

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2016
NAME OF PROVIDER OR SUPPLIER MOUNT OLIVE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365		
(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 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and record review, the facility failed to provide dignity to 1 of 4 residents by placing the continent resident in incontinence briefs during the day (Resident #5). Findings included: Resident #5 was admitted on 11/13/15 with diagnoses which included flaccid hemiplegia affecting left non-dominant side. Review of Resident #5's most recent Minimum Data Set (MDS) dated 7/30/16, coded as a quarterly assessment, revealed the resident was assessed as having a Brief Interview for Mental Status (BIMS) of 14 (cognitively intact). Resident #5 was assessed as totally dependent for transfers and totally dependent on staff for toilet use. Resident #5 was assessed as always continent of bowel and bladder and required two people to assist with transfers. Resident #5 was recorded as 60 inches tall and weighed 120 pounds. Review of Resident #5's care plan updated 8/2/16 revealed the resident was care planned for Activities of Daily Living (ADL) care related to cerebrovascular disease. The goal was that the resident's ADL care needs will be anticipated and met in order to maintain the highest practicable level of functioning and physical well-being through next review. One listed intervention in the</p>	F 241	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mount Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F 241</p> <p>Resident # 5 was discharged on 10/7/16</p> <p>Other residents that may be affected by this practice will be identified by Social Services conducting interviews of residents of a BIMS of 10 and above regarding if they are given a choice of wearing a brief and any other dignity issues and lack of respect that may have occurred. Residents with a BIMS of 10 and below, Social Services will call the responsible party to ask if the residents were given a choice of wearing a brief or</p>	10/12/16	

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

TITLE

(X6) DATE

Electronically Signed

10/07/2016

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 241	<p>Continued From page 1</p> <p>care plan was to assist with transfers/toileting. Review of Resident #5's ADL record for September revealed she was recorded as continent during 18 of the last 26 days on day shift including the date of the review. The resident was also recorded as continent for 18 days, incontinent for 2 days and not recorded for 6 days of the last 26 days during the evening shift. During an interview on 9/26/16 at 1:55 PM, Resident #5 stated she was now being placed in an incontinence brief during the daytime. She further stated that she did not like wearing an incontinence brief during the day but there was nothing she could do about it. She further stated she was currently wet and did not try to hold it because there was no point if they were putting her in incontinent briefs. Resident #5 stated the Nurse Aide (NA) told her she did not want to put Resident #5 in a incontinence brief but that she had to follow the rules. She declined to give the NA's name. When asked how having to wear a incontinence brief made her feel, the resident repeated that she did not like it and it made her feel like a baby.</p> <p>During observation on 9/26/16 at 2:25 PM NA #1 performed incontinent care on the resident. The resident was observed to be in an incontinence brief at this time.</p> <p>In a staff interview on 9/26/16 at 2:30 PM, NA #1 stated she was told Resident #5 had to wear briefs. NA #1 stated that other NAs had told her that. She further stated the resident was able to let her know when she needed to go to the bathroom and was continent during the day.</p> <p>During another interview on 9/26/16 at 3:00 PM, Resident #5 stated she knew when she needed to urinate. She further stated that before they put</p>	F 241	<p>other dignity issues and lack of respect that may have occurred.</p> <p>The nursing staff, including week-end and part time staff, will be re-educated on treating the residents with dignity, respecting their individuality and giving resident choices in care by Center Nursing Executive (CNE) on October 7, 8, 9, 10, 11, and 12, 2016. The Nursing Supervisors, Assistant Center Nursing Executive (ACNE) and CNE will complete Dignity rounds on six residents on each shift (first, second, and third) including week ends three times weekly for one month, then weekly for 2 months. Social Services will conduct interviews on 10 residents with a BIMS of 10 and above concerning any dignity and lack of respect of individuality that may have occurred weekly for 3 months. Five residents with a BIMS below 10, responsible party will be interviewed regarding treatment of family member in center with respect of individuality and dignity.</p> <p>The results of the Dignity rounds will be reviewed by the CNE and any trends presented to QA committee monthly for 3 months. Results of interviews regarding dignity and respect for individuality will be presented to the QA committee by Social Services for 3 months.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	<p>Continued From page 2</p> <p>her in briefs, about a week ago, she had been holding it until her call bell was answered. Resident #5 stated that the times she had become incontinent on day and evening shift this month were when she had waited a long time for the call bell to be answered. She continued to state that in the last week she was being placed in incontinent briefs during the day and did not like it. The resident stated she does not know why they want her to wear a incontinence brief.</p> <p>During an interview on 9/26/16 at 4:20 PM NA #2 stated that the NAs will document on the ADL sheets if a resident was continent or incontinent. The NA further stated that Resident #5 was able to let her know when she needed to go or not and can usually hold it during the day. She further stated that in this facility the NAs cannot physically lift a resident up who cannot stand on their own without a mechanical lift. She stated the resident does not like the mechanical lift and because the resident refuses to be lifted by the mechanical lift to the bedside commode, she had been put in incontinent briefs.</p> <p>During a staff interview on 9/27/16 at 9:00 AM the Director of Nursing (DON) stated the resident was alert and oriented. The DON further stated she did not know about any decline in ADLs and stated that her expectation for any resident who is continent was that the resident be placed on the toilet or the bedside commode when toileting. The DON further stated that the last thing she would want is for a resident who is continent to be soiling themselves and was not aware that the resident was being placed in incontinent briefs.</p> <p>During an interview on 9/27/16 at 9:11 AM, Nurse #1 stated the resident was alert and oriented and</p>	F 241			

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F 241	Continued From page 3 was continent during the day. The nurse stated she was being placed in an incontinence brief because she was refusing to be lifted by the mechanical lift. The nurse dated Resident #5 uses the bathroom a lot and having to move her that much was strenuous on anyone.	F 241			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and record review, the facility failed to allow 1 of 1 continent residents (Resident #5) to choose not to wear incontinent briefs during the day. Findings included: Resident #5 was admitted on 11/13/15 with diagnoses which included flaccid hemiplegia affecting left non-dominant side. Review of Resident #5's most recent Minimum Data Set dated 7/30/16, coded as a quarterly assessment, revealed the resident was assessed as having a Brief Interview for Mental Status (BIMS) of 14 (cognitively intact). Resident #5 was assessed as totally dependent for transfers and totally dependent on staff for toilet use. Resident #5 was assessed as always continent of bowel and bladder and required two people to assist	F 242	F 242 Resident #5 Was discharged on 10/7/16 Other residents that may be affected by this practice will be identified by Social Services conducting interviews of residents of a BIMS of 10 and above regarding if they are given a choice of wearing a brief and other dignity issues and lack of respect that may have occurred. Residents with a BIMS of 10 and below, Social Services will call the responsible party to ask if they were given. The nursing staff, including week-end and part time staff, will be reeducated on	10/12/16	

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F 242	<p>Continued From page 4</p> <p>with transfers. Resident #5 was recorded as 60 inches tall and weighed 120 pounds. Review of Resident #5's care plan updated 8/2/16 revealed the resident was care planned for Activities of Daily Living (ADL) care related to cerebrovascular disease. The goal was that resident's ADL care needs will be anticipated and met in order to maintain the highest practicable level of functioning and physical well-being through next review. One listed intervention was to assist with transfers/toileting.</p> <p>Review of Resident #5's ADL record for September revealed she was recorded as continent during 18 of the last 26 days on day shift including the date of the review. The resident was also recorded as continent for 18 days, incontinent for 2 days and not recorded for 6 days of the last 26 days during the evening shift. During an interview on 9/26/16 at 1:55 PM, Resident #5 stated that she was now being placed in an incontinence brief during the daytime. She stated that she did not like wearing an incontinence brief during the day but there was nothing she could do about it. Resident #5 stated she had told the staff. She further stated the Nurse Aide (NA) told her she didn't want to put Resident #5 in an incontinence brief but that she had to follow the rules. She declined to give the NA's name. When asked how having to wear an incontinence brief made her feel, the resident repeated that she did not like it and it made her feel like a baby.</p> <p>During observation on 9/26/16 at 2:25 PM NA #1 performed incontinent care on Resident #5. The resident was observed to be in incontinent briefs at this time.</p> <p>In a staff interview on 9/26/16 at 2:30 PM NA#1 stated she was told Resident #5 had to wear</p>	F 242	<p>treating the residents with dignity, respecting their individuality and giving resident choices in care by Center Nursing Executive (CNE) on October 7, 8, 9, 10, 11, and 12, 2016. The Nursing Supervisors, Assistant Center Nursing Executive (ACNE) and CNE will complete Dignity rounds on six residents on each shift (first, second, and third) including week ends three times weekly for one month, then weekly for 2 months. Social Services will conduct interviews on 10 residents with a BIMS of 10 and above concerning any dignity, lack of respect of individuality and being allowed to make choices in care that may have occurred weekly for 3 months. Five residents with a BIMS below 10, responsible party will be interviewed regarding treatment of family member in center with respect of individuality and dignity.</p> <p>The results of the Dignity rounds will be reviewed by the CNE and any trends presented to QA committee monthly for 3 months. Results of interviews regarding dignity and respect for individuality will be presented to the QA committee by Social Services for 3 months.</p>		

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F 242	<p>Continued From page 5</p> <p>incontinent briefs. She stated that other NAs had told her that. She further stated the resident was able to let her know when she needed to go to the bathroom and was continent during the day.</p> <p>During another interview on 9/26/16 at 3:00 PM, Resident #5 stated she was able to know when she needed to urinate. She further stated that before they put her in an incontinence brief about a week ago she had been holding it until her call bell was answered. Resident #5 stated that the times she had become incontinent on day and evening shift this month were when she had waited a long time for the call bell to be answered. She continued to state that in the last week she is now being placed in briefs during the day and doesn't like it. The resident stated that it was because of the facility that she was being put in incontinent briefs during the day. The resident stated she does not know why they are pushing for her to wear an incontinence brief.</p> <p>During an interview on 9/26/16 at 4:20 PM NA #2 stated that the NAs will document on the ADL sheets if a resident was continent or incontinent. The NA further stated that Resident #5 was able to let her know when she needed to go or not and can usually hold it during the day. She further stated that in this facility the NAs cannot physically lift a resident up who cannot stand on their own without a mechanical lift. She stated the resident does not like the mechanical lift and because the resident refuses to be lifted by the mechanical lift to the bedside commode, she has been put in incontinent briefs.</p> <p>During a staff interview on 9/27/16 at 9:00 AM the Director of Nursing (DON) stated she did not know about any decline in ADLs and stated that</p>	F 242			

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F 242	Continued From page 6 her expectation for any resident who was continent was that the resident be placed on the toilet or the bedside commode when toileting. The DON further stated the last thing she would want was for a resident who was continent to be soiling themselves and was not aware that the resident was being placed in incontinence briefs.	F 242			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review, the facility failed to transcribe an order to discontinue Enablex as ordered by the Nurse Practitioner (NP) for 1 of 3 residents (Resident #5). Findings included: Resident #5 was admitted on 11/13/15 with diagnoses which included flaccid hemiplegia affecting the left non-dominant side. Review of Resident #5's most recent Minimum Data Set dated 7/30/16, coded as a quarterly assessment, revealed the resident was assessed as having a Brief Interview for Mental Status (BIMS) of 14 (cognitively intact). Review of resident's physician's order dated 8/5/16 revealed the resident's Nurse Practitioner discontinued the order for Enablex due to increased confusion, drowsiness, abdominal discomfort, constipation, and over active bladder. Review of the resident's medication administration record (MAR) for August revealed	F 281	F 281 Resident # 5 Was discharged on 10/7/16 Other residents that may be affected by this practice were identified by a chart review of orders that the physician hand wrote from July to Sept by the Unit Supervisors the week of October 3, 2016. Any missed orders were clarified with the physician and transcribed. The 100% chart audit revealed 6 missed orders that have now been corrected. Licensed nurses were reeducated on the process of transcription of orders when handwritten by the physician on October 7, 8, 9, 10, 11, and 12, 2016 by the Center Nurse Executive (CNE). The third shift licensed nurses were reeducated on the process of 24 hour chart check for all in house residents which includes review of	10/12/16	

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F 281	<p>Continued From page 7</p> <p>the order to discontinue Enblex was not transcribed until 8/7/16 resulting in one extra dose being given on 8/6/16.</p> <p>Review of the resident's chart revealed the 24 hour orders audit dated 8/6/16 at 1 AM had been performed by Nurse #3. Enblex was not marked as discontinued at that time for Resident #5.</p> <p>During a resident interview on 9/26/16 at 3:00 PM Resident #5 stated that on 8/7/16 she noticed that she was still being given Enblex in the mornings. Stated she told Nurse #4 she had been taken off the medication and refused to take it. The resident reported Nurse #4 reviewed the chart and found the order to discontinue the medication.</p> <p>During an interview on 9/27/16 at 2:29 PM Nurse #2 stated that if she initialed the MAR for Resident #5 then she did give medication. She further stated she remembered giving the medication once to resident #5, and she was not aware that the medication had been discontinued. Nurse #2 stated she would not have given a discontinued medication.</p> <p>During an interview on 9/27/16 at 2:35 PM the Nurse Practitioner stated that she intended for her order to discontinue Enblex for Resident #5 to take effect on the day she signed it which was 8/5/16. She further stated that she doubted the order would have been discontinued on 8/5/16 as it was a morning medication, however she would have expected it to not be given the next day. She stated that she alerts the staff that she has written a new order by folding over the order so that it sticks out of the chart to flag it for the staff.</p>	F 281	<p>handwritten orders and comparing charting, order sheets and comparing the order to the Medication/Treatment administration records to ensure the order has been completed by the CNE on October 12, 2016. The third shift licensed nurses will continue to complete 24 hour chart checks nightly. If an order is missed by the third shift nurse, re-education will be provided by the CNE for the first offense, and then if another offense occurs the progressive disciplinary process will be implemented. The unit supervisors and Assistant Center Nurse Executive (ACNE) will conduct an audit on resident's charts for handwritten orders 5 days a week to ensure that orders have been transcribed correctly. Also the unit supervisors will audit orders entered into Point Click Care 5 days a week to ensure that orders are processed correctly.</p> <p>The audits will be reviewed by the CNE every two weeks for trends. Trends will be presented to the QA Committee every two weeks for 3 months by the CNE. The two week review of results (15th and end of month) will be captured through an Ad-Hoc QAPI Meeting conducted by the Center Executive Director (CED) with the CNE, Assistant CNE, NPE and Unit Managers in attendance to review results and make any necessary adjustments to assure continued compliance.</p>		

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F 281	Continued From page 8 During a staff interview on 9/28/16 at 9:05 AM, Nurse #4 stated on 8/7/16 she did attempt to give Resident #5 a dose of Enablex and the resident told her the medication was discontinued. She stated she found the order and marked it as discontinued on the MAR. During a staff interview on 9/28/16 at 10:11 AM, the Director of Nursing (DON) stated the Nurse Practitioner writes the order and then folds it over so that it is flagged. The DON stated that Resident #5's order for Enablex was discontinued on 8/5/16 and Resident #5's MAR indicated the order was discontinued on 8/7/16 and was incorrect resulting in one extra dose of Enablex being given on 8/6/16. The DON further stated that it was her expectation that a discontinue order would take effect the day it was written.	F 281			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and record review, the facility failed to develop an effective toileting program for 1 of 1	F 315	F 315 Resident #5 Was discharged on 10/7/16	10/12/16	

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F 315	<p>Continued From page 9</p> <p>resident (Resident #5) to maintain daytime continence.</p> <p>Findings included:</p> <p>Resident #5 was admitted on 11/13/15 with diagnoses which included flaccid hemiplegia affecting left non-dominant side.</p> <p>Review of Resident #5's most recent Minimum Data Set dated 7/30/16, coded as a quarterly assessment, revealed the resident was assessed as having a Brief Interview for Mental Status (BIMS) of 14 (cognitively intact). Resident #5 was assessed as totally dependent for transfers and totally dependent on staff for toilet use. Resident #5 was assessed as always continent of bowel and bladder and required two people to assist with transfers. Resident #5 was recorded as 60 inches tall and weighed 120 pounds.</p> <p>Review of Resident #5's care plan updated 8/2/16 revealed the resident was care planned for Activities of Daily Living (ADL) care related to cerebrovascular disease. The goal was that resident's ADL care needs will be anticipated and met in order to maintain the highest practicable level of functioning and physical well-being through next review. One listed intervention was to assist with transfers/toileting.</p> <p>Review of Resident #5's ADL record for September revealed she was recorded as continent during 18 of the last 26 days on day shift including the date of the review. The resident was also recorded as continent for 18 days, incontinent for 2 days, and not recorded for 6 days of the last 26 days during the evening shift. During observation on 9/26/16 at 2:25 PM Nurse Aid (NA) #1 performed care for the resident. The resident was observed to be in an incontinence brief at this time.</p> <p>In a staff interview on 9/26/16 at 2:30 PM, NA #1</p>	F 315	<p>Other residents that may be affected by this practice were identified by completing a Urinary incontinence evaluation that was completed by the unit supervisors and ACNE on October 7, 2016.</p> <p>The licensed nurses were reeducated on the completion of the Urinary incontinence evaluation, Urinary Nursing Intervention and 3 day continence management diary by the CNE on October 7, 8, 9, 10, 11, and 12, 2016. Certified Nursing assistants were reeducated on the completion of the 3 day continence management diary by the CNE on October 7, 8, 9, 10, 11, and 12, 2016. Toileting programs will be implemented according to the results of the 3 day continence management diary by the unit supervisors and ACNE for identified residents. Newly admitted residents will have the Urinary incontinence evaluation completed on admission by the admitting nurses. Resident will be reevaluated when there is a change in continence by the licensed nurses. The Unit supervisor will monitor the completion of the 3 day continence management diary that is completed by the certified nursing assistants. Any Urinary incontinence evaluation completed will be review in clinical stand up 5 days a week by the Interdisciplinary team.</p> <p>The CNE will bring any trends of noncompliance to QA monthly for 3 months.</p>		

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NAME OF PROVIDER OR SUPPLIER MOUNT OLIVE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365		
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F 315	<p>Continued From page 10</p> <p>stated she was told Resident #5 had to wear briefs by other staff. She further stated the resident was able to let her know when she needed to go to the bathroom and was continent during the day.</p> <p>During another interview on 9/26/16 at 3:00 PM, Resident #5 stated she was able to know when she needed to urinate. She further stated that before they put her in briefs, about a week ago, she had been holding it until her call bell was answered. Resident #5 stated that the times she had become incontinent on day and evening shift this month were when she had waited a long time for the call bell to be answered. She continued to state that in the last week she is now being placed in briefs during the day and doesn't like it. The resident stated that it was because of the facility that she was being put in incontinent briefs during the day and she does not know why they were pushing for her to wear an incontinence brief.</p> <p>During an interview on 9/26/16 at 4:20 PM NA #2 stated that the NAs will document on the ADL sheets if a resident was continent or incontinent. The NA further stated that Resident #5 was able to let her know when she needed to go or not and can usually hold it during the day. NA #2 stated she doesn't know why the resident was using briefs during the day. She further stated this is a facility that you cannot physically lift the resident up who cannot stand on their own without a mechanical lift but the resident does not like the mechanical lift. Because the resident cannot be lifted to the bedside commode, she has been placed in incontinent briefs.</p> <p>During a staff interview on 9/27/16 at 9:00 AM the</p>	F 315			

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F 315	<p>Continued From page 11</p> <p>Director of Nursing (DON) stated when she came to the facility in June, the NAs were telling her that they were having a hard time lifting the resident to the bedside commode. She further stated the resident was alert and oriented and the family does not want the resident to be lifted with a mechanical lift. She stated that any time they need to transfer the resident including, for toileting, they should use the mechanical lift to transfer the resident. The staff spoke with the resident and spoke with the sister about transferring the resident with the mechanical lift and they were not happy with the plan. The DON stated she did not know about any decline in ADLs and stated that her expectation for any resident who was continent was that the resident be placed on the toilet or the bedside commode when toileting. The DON further stated that the last thing she would want was for a resident who is continent to be soiling themselves and was not aware that the resident was being placed in incontinent briefs.</p> <p>During an interview on 9/27/16 at 9:11 AM, Nurse #1 stated the resident was alert and oriented and was continent during the day. She further stated she had no standing abilities and cannot bear weight on her legs. The resident should be a mechanical lift but the family insists that the resident be moved by the NAs which caused a lot of tension especially with no upper management in the facility. The nurse stated she was being placed in an incontinence brief because she was refusing to be lifted by the mechanical lift. Nurse #1 added Resident #5 used the bathroom a lot and having to move her that much was strenuous on anyone. She further stated the resident had no leg power and was not a candidate for a sit to stand lift.</p>	F 315			

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F 520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facilities quality assurance (QA) committee failed to prevent the reoccurrence of deficient practice related to failing to transcribe a resident's order which resulted in a repeat citation at F281. Findings Included: This tag is cross referenced too: F281: Professional Standards: Based on resident interview, staff interview, and record review, the</p>	F 520	<p>F 520</p> <p>Below is the response to F 281 previously noted above. Significant changes to establish control and accountability include the creation of a series of checklists to be used by the Unit Supervisors to check several facets of daily operations including the transcription</p>	10/12/16	

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F 520	Continued From page 13 facility failed to transcribe an order to discontinue Enablex as ordered by the Nurse Practitioner (NP) for 1 of 3 residents (Resident #5). Review of the facility survey history revealed F281 was cited on 5/26/16 during an annual recertification survey and was recited on the current 9/29/16 complaint investigation survey. During an interview on 9/28/16 at 12:34 PM the Administrator stated that the QA committee meets monthly. He further stated that in regards to professional standards, the steps that had been taken were that the nurses were reeducated about odor transcription. The admitting nurse, who transcribed the order, would have another nurse check the orders behind the nurse. If any errors were found they would educate the staff and try to discern where the miscommunication was. The Administrator stated that the QA for professional standards related to medication transcription was still ongoing and they were looking at new orders and new admissions. He stated he had not seen anything of concern.	F 520	and accuracy of physician orders. The requirements of F 281 will be reviewed with nurse managers who will use newly implemented audit tools to assure staff remains compliant with all elements of this requirement. The results of their daily, weekly and monthly audits will be reviewed during daily clinical meetings which are attended by the Center Executive Director (CED), Center Nurse Executive (CNE), Assistant Center Nurse Executive (Assist CNE) and the Unit Supervisors. The daily/weekly chart audit results will be reviewed twice monthly on the 15th and last of each month for 3 months to review, track and trend audit results. Any deviations from acceptable professional standards will have Process Improvement Plans (PIP) developed to address and correct the identified concerns. F 281 Resident # 5 Was discharged on 10/7/16 Other residents that may be affected by this practice were identified by a chart review of orders that the physician hand wrote from July to Sept by the Unit Supervisors the week of October 3, 2016. Any missed orders were clarified with the physician and transcribed. The 100% chart audit revealed 6 missed orders that have now been corrected. Licensed nurses were reeducated on the		

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F 520	Continued From page 14	F 520	<p>process of transcription of orders when handwritten by the physician on October 7, 8, 9, 10, 11, and 12, 2016 by the Center Nurse Executive (CNE). The third shift licensed nurses were reeducated on the process of 24 hour chart check for all in house residents which included charting, order sheets and comparing the order to the Medication/Treatment administration records to ensure the order has been completed by the CNE on October 12, 2016. The third shift licensed nurses will continue to complete 24 hour chart checks nightly. If an order is missed by the third shift nurse, re-education will be provided for the first offense, and then if another offense occurs the progressive disciplinary process will be implemented. The unit supervisors and Assistant Center Nurse Executive (ACNE) will conduct an audit on resident's charts for handwritten orders 5 days a week to ensure that orders have been transcribed correctly. Also the unit supervisors will audit orders entered into Point Click Care 5 days a week to ensure that orders are processed correctly.</p> <p>The audits will be reviewed by the CNE every two weeks for trends. Trends will be presented to the QA Committee every two weeks for 3 months by the CNE. The two week review of results (15th and end of month) will be captured through an Ad-Hoc QAPI Meeting conducted by the Center Executive Director (CED) with the CNE, Assistant CNE, NPE and Unit Managers in attendance to review results and make any necessary adjustments to</p>		

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F 520	Continued From page 15	F 520	assure continued compliance.		