to ensure labs have been obtained and reported to the Medical director timely. Nurse Management/or designee will randomly audit 5 labs 3x a week x 12 weeks to ensure abnormal lab values and any labs not obtained are reported to MD/or NP for follow up. 4. The Director of Nursing/or designee will report findings of the audits to the QAPI committee monthly x 3months to evaluate the effectiveness and amend as needed. Date of compliance: 3/3/2018	

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F 580	Continued From page 3	F 580		

value. The NP stated that she was not notified of the elevated NA level on 01/24/18 and she only discovered the elevated level while reviewing labs on 01/26/18. She added that Resident #2 had only been at the facility for a week and she had only seen him once since his admission, so she reached out to the MD to discuss the high NA level. The NP stated that the MD recommended a STAT BMP, so the order was wrote for a STAT BMP and to call the results to the provider. The NP stated that she had spoken to Unit Coordinator (UC) #2 who was on duty and stated to her that the order had been written for a STAT BMP for Resident #2's high NA level. She added that UC #2 stated she would call the laboratory and have them come and draw it. The NP stated that she was not notified of the results of the STAT laboratory on 01/26/17 as instructed. The NP added she would have expected to have been notified of the elevated NA level that was drawn on 01/24/18 and of the STAT lab that was ordered on 01/26/18 and the staff's inability to obtain that BMP as ordered.

An interview was conducted with the UC #2 on 02/07/18 at 3:30 PM. UC #2 confirmed that she had signed the order off that the NP wrote for STAT BMP and to call the results to the provider written on 01/26/18. She stated that she signed the order off and called the STAT line at the laboratory to have them come and draw the blood. She stated that she called the STAT line and no one would answer the phone so she passed it off to Nurse #4 at 7:00 PM in report. UC #2 confirmed that she did not notify the MD or the NP that she was unable to reach the lab and the BMP that was ordered had not been obtained.

An interview was conducted with Nurse #4 on

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F 580	Continued From page 4	F 580		

02/07/18 at 4:11 PM. Nurse #4 confirmed that she had received report from UC #2 at 7:00 PM on 01/26/18 about Resident #2 needing a STAT BMP. Nurse #4 stated that UC #2 had reported that she was unable to reach anyone at the laboratory to come and draw the BMP. Nurse #4 stated that she also attempted to reach the laboratory and they answered her call and stated someone would call back but they never called back. She stated she should have called the provider and let them know that the BMP was not obtained and ask for further orders.

An interview was conducted with Nurse #3 on 02/08/18 at 11:14 AM. Nurse #3 confirmed that she was working with Resident #2 on 01/24/18 when the BMP was obtained that revealed Resident #3 had an elevated NA level. She stated that the laboratory company would have come and drawn the lab and then reported it back to the facility later in the day. Nurse #3 stated she did not recall receiving the results of the BMP that day but stated if she would have seen an abnormal NA level she would have notify the MD. Nurse #3 stated that she does not recall if she reviewed the lab but confirmed that she had not notified the MD or NP of the elevated NA level.

An interview was conducted with Nurse #5 on 02/08/18 at 12:07 PM. Nurse #5 confirmed that she took care of Resident #2 on 01/27/18 and had received report from Nurse #4 at the start of her shift at 7:00 AM. Nurse #5 stated that Nurse #4 had reported to her that Resident #2 had a STAT lab that was ordered on Friday 01/26/18 and it had not been drawn. She added that if the lab could not be obtained then someone should have contacted the MD or NP for further orders.

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F 580	Continued From page 5 An interview was conducted with the Director of Nursing (DON) on 02/08/18 at 1:59 PM. The DON stated she would expect the staff to pick up the phone and contact the MD or NP and notify them of abnormal laboratory values and of the STAT BMP that was not obtained and ask for further orders.	F 580		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff	F 761	This plan of correction is the centers	3/3/18

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F 761	Continued From page 6 interviews the facility failed to secure cards of medication during a medication pass observation for of 1 of 3 medication carts observed. The findings included: Review of a facility policy titled "Medication Cart Use" dated June 2008 read in part, the medication cart and its storage bins are kept locked until the specified time of medication administration. If an emergency occurs during the medication pass, the nurse securely locks the medication cart before attending to the emergency situation and no medications are kept on top of the cart. An observation was made of the medication pass on B unit with Nurse #1 on 02/07/18 at 9:55 AM. Nurse #1 was observed to prepare medications for administration and after dispensing the pill from the card of medication into the medication cup she would lay the card of remaining pills on top of her medication cart. After preparing the medications Nurse #1 realized that she needed something from the medication room and she grabbed the cup of prepared medications and locked her cart and proceed to walk approximately 10 feet to the nurses station and go into a room located behind the nurses station and closed the door. The medication cart was not visible to Nurse #1 and 4 cards of medication remained on top of the medication cart unattended by staff. The unattended medication was Neurontin (used to treat seizure or neuropathy pain), Depakote (used to seizures), Pepcid (used to treat stomach ulcers), and Trileptal (used to treat seizures). While Nurse #1 was in the medication room residents and staff were observed to be passing by the cart with one	F 761	credible allegation of compliance. Preparation and/or execution of this plan Does not constitute admission or Agreement by the provider of the truth of The facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.Nurse #1 left 4 cards of medication on top of medication cart unattended . Nurse #1 immediately secured medications once she returned to medication cart. 2.Current residents receiving medications have the potential to be affected by this alleged deficient practice. Nurse Management/or designee completed an audit of medication carts and medication rooms to ensure medications secured properly. 3.Nurse Management/or designee will re-educate licensed nurses on Medication Storage by 3/3/2018. DON or designee will audit medication storage 3 times a week x 12 weeks by rounding observations to ensure meds are being secured during the med pass. 4. The Director of Nursing/or designee will report findings	

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F 761	Continued From page 7 resident sitting in her wheelchair approximately 3 feet from the unattended medication. An observation of Nurse #1 was made on 02/07/18 at 10:01 AM. Nurse #1 emerged from a room located behind the nurses station and returned to her medication cart and recognized the cards of medications lying on top of the medication cart. Nurse #1 returned those medication to the medication cart and proceed to administer the medications after locking the cart. An interview was conducted with Nurse #1 on 02/07/18 at 10:03 AM. Nurse #1 stated that she did not see the 4 cards of medication lying on top of her medication cart when she went to the medication room. Nurse #1 confirmed that the medication cart was not in her view and was left unattended. She stated that she should have placed the medications back in her cart and locked them up and then went to the medication room. She stated that she was nervous but should not have left the medication lying on top of her medication cart unattended with residents and staff in the hallway. An interview was conducted with the Unit Coordinator (UC) on 02/07/18 at 12:30 PM. The UC confirmed that she was responsible for the B unit including Nurse #1. The UC stated that medication should be kept locked in the medication cart and should not be left on top of the cart and unattended by staff. An interview was conducted with the Director of Nursing (DON) on 02/08/18 at 1:59 PM. The DON stated that she expected that all medication to be kept locked on the medication cart and should not be left on top of the cart and unattended by the	F 761	of the audits to the QAPI committee monthly x 3months to evaluate the effectiveness and amend as needed. Date of compliance: 3/3/2018	

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F 761	Continued From page 8 staff.	F 761		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and Medical Doctor interviews the facility failed to make arrangements for a STAT (now) laboratory test to be obtained for 1 of 1 residents sampled for laboratory services (Resident #2). The finding included: Resident #2 admitted to the facility on 01/17/18. His diagnoses included: heart failure, diabetes mellitus, dementia, and others. Review of a laboratory result dated 01/18/18 revealed that Resident #2's Sodium (NA) level was 144 (normal range 135-146). Review of the most recent comprehensive minimum data set (MDS) dated 01/24/18 revealed that Resident #2 was severely cognitively impaired for daily decision making and required extensive assistance of one staff member with activities of daily living.	F 770	This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan Does not constitute admission or Agreement by the provider of the truth of The facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. The facility failed to make arrangements for STAT lab test to be obtained for Resident #2. Resident #2 is no longer in facility. 2. Current residents who use laboratory services have the potential to be affected by this alleged deficient practice. An audit of STAT labs ordered as of	3/3/18

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F 770	Continued From page 9 Review of a laboratory value dated 01/24/18 revealed that Resident #2's NA level was 153. Review of a physician's order dated 01/26/18 at 3:07 PM read, STAT (now) basic metabolic panel (BMP) for hypernatremia (high NA level). Call provider with results. Discontinue Lasix (diuretic). Diagnoses increased NA and creatinine level. The order was signed by the Nurse Practitioner (NP). Review of Resident #2 medical record on 02/07/18 revealed no laboratory results for the STAT BMP that was ordered on 01/26/18. An interview was conducted with the Medical Doctor (MD) on 02/07/18 at 2:14 PM. The MD stated that on 01/26/18 the NP had called to consult about Resident #2's NA level that at the time was 153. The MD explained that was an abnormal high level and given that his NA level on 01/18/18 was normal, we had to determine if the NA level was still high and if so how high was it. She added that depending on how high the NA level was would determine the course of treatment for Resident #2. The MD instructed the NP to write an order for a STAT BMP and to call the results to the provider so that the course of treatment could be determined. The MD went on to explain that when she arrived at the facility on 01/27/18 which was her next scheduled day at the facility she asked the staff where the STAT BMP was because it has not been called to the provider. The staff stated that the BMP was unable to be obtained and they were going to wait until Monday 01/29/18 to get it. The MD stated she instructed the staff to obtain the laboratory test and went on to see another resident.	F 770	1/9/18 has been completed to ensure that no other STAT labs were omitted . MD notified of any STAT labs not obtained as a result of audit. 3. The Director of Nursing or designee will re-educate licensed nurses on laboratory services to include: processing orders, obtaining lab specimens, and notification to MD if unable to obtain lab. Education for current staff completed on 3/3/2018. PRN Staff will not work on the floor before completing their education on the STAT lab protocol addendum. We will include the STAT lab protocol in the nurse education section during their new hire orientation. The DON or designee will audit 5 labs 3 times a week x12 weeks to ensure labs obtained accurately/timely and MD notified. We have amended the lab protocol to include the perimeters for stat lab retrieval. We have clarified that the expected STAT, turnaround time for labs is four hours. The nurse must initially attempt to draw the lab and if unsuccessful,a second attempt will be made by another nurse or the phlebotomist.	

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F 770	Continued From page 10 An interview was conducted with the NP on 02/07/18 at 2:33 PM. The NP stated that on 01/26/18 she was reviewing laboratory values and discovered that on 01/24/18 Resident #2's NA level was 153 which was an abnormal high value. She added that Resident #2 had only been at the facility for a week and she had only seen him once since his admission, so she reached out to the MD to discuss the high NA level. The NP stated that the MD recommended a STAT BMP, so the order was wrote for a STAT BMP and to call the results to the provider. The NP stated that she had spoken to Unit Coordinator (UC) #2 who was on duty and stated to her that the order had been written for a STAT BMP for Resident #2's high NA level. She added that UC #2 stated she would call the laboratory and have them come and draw it. She explained that STAT meant as quickly as humanly possible. The NP stated that she was not notified of the results of the STAT laboratory on 01/26/17 as instructed. The NP added that the results of the BMP including the NA level would have determined the course of treatment for Resident #2. An interview was conducted with the UC #2 on 02/07/18 at 3:30 PM. UC #2 confirmed that she had signed the order off that the NP wrote for STAT BMP and to call the results to the provider written on 01/26/18. She stated that she signed the order off and called the STAT line at the laboratory to have them come and draw the blood. She stated that she called the STAT line and no one would answer the phone so she passed it off to Nurse #4 at 7:00 PM in report. UC #2 stated that STAT meant immediately but stated "she was following the process that she had been instructed to follow" for STAT labs. UC	F 770	If we are still unable to obtain the specimen, the physician will be notified for further instruction. 4. The DON will present the results of the audits monthly for three months at the facility QAPI meeting. The committee will evaluate the effectiveness and amend as needed. Date of Compliance: 3/3/2018	

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(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
F 770	Continued From page 11	F 770		

#2 stated that she had never drawn blood at the facility and she was just following the process.

An interview was conducted with Nurse #4 on 02/07/18 at 4:11 PM. Nurse #4 confirmed that she had received report from UC #2 at 7:00 PM on 01/26/18 about Resident #2 needing a STAT BMP. Nurse #4 stated that UC #2 had reported that she was unable to reach anyone at the laboratory to come and draw the BMP. Nurse #4 stated that she also attempted to reach the laboratory and they answered her call and stated someone would call back but they never called back. Nurse #4 added that she knew the MD would be coming to the facility in the morning of 01/27/18 and she would let her know that they were unable to reach the laboratory to come and draw the BMP. Nurse #4 stated that STAT indicated it needed to be drawn now and she should have went down and tried to obtain the ordered BMP but she did not. Nurse #4 added that at the facility the nurses generally did not obtain labs on residents that the laboratory would come and obtain them. Nurse #4 added she had not been educated on how to draw labs and did not feel comfortable in doing so. She further stated that not drawing the ordered BMP was unacceptable and she should have attempted and then called the provider and let them know that the BMP was obtained or not and ask for further orders.

An interview was conducted with Nurse #5 on 02/08/18 at 12:07 PM. Nurse #5 confirmed that she took care of Resident #2 on 01/27/18 and had received report from Nurse #4 at the start of her shift at 7:00 AM. Nurse #5 stated that Nurse #4 had reported to her that Resident #2 had a STAT lab that was ordered on Friday 01/26/18

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	345243	A. BUILDING _____ B. WING _____	C 02/09/2018

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F 770	Continued From page 12 and it had not been drawn because they could not get ahold of the laboratory company to come and draw it. Nurse #5 stated that she had immediately called the laboratory number and left a message and they returned the call and stated it would take 2-4 hours for someone to get to the facility. Nurse #5 stated that she could not understand why the lab had not been drawn, she added that if the lab could not be reached then someone should have contacted the MD and sent him to the ER so the lab could have been drawn. She added that waiting almost 24 hours to obtain a STAT lab was unacceptable and someone should have drawn the lab or contacted the MD for further orders. An interview was conducted with the Director of Nursing (DON) on 02/08/18 at 1:59 PM. The DON stated that the process for obtaining labs within the facility was once the order was obtained it was entered into the electronic laboratory system and the labs would be drawn on the next scheduled lab day. She added that STAT labs would be called directly to the lab to alert them of the STAT lab and they would arrange for someone to come and draw the lab. She further explained that the nurses at the facility did not draw blood on a routine basis, the process has always been for the lab to come and draw them. So the nursing staff "is conditioned to just let the laboratory staff draw the labs." The DON stated that going and drawing the STAT BMP was never an option or a thought to those nurses, however she would expect them to pick up the phone and contact the MD for further orders. The DON stated that not obtaining a STAT lab was unacceptable to her.	F 770		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		3/3/18

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F 842	Continued From page 13 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, 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	F 842		

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F 842	Continued From page 14 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed 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 reviews and staff interviews the facility failed to maintain accurate electronic medication administration record for 1 of 5 residents sampled (Resident #2). The findings included: Resident #2 was admitted to the facility on 01/17/18. Resident #2's diagnoses included heart failure, diabetes mellitus, dementia, and others.	F 842	This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan Does not constitute admission or Agreement by the provider of the truth of The facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 842	Continued From page 15 Review of a physician order dated 01/21/18 read in part, Ativan (controlled narcotic antianxiety medication) 1 milligram (mg) by mouth every 6 hours (hrs) as needed for anxiety and/or agitation. Review of the electronic Medication Administration Record (eMAR) dated 01/01/18 through 01/31/18 revealed no staff signatures indicating that Ativan had not been given to Resident #2. Review of the controlled narcotic sign out sheet indicated that Resident #2 had received the Ativan on 4 occasions: 1 time on 01/24/18, 1 time on 01/25/18, and 2 times on 01/26/18. An interview was conducted with Nurse # 3 on 02/08/17 at 11:14 AM. Nurse #3 stated that on 01/21/18 she had administered Ativan 1 mg by mouth to Resident #2 because he was agitated and was throwing feces at the staff. Nurse #3 stated that the Ativan 1 mg had not arrived from the pharmacy so she had to pull the Ativan out of the facility's back up supply. She indicated that she had signed out for the Ativan in the back up supply but had not gone back to the eMAR and documented it there. Nurse #3 indicated that it should have been documented in the eMAR and she just forgot. An attempt to speak with Nurse #2 was made on 02/08/18 at 12:51 PM and was unsuccessful. Nurse #2 signed out for the Ativan on 01/24/18 on the controlled narcotic sheet for Resident #2. An interview was conducted with the Director of Nursing (DON) on 02/08/18 at 1:00 PM. The DON stated that she expected for the staff to document	F 842	1. Nurse #2, Nurse #3, Nurse #4, UC #1, and UC #2 forgot to sign out a controlled narcotics in the eMAR for Resident #2. Resident #2 electronic medication record updated to reflect administration of narcotics. 2. Current residents who have orders for narcotics have the potential to be affected by this alleged deficient practice. An audit of eMARs for the past 30 days starting 1/9/18 has been completed to ensure that narcotics were signed out in eMAR . Any identified discrepancies were corrected. 3. The Director of Nursing or designee will re-educate licensed nurses on the policy for documenting accurately in the medical record during medication administration by 3/3/2018. Nurse Management /or designee will audit 5 eMARS 3x week for 12 weeks to ensure controlled narcotics administered are being documented on the eMARS. 4. The DON or designee will present the results of the audits	

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F 842	Continued From page 16 the administration of controlled narcotics on both the controlled sign out sheet and the eMAR and it should be second nature to them. An interview was conducted with the Unit Coordinator (UC) #1 on 02/08/18 at 1:10 PM. UC #1 confirmed that she administered Ativan 1 mg by mouth to Resident #2 on 01/25/18 in the morning time and had signed it out on the controlled narcotic sheet but had forgotten to go to the eMAR and document the administration there. She stated that the administration should be documented on both the eMAR and the controlled narcotic sheet and she had just forgotten to document it in both places. An interview was conducted with UC #2 on 02/08/18 at 1:15 PM. UC #2 confirmed that she administered Ativan 1 mg by mouth to Resident #2 on 01/26/18 at 8:10 AM and had signed out for it on the controlled narcotic sheet but had forgotten to go to the eMAR and document it there. She stated that the administration should be documented in both places and she had just forgotten to go back and document it on the eMAR. An interview was conducted with Nurse #4 on 02/09/18 at 8:03 AM. Nurse #4 confirmed that she had administered Ativan on 01/26/18 at 8:00 PM and had signed out for it on the controlled narcotic sheet but had forgotten to sign out for it on the eMAR. Nurse #4 stated that the administration should have been documented in both places.	F 842	monthly for three months at the facility QAPI meeting. The committee will evaluate the effectiveness and amend as needed. Date of Compliance: 3/3/2018	