STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification and Complaint survey was conducted on 10/28/2019 through 10/31/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #XWMD11.	E 000		
F 000	INITIAL COMMENTS A recertification with complaints investigation survey was conducted 10/28/2019 thru 10/31/2019 and 1 of the 12 allegations was substaniated but did not result in deficiency.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		11/18/19

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

Electronically Signed | 11/16/2019

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F 585	Continued From page 1	F 585		

of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately

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F 585	Continued From page 2 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review, the facility failed to provide evidence that a written grievance investigation summary with resolution was provided to 2 (Resident #4 and Resident #38) of 2 residents reviewed for grievances. The findings included: 1. Resident #4 was admitted on 4/19/19 with cumulative diagnoses of Cerebral Vascular	F 585	Preparation and/or execution of this plan, does not constitute agreement or admission by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and sate law.	

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F 585	Continued From page 3 Accident, urinary tract infection (UTI). Resident #4's quarterly Minimum Data Set (MDS) dated 7/12/19 indicated she was cognitively intact and exhibited no behaviors. Review of the facility grievance log for October 2019 revealed a grievance was filed on 10/9/19. The grievance indicated it was resolved with the investigation results and resolution steps reported to Resident #4 verbally. The grievance was signed by the Administrator and dated 10/15/19. Interview on 10/29/19 at 11:45 AM, the Administrator stated a written grievance investigation summary with resolution was given if requested but, in most circumstances, the person filing the grievance declined a written response. He stated the Social Worker (SW) was the facility's grievance officer. Interview on 10/30/19 at 8:50 AM, Resident #4 stated the SW spoke with her and her family after the grievance was filed on 10/9/19 but did not recall being offered a written response. Interview on 10/30/19 at 9:55 AM, the SW stated she started at the facility in May 2019 and at her previous job, she mailed out the written grievance investigation with summary resolution but the practice at the facility was to offer a written copy, but the facility always responded verbally to the person filing the grievance. She stated once a grievance was resolved, they were given to the Administrator to review for completion. Interview on 10/31/19 at 10:40 AM, the Administrator stated he expected evidence of a written grievance investigation summary was	F 585	F585 Grievances CFR(s): 483.10(j)(1)-(4) On 10/30/19, residents' #4 and #38, and, family members' of residents' #4 and #38,were offered follow up written conclusion and outcomes of the grievances filed on 10/9/19, regarding resident #4, and grievance filed on 10/8/19, regarding resident #38. Documentation of such is written on the actual original grievance. Residents' #4 and #38, and, family members' of residents' #4 and #38, had no further concerns after being offered that documentation. On 10/30/19, the Executive Director educated the Social Worker, who is the Grievance Officer, regarding the regulation on Grievances 483.10(j)(1)-(4), and specifically on providing written documentation to the resident, family member or responsible party upon conclusion of the grievance, or, document the refusal of the resident, family member or responsible party, to receive a written conclusion. All residents have the potential to be affected by this deficiency. In addition to the education of the Social Worker by the Executive Director noted above, a monitoring system will be put into place to ensure the facility remains in compliance. On 11/4/19, the Executive Director met with the Resident Council President and reviewed the plan of correction for this citation who gave her (the Resident Council President's) approval. On	

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F 585	Continued From page 4 offered to the person filing the grievance and if they refused, the refusal be documented. 2) Resident #38 was admitted to the facility on 2/15/19 with diagnoses that included a history of a stroke, chronic obstructive pulmonary disease (COPD) and rheumatoid arthritis. A review of the quarterly Minimum Data Set (MDS) dated 10/8/19 revealed the resident to be cognitively intact and displayed no behaviors. She required extensive assistance for Activities of Daily Living (ADL's). Review of the facility grievance log for October 2019 revealed a grievance filed on 10/8/19 by Resident #38's Responsible Party (RP) on her behalf. The grievance form indicated it was resolved with the investigation results and resolution steps reported to Resident #38 and her RP verbally. The grievance was signed by the Administrator and dated 10/15/19. There was no indication a written response was offered, requested or provided. An interview was conducted with the Administrator on 10/29/19 at 11:45am. He explained the grievance resolutions were provided verbally to the person completing the grievance and the resident if applicable. A written grievance investigation summary was offered but normally declined. He stated the Social Worker was the facility's grievance officer. On 10/29/19 at 4:15pm an interview occurred with Resident #38. She recalled someone talking to her about the outcome of the grievance but was not offered a copy of the grievance nor provided a written response.	F 585	11/14/19, a Quality Assurance & Performance Improvement Committee Meeting was held to review and approve the plan of correction for the citation regarding Grievances under F585. To maintain compliance, on 11/4/19, a risk management/quality improvement/monitoring tool, was established to include; (a) Grievances resolved timely per policy, (b) Grievance log is up to date, (c) Copy of written resolution offered/given to Resident/Representative, (d) Refusal by Resident/Representative of written resolution documented, (e) Grievance resolved to the Resident's/Representative's satisfaction. Monitoring of this data will be completed daily for 3 weeks, weekly for 3 weeks, then monthly thereafter as determined by the Quality Assurance & Performance Improvement Committee to maintain compliance. The results of the Quality Assurance monitoring will be reported to the Quality Assurance & Performance Improvement Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The Quality Assurance & Performance Improvement Committee will evaluate the effectiveness of the monitoring/observations for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance & Performance Improvement Committee meets at least quarterly and consists of the Executive Director, Director of	

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F 585	Continued From page 5 On 10/30/19 at 9:55am an interview occurred with the Social Worker. She explained she started at the facility in May 2019 and at her previous job, she mailed out the written grievance summary with resolution but the practice at the facility was always to respond verbally to the person filing the grievance and offer a written copy. She further stated once the grievance was resolved, they were given to the Administrator to review for completion. A phone call was placed to the responsible party on 10/30/19 at 11:00am with a request for a return call. A return call was not received during the survey. In an interview with the Administrator on 10/31/19 at 10:40am, he stated it was his expectation evidence of a written grievance investigation summary was offered to the person filing the grievance and documented if refused.	F 585	Nursing, Physician, Social Services Director, Dietary Manager and others as assigned. The Executive Director is responsible for implementing and executing this plan. Date of compliance: November 18, 2019.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of Activities of Daily Living (ADL's) and medication for 1 of 23 sampled residents. (Resident #143). The findings included:	F 641	F641 Accuracy of Assessments CFR(s): 483.20(g) On 11/13/19, resident #143's Minimum Data Set (MDS) was updated to accurately reflect the resident's MDS Assessment for Activities of Daily Living (ADL) and Injections/Insulin usage by the	11/18/19

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F 641	Continued From page 6 Resident #143 was originally admitted to the facility on 3/5/18 with diagnoses that included chronic obstructive pulmonary disease (COPD), history of a stroke, diabetes, heart failure and chronic pain syndrome. A) A quarterly Minimum Data Set (MDS) assessment dated 4/21/19 revealed Resident #143 to be cognitively intact. She received setup assistance for personal hygiene, limited assistance for bathing and extensive assistance for dressing and toileting. The most recent quarterly MDS assessment dated 7/22/19 indicated Resident #143 was cognitively intact. She was coded as activity only occurred once or twice with staff member assistance for dressing, toileting and personal hygiene and coded as activity did not occur for bathing during the 7 day look back period. On 10/29/19 at 3:45pm an interview occurred with Nurse Aide #1. She stated Resident #143 received daily and as needed assistance from staff for dressing, toileting and personal hygiene as well as daily assistance with sponge baths and twice a week bed baths in July 2019. An interview was completed with Unit Manager #1 on 10/30/19 at 12:00pm. She indicated the resident during July of 2019 Resident #143 received daily and as needed assistance from staff for dressing, personal hygiene, toileting and bathing. On 10/31/19 at 10:20am an interview occurred with the Regional MDS Consultant. After reviewing the 7/22/19 MDS, she confirmed the MDS assessment was coded incorrectly for	F 641	Regional Minimum Data Set nurse. All residents have the potential to be affected by this deficiency. On 11/13/19, the Regional Minimum Data Assessment nurse performed Quality Improvement monitoring of assessments with an Assessment Reference Date (ARD) of 10/1/19 to 11/11/19, that were completed, transmitted and accepted for accurate coding. Of the 74 assessments audited, no coding inaccuracies were identified. On 11/14/19, the Interim MDS Coordinator was re-educated by the Regional Minimum Data Set nurse on accurate coding of MDS, specifically the areas: G0110 A thru J – ADL coding, and G0120 A and B – Bathing coding, and N0300 – Injections, and N0350 – Insulin. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS assessments for Accuracy of MDS Assessments – to include ADL/Bathing coding, Injections and Insulin – on four random MDS assessments three times per week for four weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 11/18/19. The results of the Quality Assurance monitoring (audits) will be reported to the Quality Assurance & Performance Improvement Committee monthly by the Director of Nursing for twelve months and/or until substantial compliance is obtained. The Quality	

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F 641	Continued From page 7 dressing, toileting, personal hygiene and bathing. The Regional MDS Consultant explained the computerized aide documentation was changed during June and July of 2019, it was obvious the documentation was not accurate, and the Activities of Daily Living (ADL) coding failed to be questioned by the previous MDS staff member who was completing the assessment. During an interview on 10/31/19 at 11:00am, the Director of Nursing indicated it was her expectation for the MDS to be coded accurately. B) A review of Resident #143's physician order summary for July 2019 included Basaglar (an insulin) 25 units at bedtime and Novolog Flexpen sliding scale insulin twice a day at 6:30am and 8:00pm. A review of the Medication Administration Record (MAR) for Resident #143 from 7/16/19 to 7/22/19 revealed the resident received Basaglar 25 units at bedtime 4 of 7 days. The quarterly Minimum Data Set (MDS) assessment dated 7/22/19 indicated Resident #143 was cognitively intact. She was coded with insulin injections 1 of 7 days. On 10/31/19 at 10:20am an interview occurred with the Regional MDS Consultant. She reviewed the 7/22/19 MDS and July MAR, confirming the insulin injections should have been coded as 4 days instead of 1 day. During an interview on 10/31/19 at 11:00am, the Director of Nursing indicated it was her expectation for the MDS to be coded accurately.	F 641	Assurance & Performance Improvement Committee will evaluate the effectiveness of the monitoring/observations (audits) for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance & Performance Improvement Committee meets at least quarterly and consists of the Executive Director, Director of Nursing, Physician, Social Services Director, Dietary Manager and others as assigned. The Director of Nursing is responsible for implementing and executing this plan. Date of Compliance: November 18, 2019.	

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		11/18/19

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F 656	Continued From page 9 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop a comprehensive care plan in the areas of anticoagulants (Resident #4, Resident #31 and Resident #38), psychotropic medications (Resident #93), Congestive Heart Failure (Resident #94) and limited range of motion (Resident #6). This was for 6 of 23 residents reviewed for comprehensive care planning. The finding included: 1. Resident #4 was admitted on 4/19/19 with cumulative diagnoses of Cerebral Vascular Accident, urinary tract infection (UTI) and a history of an embolism to her left upper extremity. Resident #4's quarterly Minimum Data Set (MDS) dated 7/12/19 indicated she was cognitively intact and exhibited no behaviors. She was not coded for an anticoagulant. Review of Resident #4's October 2019 Physician orders included an order dated 7/15/19 which read: Eliquis (anticoagulant used to prevent blood clots) for an embolism to her left upper extremity. Review of Resident #4's undated electronic comprehensive care plan did not include a care plan for Eliquis. Interview on 10/31/19 at 9:43 AM, the Regional MDS Consultant stated the facility's MDS Nurse recently resigned. She stated the facility switched over to electronic charting in either June 2019 or July 2019 and the previous MDS Nurse was out	F 656	F656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) On 11/13/19, residents #4, #31 and #38 Care Plans were updated to accurately reflect the residents Care Plan for Anticoagulants; resident #93's Care Plan was updated to accurately reflect the residents Care Plan for Psychotropic Medications; resident #94's Care Plan was updated to accurately reflect the residents Care Plan for CHF; and resident #6's Care Plan was updated to accurately reflect the residents Care Plan for Limited Range of Motion (ROM)/prevention of further decline by the Regional Minimum Data Set nurse. All residents have the potential to be affected by this deficiency. On 11/13/19, the Regional Minimum Data Assessment nurse performed Quality Improvement monitoring of Care Plans updated in conjunction with an assessment with an Assessment Reference Date (ARD) of 10/1/19 to 11/11/19, that were completed, transmitted and accepted for Care Plan accuracy. The total number of resident care plans reviewed was 44, with 5 care plans revised to accurately reflect the resident's conditions. On 11/14/19, the Interdisciplinary Team was re-educated by the Regional	

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F 656	Continued From page 10 on leave at that time. The Regional MDS Consultant stated the previous MDS Nurses' plan was to catch up on care plans as they were due, and the facility was more focused on the Patient Driven Payment Method (PDPM) that went into effect on 10/1/19. The Regional MDS Consultant stated when the previous MDS Nurse returned from leave, she was unfamiliar with the new computer program and did not received computer training. Interview on 10/31/19 at 10:40 AM, the Administrator and Director of Nursing stated it was their expectation that Resident #4's comprehensive care plan include a care plan for her anticoagulant. 2. Resident #31 was admitted on 5/30/19 with a diagnosis of Atrial Fibrillation (A-Fib). Review of Resident #31's quarterly Minimum Data Set (MDS) dated 10/4/19 indicated he was cognitively intact and exhibited no behaviors. He was coded for A-Fib and coded for the anticoagulant for 7 of 7 days of the look back period. Review of Resident #31's October 2019 Physician orders included an order dated 7/15/19 for Eliquis (anticoagulant used to prevent blood clots) for A-Fib. Review of Resident #31's undated electronic comprehensive care plan did not include a care plan for Eliquis. Interview on 10/31/19 at 9:43 AM, the Regional MDS Consultant stated the facility's MDS Nurse	F 656	Minimum Data Set nurse on Care Planning of active Medications – Anticoagulants and Psychotropics; Diagnoses – CHF; and Limited Range of Motion (ROM)/prevention of decline to accurately reflect the resident. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of Care Plans for active Medications and Diagnoses, and Limited ROM/prevention of decline on four random Minimum Data Set (MDS) assessments three times per week for four weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 11/18/19. The results of the Quality Assurance monitoring (audits) will be reported to the Quality Assurance & Performance Improvement Committee monthly by the Director of Nursing for twelve months and/or until substantial compliance is obtained. The Quality Assurance & Performance Improvement Committee will evaluate the effectiveness of the monitoring/observations (audits) for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance & Performance Improvement Committee meets at least quarterly and consists of the Executive Director, Director of Nursing, Physician, Social Services Director, Dietary Manager and others as assigned. The Director of Nursing is responsible for implementing and executing this plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 656	Continued From page 11 recently resigned. She stated the facility switched over to electronic charting in either June 2019 or July 2019 and the previous MDS Nurse was out on leave at that time. The Regional MDS Consultant stated the previous MDS Nurses' plan was to catch up on care plans as they were due, and the facility was more focused on the Patient Driven Payment Method (PDPM) that went into effect on 10/1/19. The Regional MDS Consultant stated when the previous MDS Nurse returned from leave, she was unfamiliar with the new computer program and did not received computer training. Interview on 10/31/19 at 10:40 AM, the Administrator and Director of Nursing stated it was their expectation that Resident #31's comprehensive care plan include a care plan for his anticoagulant. 3. Resident #93 was admitted 9/5/19 with cumulative diagnoses of depression and anxiety. Review of Resident #93's admission Minimum Data Set (MDS) dated 9/12/19 indicated severe cognitive impairment and she was coded for no behaviors or mood concerns. She was not coded as taking any antidepressants or antianxiety medications. Review of Resident #93's October 2019 Physician orders included an order dated 9/16/19 for Zoloft (antidepressant) and an order dated 9/30/19 for Clonazepam (antianxiety). Review of Resident #93's undated electronic comprehensive care plan did not include a care plan for Zoloft or Clonazepam.	F 656	Date of Compliance: November 18, 2019.	

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F 656	Continued From page 12	F 656		

Interview on 10/31/19 at 9:43 AM, the Regional MDS Consultant stated the facility's MDS Nurse recently resigned. She stated the facility switched over to electronic charting in either June 2019 or July 2019 and the previous MDS Nurse was out on leave at that time. The Regional MDS Consultant stated the previous MDS Nurses' plan was to catch up on care plans as they were due, and the facility was more focused on the Patient Driven Payment Method (PDPM) that went into effect on 10/1/19. The Regional MDS Consultant stated when the previous MDS Nurse returned from leave, she was unfamiliar with the new computer program and did not received computer training.

Interview on 10/31/19 at 10:40 AM, the Administrator and Director of Nursing stated it was their expectation that Resident #93's comprehensive care plan include a care plans for her antidepressant and her antianxiety medications.

4. Resident #94 was admitted on 9/22/19 with a diagnosis of Congestive Heart Failure (CHF).

Review of Resident #94's admission Minimum Data Set (MDS) dated 9/29/19 indicated she was cognitively intact and exhibited no behaviors. She was coded for CHF and as taking a diuretic 7 of 7 days during the look back period.

Review of Resident #94's October 2019 Physician orders included an order dated 10/4/19 for Lasix (diuretic) for CHF.

Review of Resident #94's undated electronic

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F 656	Continued From page 13 comprehensive care plan did not include a care plan for CHF. Interview on 10/31/19 at 9:43 AM, the Regional MDS Consultant stated the facility's MDS Nurse recently resigned. She stated the facility switched over to electronic charting in either June 2019 or July 2019 and the previous MDS Nurse was out on leave at that time. The Regional MDS Consultant stated the previous MDS Nurses' plan was to catch up on care plans as they were due, and the facility was more focused on the Patient Driven Payment Method (PDPM) that went into effect on 10/1/19. The Regional MDS Consultant stated when the previous MDS Nurse returned from leave, she was unfamiliar with the new computer program and did not received computer training. Interview on 10/31/19 at 10:40 AM, the Administrator and Director of Nursing stated it was their expectation that Resident #94's comprehensive care plan include a care plan for her CHF. 5) Resident #38 was admitted to the facility on 2/15/19 with diagnoses that included a history of a stroke, chronic obstructive pulmonary disease	F 656		

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(COPD) and atrial fibrillation (an irregular heartbeat).

A review of the October 2019 physician order summary revealed an order for 2.5 milligrams (mg) of Eliquis (an oral anticoagulant medication) to be given as one tablet by mouth twice a day.

A review of the quarterly Minimum Data Set (MDS) dated 10/8/19 revealed the resident to be cognitively intact and required extensive assistance for Activities of Daily Living (ADL's). She was coded for an anticoagulant 7 of 7 days during the look back period.

Review of Resident #38's active care plan revealed the use of an anticoagulant medication for Atrial Fibrillation was not addressed.

On 10/31/19 at 10:20am an interview was held with the Regional MDS Consultant, who stated a care plan should have been developed for the use of an anticoagulant medication related to Atrial Fibrillation.

An interview was conducted with the Director of Nursing on 10/31/19 at 11:00am. She stated it was her expectation for Resident #38 to have a care plan related to the use of an anticoagulant medication used to treat Atrial Fibrillation.

6) Resident #6 was admitted to the facility on 7/19/19 with diagnoses that included Alzheimer's disease, history of a traumatic subarachnoid hemorrhage (blood leaks into the space between two of the membranes that surround the brain) and muscle weakness.

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F 656	Continued From page 15 The admission Minimum Data Set (MDS) assessment dated 7/26/19 revealed Resident #6 with impaired cognition. He required extensive to total assistance from staff for all Activities of Daily Living (ADL's) except setup supervision for eating. He was coded with impaired range of motion (ROM) to both lower extremities. Resident #6's active care plan was reviewed and there was no care plan developed to prevent further decline of bilateral lower extremity contractures. On 10/31/19 at 10:20am an interview occurred with the Regional MDS Consultant, who reviewed the MDS dated 7/26/19 and the active care plan. She verified a care plan was not present and stated she would have expected a care plan to be developed for the limited ROM to Resident #6's lower extremities. In an interview on 10/31/19 at 11:00, the Director of Nursing stated she expected a care plan to be developed for residents with limited ROM.	F 656		