

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345526</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/09/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA REHAB CENTER OF BURKE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3647 MILLER BRIDGE ROAD</b> <b>CONNELLY SPG, NC 28612</b>	
(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 658 SS=D	<p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, staff interviews, Nurse Practitioner, and Medical Doctor interviews the facility failed to sign off and carry out physician orders for approximately 2 days for 3 of 5 residents sampled (Resident # 9, 8, and 4).</p> <p>The findings included:</p> <p>1. Resident #8 admitted to the facility on 06/15/18 with diagnoses that included hypertension. Resident #8 discharged home on 07/04/18.</p> <p>Review of the comprehensive minimum data set (MDS) dated 06/22/18 revealed that Resident #8 was cognitively intact and required extensive assistance with his activities of daily living.</p> <p>Review of a progress note from the Nurse Practitioner (NP) dated 06/29/18 revealed that Resident #8 was being seen for "follow up complaints of dizziness, continued management of heart failure, renal." The history of present illness read in part, Resident #8 "continues to complain of some of mild dizziness. He continues on multiple antihypertensives including labetalol, clonidine, and Norvasc." The diagnosis and assessment read in part, benign essential hypertension, chronic kidney disease, coronary artery disease, and dizziness. The plan read in</p>	F 658	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.</p> <p>F658</p> <p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Facility failed to follow facility policy in regards to discontinuation of medications and implementing physician orders as ordered, which allowed a patient to not receive a medication that was ordered.</p> <p>When an order is obtained to discontinue a medication, give a medication or change the dosage from the</p>	9/6/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/31/2018

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 658	<p>Continued From page 1</p> <p>part, decrease Norvasc to 5 milligrams (mg) by mouth daily hold for systolic blood pressure less than 130.</p> <p>Review of a physician order signed and dated by the NP on 06/29/18 and provided by Nurse #4 read in part, decrease Norvasc to 5 mg by mouth every day. Hold for systolic blood pressure less than 130.</p> <p>Review of the medication administration record (MAR) dated 06/01/18 through 06/30/18 revealed that on 06/29/18 and 06/30/18 Resident #8 received Norvasc 10 mg by mouth instead of 5 mg by mouth as ordered on 06/29/18.</p> <p>An interview was conducted with the NP on 08/09/18 at 9:29 AM. The NP stated that when she wrote an order she filled out the order and placed it in the communication book and left the book at the nurse's station and the nursing staff processed the orders. The NP confirmed that she had written the orders for the Norvasc on 06/29/18 and per the facility's routine left the orders in the communication book at the nurse's station. The NP stated, "that it depended on the medication as to when the order should be processed." The NP stated that to her knowledge the orders were missed and when they discovered the missed orders on 07/01/18 they called the on-call service and made them aware.</p> <p>An interview was conducted with the Unit Coordinator (UC) on 08/09/18 at 11:11 AM. The UC stated that on 06/29/18 she was the nurse who was responsible for Resident #8. The UC stated that when the NP or the Medical Doctor (MD) saw a resident they place any orders in the communication book that was kept at the nurse's</p>	F 658	<p>physician/practitioner, the nurse will place the order in the Electronic Medical Record, and scan the old medication card and return to pharmacy by placing the medication in the Red Bag in the Medication Room. If the Medication in question is, a narcotic the same process will be used except the medication will be placed in a red bag and secured in the drawer of the medication cart, so that the medication remains secured until picked up by the courier. Upon discontinuation if the dosage has changed or a new medication order received, the order will be entered into the Electronic Medical Record and the new medication ordered from pharmacy. Now orders should be administered, now if medication is on hand in the Omni-cell, but within two hours of receiving the order if outside sources are utilized to obtain the medication, if medication is not available outside that time frame, physician should be made aware so additional orders may be obtained if needed. Document in the progress note to indicate the conversation and request. The nurse will take the order; telephone, written or verbal and enter the order into the electronic medical record, indicate the order was noted and place in the communication book for audit. Then the order will be given to medical records to be scanned into the record.</p> <p>The Procedure for implementing the acceptable plan of correction for the specific deficiency cited: A 100% audit of all charts checking new medication orders</p>		

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F 658	<p>Continued From page 2</p> <p>station and the nursing staff checked it routinely throughout the day for any new orders that were present. The UC stated that each nurse was ultimately responsible for signing off and carrying out any new orders that came in during their shift. She added that after the orders were signed off and carried out they went back into the notebook and 3rd shift conducted the 2nd check of the order to ensure that it was carried out correctly. She confirmed that she was responsible for carrying out the orders for Resident #8 on 06/29/18 but did not recall seeing those orders possibly because she was responsible for 2 medication carts that day and got busy.</p> <p>An interview was conducted with the MD on 08/09/18 at 11:27 AM. The MD stated that she had been made aware of the orders for Resident #8 that were missed but could not recall if there was any negative outcome for Resident #8. The MD stated that she expected that once orders were written that they should be carried out during that shift or at least the same day.</p> <p>An interview was conducted with Nurse #3 on 08/09/18 at 3:46 PM. Nurse #3 stated that he worked 3rd shift at the facility. Nurse #3 stated that when the NP or MD wrote orders most of the time it was on 1st shift and they placed the orders in a communication book at the nurse's station. The nurse on the unit would carry out the order and place the order back in the book and 3rd shift would go back through the orders and make sure that they were carried out correctly. Nurse #3 stated that they also checked the book for any orders that were missed. He further stated that he did not recall seeing the orders for Resident #8 on 06/29/18 or he would have carried them out immediately.</p>	F 658	<p>from August 27th <input type="checkbox"/> August 31st, 2018 completed to ensure that all orders have been transcribed from the Fax Communication form as ordered and medications removed and returned to pharmacy if appropriate or new order medication received and administered. The nurses were re-educated on Nursing Policy 2301, History and Physical (All verbal orders shall be immediately recorded and signed by the individual receiving them and shall be countersigned by the prescribing physician.). Now orders should be administered, now if medication is on hand in the Omni-cell, but within two hours of receiving the order if outside sources are utilized to obtain the medication, if medication is not available outside that time frame, physician should be made aware so additional orders may be obtained if needed. Document in the progress note to indicate the conversation and request. Education for the Nurses was completed on September 4, 2018 by the Regional Nurse Consultant, Director of Nursing and the Corporate QA Monitor. Any nurse, which does not receive the education by the date of compliance, will be removed from the schedule, until education is received in-person or via telephone if necessary. During the audits, if infractions are found in regards to not following the policy, will result in initial verbal with additional education. If the infraction occurs again a written counselling will be placed in the employees file. New hired nurses will receive the education during orientation.</p>		

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F 658	<p>Continued From page 3</p> <p>An interview was conducted with the Director of Nursing (DON) on 08/09/18 at 6:49 PM. The DON stated that the NP and MD wrote orders and placed those orders in a communication book at the nurse's station. Once the nursing staff received the orders they were to enter them into the electronic system and then place the orders back in the book so that 3rd shift could perform the 2nd check of the order. The DON stated that 3rd shift checked to make sure the order was carried out and was correctly entered into the electronic system. She added that was how they identified any errors. The DON stated that she expected orders to be carried out the same day they were written and if one shift missed those orders then 3rd shift should be catching them.</p> <p>2. Resident #4 readmitted to the facility on 01/24/18 with diagnosis that included sicca syndrome (dry mouth making it difficult to swallow), anemia, atrial fibrillation, and hyperlipidemia.</p> <p>Review of the quarterly minimum data set (MDS) dated 06/15/18 revealed that Resident #4 was cognitively intact and required limited assistance with activities of daily living.</p> <p>Review of a physician order dated 06/29/18 signed by the Nurse Practitioner (NP) and provided by Nurse #4 read, stop omeprazole and start Protonix 40 milligrams (mg) by mouth 2 times a day for 4 weeks then Protonix 40 mg by mouth every day.</p> <p>Review of the medication administration record (MAR) dated 06/01/18 thorough 06/30/18 revealed that Resident #4 had received</p>	F 658	<p>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: Chart orders will be audited by DON, Nursing Supervisor or Staff Development Coordinator for changes in medication orders, daily x4 weeks then every two weeks x2 months and then monthly x1 months.</p> <p>The Title of the person responsible for implementing the acceptable plan of correction: Director of Nursing will be responsible for ensuring an acceptable Plan of Correction, is maintained and audits completed, All audits, will be reviewed and reported, to the Quality Assurance Performance Improvement Committee, monthly and Quarterly thereafter for continued compliance/revisions to the plan if needed.</p>		

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F 658	<p>Continued From page 4</p> <p>omeprazole (that was discontinued on 06/29/18) on 06/29/18 and again on 06/30/18. The MAR further revealed that no Protonix was administered on 06/29/18 or on 06/30/18 as ordered.</p> <p>An observation of Resident #4 was made on 08/08/18 at 2:18 PM. Resident #4 was resting in bed watching TV and denied any complaints.</p> <p>An interview was conducted with the NP on 08/09/18 at 9:29 AM. The NP stated that when she wrote an order she filled out the order and placed it in the communication book and left the book at the nurse's station and the nursing staff processed the orders. The NP confirmed that she had written the orders for Resident #4 on 06/29/18 and per the facility's routine left the orders in the communication book at the nurse's station. The NP stated, "that it depended on the medication as to when the order should be processed." The NP stated that to her knowledge the orders were missed and when they discovered the missed orders on 07/01/18 they called the on-call service and made them aware.</p> <p>An interview was conducted with the Unit Coordinator (UC) on 08/09/18 at 11:11 AM. The UC stated that on 06/29/18 she was the nurse who was responsible for Resident #4. The UC stated that when the NP or the Medical Doctor (MD) saw a resident they place any orders in the communication book that was kept at the nurse's station and the nursing staff checked it routinely throughout the day for any new orders that were present. The UC stated that each nurse was ultimately responsible for signing off and carrying out any new orders that came in during their shift. She added that after the orders were signed off</p>	F 658			

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F 658	<p>Continued From page 5</p> <p>and carried out they went back into the notebook and 3rd shift conducted the 2nd check of the order to ensure that it was carried out correctly. She confirmed that she was responsible for carrying out the orders for Resident #4 on 06/29/18 but did not recall seeing those orders possibly because she was responsible for 2 medication carts that day and got busy.</p> <p>An interview was conducted with the MD on 08/09/18 at 11:27 AM. The MD stated that she had been made aware of the orders for Resident #4 that were missed. The MD stated that she expected that once orders were written that they should be carried out during that shift or at least the same day.</p> <p>An interview was conducted with Nurse #3 on 08/09/18 at 3:46 PM. Nurse #3 stated that he worked 3rd shift at the facility. Nurse #3 stated that when the NP or MD wrote orders most of the time it was on 1st shift and they placed the orders in a communication book at the nurse's station. The nurse on the unit would carry out the order and place the order back in the book and 3rd shift would go back through the orders and make sure that they were carried out correctly. Nurse #3 stated that they also checked the book for any orders that were missed. He further stated that he did not recall seeing the orders for Resident #4 on 06/29/18 or he would have carried them out immediately.</p> <p>An interview was conducted with the Director of Nursing (DON) on 08/09/18 at 6:49 PM. The DON stated that the NP and MD wrote orders and placed those orders in a communication book at the nurse's station. Once the nursing staff received the orders they were to enter them into</p>	F 658			

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F 658	<p>Continued From page 6</p> <p>the electronic system and then place the orders back in the book so that 3rd shift could perform the 2nd check of the order. The DON stated that 3rd shift checked to make sure the order was carried out and was correctly entered into the electronic system. She added that was how they identified any errors. The DON stated that she expected orders to be carried out the same day they were written and if one shift missed those orders then 3rd shift should be catching them.</p> <p>3. Resident #9 readmitted to the facility on 06/28/18 with diagnoses that included left femur fracture, weakness, diabetes, major depressive disorder, anemia, and hyperlipidemia.</p> <p>Review of the comprehensive minimum data set (MDS) dated 05/03/18 revealed that Resident #9 was cognitively intact and required extensive assistance with her activities of daily living.</p> <p>Review of a progress note from the Nurse Practitioner (NP) dated 06/29/18 revealed that Resident #9 was being seen for follow up readmission after a left femur fracture. The history of present illness read in part, Resident #9 "has been readmitted to our facility after a short stay at home with notable continued decline, fall, and debility." The diagnosis and assessment read in part, fall against object, insulin dependent diabetes mellitus, bilateral lower extremity edema, renal insufficiency, and debility. The plan read in part, discontinue biotin, Vitamin C, oxycodone. Oxycodone 5 milligrams (mg) by mouth every 6 hours when necessary, Klonopin 0.5 mg by mouth daily for 14 days, additional Lasix 40 mg by mouth for 3 days and glucose checks twice a day. The note was electronically signed by the NP.</p>	F 658			

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F 658	Continued From page 7  Review of a physician order dated 06/29/18 signed by the NP and provided by Nurse #4 read in part, stop all oxycodone and Klonopin orders. Oxycodone 5 mg by mouth every 6 hours as needed for pain, Klonopin 0.5 mg by mouth daily as needed for anxiety for 14 days, stop biotin and vitamin C, additional Lasix 40 mg by mouth for 3 days due to increased edema, and glucose checks twice a day for diabetes mellitus.  Review of the medication administration record (MAR) dated 06/01/18 through 06/30/18 revealed that Resident #9 had received the biotin and Vitamin C (that was discontinued on 06/29/18) on both 06/29/18 and 06/30/18. The MAR further revealed that Resident #9 did not receive the additional Lasix 40 mg by mouth x 3 days on 06/29/18 or 06/30/18 and the oxycodone and Klonopin orders were not carried out on 06/29/18 or 06/30/18.  An observation and interview were conducted with Resident #2 on 08/08/18 at 2:11 PM. Resident #9 was up in her wheelchair at bedside. She was alert and oriented and stated she had been at the facility for a couple of months and was doing well. She stated that she does have left leg pain and she requested her pain medication and the staff brought it to her, but she could not recall what the name of it was. Resident #9 stated that it does take a while for the pain to ease once she has had her medication.  An interview was conducted with the NP on 08/09/18 at 9:29 AM. The NP stated that when she wrote an order she filled out the order and placed it in the communication book and left the book at the nurse ' s station and the nursing staff	F 658			



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F 658	<p>Continued From page 8</p> <p>processed the orders. The NP confirmed that she had written the orders for Resident #9 on 06/29/18 and per the facility's routine left the orders in the communication book at the nurse's station. The NP stated, "that it depended on the medication as to when the order should be processed." The NP stated that to her knowledge the orders were missed and when they discovered the missed orders on 07/01/18 they called the on-call service and made them aware.</p> <p>An interview was conducted with the Unit Coordinator (UC) on 08/09/18 at 11:11 AM. The UC stated that on 06/29/18 she was the nurse who was responsible for Resident #9. The UC stated that when the NP or the Medical Doctor (MD) saw a resident they place any orders in the communication book that was kept at the nurse's station and the nursing staff checked it routinely throughout the day for any new orders that were present. The UC stated that each nurse was ultimately responsible for signing off and carrying out any new orders that came in during their shift. She added that after the orders were signed off and carried out they went back into the notebook and 3rd shift conducted the 2nd check of the order to ensure that it was carried out correctly. She confirmed that she was responsible for carrying out the orders for Resident #9 on 06/29/18 but did not recall seeing those orders possibly because she was responsible for 2 medication carts that day and got busy.</p> <p>An interview was conducted with the MD on 08/09/18 at 11:27 AM. The MD stated that she had been made aware of the orders for Resident #9 that were missed. The MD stated that she expected that once orders were written that they should be carried out during that shift or at least</p>	F 658			

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F 658	Continued From page 9 the same day.  An interview was conducted with Nurse #3 on 08/09/18 at 3:46 PM. Nurse #3 stated that he worked 3rd shift at the facility. Nurse #3 stated that when the NP or MD wrote orders most of the time it was on 1st shift and they placed the orders in a communication book at the nurse's station. The nurse on the unit would carry out the order and place the order back in the book and 3rd shift would go back through the orders and make sure that they were carried out correctly. Nurse #3 stated that they also checked the book for any orders that were missed. He further stated that he did not recall seeing the orders for Resident #9 on 06/29/18 or he would have carried them out immediately.  An interview was conducted with the Director of Nursing (DON) on 08/09/18 at 6:49 PM. The DON stated that the NP and MD wrote orders and placed those orders in a communication book at the nurse ' s station. Once the nursing staff received the orders they were to enter them into the electronic system and then place the orders back in the book so that 3rd shift could perform the 2nd check of the order. The DON stated that 3rd shift checked to make sure the order was carried out and was correctly entered into the electronic system. She added that was how they identified any errors. The DON stated that she expected orders to be carried out the same day they were written and if one shift missed those orders then 3rd shift should be catching those orders.	F 658			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		9/6/18	

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F 686	<p>Continued From page 10</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews and staff interviews the facility failed to initiate pressure ulcer treatments to a resident admitted with pressure ulcers for 1 of 3 residents reviewed for pressure ulcers (Resident #12).</p> <p>The findings included:</p> <p>Resident #12 was admitted to the facility on 06/29/18 with diagnoses which included acute myocardial infarction, diabetes mellitus and right femur fracture.</p> <p>Review of Resident #12's Admission Nursing Assessment (ANA) dated 06/29/18 revealed he had a stage I pressure sore on his left buttock that measured 5.2 centimeters (cm) x 3.7 cm x 0.1 cm AND a suspected deep tissue injury on his right heel (unstageable).</p> <p>Review of Resident #12's Admission Minimum Data Set (MDS) assessment revealed he was cognitively intact, required extensive assistance</p>	F 686	<p>F686</p> <p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: A nurse failed to follow facility policy in regards to Admissions Skin Assessments and identifying wounds on that assessment and failed to implement a treatment on the identified wound found on the admission assessment. All nurses were re-educated on Nursing Policy 2402, Pressure Ulcer Monitoring and Documentation (A licensed nurse will assess patients for the presence of pressure ulcers; if a pressure ulcer is present, the nurse will evaluate for complications) and Nursing Policy 3201, General Wound Care and Dressing Changes, notify the physician and obtain orders for treatment(s) and dressing changes. The approved interim treatment orders may be utilized utilizing recognized</p>		

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F 686	<p>Continued From page 11 with bed mobility, transfers, dressing and toileting. The MDS also indicated he had one stage 2 and 1 unstageable pressure ulcers on admission.</p> <p>Review of Resident #12's Interim Care Plan dated 06/29/18 indicated he had a potential for skin impairment with interventions that included keeping the skin clean and dry and a pressure reducing mattress on his bed.</p> <p>Review of Resident #12's Medication Administration Record (MAR) dated 06/29/18 to 06/30/18 indicated there were no medication orders prescribed to treat neither of the areas on his left buttock nor his right heel.</p> <p>Review of Resident #12's Treatment Administration Record (TAR) dated 06/29/18 through 06/30/18 indicated no treatment had been set up for the areas on his right heel or his left buttock.</p> <p>Review of Resident #12's July 2018 MAR revealed Skin Prep was applied to his buttocks and heels once a day from 07/10/18 through 07/17/18.</p> <p>Review of Resident #12's July 2018 TAR revealed a treatment was initiated on 07/10/18 to cleanse the bilateral heels with wound cleanser, apply skin prep, pad with gauze and ABD pad then wrap with Kerlix after his showers on Wednesdays and Saturdays. According to the TAR Resident #12 only received the treatment on Saturday July 14th 2018. The TAR also indicated that bilateral multi podis boots (boots worn to prevent heels from touching the surface) were applied from 07/10/18 evening shift to 07/12/18 evening shift.</p>	F 686	<p>standards of practice regarding dressing change(s). Document unusual findings and follow-up interventions including notification of physician/responsible party.</p> <p>The Procedure for implementing the acceptable plan of correction for the specific deficiency cited: 100% audit of all new admissions, to ensure that all wounds on admission had appropriate treatments put in place at the time wounds were identified from August 27th <input type="checkbox"/> August 31st, 2018. All nurses were re-educated on Nursing Policy 2402, Pressure Ulcer Monitoring and Documentation (A licensed nurse will assess patients for the presence of pressure ulcers; if a pressure ulcer is present, the nurse will evaluate for complications) and Nursing Policy 3201, General Wound Care and Dressing Changes (Notify the physician and obtain orders for treatment(s) and dressing changes. The approved interim treatment orders may be utilized utilizing recognized standards of practice regarding dressing change(s). Document unusual findings and follow-up interventions including notification of physician/responsible party.) Education for the Nurses was completed on September 4, 2018 by the Regional Nurse Consultant, Director of Nursing and the Corporate QA Monitor. Any nurse, which does not receive the education by the date of compliance, will be removed from the schedule, until education is received in-person or via telephone if necessary. During the audits, if infractions are found in regards to not</p>		

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F 686	Continued From page 12  Review of Resident #12's Weekly Skin Assessment (WSA) dated 07/01/18 revealed a stage I pressure ulcer on his left buttock which measured 5.2 cm x 3.7 cm x 0.1 cm and a suspected deep tissue injury on his right heel which was unstageable. A WSA dated 07/08/18 revealed the left buttock had measured 5.0 cm x 3.5 cm x 0.1 cm and the right heel remained unstageable.  Review of Resident #12's Wound Record (WR) dated 07/12/18 revealed a suspected deep tissue injury to his right heel described as a blood/serum filled blister which had opened and measured 10.0 cm x 10.0 cm x 0.1 cm. The WR indicated the current treatment plan was to discontinue the multi podis boot and apply skin prep, cushion with the gauze and dry dressing then wrap with Kerlix. The WR also indicated he had developed a fluid filled unstageable blister to his left heel that measured 4.0 cm x 4.0 cm x 0.1 cm. The same treatment had been started for the new area.  Review of Resident #12's Nurses' Progress Notes dated 07/12/18 revealed the blister to his right heel had opened up and drained large amounts of fluid. The note indicated he had bilateral blisters to his heels on admission.  On 08/09/18 at 5:50 PM during an interview with Nurse #1, he stated that he admitted Resident #12 on 06/29/18 and recalled that the resident had pressure areas on his left buttock and right heel. Nurse #1 stated the normal protocol was to initiate wound treatments on the residents when they were admitted with pressure ulcers but Nurse #1 could not locate in the chart where he had done so on Resident #12. Nurse #1 stated he	F 686	following the policy, will result in initial verbal with additional education. If the infraction occurs again a written counselling will be placed in the employees file. New hired nurses will receive the education during orientation.  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: New admissions will be checked daily and skin assessment reviewed, if a wound had been identified that a treatment had not been initiated, a treatment will be implemented. An audit will be completed daily x4 weeks then every two weeks x2 months and then monthly x1 months.  The Title of the person responsible for implementing the acceptable plan of correction: Director of Nursing will be responsible for ensuring an acceptable Plan of Correction, is maintained and audits completed, All audits, will be reviewed and reported, to the Quality Assurance Performance Improvement Committee, monthly and Quarterly thereafter for continued compliance/revisions to the plan if needed.		

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PRINTED: 09/06/2018  
FORM APPROVED  
OMB NO. 0938-0391

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F 686	Continued From page 13 should have initiated pressure ulcer treatments for Resident #12.  An interview was conducted with the Director of Nursing (DON) on 08/09/18 at 6:50 PM who reviewed Resident #12's chart and could not find where treatments for his pressure ulcers had been initiated on admission. The DON stated her expectation would be for wound treatments be initiated on admission to the facility.	F 686			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(2) For excessive duration; or  §483.45(d)(3) Without adequate monitoring; or  §483.45(d)(4) Without adequate indications for its use; or  §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or  §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff	F 757		9/6/18	
			F757		

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F 757	<p>Continued From page 14</p> <p>interviews, Nurse Practitioner, and Medical Doctor interviews the facility failed to remove a discontinued narcotic from the medication cart and the medication was given 6 times after it was discontinued for 1 of 5 residents sampled (Resident #7).</p> <p>The findings included:</p> <p>1. Resident #7 admitted to the facility on 01/27/17 with diagnoses that included chronic pain, poly-osteoarthritis and end stage renal disease.</p> <p>Review of a physician order dated 06/11/18 read in part, discontinue tramadol. Percocet 5/325 milligrams (mg) by mouth 3 times a day.</p> <p>Review of the most recent quarterly minimum data set (MDS) dated 06/12/18 revealed that Resident #7 was cognitively intact and was independent with activities of daily living. The MDS further revealed that Resident #7 experienced pain frequently and on a pain scale rated her pain at a 4 and required 7 days of an opioid (pain medication) during the assessment reference period. The MDS also revealed that Resident #7 received dialysis during the assessment reference period.</p> <p>Review of a medication administration record (MAR) dated 06/01/18 through 06/30/18 revealed that the tramadol had been discontinued on 06/11/18 as ordered.</p> <p>Review of the narcotic administration record that was still present on the medication cart revealed that Resident #7 received tramadol on 06/12/18, 06/28/18, 07/05/18, 07/28/18, 08/02/18, and 08/04/18.</p>	F 757	<p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Facility failed to follow facility policy in regards to discontinuation of medications and implementing physician orders as ordered. A patient received doses of a medication that had been discontinued.</p> <p>When an order is obtained to discontinue a medication or decrease the dosage from the physician/practitioner, the nurse will place the order in the Electronic Medical Record, and scan the old medication card and return to pharmacy by placing the medication in the Red Bag in the Medication Room. If the Medication in question is, a narcotic the same process will be used except the medication will be placed in a red bag and secured in the drawer of the medication cart, so that the medication remains secured until picked up by the courier. Upon discontinuation if the dosage has changed or a new medication order received, the order will be entered into the Electronic Medical Record and the new medication ordered from pharmacy. The nurse will take the order; telephone, written or verbal and enter the order into the electronic medical record, indicate the order was noted and place in the communication book for audit. Then the order will be given to medical records to be scanned into the record.</p> <p>The Procedure for implementing the</p>		

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F 757	<p>Continued From page 15</p> <p>An observation and interview were conducted with Resident #7 on 08/08/18 at 2:39 PM. Resident #7 was resting in bed and stated that she had been at the facility for about a year and a half and was doing well. She stated that she took Percocet for her pain and had taken that most of her life as that was the only thing could control her pain. Resident #7 stated that the Tramadol was discontinued a month or so ago because it was not effective in controlling her pain. She stated that she often would request something for pain in the mornings before her dialysis treatment and the staff would give it to her, but she assumed it was the Percocet because the Tramadol had been discontinued. Resident #7 stated she was always in some kind of pain but had not had increased in her pain levels recently.</p> <p>An interview was conducted with the Unit Coordinator (UC) on 08/08/18 at 4:22 PM. The UC confirmed that she had administrated the tramadol on 06/12/18 and explained that in the mornings Resident #7 was always in a hurry to get to dialysis and would request something for pain. She stated that on 06/12/18 Resident #7 requested something for pain and she did not take the time to check the orders, so she pulled the tramadol out of the narcotic drawer and gave the medication and signed it out on the narcotic administration sheet. The UC stated it was an error on her part and she should have checked the MAR to see that the medication had been discontinued. She added that the currently there was no process for pulling discontinued narcotics off the medication cart and she was in the process of developing a process so that the nurses would make it a habit to pull the narcotics off the medication cart when they were</p>	F 757	<p>acceptable plan of correction for the specific deficiency cited: 100% audit of all charts checking for new medication orders from August 27th □ August 31st, 2018 completed to ensure that all orders have been transcribed removing old dose or medication from the medication cart and returning to pharmacy. Re-education on Omnicare LTC Pharmacy Services Procedure Manual, 8.1 Return Medications to Pharmacy and Credits and Omnicare LTC Pharmacy Services Procedure Manual, 8.2 Disposal/Destruction of Expired or Discontinued Medications. Education for the Nurses was completed on September 4, 2018 by the Regional Nurse Consultant, Director of Nursing and the Corporate QA Monitor. Any nurse, which does not receive the education by the date of compliance, will be removed from the schedule, until education is received in-person or via telephone if necessary. During the audits, if infractions are found in regards to not following the policy, will result in initial verbal with additional education. If the infraction occurs again a written counselling will be placed in the employees file. New hired nurses will receive the education during orientation.</p> <p>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: Chart orders/Routine/Non-emergency Fascimile Sheets will be audited Monday-Sunday by DON, Nursing Supervisor or Staff</p>		



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F 757	<p>Continued From page 16 discontinued.</p> <p>An attempt to speak to Nurse #5 was made on 08/09/18 at 2:55 PM was unsuccessful. Nurse #5 was the nurse that signed out the tramadol for Resident #7 on the narcotic administration record on 06/28/18 and 07/05/18.</p> <p>An interview was conducted with Nurse #3 on 08/09/18 at 3:46 PM. Nurse #3 confirmed that he had administered tramadol to Resident #7 on 07/28/18, 08/02/18, and 08/04/18 by mistake. He stated that Resident #7 left the facility early in the morning for dialysis and would always request something for pain on her way out of the facility. Nurse #3 stated that the early morning hours were a very busy time for him and so he would just open the narcotic drawer and administer the medication without checking the MAR to ensure the correct medication and dose. Nurse #3 stated he was not sure of what the process for removing discontinued narcotic was, but he would assume that whoever took the order would pull the narcotic off the medication cart and prepare it for return to the pharmacy. He further explained that the return of a narcotic was lengthy process, but the medication was placed in a special red bag and then placed back in the narcotic drawer until the pharmacy picked it up. He added that at least that way the medication would not be available for administration and the staff would recognize the red bag and could give to the pharmacy when they delivered the medication each night. Nurse #3 further stated that last week he went through the narcotic medications and saw the narcotic sign out sheet still in the book and did not verify the order and that was how they missed pulling that medication off the cart.</p>	F 757	<p>Development Coordinator for medication discontinuation orders, daily x4 weeks then every two weeks x2 months and then monthly x1 months.</p> <p>The Title of the person responsible for implementing the acceptable plan of correction: Director of Nursing will be responsible for ensuring an acceptable Plan of Correction, is maintained and audits completed, All audits, will be reviewed and reported, to the Quality Assurance Performance Improvement Committee, monthly and Quarterly thereafter for continued compliance/revisions to the plan if needed.</p>		

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F 757	Continued From page 17 An interview was conducted with the Director of Nursing (DON) on 08/09/18 at 6:49 PM. The DON stated that systemic breakdown of the nursing staff not pulling discontinued medications off the medication carts was how Resident #7 received the tramadol 6 times after it was discontinued on 06/11/18. She explained that returning narcotics was such a laborious process and the last pharmacy pick up was on 2nd shift so she was going to make them responsible for ensuring that discontinued narcotics were immediately pulled off the medication cart and placed in the red bags and placed back in the narcotic drawer until the pharmacy could pick them up. She added that if the discontinued medications were in the red bags they were unavailable to be administered and the staff could easily identify that they were discontinued and needed to be returned to the pharmacy.	F 757			
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)  The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and Medical Director interviews the facility failed to prevent a significant medication error when the facility failed to carry out and administer a physicians order for intravenous (IV) Lasix (diuretic) for 2 days for 1 of 3 residents sampled (Resident #10).  The findings included:  Resident #10 readmitted to the facility on	F 760	F760  The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Facility failed to follow facility policy in regards to discontinuation of medications and implementing physician orders as ordered, which allowed patients to not receive medications that had been ordered.	9/6/18	

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F 760	<p>Continued From page 18</p> <p>06/20/18 with diagnoses that included: acute pulmonary edema, congestive heart failure, acute respiratory failure, and metabolic encephalopathy. Resident #10 expired in the facility on 07/31/18.</p> <p>Review of Resident #10's most recent comprehensive minimum data set (MDS) dated 05/28/18 revealed that she was cognitively intact and required limited to extensive assistance with her activities of daily living. The MDS further revealed that Resident #10 required the use of oxygen and had received 6 days of diuretic (medication that increased the passing of urine) therapy during the assessment reference period.</p> <p>Review of a progress note from the Nurse Practitioner (NP) dated 06/29/18 revealed that Resident #10 was being seen for "worsening edema." The history of present illness read in part, "She has also noted some increase in edema, feels like she continues to gain weight." Resident #10 "had no change in oxygenation need reported." The physical exam revealed the following, 3+ edema to bilateral upper and lower extremities. The respiratory exam revealed normal respiratory effort. The diagnosis and assessment revealed the following, acute on chronic systolic heart failure. The plan read in part, Lasix (diuretic) 40 milligrams (mg) now and repeat at 10:00 PM. Tomorrow (06/30/18) Lasix 40 mg at 6:00 AM and again at 2:00 PM. Continue to recommend Resident #10 for hospice services given her overall decline. The note was electronically signed by the NP.</p> <p>Review of a physician order dated 06/29/18 and signed by the NP and provided by Nurse #4 read in part, Lasix 40 mg via peripherally inserted central catheter (PICC) now and repeat at 10:00</p>	F 760	<p>When an order is obtained to administer a medication from the physician/practitioner, the nurse will place the order in the Electronic Medical Record. Now orders should be administered now if medication is on hand in the Pyxis, but within two hours of receiving the order if outside sources are utilized to obtain the medication, if medication is not available and will fall outside that time frame, notify the physician to make them aware so additional orders may be obtained if needed. Document in the progress note to indicate the conversation and request. The nurse will take the order; telephone, written or verbal and enter the order into the electronic medical record, indicate the order was noted and place in the communication book for audit. Then the order will be given to medical records to be scanned into the record.</p> <p>The Procedure for implementing the acceptable plan of correction for the specific deficiency cited: A 100% audit of all charts checking new medication orders from August 27th <input type="checkbox"/> August 31st, 2018 completed to ensure that all orders have been transcribed from the Fax Communication form as ordered and medications removed and returned to pharmacy if appropriate or new order medication received and administered. The nurses were re-educated on Nursing Policy 2301, History and Physical (All verbal orders shall be immediately recorded and signed by the individual receiving them and shall be countersigned</p>		

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F 760	<p>Continued From page 19</p> <p>PM (Lasix 40 mg). On 06/30/18 give Lasix 40 mg via PICC at 6:00 AM and 2:00 PM.</p> <p>Review of the medication administration record (MAR) dated 06/01/18 through 06/30/18 revealed that Resident #10 did not received Lasix 40 mg via PICC line on 06/29/18 or 06/30/18 as ordered.</p> <p>An interview was conducted with the NP on 08/09/18 at 9:29 AM. The NP stated that when she wrote an order she filled out the order and placed it in the communication book and left the book at the nurse's station and the nursing staff processed the orders. The NP confirmed that she had written the orders for the Lasix on 06/29/18 and per the facility's routine left the orders in the communication book at the nurse's station. She added that the "now" Lasix should have been administered as soon as possible and was not something we would have waited a couple of days to give. The NP stated that to her knowledge the orders were missed and when they discovered the missed orders on 07/01/18 they called the on-call service and made them aware.</p> <p>An interview was conducted with the Unit Coordinator (UC) on 08/09/18 at 11:11 AM. The UC stated that on 06/29/18 she was the nurse who was responsible for Resident #10. The UC stated that when the NP or the Medical Doctor (MD) saw a resident they place any orders in the communication book that was kept at the nurse's station and the nursing staff checked it routinely throughout the day for any new orders that were present. The UC stated that each nurse was ultimately responsible for signing off and carrying out any new orders that come in during their shift. She added that after the orders were signed off and carried out they went back into the notebook</p>	F 760	<p>by the prescribing physician.). Now orders should be administered, now if medication is on hand in the Pyxis, but within two hours of receiving the order if outside sources are utilized to obtain the medication, if medication is not available outside that time frame, physician should be made aware so additional orders may be obtained if needed. Document in the progress note to indicate the conversation and request. During the audits, if infractions are found in regards to not following policy, will result in initial verbal with additional education. If the infraction occurs again a written counselling will be placed in the employees filed. Education for the Nurses was completed on September 4, 2018 by the Regional Nurse Consultant, Director of Nursing and the Corporate QA Monitor. Any nurse, which does not receive the education by the date of compliance, will be removed from the schedule, until education is received in-person or via telephone if necessary. During the audits, if infractions are found in regards to not following the policy, will result in initial verbal with additional education. If the infraction occurs again a written counselling will be placed in the employees file. New hired nurses will receive the education during orientation.</p> <p>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: Chart orders will be audited by DON, Nursing Supervisor or Staff Development Coordinator for</p>		

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F 760	<p>Continued From page 20</p> <p>and 3rd shift conducted the 2nd check of the order to ensure that it was carried out correctly. She confirmed that she was responsible for carrying out the orders for Resident #10 on 06/29/18 but did not recall seeing those orders possibly because she was responsible for 2 medication carts that day and got busy. The UC confirmed that the facility had the Lasix in the back up medication system and the "now" order of Lasix should have been given immediately when the order was signed off and repeated as the order specified.</p> <p>An interview was conducted with the MD on 08/09/18 at 11:27 AM. The MD stated that she had been made aware of the orders for Resident #10 that were missed. She added that Resident #10 had chronic overload issues and during that time frame did not require any increase oxygen needs and her blood pressure was stable which indicated to her that there was no significant outcome for the resident. The MD stated that she expected that once orders were written that they should be carried out during that shift or at least the same day.</p> <p>An interview was conducted with Nurse #3 on 08/09/18 at 3:46 PM. Nurse #3 stated that he worked 3rd shift at the facility. Nurse #3 stated that when the NP or MD wrote orders most of the time it was on 1st shift and they placed the orders in a communication book at the nurse's station. The nurse on the unit would carry out the order and place the order back in the book and 3rd shift would go back through the orders and make sure that they were carried out correctly. Nurse #3 stated that they also checked the book for any orders that were missed. He further stated that he did not recall seeing the orders for Resident #10</p>	F 760	<p>changes in medication orders, daily x4 weeks then every two weeks x5 months and then monthly x6 months.</p> <p>The Title of the person responsible for implementing the acceptable plan of correction: Director of Nursing will be responsible for ensuring an acceptable Plan of Correction, is maintained and audits completed, All audits, will be reviewed and reported, to the Quality Assurance Performance Improvement Committee, monthly and Quarterly thereafter for continued compliance/revisions to the plan if needed.</p>		

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F 760	Continued From page 21 on 06/29/18 or he would have carried them out immediately. Nurse #3 stated the "now" order of Lasix should have been given immediately after the order was written and given to the nursing staff and should not have been carried out 2 days later.  An interview was conducted with the Director of Nursing (DON) on 08/09/18 at 6:49 PM. The DON stated that the NP and MD wrote orders and placed those orders in a communication book at the nurse 's station. Once the nursing staff received the orders they were to enter them into the electronic system and then place the orders back in the book so that 3rd shift could perform the 2nd check of the order. The DON stated that 3rd shift checked to make sure the order was carried out and was correctly entered into the electronic system. She added that was how they identified any errors. The DON stated that she expected orders to be carried out the same day they were written and if one shift missed those orders then 3rd shift should be catching them. She further explained that the "now" order of Lasix should have given as soon as the order was written, and the staff was aware.	F 760			
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)  §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		9/6/18	

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F 842	Continued From page 22  §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized  §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.  §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.  §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when	F 842			

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F 842	<p>Continued From page 23</p> <p>there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and Medical Doctor interviews the facility failed to maintain an complete and accurate medical record by failing to retain original copies of physician orders for 3 of 5 residents sampled (Residents #10, #9, and #8) and failed to accurately document the administration of narcotics on the medication administration record for 5 of 5 residents sampled (Resident #4, 3, 5, 6, and 7).</p> <p>The findings included</p> <p>1a. Resident #10 readmitted to the facility on 06/20/18 with diagnoses that included: acute pulmonary edema, congestive heart failure, acute respiratory failure, and metabolic encephalopathy. Resident #10 expired in the facility on 07/31/18.</p> <p>Review of Resident #10's most recent comprehensive minimum data set (MDS) dated</p>	F 842	<p>The plan for correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited. Facility failed follow policies in regards to Signing off Narcotics on the Narcotic Sheet and signing off on the MAR. It was discovered that discrepancies between documentation on narcotic count sheet and MAR were noted. Nurses were educated to maintain hand written orders given to them by the physician and placed in the Unit Communication Book which will be maintained at the nurses station, the night nurse will run a daily listing report and ensure that the orders in the Communication Book have all been placed in the Electronic Medical Record and order has been started, utilizing the Facility MD/NP Communication Form. The nurse will take the order; telephone,</p>		



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F 842	<p>Continued From page 24</p> <p>05/28/18 revealed that she was cognitively intact and required limited to extensive assistance with her activities of daily living.</p> <p>Review of a progress note from the Nurse Practitioner (NP) dated 06/29/18 revealed that Resident #10 was being seen for "worsening edema." The plan read in part, Lasix (diuretic) 40 milligrams (mg) now and repeat at 10:00 PM. Tomorrow (06/30/18) Lasix 40 mg at 6:00 AM and again at 2:00 PM. The note was electronically signed by the NP.</p> <p>Review of the medication administration record (MAR) dated 06/01/18 through 06/30/18 revealed that Resident #10 did not received Lasix 40 mg via PICC line on 06/29/18 or 06/30/18 as ordered.</p> <p>b. Resident #9 readmitted to the facility on 06/28/18 with diagnoses that included left femur fracture, weakness, diabetes, major depressive disorder, anemia, and hyperlipidemia.</p> <p>Review of the comprehensive minimum data set (MDS) dated 05/03/18 revealed that Resident #9 was cognitively intact and required extensive assistance with her activities of daily living.</p> <p>Review of a progress note from the Nurse Practitioner (NP) dated 06/29/18 revealed that Resident #9 was being seen for follow up readmission after a left femur fracture. The plan read in part, discontinue Biotin, Vitamin C, Oxycodone. Oxycodone 5 milligrams (mg) by mouth every 6 hours when necessary, Klonopin 0.5 mg by mouth daily for 14 days, additional Lasix 40 mg by mouth for 3 days and glucose checks twice a day. The note was electronically signed by the NP.</p>	F 842	<p>written or verbal and enter the order into the electronic medical record, indicate the order was noted and place in the communication book for audit. Then the order will be given to medical records to be scanned into the record. Upon scanning of the records they become part of the permanent medical record and are retained for 10 years per medical record policy.</p> <p>The procedure for implementing the acceptable plan of correction for the specific deficiency cite; corrected and/or in compliance with the regulatory requirements. Nurses were educated on The Routine/Non-Emergency Facsimile Sheet is to be utilized for it's intended purpose of sending information to the physician via fax to obtain orders if appropriate.</p> <p>All New Licensed nurses will receive education to include "When signing out a scheduled or prn narcotic for a resident you MUST document it on the Narcotic Count Sheet and it MUST be signed out on the Electronic Medication Administration Record." and "when a narcotic medication is dc'd, nurse must pull narcotic sheet from the book and narcotic from the medication drawer, and dc order", then the medication is placed in a red bag and then secured in the narcotic drawer to maintain security until picked up by courier. Routine/Non-Emergency Facsimile forms are to be transcribed immediately if a "now/stat" order is written and given during the shift the order was</p>		

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F 842	<p>Continued From page 25</p> <p>Review of the medication administration record (MAR) dated 06/01/18 through 06/30/18 revealed that Resident #9 had received the Biotin and Vitamin C (that was discontinued on 06/29/18) on both 06/29/18 and 06/30/18. The MAR further revealed that Resident #9 did not receive the additional Lasix 40 mg by mouth x 3 days on 06/29/18 or 06/30/18 and the oxycodone and Klonopin orders were not carried out on 06/29/18 or 06/30/18.</p> <p>c. Resident #8 admitted to the facility on 06/15/18 with diagnoses that included hypertension. Resident #8 discharged home on 07/04/18.</p> <p>Review of the comprehensive minimum data set (MDS) dated 06/22/18 revealed that Resident #8 was cognitively intact and required extensive assistance with his activities of daily living.</p> <p>Review of a progress note from the Nurse Practitioner (NP) dated 06/29/18 revealed that Resident #8 was being seen for "follow up complaints of dizziness, continued management of heart failure, renal." The plan read in part, decrease Norvasc to 5 milligrams (mg) by mouth daily hold for systolic blood pressure less than 130. The form was electronically signed by the NP.</p> <p>Review of the medication administration record (MAR) dated 06/01/18 through 06/30/18 revealed that on 06/29/18 and 06/30/18 Resident #8 received Norvasc 10 mg by mouth instead of 5 mg by mouth as ordered on 06/29/18</p> <p>An interview was conducted with the Director of Nursing (DON) on 08/08/19 at 1:18 PM who</p>	F 842	<p>received. "Now" orders should be administered, now if medication is on hand in the Pyxis, but within two hours of receiving the order if outside sources are utilized to obtain the medication, if medication is not available outside that time frame, physician should be made aware so additional orders may be obtained if needed. Document in the progress note to indicate the conversation and request. The nurse will take the order telephone, written or verbal and enter the order into the electronic medical record, indicate the order was noted and place in the communication book for audit. Then the order will be given to medical records to be scanned into the record.</p> <p>Education for the Nurses was completed on September 4, 2018 by the Regional Nurse Consultant, Director of Nursing and the Corporate QA Monitor. Any nurse, which does not receive the education by the date of compliance, will be removed from the schedule, until education is received in-person or via telephone if necessary. During the audits, if infractions are found in regards to not following the policy, will result in initial verbal with additional education. If the infraction occurs again a written counselling will be placed in the employees filed. During the audits, if infractions are found in regards to not following policy, will result in initial verbal with additional education. If the infraction occurs again a written counselling will be placed in the employees file. New hired nurses will receive the education during orientation.</p>		

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F 842	<p>Continued From page 26</p> <p>reported that once the physician orders were signed off and carried out and the 2nd check completed the order was destroyed. The DON confirmed she could not provide a copy of the original physician orders for Resident #10, 9, or 8 that were written on 06/29/18.</p> <p>An interview was conducted with the NP on 08/09/18 at 9:29 AM. The NP stated that when she wrote an order she filled out the order and placed it in the communication book and left the book at the nurse's station and the nursing staff processed the orders. The NP confirmed that she had written the orders for Resident #10, 9, and 8 on 06/29/18 and per the facility's routine left the orders in the communication book at the nurse's station. The NP stated she followed the rules of the facility and was not aware of what the facility did with orders once they were written.</p> <p>An interview was conducted with the Medical Doctor (MD) on 08/09/18 at 11:27 AM. The MD stated that once an order was written per the facility protocol it was left in the communication book at the nurse's station and the nursing staff would take care of the orders. She stated that each facility was different in what they did with the orders once they were written. She stated she went along with whatever the facility wanted to do with them. The MD added that most facilities were not holding to paper items, but she was not aware of what the facility did with the orders once they were written.</p> <p>An interview was conducted with Nurse #3 on 08/09/18 at 3:46 PM. Nurse #3 stated that he worked 3rd shift at the facility. Nurse #3 stated that when the NP or MD wrote orders most of the time it was on 1st shift and they placed the orders</p>	F 842	<p>How the facility plans to monitor and ensure correction is achieved and sustained</p> <p>Director of Nursing and/or RN Unit Managers, and/or Staff Development nurse will audit 20% of patients on each unit to ensure that order changes have been implemented and placed in the Electronic Medical Record MAR by running a daily order summary and checking the MD/NP Communication Form to ensure the orders have been started, these audits will be done weekly X 4, every two weeks x5 months and Monthly x6. Results of audits will be reviewed at weekly Quality Assurance Risk Meeting, and at Quarterly Quality Assurance meeting X 12 for further problem resolution if needed.</p> <p>Any errors found will have a corresponding Medication Error Incident Report completed.</p> <p>The title of the person responsible for implementing the acceptable plan of correction.</p> <p>Director of Nursing will be responsible for ensuring an acceptable Plan of Correction, is maintained and audits completed, All audits, will be reviewed and reported, to the Quality Assurance Performance Improvement Committee, monthly and Quarterly thereafter for continued compliance/revisions to the plan if needed.</p>		

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F 842	<p>Continued From page 27</p> <p>in a communication book at the nurse's station. The nurse on the unit would carry out the order and place the order back in the book and 3rd shift would go back through the orders and make sure that they were carried out correctly. Nurse #3 stated that once they performed the 2nd check of the orders they placed the orders in a filing cabinet and when the filing cabinet was full the facility administration did something with them, but he was not sure what. Nurse #3 stated that the facility management did not want the orders uploaded into the system and when he questioned why they did not want them uploaded to the electronic system he never received an answer.</p> <p>An interview was conducted with the Director of Nursing (DON) on 08/09/18 at 6:49 PM. The DON stated that the NP and MD wrote orders and placed those orders in a communication book at the nurse ' s station. Once the nursing staff received the orders they were to enter them into the electronic system and then place the orders back in the book so that 3rd shift could perform the 2nd check of the order. The DON stated that after the 2nd check was completed by 3rd shift staff the order was destroyed. The DON stated that once the order was entered into the electronic system it could be printed and the original copy was not needed and that was their facility's policy. The DON again confirmed that the orders for Resident #10, 9, and 8 had been destroyed.</p> <p>2a. Resident #4 readmitted to the facility on 01/24/18 with diagnosis that included sicca syndrome (dry mouth making it difficult to swallow), anemia, atrial fibrillation, and hyperlipidemia.</p>	F 842			

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F 842	<p>Continued From page 28</p> <p>Review of the quarterly minimum data set (MDS) dated 06/15/18 revealed that Resident #4 was cognitively intact and required limited assistance with activities of daily living.</p> <p>Review of the medication administration record (MAR) for Resident #4 dated 06/01/18 through 06/30/18 revealed that on 06/07/18 Resident #4 received Tramadol (pain medication) 50 milligrams (mg) at 12:10 AM.</p> <p>Review of the narcotic administration record for Resident #4 revealed that on 06/07/18 Resident #4 had received Tramadol 50 mg at 12:11 AM and again at 8:20 PM by the Unit Coordinator (UC).</p> <p>b. Resident #3 admitted to the facility on 10/19/17 with diagnoses that included: fracture of left femur, acquired absence of left leg, hyperkalemia, and diabetes mellitus.</p> <p>Review of the comprehensive minimum data set (MDS) dated 06/07/18 revealed that Resident #3 was cognitively intact and required extensive assistance with activities of daily living.</p> <p>Review of the medication administration record (MAR) for Resident #3 dated 06/01/18 through 06/30/18 revealed that on 06/12/18 no Oxycodone (pain medication) 5/325 milligrams (mg) was administered.</p> <p>Review of the narcotic administration record revealed that on 06/12/18 the Unit Coordinator (UC) had administered the Oxycodone 5/325 mg at 12:18 AM.</p>	F 842			

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F 842	<p>Continued From page 29</p> <p>c. Resident #5 admitted to the facility on 05/25/18 with diagnoses that included malignant neoplasm of spinal cord and bone, weakness, and anxiety. Resident #5 discharged from the facility on 06/27/18.</p> <p>Review of the minimum data set (MDS) 06/27/18 revealed that Resident #5 was cognitively intact and required supervision with his activities of daily living.</p> <p>Review of the medication administration record (MAR) for Resident #5 dated 06/01/18 through 06/30/18 revealed that on 06/05/18 and 06/07/18 no Valium 5 milligrams (mg) was administered.</p> <p>Review of the narcotic administration record revealed that on 06/05/18 Resident #5 received Valium 5 mg at 3:00 AM by the Unit Coordinator (UC). Further review of the narcotic administration record revealed that on 06/07/18 Resident #5 received Valium 5mg at 12:00 AM by the UC.</p> <p>d. Resident #6 admitted to the facility on 05/04/18 with diagnoses that included: end stage renal disease, diabetes mellitus, dysphagia, and long-term use of insulin. Resident #6 discharged from the facility on 06/27/18.</p> <p>Review of the quaterly minimum data set (MDS) dated 06/27/18 revealed that Resident #6 was cognitively intact and required limited to extensive assistance with her activities of daily living.</p> <p>Review of the medication administration record for Resident #6 dated 06/01/18 through 06/30/18 revealed that on 06/09/18 she received hydrocodone 5/325 milligrams (mg) at 7:48 PM.</p>	F 842			

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F 842	Continued From page 30  Review of the narcotic administration record for Resident #6 revealed that on 06/09/18 Resident #6 had received hydrocodone 5/325 mg at 8:00 AM and 7:48 PM from the Unit Coordinator (UC).  e. Resident #7 admitted to the facility on 01/27/17 with diagnoses that included chronic pain, poly-osteoarthritis and end stage renal disease.  Review of the most recent quarterly minimum data set (MDS) dated 06/12/18 revealed that Resident #7 was cognitively intact and was independent with activities of daily living.  Review of the medication administration record for Resident #7 dated 06/01/18 through 06/30/18 revealed that on 06/12/18 no Tramadol (pain medication) 50 milligrams had been administered.  Review of the narcotic administration record for Resident #7 revealed that on 06/12/18 Resident #7 had received Tramadol 50mg at 5:15 AM by the Unit Coordinator (UC).  An interview was conducted with the UC on 08/08/18 at 4:22 PM. The UC stated when she administered narcotics in the facility there was 2 places that the narcotic had to be signed out for. One was on the MAR and the other was the narcotic administration record. The UC confirmed that she had administered the narcotics to Resident #4, 3, 5, 6, and 7 and she had forgotten to sign it out on the MAR. The UC stated she always signed it out on the narcotic administration record but would often forget to go back and sign it out on the MAR and that was just a human error.	F 842			

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

PRINTED: 09/06/2018  
FORM APPROVED  
OMB NO. 0938-0391

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F 842	Continued From page 31  An interview was conducted with the Director of Nursing (DON) on 08/09/18 at 6:49 PM. The DON stated that when narcotics were administered in the facility there was 2 places that the narcotic had to be signed out for. One was on the MAR and the other was the narcotic administration record. The DON that she expected the staff to sign out for the narcotic in both places. She added that this has been an ongoing issue in the facility and she had 3 recent nurses meeting where she educated the staff on the process and where they need to sign out for the medication at. The DON state that most of the staff was good about doing it the correct way but about 10% of the staff still was not doing as they had been instructed and she was going to have to resort to disciplinary action to hold everyone accountable.	F 842			
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Atmpt CFR(s): 483.75(a)(2)(h)(i)  §483.75(a) Quality assurance and performance improvement (QAPI) program.  §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;  §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.  §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 865		9/6/18	



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F 865	<p>Continued From page 32</p> <p>a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff, Nurse Practitioner, and Medical Doctor interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in March 2018 following a complaint survey and April 2018 following a follow up/complaint survey subsequently recited in August 2018 on the current complaint survey. The repeat deficiencies are in the areas of significant medication errors (760) and complete and accurate medical record (F842). These deficiencies were recited during the facility's current complaint survey. The continued failure of the facility during 3 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.</p> <p>The findings included:</p> <p>This tag is cross referred to:</p> <p>1.F760: Significant Medication errors: Based on record review, staff, Nurse Practitioner, and Medical Director interviews the facility failed to prevent a significant medication error when the facility failed to carry out and administer a physician ' s order for intravenous (IV) Lasix (diuretic) for 2 days for 1 of 3 residents sampled (Resident #10).</p> <p>During the follow up/complaint survey of 04/13/18 this regulation was cited for failing to prevent a significant medication error when a nurse failed to correctly identify a resident which resulted in the administration of the wrong medications to the</p>	F 865	<p>F865</p> <p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: This is a direct result of the Quality Assurance Performance Improvement Committee from recognizing and altering processes. F760 - Facility failed to follow facility policy in regards to discontinuation of medications and implementing physician orders as ordered, which allowed patients to not receive medications that had been ordered.</p> <p>When an order is obtained to administer a medication from the physician/practitioner, the nurse will place the order in the Electronic Medical Record. Now orders should be administered now if medication is on hand in the Pyxis, but within two hours of receiving the order if outside sources are utilized to obtain the medication, if medication is not available and will fall outside that time frame, notify the physician to make them aware so additional orders may be obtained if needed. Document in the progress note to indicate the conversation and request. The nurse will take the order telephone, written or verbal and enter the order into the electronic medical record, indicate the order was noted and place in the communication book for audit. Then the order will be given to medical records to be scanned into the record.</p>		

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F 865	<p>Continued From page 33</p> <p>resident. This effected 1 of 3 residents sampled for significant medication error (Resident #1).</p> <p>2. F842: Complete an Accurate Medical Record: Based on record review, staff, Nurse Practitioner, and Medical Doctor interviews the facility failed to maintain an complete and accurate medical record by failing to retain original copies of physician orders for 3 of 5 residents sampled (Residents #10, #9, and #8) and failed to accurately document the administration of narcotics on the medication administration record for 5 of 5 residents sampled (Resident #4, 3, 5, 6, and 7).</p> <p>During the complaint survey of 03/22/18, this regulation was cited for failing to accurately document and record the distribution of a controlled medication to 1 of 1 residents sampled (Resident #1).</p> <p>An interview was conducted with the Administrator on 08/09/18 at 7:44 PM. The Administrator stated the facility's Quality Assurance (QA) committee met monthly and included herself and all the department heads and the Medical Director. She added that the pharmacist attended the QA meeting on a quarterly basis but submitted reports monthly. The Administrator stated that they always had an agenda that included going over previous months minutes, each department would present areas of positivity or areas that needed improvement. If the area needed improvement the QA committee would place the area on a performance improvement plan with audit tools to monitor for any deficient practice. The Administrator stated that they continued to monitor for accuracy regarding documentation from the recent</p>	F 865	<p>F842 - Facility failed follow policies in regards to Signing off Narcotics on the Narcotic Sheet and signing off on the MAR. It was discovered that discrepancies between documentation on narcotic count sheet and MAR were noted. Nurses were educated to maintain hand written orders given to them by the physician and placed in the Unit Communication Book which will be maintained at the nurses station, the night nurse will run a daily listing report and ensure that the orders in the Communication Book have all been placed in the Electronic Medical Record and order has been started, utilizing the Facility MD/NP Communication Form. The nurse will take the order; telephone, written or verbal and enter the order into the electronic medical record, indicate the order was noted and place in the communication book for audit. Then the order will be given to medical records to be scanned into the record.</p> <p>The Procedure for implementing the acceptable plan of correction for the specific deficiency cited: F760 - A 20% audit of all charts checking new medication orders from August 27th <input type="checkbox"/> August 31st, 2018 completed to ensure that all orders have been transcribed from the Fax Communication form as ordered and medications removed and returned to pharmacy if appropriate or new order medication received and administered. The nurses were re-educated on Nursing Policy 2301, History and Physical (All</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 865	Continued From page 34 complaint survey and continued the audits because we felt like there was room for improvement. The Administrator stated that they would have to look at other options that the facility could implement to prevent repeat deficient practice.	F 865	<p>verbal orders shall be immediately recorded and signed by the individual receiving them and shall be countersigned by the prescribing physician.). Now orders should be administered, now if medication is on hand in the Pyxis, but within two hours of receiving the order if outside sources are utilized to obtain the medication, if medication is not available outside that time frame, physician should be made aware so additional orders may be obtained if needed. Document in the progress note to indicate the conversation and request. During the audits, if infractions are found in regards to not following policy, will result in initial verbal with additional education. If the infraction occurs again a written counselling will be placed in the employees file. New hired nurses will receive the education during orientation.</p> <p>F842- Director Of Nursing, SDC and Supervisor educated all Licensed nurses on correct practice of documenting administration of narcotic medication to include When signing out a scheduled or prn narcotic for a resident you MUST document it on the Narcotic Count Sheet and it MUST be signed out on the Electronic Medication Administration Record and when a narcotic medication dc□d, nurse must pull narcotic sheet and medication from narcotic book and drawer, and dc order Completion 8/9/18.</p> <p>All New Licensed nurses will receive education on include When signing out a scheduled or prn narcotic for a resident</p>		

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F 865	Continued From page 35	F 865	<p>you MUST document it on the Narcotic Count Sheet and it MUST be signed out on the Electronic Medication Administration Record. and when a narcotic medication dc□d, nurse must pull narcotic sheet and medication from narcotic book and drawer, and dc order as well as Routine/Non-Emergency Facsimile forms are to be transcribed immediately if a now/stat order and during their shift if received on their shift and medication administered as soon as medication is obtained.</p> <p>Re-education for the Administrator and Director of Nursing on the purpose of Quality Assurance Performance Improvement Committee and the need to follow-up on Plans of Correction was completed on August 30, 2018 by the Regional Nurse Consultant and the Corporate QA Monitor.</p> <p>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: F760 - Chart orders will be audited by DON, Nursing Supervisor or Staff Development Coordinator for changes in medication orders, daily x4 weeks then every two weeks x5 months and then monthly x6 months.</p> <p>F842 - Director of Nursing, RN Unit Managers, Supervisor and/or Staff Development nurse will audit 20% of patients on each unit to ensure that order</p>		

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F 865	Continued From page 36	F 865	<p>changes have been implemented and placed in the Electronic Medical Record (MAR), by running a daily order summary and checking the MD/NP Communication Form to ensure the orders have been started, these audits will be done weekly X 4, two weeks x5 months and Monthly x6.</p> <p>The above audits will be taken to the Quality Performance Improvement Committee for review/ revision if needed utilizing the following schedule: weekly for four (4) weeks and then monthly for eleven (11) months.</p> <p>The Title of the person responsible for implementing the acceptable plan of correction: The Administrator will be responsible for ensuring an acceptable Plan of Correction is maintained and audits completed. If the Administrator is not present then the Director of Nursing will step in for the Administrator. All audits, will be reviewed and reported, to the Quality Assurance Performance Improvement Committee, monthly and Quarterly thereafter for continued compliance/revisions to the plan if needed.</p>		