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BRIAN CENTER HEALTH & REHABILITATION/WINDSOR	**1306 SOUTH KING STREET WINDSOR, NC 27983**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/16/22 through 5/19/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #NUZD11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/16/22 through 5/19/22. Event ID# NUZD11. The following intakes were investigated NC00188450 and NC00187697. 2 of the 4 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		6/16/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 06/03/2022

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 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to treat a resident with dignity and respect by not knocking or announcing their presence before entering in a resident ' s room for 2 of 2 resident reviewed for dignity (Resident #27 and Resident #19). Findings included: 1. Resident #27 was admitted to the facility on 8/11/21. Resident #27 ' s minimum data set assessment dated 3/28/22 revealed he was assessed as cognitively intact. During an interview on 5/16/22 at 12:30 PM Resident #27 stated it bothered him when staff did not knock or let him know they were coming in	F 550	Residents #27 and #19 suffered no ill effects related to this incident. The facility failed to treat a resident with dignity and respect by not knocking or announcing their presence before entering their rooms. All facility residents have the potential to be affected by this deficient practice. Facility staff will be in serviced on Resident rights and Dignity, with focus on proper knocking on doors and announcing oneself, getting permission from the resident prior to entering a resident's room. This will be completed by the DON/designee by on 06-16-22. The DON/desingee will audit employees during their assigned shifts to observe residents/dignity is being maintained prior to entering a resident room. Audits will be daily x 12 weeks. Results of the audits	

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the room before they just walked in. He stated staff would enter his room without knocking often and it would shock him because he might be doing something like using the urinal.

During observation on 5/16/22 at 12:32 PM Nurse #1 was observed to enter Resident #27 ' s room and did not knock or announce her presence before opening the door an entering the resident ' s room.

During an interview on 5/16/22 at 12:45 PM Nurse #1 stated staff were to knock or announce their presence prior to entering a resident room if the door was closed. She further stated she forgot to knock on Resident #27 ' s room.

During an interview on 5/16/22 at 3:00 PM the Administrator stated staff were to knock or announce presence before entering the room. He further stated staff should knock prior to entering a resident ' s room even if the room door is open to promote dignity and a homelike environment.

2. Resident #19 was admitted to the facility on 4/2/15.

Resident #19 ' s minimum data set assessment dated 3/10/22 revealed she was assessed as cognitively intact.

During observation on 5/16/22 at 12:36 PM Nurse #1 was observed to entered Resident #19 ' s room without knocking or announcing their presence. The door to the resident ' s room was open when the nurse entered.

During an interview on 5/16/22 at 12:45 PM Nurse #1 stated staff were to knock or announce

F 550

and any concerns identified will be reported/ trended to our Quality Assurance committee monthly times three and will be fixed then to make sure this will not be a continuous pattern. New hires for facility and including agency staff will be in-serviced on making sure to always knock on residents door whether it is closed or opened and to introduce self to resident and make sure that it is okay to come into the room after introduction.

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F 550	Continued From page 3 their presence prior to entering a resident room if the door was closed. She further stated because Resident #19 ' s door was open; she did not have to knock or announce her presence before entering the room. During an interview on 5/17/22 at 9:09 AM Resident #19 stated she would rather staff knock or announce their presence before entering her room but not all staff did. She stated she preferred staff knocked so she could be prepared when they came in even if the door was open. During an interview on 5/16/22 at 3:00 PM the Administrator stated staff were to knock or announce presence before entering the room. He further stated staff should knock prior to entering a resident ' s room even if the room door is open to promote dignity and a homelike environment.	F 550		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide showers (Residents #43 and #153) and failed to keep dependent residents' fingernails clean and filed or trimmed (Residents #12 and #6) for 4 of 6 residents reviewed for activities of daily living (ADL) care. Findings included:	F 677	Residents #43, #153, #12 and #6 suffered no ill effects is related to this incident. The facility failed to provide showers, and failed to keep dependent resident's fingernails clean, filed or trimmed. All facility residents have the potential to be affected by this deficient practice of not providing showers or providing fingernail care to dependent residents. DON/designee will review all	6/16/22

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1. Resident #43 was admitted to the facility on 1/04/21 with diagnoses which included Diabetes Mellitus and hemiplegia.

The quarterly Minimum Data Set dated 4/25/22 indicated Resident #43 was cognitively intact and was coded as 1-person physical help in part of bathing activity.

Resident #43's care plan last revised on 5/07/22 revealed she had a focus area for ADL self-care performance with an intervention which read in part that she required assistance by staff with bathing/showering.

An interview on 5/16/22 at 11:20 AM with Resident #43 revealed she had not been getting her showers and she wanted them. She stated she had received only 3 or 4 showers since she was admitted to the facility and she didn't know why she had not received them.

An interview on 5/17/22 at 3:53 PM with Nursing Aide (NA) #4 she stated she had never given Resident #43 a shower. She stated she had never given any residents at the facility a shower and had been unaware there was a resident shower schedule until that day.

An interview on 5/18/22 at 12:43 PM with NA #5 revealed she was assigned Resident #43 some days. She stated she had never given Resident #43 a shower, that she had always given her a bed bath. She stated she documented showers or bed baths on a shower sheet which she gave to the nurse or the Unit Coordinator.

An interview on 5/18/22 at 1:04 PM with the Unit Manager revealed he received the shower sheets

F 677

residents for appropriate shower/bathing preferences, review of documentation of shower completions and audit all fingernail care in the center, focus with diabetic residents and fingernail care they are receiving. There was an 100% audit of all residents who are on the shower list and or prefer to go to the shower, with only two residents who didn't want to go shower room and this was there preference. Facility nursing staff will be educated on showering/bathing expectations for resident's and the procedures on reporting if resident refuses shower/bath as well as the policy and procedures regarding resident fingernail care. This will be completed by the DON/designee by 6/16/2022. The DON/designee will complete a random audit on resident shower routines, fingernail care for 5x a week for the next 12 weeks to ensure nursing staff is following the policies and procedures for ADL care with showering/bathing and fingernail care. Results of the audits and any concerns identified will be reported/trended to our Quality Assurance committee monthly times three. All nursing staff which includes new hires and agency staff will be in-serviced during orientation on to make sure they are aware where the shower list is located in the assignment book and to make sure they are notifying the right person for nail care if nurse assistant isn't able to.

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and documented the shower or bed bath in a nurses' progress note in the electronic medical record.

A subsequent interview on 5/19/22 at 8:00 AM with the Unit Manager revealed he was unable to locate any shower sheets or documentation related to Resident #43 having had a shower.
An interview on 5/19/22 at 10:06 with the Director of Nursing (DON) revealed that she expected every resident to be offered and/or given a shower on their shower days and she did not know why Resident #43 had not been receiving her showers.

An interview on 5/19/22 at 7:41 AM with the Administrator revealed that residents should be showers and refusals should be documented. He further stated that agency staff and facility staff were educated about showers.

2. Resident #153 was admitted to the facility on 5/03/22.

Resident #153 did not have a completed Minimum Data Set.

Resident #153's care plan last revised on 5/16/22 revealed she had a focus area for ADL self-care performance with an intervention which read in part that she required staff assistance with personal hygiene.

An interview on 5/16/22 at 11:11 AM with Resident #153 revealed she had not been getting her showers and she wanted them. She stated she had not received a shower since she was admitted to the facility.

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An interview on 5/17/22 at 3:53 PM with Nursing Aide (NA) #4 she stated she had never given Resident #153 a shower. She stated she had never given any residents at the facility a shower and had been unaware there was a resident shower schedule until that day.

An interview on 5/18/22 at 1:04 PM with the Unit Manager revealed he received the shower sheets and documented the shower or bed bath in a nurses' progress note in the electronic medical record.

A subsequent interview on 5/19/22 at 8:00 AM with the Unit Manager revealed he was unable to locate any shower sheets or documentation related to Resident #153 having had a shower.

An interview on 5/19/22 at 10:06 with the Director of Nursing (DON) revealed that she expected every resident to be offered and/or given a shower on their shower days and she did not know why Resident #153 had not been receiving her showers.

An interview on 5/19/22 at 7:41 AM with the Administrator revealed that residents should be showers and refusals should be documented. He further stated that agency staff and facility staff were educated about showers.

3. Resident #12 was admitted to the facility on 9/19/14. His active diagnoses included hemiplegia following cerebral infarction affecting left non-dominate side and diabetes mellitus.

A review of Resident #12 ' s minimum data set assessment dated 3/9/22 revealed he was

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assessed as severely cognitively impaired. He was documented to have no behaviors. Resident #12 required extensive assistance by one staff for personal hygiene.

A review of Resident #12 ' s care plan dated 3/23/22 revealed he was care planned for activities of daily living self-care performance deficit related to hemiplegia, cerebrovascular incident, and dementia. The interventions included to provide assistance by staff with personal hygiene.

During observation on 5/16/22 at 12:16 PM Resident #12 was observed to have long, untrimmed fingernails.

During observation on 5/18/21 at 8:10 AM Resident #12 was observed to again have long, untrimmed fingernails.

During an interview on 5/18/22 at 8:11 AM Nurse Aide #1 stated nurse aides did not trim nails for diabetic residents and Resident #12 was diabetic. She further stated during morning care, staff would inform the nurse of any concerns with long nails for diabetic residents. Upon observing Resident #12 ' s nails she stated the nails should have been reported to the nurse prior to now. She concluded she had worked with the resident many times, he got his morning care on the night shift, and she had not noticed his nails being long which was why she had not reported it.

During an interview on 5/18/22 at 8:15 AM Nurse #3 stated he had not been informed that Resident #12 ' s nails needed to be trimmed and had not observed them himself.

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During an interview on 5/18/22 at 8:19 AM the Director of Nursing stated nurse aides would observe the nails on residents during activities of daily living care and if the resident was diabetic, they should report long nails to the nurse to be trimmed. Upon observing Resident #12 ' s nails the Director of Nursing stated the residents ' nails were long should have been reported to the nurse as the resident was diabetic so they could get the nails trimmed.

4. Resident #6 was admitted to the facility on 02/28/2022 with diagnoses of left hip fracture and dementia.

A review of her 5-day Minimum Data Set (MDS) assessment dated 03/07/2022 revealed she was moderately cognitively impaired. She had no behaviors or rejection of care. Resident #6 required the extensive assistance of 2 people for dressing and the extensive assistance of 1 person for personal hygiene. She was totally dependent for bathing.

A review of the current comprehensive care plan for Resident #6 revealed the focus area initiated on 03/03/2022 of activities of daily living (ADL) self-performance deficit related to left hip fracture and dementia. The goal was for Resident #6 to improve her current level of function through the next review. An intervention was assistance with bathing, personal hygiene, and oral care.

On 05/17/2022 at 11:14 AM an observation of Resident #6 revealed fingernails on both hands that were broken and jagged. An interview with Resident #6 at that time indicated she got a bath daily. She stated she knew her fingernails needed attention but she was not able to clip or file them

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because she did not have any equipment. She stated they really didn't bother her and evidently did not bother the staff. She went on to say if someone had offered to trim or file her fingernails, she would have gladly accepted. Resident #6 stated she had not asked staff to trim or file her fingernails because she did not want to be a bother. She went on to say she did not recall staff offering to do this.

On 05/17/2022 at 4:00 PM an observation of Resident #6 revealed fingernails on both hands remained broken and jagged.

A review of the Nursing Daily Skilled Charting form dated 05/17/2022 at 11:15 AM revealed documentation by Nurse #4 indicating Resident #6's fingernails were clean and trimmed.

On 05/18/2022 at 1:09 PM an observation of Resident #6 revealed fingernails on both hands remained broken and jagged.

A review of the Nursing Daily Skilled Charting form dated 05/18/2022 at 11:15 AM revealed documentation by Nurse #3 indicating Resident #6's fingernails were not clean and trimmed.

On 05/19/2022 at 8:07 AM an observation of Resident #6 revealed fingernails on both hands remained broken and jagged. An interview with Resident #6 at that time indicated she had her bath that morning.

On 05/19/2022 at 8:11 AM an interview with NA #3 indicated she provided a bath and ADL care to Resident #6 on 05/18/2022 on the 7AM-3PM shift. She went on to say she was also assigned to Resident #6 today but Resident #6 already had

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her bath on the previous shift when she got to work this morning. She stated bathing included washing Resident #6's hands. NA #3 went on to say she had not really paid attention to Resident #6's fingernails . She stated she did not notice if they were broken or jagged. She further indicated Resident #6 had not asked and she had not offered to trim or file Resident #6's fingernails. NA #3 went on to say if she noticed a resident's fingernails needed trimming or filing, she would either do this herself or let the nurse know.

On 05/19/2022 at 8:13 AM an interview with Nurse #3 indicated he completed the Nursing Daily Skilled Charting form for Resident #6 dated 05/18/2022. He stated he had not noticed Resident #6's broken and jagged fingernails. He further indicated she had not asked and he had not offered to trim or file them. He stated he documented they were not clean and trimmed because he had not done this. He went on to say he didn't really know what the procedure was for the care of a resident's fingernails, but if he noticed fingernails needing cleaning or trimming, he would do it.

On 05/19/2022 at 8:18 AM an observation of Resident #6's fingernails was conducted with the Unit Coordinator (UC). An interview with the UC at that time indicated Resident #6 had broken and jagged fingernails on both hands. He stated observation of Resident #6's fingernails was part of her daily bathing care and was included on the Nursing Daily Skilled Charting form. He went on to say either the NA performing Resident #6's bath or the nurse completing the observations for the Daily Skilled Charting form should have noticed Resident #6's broken and jagged fingernails and offered to trim or file them.

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On 05/19/2022 at 8:24 AM an observation of Resident #6's fingernails was conducted with the Director of Nursing (DON). The DON stated she would have expected the NA assisting Resident #6 with her daily bath or the nurse completing the Daily Skilled Charting form to have noticed her broken and jagged fingernails and offered to trim or file them.

On 05/19/2022 at 08:42 AM an interview with Nurse #4 indicated she completed the Daily Skilled Charting form for Resident #6 dated 05/17/2022. She stated she did not actually assess the condition of Resident #6's fingernails. She went on to say she documented that Resident #6's fingernails were clean and trimmed on the Daily Skilled Charting form because staff did do that for residents at times. Nurse #4 further indicated if she had noticed Resident #6's fingernails were broken and jagged she would have offered to trim or file them.

On 05/19/2022 at 8:46 AM an interview with NA #2 indicated she provided Resident #6 with her daily bath on 05/16/2022. She stated this included washing Resident #6's hands. NA #2 stated she had not noticed if Resident #6 had broken or jagged fingernails. She went on to say she had not offered to trim or file them. She further indicated if she noticed a resident's fingernails needed trimming or filing, she would do this herself unless the resident was a diabetic. NA #2 stated Resident #6 was not a diabetic.

On 05/19/2022 at 10:48 AM an interview with the Administrator indicated care of Resident #6's fingernails should be addressed during her daily bathing care.

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F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		6/16/22

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F 756	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff, Consultant Pharmacist, and Physician interviews, the Pharmacy Consultant failed to identify and address the need to monitor the Levothyroxine (medication for hypothyroidism) for 1 of 6 residents reviewed for unnecessary medications (Resident #42). Findings included: Resident #42 was admitted to the facility on 10/28/16 with diagnoses which included hypothyroidism. A Physician's order dated 10/02/20 indicated Levothyroxine Sodium Table 25 micrograms (mcg) to give 1 tablet by mouth one time a day for hypothyroid. A Physician's order dated 10/02/20 indicated Synthroid tablet 100 mcg (Levothyroxine Sodium) to give 2 tablets by mouth one time a day for hypothyroid. Reviews of the Consultant Pharmacist monthly drug regimen reviews for August 2021 through May 2022 for Resident #42 revealed no recommendations to obtain laboratory work to monitor her thyroid level. An interview on 5/19/22 at 9:14 AM with the Consultant Pharmacist revealed she should have recommended laboratory work to monitor Resident #42's thyroid level. She stated that Resident #42 should have had a thyroid level completed in December 2021 or January 2022. She stated she did not know why it had not been	F 756	Resident #42 suffered no ill effects related to this incident. The Pharmacy Consultant failed to identify and address the need to monitor the Levothyroxine for 1 of 6 residents reviewed for unnecessary medication. All Facility residents that are currently on Levothyroxine have the potential to be affected by this deficient practice of not obtaining a TSH level per consultants' recommendation and physician order. DON/designee will review all residents that have been prescribed Levothyroxine to ensure any monitoring via laboratory is implemented per protocols of the Pharmacy consultant and physician orders. There was a 100% audit completed on 6/6/22 with no new findings. Pharmacy consultant will be educated on the guidelines for recommendations on any resident receiving Levothyoxine medication for Hypothyroidism. This education including the rationale for when and why we are to obtain TSH labs while any resident is prescribed this medication. This will be completed by the DON/designee by 6-16-2022. The DON/designee will audit all residents currently taking Levothyroxine for Hypothyroidism for TSH laboratory monitoring per Medical Doctor orders and pharmacy consultant recommendations, this includes new admissions on that same medication, as well as if resident is prescribed that medication during their medical stay at the facility. This audit will be performed 3x times a week for 12 weeks to ensure proper recommendations	

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F 756	Continued From page 14 done and she had just missed it. An interview on 5/18/22 at 4:24 PM with the Physician revealed that Resident #42 should have had thyroid level laboratory work completed. He stated it must have 'fallen through the cracks.' He also stated that the Consultant Pharmacist should have caught the oversight and recommended it to him. An interview on 5/19/22 at 7:38 AM with the Administrator revealed that he expected the Physician and the Consultant Pharmacist to obtain the necessary laboratory work to ensure residents medications were monitored.	F 756	have been completed by the pharmacy consultant for monitoring thyroid levels per policy for all residents on Levothyroxine medication. Results of the audits and any concerns identified will be reported/trended to our Quality Assurance committee monthly for three times. All new nurses that are hired for the facility, including agencies will be on educated in orientation on to make sure they are aware of residents who are currently on medication for hypothyroidism and making sure proper labs are ben obtained and any recommendations are followed up on in a timely manner.	
F 757 SS=E	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	F 757		6/16/22

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F 757	Continued From page 15 stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and Physician interviews, the facility failed to monitor the thyroid level (Thyroid-stimulating hormone) (TSH) for 1 of 6 residents reviewed for unnecessary medications (Resident #42). Findings included: Resident #42 was admitted to the facility on 10/28/16 with diagnoses which included hypothyroidism. Review of Resident #42's care plan last revised on 2/27/22 revealed a focus for hypothyroidism with interventions which read in part to obtain lab or diagnostic work as ordered. Review of Resident #42's lab work revealed her most recent TSH had been completed in December 2020. A Physician's order dated 10/02/20 indicated Levothyroxine Sodium Table 25 micrograms (mcg) to give 1 tablet by mouth one time a day for hypothyroid. A Physician's order dated 10/02/20 indicated Synthroid tablet 100 mcg (Levothyroxine Sodium) to give 2 tablets by mouth one time a day for hypothyroid. Reviews of the Consultant Pharmacist monthly drug regimen reviews for August 2021 through May 2022 for Resident #42 revealed no recommendations to obtain TSH laboratory work	F 757	1. Resident #42 suffered no ill effects related to this incident. The facility failed to monitor the TSH laboratory value per policy for 1 of 6 residents reviewed for unnecessary medications. 2. All Facility residents that are currently on Hypothyroid medications that require a TSH laboratory value for monitoring have the potential to be affected by this deficient practice. A physician order is needed for the necessary laboratory work (TSH), to ensure residents� medications were monitored per policy. DON/designee will review all residents that have been prescribed medication requiring a TSH level to be obtained to ensure the physician is aware to order the TSH orders for monitoring of TSH levels. This audit was completed on 06-09-2022. 3. Facility nursing staff and physician services will be educated regarding the guidelines for recommendations on any resident receiving a medication for Hypothyroidism and requiring a TSH level to be ordered and monitored. This education including the rationale for when and why we are to obtain TSH labs while any resident is prescribed this medication. This will be completed by the DON/ designee by 06/16/2022. 4. The DON/ designee will audit all residents currently taking medication for Hypothyroidism for TSH laboratory monitoring per Md orders and pharmacy consultant recommendations, this	

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F 757	Continued From page 16 to monitor her thyroid level. An interview on 5/18/22 at 4:24 PM with the Physician revealed that Resident #42 should have had TSH level laboratory work completed. He stated it must have 'fallen through the cracks.' An interview on 5/19/22 at 10:06 AM with the Director of Nursing (DON) revealed that Resident #42 should have had a TSH level completed and she did not know why it had not been completed. An interview on 5/19/22 at 7:38 AM with the Administrator revealed that he expected the Physician to obtain the necessary laboratory work to ensure residents medications were monitored.	F 757	includes and all new admissions on that same medication, as well as if a resident is prescribed that medication during their medical stay at the facility. This audit will be performed daily x 12 weeks. Results of the audits and any concerns identified will be reported/ trended to our Quality Assurance committee monthly times three. 5. Compliance date: 06/16/2022	
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. §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	F 842		6/16/22

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§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 there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening

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F 842	Continued From page 18 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 and staff interviews the facility failed to accurately document on a resident ' s medication administration record nine times when a medication was not administered. This was evidenced in 1 of 6 residents reviewed for unnecessary medications. (Resident #27) Findings included: Resident #27 was admitted to the facility on 8/11/21. His active diagnoses included diabetes mellitus. Resident #27 ' s order dated 8/15/21 revealed he was ordered insulin aspart flexpen 100 units per 1 milliliter insulin pen inject 5 units subcutaneously before meals for diabetes mellitus. Hold insulin if blood sugar was less than 150. Review of the medication administration record for May 2022 revealed on 5/1/22 at 11:30 AM Resident #27's blood sugar was 101 and at 4:30 PM his blood sugar was 121. He was documented with a check mark to have received 5 units of insulin both times. On 5/5/22 at 11:30 AM his blood sugar was 127 and at 4:30 PM his blood sugar was 142. He was documented with a check mark to have received 5 units of insulin both times. On 5/7/22 at 4:30 PM his blood sugar was 118. He was documented with a check mark to have received 5 units of insulin at that time. On	F 842	Resident #27 suffered no ill effects related to this incident. The facility failed to accurately document in a resident's medication administration record nine times when a medication was not administered. All facility residents that are on insulin administration for treatment for their diabetic condition potentially can be affected by this deficient practice DON/designee will review all residents that have been prescribed insulin to ensure that the medication administration records are accurate and documented correctly on the Electronic Health Record. Facility licensed nursing staff will be educated in regard to proper documentation in the Electronic Health Record to reflect accuracy and documented correctly per the physicians orders. This will be completed by the DON/designee by 6-16-2022. The DON/designee will audit all residents currently prescribed insulin to ensure the medication administration records are accurate and documented correctly in the Electronic Health Record. This audit will be performed daily for 12 weeks. Results of the audits and any concerns identified will be reported/trended to our Quality Assurance committee monthly times three. All new staff for the facility including	

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5/8/22 at 11:30 AM his blood sugar was 138 and at 4:30 PM his blood sugar was 122. He was documented with a check mark to have received 5 units of insulin both times. On 5/14/22 at 11:30 AM his blood sugar was 139 and at 4:30 PM his blood sugar was 120. He was documented with a check mark to have received 5 units of insulin both times. These were documented by Nurse #2.

During an interview on 5/17/22 at 1:55 PM Nurse #2 stated if there was a check mark on the medication administration record, it meant the medication was given to the resident at that time. She further stated she did not give 5 units of insulin to Resident #27 on the days his blood sugar was below 150 in accordance with the orders, however the program on the computer would not let her continue unless she entered something so she had documented the blood sugar and route and location she would have used if it was over 150. She concluded she did not document correctly on the days his blood sugar was under 150 and she should have written a note and did not.

During an interview on 5/17/22 at 2:25 PM the Director of Nursing stated medication administration records should be accurate and documented correctly. She further stated because the nurse was new to the system, she was unaware how to continue charting medication pass without entering the medication as given which resulted in the inaccurate documentation.

agency will be in-serviced to make sure they are properly documenting in the residents Electronic Health Record the correct amount of administrations.