

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345356	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/12/2017
NAME OF PROVIDER OR SUPPLIER RICH SQUARE NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	
(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID 06GT11. The survey team exited the facility on 10/11/17 but the survey was not closed until 10/12/17 due to the need for a physician's interview that was conducted on 10/12/17.	F 000		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (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	F 279		11/6/17

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

TITLE

(X6) DATE

Electronically Signed

11/03/2017

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 279	<p>Continued From page 1</p> <p>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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to care plan 1 of 1 (Resident #88) residents for antipsychotic medications.</p> <p>The findings include:</p> <p>Resident # 88 was admitted to the facility on 9/8/17 with diagnoses including Multiple</p>	F 279	<p>The plan for correcting the specific deficiency. Resident #88 care plan was reviewed and updated on 10/10/2017 to reflect the use of Seroquel medication. Resident #88 was seen by Life Source psychiatric services on 10/13/2017. The Seroquel was tapered down and then discontinued. The process that led to the</p>		

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F 279	<p>Continued From page 2</p> <p>Myeloma, Dementia without Behavior Disturbance and Hypertension #88.</p> <p>Review of the Care Area Assessment Summary (CAA) dated 9/15/17, noted Resident #88 received Seroquel, an anti-psychotic medication for anxiety and as a mood stabilizer. It was also noted that Resident #88 received Seroquel for dementia. The CAA also noted there were no behaviors related to the dementia disease process.</p> <p>Review of the Minimum Data Set (MDS) dated 9/15/17, revealed Resident #88 triggered for anti-psychotic medication. The MDS noted anti-psychotic medication should be care planned. There was a recommendation to request a psychiatric consult to evaluate medication regimen.</p> <p>On 10/10/17 Resident #88's care plan dated 9/18/17 was reviewed and the anti-psychotic medication, Seroquel was not on the care plan.</p> <p>During an interview on 10/11/2017 at 3:19 PM the MDS Coordinator revealed anti-psychotic medication was not care planned initially may not have seen it.</p> <p>During an interview on 10/11/17 at 4:34 PM, the Mood and Behavior Nurse revealed the reason anti-psychotic medication was not on the care plan because it was an oversight and a MDS Nurse brought it to her attention.</p> <p>During an interview on 10/11/17 at 5:23 PM, the facility Administator revealed anti-psychotic medication should have been care planned.</p>	F 279	<p>deficiency was related to staff oversight of the missing diagnosis for Seroquel medication.</p> <p>The procedure for implementing the acceptable plan of correction for the deficiency cited. Any resident receiving Seroquel medication without a care plan could be at risk so therefore the (Interdisciplinary Team)IDT members conducted a care plan audit on current resident population receiving Seroquel medication to ensure that each resident had an appropriate plan of care in place regarding the use of Seroquel. No other resident has been identified as having missing antipsychotic care plan in the audit. An in-service was conducted with the (Interdisciplinary Team)IDT members by the Regional MDS Consultant on 10/11/2017 regarding the importance of completing a care plan for residents receiving antipsychotic medication with an emphasis on Seroquel.</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency remains corrected and/or in compliance with the regulatory compliance. The DON or MDS Coordinator will audit 10 residents' records receiving antipsychotics medication weekly X4 then Biweekly x2 then monthly x3 to ensure that the residents receiving antipsychotics medication have a care plan in place.</p> <p>Data results will be analyzed and reviewed at the centers monthly QAPI</p>		

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F 280 SS=D	<p>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)</p> <p>483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:</p> <p>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.</p> <p>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.</p> <p>(iv) The right to receive the services and/or items included in the plan of care.</p> <p>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.</p> <p>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p>	F 280	meeting for 3 months with a subsequent plan of correction as needed. The DON is responsible for overall compliance.	11/6/17	

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F 280	Continued From page 4 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 280			

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F 280	<p>Continued From page 5 or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update a resident ' s Care Plan after a fall to include 2 person assist for turning and repositioning for 1 of 1 residents reviewed for falls (Resident #37).</p> <p>The findings included:</p> <p>Resident #37 was admitted to the facility on 11/23/13 and had a diagnosis of Cerebrovascular Accident (stroke) and Alzheimer ' s disease.</p> <p>The resident ' s current Care Plan for ADLs (activities of daily living) dated 1/13/14 revealed the resident required total care with ADLs and was at risk for falls related to dementia, impaired mobility and mechanical lift status. The Care Plan directed staff to assist in repositioning routinely and as needed and to provide incontinent care as needed.</p> <p>The Quarterly Minimum Data Set Assessment dated 4/17/17 revealed the resident was rarely/never understood, had short and long term memory loss and severe cognitive impairment. The MDS noted the resident required extensive assistance for bed mobility, total assistance for toileting and was incontinent of bowel and bladder.</p> <p>Review of the nurse ' s notes and an incident</p>	F 280	<p>The plan for correcting the specific deficiency. Resident #37 care plan was reviewed and updated by the Interdisciplinary Team on 10/23/2017 to include bilateral bolsters. Resident #37 was assessed by the RN for bed mobility and determined that when positioned properly during care one person assist is appropriate.</p> <p>The process that lead to the deficiency cited was related to a miscommunication to the IDT members regarding level of assistance for positioning in bed while rendering care. The SDC did not inform the IDT members to update the care plan for Resident #37 to reflect the increased level of assistance with bed mobility on 06/19/2017.</p> <p>The procedure for implementing an acceptable plan of correction for the specific deficiency cited. Any resident with restricted bed mobility requiring staff assistance could be at risk and should be care plan as such. The MDS/Care Plan nurse audited the care plans of residents with restricted bed mobility to ensure that the appropriate level of assistance for positioning in bed is documented on the care plan. The DON and the RN Manager</p>		

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F 280	<p>Continued From page 6</p> <p>report revealed on 6/17/17 at 4:50 AM, NA #1 was providing incontinent care and the resident rolled off the bed onto the floor sustaining 2 fifty cent sized hematomas over the right eye region. The notes revealed the resident was sent to the Emergency Department (ED) for evaluation where she had a negative CAT Scan of the head and discharged back to the facility with a diagnosis of closed head injury.</p> <p>The Care Plan for Resident #37 was updated on 6/19/17 and noted the resident had an actual fall on 6/17/17 and was unable to control body momentum when being turned due to poor balance and poor communication/comprehension. The Care Plan noted the staff was in-serviced on correct turning and positioning for residents.</p> <p>On 10/11/17 at 3:35 PM an interview was conducted with NA #2 who was providing care for Resident #37 on 6/17/17 when the resident rolled off of the bed. NA #2 stated they had an in-service and was told to make the resident was a 2 person assist during turning and repositioning.</p> <p>On 10/11/17 at 4:00 PM the Director of Nursing (DON) was not able to provide the content of the in-service provided for the staff. The DON stated the Staff Development Coordinator (SDC) did the in-service and she did not know where the information was located and the SDC was not available.</p> <p>On 10/11/17 at 4:05 PM Nurse #1 stated in an interview that after the fall, the SDC called all the staff together and talked about turning and repositioning and said to use 2 persons when</p>	F 280	<p>in-serviced the Licensed Nursed and CNA's to report any changes to a residents plan of care for positioning in bed to the MDS nurse, Care Plan Nurse, or Director Of Nurses for care plan evaluation and revision as needed. The Regional MDS Consultant re-educated the IDT members on 10/11/2017 regarding the importance of updating the care plan as needed.</p> <p>The Director of Nurses or the RN Manager will review 10 residents care plan for positioning weekly x4 week, biweekly x2 weeks, then monthly x3 months to ensure ongoing compliance in appropriately care planning the level of assistance with resident positioning in bed.</p> <p>Data results will be analyzed and reviewed at the centers monthly QAPI meeting for 3 months with a subsequent plan of correction as needed. The DON is responsible for overall compliance.</p>		

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F 280	<p>Continued From page 7 working with Resident #37.</p> <p>On 10/11/17 at 4:07 PM, the Activity Director stated in an interview she attended an in-service and was told to use 2 persons when working with Resident #37.</p> <p>On 10/11/17 at 4:09 PM Nurse #2 stated in an interview she attended an in-service and was told to use 2 persons to turn and reposition Resident #37.</p> <p>On 10/11/17 at 4:11 PM NA #3 stated in an interview she attended an in-service and was told to use 2 persons to turn and reposition Resident #37.</p> <p>On 10/11/17 at 4:12 PM NA #4 stated in an interview she attended an in-service and was told to use 2 persons to turn and reposition Resident #37.</p> <p>The resident ' s Care Plan updated on 6/19/17 did not include information to use 2 person assist to turn and position Resident #37. The resident ' s Care Guide used by the NAs as a reference for the resident ' s care did not contain information to use 2 person assist when turning and repositioning Resident #37.</p> <p>On 10/11/17 at 4:53 PM the DON stated in an interview the staff told her they were instructed to use 2 person assist to turn and position Resident #37. The DON stated this information should be on the resident ' s Care Plan and Care Guide.</p> <p>On 10/11/17 at 5:03 PM the MDS Nurse stated in an interview she was the one who updated the resident ' s Care Plan on 6/19/17. The MDS Nurse stated she did not attend the in-service and</p>	F 280			

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F 280	Continued From page 8 if she had known the staff were told to use 2 persons to turn and reposition Resident #37, she would have added this to the resident ' s Care Plan. On 10/11/17 at 5:23 PM the Administrator stated in an interview that when changes in a resident ' s care were made, the changes should be included in the Care Plan.	F 280			
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323		11/6/17	

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F 323	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician ' s interviews, the facility failed to keep a resident safe by not correctly positioning the resident prior to turning and the staff member turned away from the resident that resulted in the resident falling off of the bed sustaining a closed head injury for 1 of 1 sampled residents reviewed for falls (Resident #37).</p> <p>The findings included:</p> <p>Resident #37 was admitted to the facility on 11/23/13 and had a diagnosis of Cerebrovascular Accident (stroke) and Alzheimer ' s disease.</p> <p>The Care Plan for Resident #37 updated on 4/17/17 revealed the resident required total care with activities of daily living and was at risk for falls related to dementia and impaired mobility. The Care Plan directed staff to assist in repositioning routinely and as needed and to provide incontinent care as needed.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 4/17/17 revealed the resident was rarely/never understood and had short and long term memory loss and severe cognitive impairment. According to the MDS, the resident required extensive assistance with bed mobility, was total assistance with toileting and was incontinent of bowel and bladder. The MDS noted the resident had a limitation in range of motion of the upper and lower extremities on one side (left).</p> <p>Review of a nurse ' s note dated 6/17/17 at 6:17 AM noted the nurse was called to the room by a NA (Nursing Assistant) and the resident rolled off</p>	F 323	<p>The plan for correcting the specific deficiency. The Certified Nursing Assistant (CNA) for Resident #37, was in serviced on 06/17/2017 by the Staff Development Coordinator (SDC) and on 10/11/2017 by the Director of Nurses regarding the importance of resident positioning while providing care in bed. The process that led to the deficiency was related to the CNA being unaware of the Resident #37 position in bed when she looked away.</p> <p>The procedure for implementing an acceptable plan of correction for the specific deficiency cited. Any resident with restricted bed mobility requiring staff assistance could be at risk so therefore The DON in-serviced the Licensed Nursed and CNA's regarding the importance of resident positioning while in bed when providing care with an emphasis on not placing resident too close to the edge of the bed and to keep frequently used items close.</p> <p>New hire orientation will include the importance of resident positioning while providing care in bed with emphasis on not placing resident too close to the edge of the bed and to keep frequently used items close.</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the</p>		

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F 323	<p>Continued From page 10</p> <p>the bed onto the floor while incontinent care was being provided at 4:50 AM. The note revealed the resident was observed lying face down on the floor on the left side of the bed and when rolled over had 2 fifty cent sized hematomas over the right eye region. The note revealed the resident was non-verbal and had no facial grimaces. The note revealed the physician was notified and orders received to send the resident to the Emergency Department (ED) for evaluation. The note revealed 911 was called and the resident was transported to the hospital at 6:00 AM.</p> <p>An incident report dated 6/17/17 described the incident as per the nurse 's note dated 6/17/17. The report noted the bed position was low/neutral and a witnessed fall with injury and the resident was totally dependent for mobility.</p> <p>Attached to the incident report was a written account of the incident by the NA (NA #2) providing the care on 6/17/17 and read: "Around 4:50 AM entered room to assist resident with incontinent care. I log rolled her to the left and proceeded to clean her up. She was lying still, was not hanging off of bed as I turned my head and reached for a wipe from the box I heard a bump, bump sound and turned my head back around towards resident. She was on the floor. I immediately let the nurse know what had happened. We proceeded to get her vitals and to remove her from the floor with the lift.</p> <p>The Outcome/Conclusion on the incident report read as follows: Resident turned to administer personal care and the momentum caused her to roll to floor. Staff must ensure correct positioning when turning to avoid resident rolling off of bed.</p>	F 323	<p>regulatory requirements. The charge nurse and or the Administrative Nurses will monitor 10 residents positioning in bed during care weekly x4 week, biweekly x2 weeks and monthly thereafter until compliance is achieved with appropriate resident positioning in bed while care is being rendered.</p> <p>Data results will be analyzed and reviewed at the centers monthly QAPI meeting for 3 months with a subsequent plan of correction as needed. The DON is responsible for overall compliance.</p>		

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F 323	<p>Continued From page 11</p> <p>Review of the ED record dated 6/17/17 revealed Resident #37 was seen in the ED for an accidental fall. A CAT scan of the head was done and showed soft tissue swelling but no bleeding in the brain. The ED record revealed the resident was discharged back to the facility with a diagnosis of closed head injury.</p> <p>The resident ' s Care Plan was updated on 6/19/17 and read: "Resident had an actual fall on 6/17/17. Unable to control body momentum when being turned due to poor balance and poor communication/comprehension. Staff in-serviced on correct turning and positioning of residents."</p> <p>On 10/11/17 at 11:37 AM the Administrator stated in an interview the NA involved in the incident was in-serviced regarding turning and positioning residents after the incident with Resident #37. The Administrator was unable to provide documentation of in-services provided for the NA or for the nurses and NAs involved in direct care of the residents and stated she did not do a full plan of correction after the incident.</p> <p>On 10/11/17 at 2:20 PM an interview was conducted with NA #1 who was assigned to Resident #37 on that time. The NA stated they try to use 2 people when providing incontinent care for the resident. The NA further stated if you pull her towards you and then turn her, she will stay there and use her right hand to hold onto the mattress but if too close to the edge, she would continue to roll and fall off of the bed.</p> <p>On 10/11/17 at 3:35 PM an interview was conducted with NA #2 who was assigned to the resident on 6/17/17 at the time of the fall. The NA stated the resident was lying on her back and she</p>	F 323			

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F 323	Continued From page 12 turned the resident over and she had had a small bowel movement. The NA stated she turned and reached for a wipe and heard a bump, bump and the resident was on the floor. The NA further stated the resident had a goose egg on her forehead. The NA stated an in-service was provided at the nurse ' s desk by the staff development coordinator to make sure to use 2 person assist for turning and repositioning Resident #37. On 10/11/17 at 4:00 PM the Director of Nursing (DON) stated in an interview the Staff Development Coordinator (SDC) did in-services with the staff and the sign in sheets were usually attached to the incident report but she was unable to find them and the SDC was not available. On 10/11/17 at 4:05 PM, Nurse #1 stated in an interview the SDC called all the staff together at the nurse ' s station and talked about turning and repositioning and said to use 2 persons when turning Resident #37. On 10/12/17 at 8:55 AM an interview was conducted with the physician who cared for Resident #37 in the facility. The Physician stated after the fall the resident was sent to the ED for evaluation and he later spoke with the ED physician about the resident and was told everything was fine. The Physician stated the resident did not have a change in condition following the fall.	F 323			
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2)	F 329		11/6/17	

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F 329	<p>Continued From page 13</p> <p>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--</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by:</p>	F 329			

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F 329	<p>Continued From page 14</p> <p>Based on observations, record reviews and staff interviews, the facility failed to ensure a resident drug regimen was free from unnecessary medication by administering an antipsychotic medication without an appropriate indication of use for 1 of 5 residents reviewed for unnecessary medications. (Resident #88).</p> <p>The findings include:</p> <p>Resident #88 was admitted the facility on 9/8/17 with diagnoses including Multiple Myeloma not having achieved remission, Hypertension and unspecified dementia without behavior disturbance.</p> <p>Review of Resident #88's Care Area Assessment Summary (CAA) from the Minimum Data Set (MDS) dated 9/15/17 read in part, "Seroquel received for anxiety and as a mood stabilizer. Seroquel used for dementia. There are no behaviors related to the dementia disease process."</p> <p>According to the most recent Admission Minimum Data Set (MDS) dated 9/15/17, Resident #88 required extensive assistance with bed mobility with one person physical assistance. He required minimum assistance with transfers and minimum assistance with walking both on and off the unit, with one person physical assistance. Resident #88 required extensive assistance in the areas of toileting, personal hygiene and bathing, with one person physical assistance. Resident #88 was ambulatory and also used a wheelchair for long distance mobility in the facility.</p> <p>During an interview on 10/11/2017 at 11:31 AM, the Mood and Behavior Nurse revealed Resident</p>	F 329	<p>The plan for correcting the specific deficiency. Resident #88 was seen by Life Source psychiatric services on 10/13/2017. The Seroquel was tapered down and then discontinued. The process that led to the deficiency was related to staff oversight of the missing diagnosis for Seroquel medication.</p> <p>The procedure for implementing an acceptable plan of correction for the specific deficiency cited. Any resident on an antipsychotic medication without an appropriate indication for use can be at risk. The nursing administrative staff audited the medical records for current resident population receiving antipsychotic medications to validate that behavior monitoring logs are in place, and the medication is necessary to treat a specific documented diagnosed condition. Any residents identified through this process as to not having the appropriate diagnosis the physician was notified for a diagnosis clarification or gradual dose reduction. The DON re-educated the Licensed Nurses to implementing behavior monitoring logs for residents receiving antipsychotic medication and to notify the physician for diagnosis clarification for residents on antipsychotic medication without an appropriate indication/diagnosis for use.</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency remains corrected</p>		

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F 329	<p>Continued From page 15</p> <p>#88 was admitted from the hospital on 9/8/17 and he had been evaluated by the Psychiatrist. After further review she determined that Resident #88 had not been seen by the Psychiatrist and she scheduled him for 10/13/17. The Mood and Behavior Nurse revealed Resident #88 received the antipsychotic Seroquel for dementia without behavior and depression. She revealed the medication was used as a mood stabilizer. After further review, the Mood and Behavior Nurse revealed Resident #88 received Seroquel for dementia and there were no behaviors indicated. When asked if she got clarification for a diagnoses for the medication, she revealed the attending physician signed the doctor's orders on 9/11/17.</p> <p>During an interview on 10/11/17 at 1:31 PM, Staff Nurse #2, the first shift nurse on Resident #88's unit, revealed she had not seen Resident #88 exhibit any behaviors. She stated she did not know why he was on Seroquel and revealed the resident came from the hospital on the medication. She revealed she was not aware of where behavior monitoring information was located.</p> <p>During an interview on 10/11/2017 at 1:51 PM, Nursing Assistant (NA#5), revealed Resident #88 could do a lot for himself. She stated what Resident #88 needed, she would get it for him. She revealed Resident #88 went to the bath room independently. She stated she assisted in changing him when he had toileting accidents. NA#5 revealed Resident #88 did not exhibit any behaviors. She stated he got anxious when he had a toileting accident and would apologize for what he did. NA#5 stated Resident #88 sat on his bed or his wheelchair in his room. She revealed</p>	F 329	<p>and/or in compliance with the regulatory compliance. The DON and/or MDS/Care Plan Nurse will audit 10 resident's physician's orders on weekly x4 weeks, biweekly x2, then monthly x3 to ensure that behavior monitoring logs are implemented and that the resident's receiving antipsychotic medications have an appropriate documented diagnosed condition.</p> <p>Data results will be analyzed and reviewed at the centers monthly QAPI meeting for 3 months with a subsequent plan of correction as needed. The DON is responsible for overall compliance.</p>		

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F 329	<p>Continued From page 16</p> <p>he did not sleep a lot during the day in his room. NA#5 stated she did not know what medication Resident #88 received.</p> <p>During another interview on 10/11/2017 at 3:00 PM, the Mood and Behavior Nurse revealed she monitored Resident #88's side effects from Seroquel with the AIMS test which was initiated when he was admitted and every three months. She revealed she did not have a form specifically to monitor behaviors and side effects of Seroquel.</p> <p>During an interview on 10/11/2017 at 4:14 PM the facility Pharmacist revealed since she did not have Resident #88's entire medical record to review, she did not know if non-Alzheimer's dementia was an appropriate diagnosis to be on Seroquel.</p> <p>During an interview on 10/11/2017 at 4:15 PM, the Director of Nursing, (DON) revealed psychiatric services was supposed to see Resident #88 on 10/13/17. She stated when Resident #88 was admitted to the facility, they looked at the orders and put them in the computer. She stated they called the doctor if the medication was not appropriate.</p> <p>During an interview on 10/11/2017 at 4:34 PM, the Mood and Behavior Nurse stated she contacted the doctor and the doctor said he was not Resident #88's primary doctor and suggested that the resident be referred to psychiatric services. She revealed an order was written on 9/28/17 and Resident #88 was supposed to see the psychiatrist on 10/13/17.</p> <p>During an interview on 10/11/17 at 5:23 PM, the facility Administrator revealed her expectation</p>	F 329			

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F 329	Continued From page 17 was if a resident was on antipsychotic medication and did not have any behaviors, the medication order needed to be clarified.	F 329			
F 371 SS=E	<p>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3)</p> <p>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store food under sanitary conditions by failing to date the opening of food in the refrigerator and freezer for 2 of 2 days observed.</p>	F 371		11/6/17	
			The plan for correcting the deficient practice. The bologna, shredded cheese, yellow cheese and chicken tenders were dated by the Dietary Manager on 10/10/2017. The process that lead to the		

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F 371	Continued From page 18 The findings included: During the initial tour of the facility on 10/8/17 at 12:45 PM there was a roll of bologna wrapped in plastic wrap and was not dated when opened. There was part of a package of white shredded cheese that had been opened but was not dated with the date it was opened and a block of yellow cheese wrapped in plastic wrap that was not dated when opened. On 10/8/17 at 12:50 PM a bag of chicken tenders was observed in the freezer and had been opened but was not dated with the date it was opened. On 10/10/17 at 1:45 PM an observation of the refrigerator in the kitchen with the dietary manager revealed 2 yellow blocks of cheese wrapped in plastic wrap and was not dated with the date they were opened. During the observation the Dietary Manager stated the cheese should have been dated when opened. On 10/11/17 at 11:37 AM the Dietary Manager stated in an interview as soon as the dietary staff opened something it should be dated before it was put back in the refrigerator or the freezer. On 10/11/17 at 5:23 PM the Administrator stated in an interview she would expect food in the kitchen to be dated when opened.	F 371	deficiency was related to the staff rushing to prepared food and not following procedures for dating food items when opened. Any resident is at risk when food is not dated upon opening. The freezer and refrigerator was audited on 10/10/2017 by the Dietary Manager to ensure all foods were dated appropriately. The Dietary Manager re-educated the dietary staff on 10/22/2017 regarding the policy and procedure for dating food items when opening. The Dietary manager and or Administrator will audit the freezer and refrigerator 3 times weekly x4 weeks, 2 times weekly for 4 weeks, then weekly for 4 weeks for opened undated food items. Any deficient practice will result in staff re-education for proper procedure for dating items when opened. Data results will be analyzed and reviewed at the center monthly QAPI meeting for 3 months with a subsequent plan of correction as needed. The Dietary Manager is responsible for overall compliance.		
F 372 SS=E	DISPOSE GARBAGE & REFUSE PROPERLY CFR(s): 483.60(i)(4) (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced	F 372		11/9/17	

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F 372	<p>Continued From page 19</p> <p>by:</p> <p>Based on observation and staff interviews the facility failed to ensure the proper closing of the dumpster doors, failed to contain waste in a dumpster and failed to keep the area around the dumpsters clean and free of debris to prevent the harboring of pests for 2 of 4 dumpsters (Dumpster #1 and Dumpster #3).</p> <p>The findings included:</p> <p>On 10/8/17 at 8:10 AM an observation of the dumpsters revealed 4 dumpsters on a large concrete area. A large plastic bag was lying on the ground against dumpster #1 and a Kleenex on the ground near the dumpster.</p> <p>On 10/9/17 at 10:34 AM the door to dumpster #1 was partially open with a white trash bag protruding out the open door. There was a large plastic bag lying on the ground against the dumpster in the same place as the previous observation.</p> <p>On 10/10/17 at 1:50 PM an observation of the dumpster area was made with the dietary manager. There was a large plastic bag lying on the ground against dumpster #1. During the observation, Housekeeper #1 walked out to the dumpster area and stated the large plastic bag on the ground against the dumpster was coming out of the drain hole near the bottom of the dumpster and they could not remove it. The Housekeeper stated she had told one of the men who emptied the dumpsters about the bag. The Dietary Manager asked the housekeeper if the bag could be cut away from the dumpster and the Housekeeper responded: "I guess so." Dumpster #3 was observed with the door on the left side</p>	F 372	<p>The plan for correcting the specific deficiency. Maintenance bleached and hosed the pavement containing the maggots that were in front of the dumpsters. Routine trash pick up was done on 10/10/2017. Maintenance at that time put bleach in the receptacles. Steri-tech came in on 10/12/2017 and disinfected the containers and surrounding area. On 10/24/2017 all receptacles had been replaced with new ones. The process that lead to the deficiency being cited related to improper closure of dumpster door and the absence of staff notification in reporting the improper closing of the dumpster door to the Maintenance Director.</p> <p>The procedure for implementing the plan of correction. The RN Manger in-serviced all department staff on the appropriate disposal of trash and maintaining closed trash receptacles. Staff were instructed to report any dumpster issues to the Maintenance Director.</p> <p>The Maintenance Director and/or the Housekeeping Supervisor will monitor the dumpsters 5x weekly for 4 weeks, 3 times weekly x4 weeks, then 2 times weekly until compliance is achieved in keeping the area around the dumpsters clean and free of debris and pest control.</p> <p>Data results will be analyzed and reviewed at the centers monthly QAPI meeting for 3 months with a subsequent plan of correction as needed. The</p>		

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F 372	<p>Continued From page 20</p> <p>open about 3 inches. There was one plastic lid, a straw sleeve and a glove lying on the ground near the dumpster. During the observation, a large number (hundreds) of white worm like insects were crawling around on the pavement near the dumpsters. The Dietary Manager stated they were maggots. The Maintenance Director joined the interview and stated the insects crawling on the pavement were maggots. The Maintenance Director further stated the door to dumpster #1 did not close tightly and allowed flies to enter and breed producing the maggots. The Maintenance Director stated he had never seen this before.</p> <p>On 10/11/17 at 9:30 AM the Administrator stated in an interview at one time the dumpster door was off tract and they had the company fix the door. The Administrator stated they had contacted the exterminator and were told to pour bleach in the dumpsters to sanitize them and if that did not work they would replace the dumpsters.</p> <p>On 10/11/17 at 11:13 AM an interview was conducted with the Housekeeper #1. The Housekeeper stated the large plastic bag coming from the drain hole in dumpster #1 had been there since probably July 2017. The Housekeeper further stated she told the trash truck driver about the bag and he said okay but never got out of the truck. The Housekeeper stated she did not tell anyone else about the bag. The Housekeeper stated she saw the maggots around the dumpster yesterday and had never seen that before.</p> <p>On 10/11/17 the Maintenance Director stated when the trash truck picked up the dumpsters they bang the dumpsters and the dumpster was bent so it created a crack between the dumpster and the door. The Maintenance Director stated</p>	F 372	Administrator is responsible for overall compliance.		

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F 372	Continued From page 21 the large plastic bag got stuck in the drain hole and he pulled the bag out and threw it away. The Maintenance Director stated there was too much water in the dumpsters to sanitize them so he had called the company to bring new dumpsters and had called pest control to come to see what else they needed to do.	F 372			
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (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 (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 514		11/6/17	

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F 514	<p>Continued From page 22</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to maintain accurate clinical records by failing to keep physician ' s progress notes on the medical record for 9 of 17 residents reviewed (Residents #2, 17, 65, 79, 7, 29, 37, 88 and 90).</p> <p>1. Resident #2 was admitted to the facility on 10/23/15 with diagnoses including Hypertension, Paraplegia, Pressure Ulcer and Gastro-Esophageal Reflux disease.</p> <p>Review of the Medical Record facility physician visit list documented the physician had seen Resident #2 on 2/16/17, 4/30/17 and 7/17/17.</p> <p>Review of the medical record showed the last physician progress note of 2/16/17 on the medical record. There were no progress notes for the visits of 4/30/17 and 7/17/17.</p> <p>During an interview with Medical Records on 10/11/17 at 2:10 PM she stated the facility had a computer program which would let her know who was to be seen by each physician weekly. After each physician visited weekly they would dictate their progress notes and then two of three physicians would fax their notes and one physician would either bring his notes to the facility or have the facility pick them up after notifying the facility. She stated after she received the physician ' s progress notes she</p>	F 514	<p>The plan for correcting the deficiency. Resident #2, 17, 65, 79, 7, 29, 37, 88 and 90 physician progress notes have been filed on the chart. The deficient practice is related to untimely transcription service and the lack of the physician staff awareness of transcription timelines for having notes put on the clinical record.</p> <p>Any resident is at risk for not having progress notes on there medical record for continuation of clinical information so therefore an audit was completed by the Medical Records attendant on 10/14/2017 for missing progress notes. Dr. Khoury's office was notified and missing progress notes were obtained and placed on the clinical record. The RN Manager re-educated the Medical Records staff regarding the importance of notifying the physician and the Administrator for missing physician's progress notes. Dr. Khoury will document his progress notes in the facility clinical records for timely transcriptions.</p> <p>The Medical Records attendant will audit the physician progress notes after each physician's visit for 5 residents weekly x8 weeks, then biweekly x3 months until compliance is achieved with timely</p>		

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F 514	<p>Continued From page 23</p> <p>placed them in the resident ' s charts. She stated to date, everything she had received had been filed on the medical records. She stated she did not know why all notes were not in the medical record.</p> <p>During an interview with the Director of Nursing on 10/11/17 at 2:15 PM she stated the physician ' s office who had missing progress notes had been called and the physician stated he would get the facility his progress notes as soon as he could.</p> <p>During an interview with the Administrator on 10/11/17 at 3:08 PM she stated she would expect the physician progress notes to be on the medical record.</p> <p>2. Resident #17 was admitted to the facility on 3/22/16 with diagnoses including Diabetes Mellitus, Neuropathy, Chronic Obstructive Pulmonary Disease, Heart Failure, Osteoarthritis and Cardiac Pacemaker.</p> <p>Review of the Medical Record facility physician visit list documented the physician had seen Resident #17 on 4/6/17, 6/10/17, 8/17/17 and 9/14/17.</p> <p>Review of the medical record showed no physician progress notes on the chart.</p> <p>During an interview with Medical Records on 10/11/17 at 2:10 PM she stated the facility had a computer program which would let her know who was to be seen by each physician weekly. After each physician visited weekly they would dictate</p>	F 514	<p>physician transition in the medical record. Data results will be analyzed and reviewed at the centers monthly QAPI meeting for 3 months with a subsequent plan of correction as needed. The Director of Nurses is responsible or overall compliance.</p>		

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F 514	<p>Continued From page 24</p> <p>their progress notes and then two of three physicians would fax their notes and one physician would either bring his notes to the facility or have the facility pick them up after notifying the facility. She stated after she received the physician ' s progress notes she placed them in the resident ' s charts. She stated to date, everything she had received had been filed on the medical records. She stated she did not know why all notes were not in the medical record.</p> <p>During an interview with the Director of Nursing on 10/11/17 at 2:15 PM she stated the physician ' s office who had missing progress notes had been called and the physician stated he would get the facility his progress notes as soon as he could.</p> <p>During an interview with the Administrator on 10/11/17 at 3:08 PM she stated she would expect the physician progress notes to be on the medical record.</p> <p>3. Resident #65 was admitted to the facility on 2/24/14 and re-admitted on 1/16/16 with diagnoses including Dementia, Hypertension, Anemia, Dysphagia, Gastrostomy status and Thyroid disease.</p> <p>Review of the Medical Record facility physician visit list documented the physician had seen Resident #65 on 6/23/17 and 8/27/17.</p> <p>Review of the medical record showed the last physician progress note on the medical record was 6/23/17. There was no progress note for the</p>	F 514			

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F 514	<p>Continued From page 25 visit of 8/27/17.</p> <p>During an interview with Medical Records on 10/11/17 at 2:10 PM she stated the facility had a computer program which would let her know who was to be seen by each physician weekly. After each physician visited weekly they would dictate their progress notes and then two of three physicians would fax their notes and one physician would either bring his notes to the facility or have the facility pick them up after notifying the facility. She stated after she received the physician ' s progress notes she placed them in the resident ' s charts. She stated to date, everything she had received had been filed on the medical records. She stated she did not know why all notes were not in the medical record.</p> <p>During an interview with the Director of Nursing on 10/11/17 at 2:15 PM she stated the physician ' s office who had missing progress notes had been called and the physician stated he would get the facility his progress notes as soon as he could.</p> <p>During an interview with the Administrator on 10/11/17 at 3:08 PM she stated she would expect the physician progress notes to be on the medical record.</p> <p>4. Resident #79 was admitted to the facility on 7/24/17 with diagnoses including End Stage Renal Disease, Diabetes Mellitus, Dementia, Anemia, and Vitamin D deficiency, Hyperlipidemia, Hypertension and Osteomyelitis.</p>	F 514			

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F 514	<p>Continued From page 26</p> <p>Review of the Medical Record facility physician visit list documented the physician had seen Resident #79 had been seen by the physician on 7/28/17, 8/17/17 and 9/14/17.</p> <p>Review of the medical record showed the last physician progress note on the medical record was 7/28/17. There were no physician progress notes on the medical record for the visits of 8/17/17 and 9/14/17.</p> <p>During an interview with Medical Records on 10/11/17 at 2:10 PM she stated the facility had a computer program which would let her know who was to be seen by each physician weekly. After each physician visited weekly they would dictate their progress notes and then two of three physicians would fax their notes and one physician would either bring his notes to the facility or have the facility pick them up after notifying the facility. She stated after she received the physician ' s progress notes she placed them in the resident ' s charts. She stated to date, everything she had received had been filed on the medical records. She stated she did not know why all notes were not in the medical record.</p> <p>During an interview with the Director of Nursing on 10/11/17 at 2:15 PM she stated the physician ' s office who had missing progress notes had been called and the physician stated he would get the facility his progress notes as soon as he could.</p> <p>During an interview with the Administrator on 10/11/17 at 3:08 PM she stated she would expect the physician progress notes to be on the medical record.</p>	F 514			

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F 514	Continued From page 27 5. Resident #7 was admitted to the facility on 9/9/15 and had a diagnosis of a hip fracture and a seizure disorder. Review of the clinical record revealed the last physician ' s notes were dated 1/26/17. Review of the facility physician visit list documented the physician had seen Resident #7 on 7/17/17. During an interview with Medical Records on 10/11/17 at 2:10 PM she stated the facility had a computer program which would let her know who was to be seen by each physician weekly. After each physician visited weekly they would dictate their progress notes and then two of three physicians would fax their notes and one physician would either bring his notes to the facility or have the facility pick them up after notifying the facility. She stated after she received the physician ' s progress notes she placed them in the resident ' s charts. She stated to date, everything she had received had been filed on the medical records. She stated she did not know why all notes were not in the medical record. During an interview with the Director of Nursing on 10/11/17 at 2:15 PM she stated the physician ' s office who had missing progress notes had been called and the physician stated he would get the facility his progress notes as soon as he	F 514			

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F 514	<p>Continued From page 28</p> <p>could.</p> <p>During an interview with the Administrator on 10/11/17 at 3:08 PM she stated she would expect the physician progress notes to be on the medical record.</p> <p>6. Resident #29 was admitted to the facility on 1/10/11 and had a diagnosis of dementia, congestive heart failure and anemia.</p> <p>Review of the clinical record revealed the last physician ' s notes on the record were dated 3/18/17.</p> <p>Review of the facility physician visit list revealed the physician had seen Resident #29 on 4/6/17 and 8/10/17.</p> <p>During an interview with Medical Records on 10/11/17 at 2:10 PM she stated the facility had a computer program which would let her know who was to be seen by each physician weekly. After each physician visited weekly they would dictate their progress notes and then two of three physicians would fax their notes and one physician would either bring his notes to the facility or have the facility pick them up after notifying the facility. She stated after she received the physician ' s progress notes she placed them in the resident ' s charts. She stated to date, everything she had received had been filed on the medical records. She stated she did not know why all notes were not in the medical record.</p> <p>During an interview with the Director of Nursing on 10/11/17 at 2:15 PM she stated the physician '</p>	F 514			

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F 514	<p>Continued From page 29</p> <p>s office who had missing progress notes had been called and the physician stated he would get the facility his progress notes as soon as he could.</p> <p>During an interview with the Administrator on 10/11/17 at 3:08 PM she stated she would expect the physician progress notes to be on the medical record.</p> <p>7. Resident #37 was admitted to the facility on 11/22/13 and had a diagnosis of Alzheimer ' s disease anemia, chronic kidney disease, anemia, seizures and stroke.</p> <p>Review of the clinical record the last physician ' s notes on the record were dated 3/18/17.</p> <p>Review of the facility physician visit list revealed the physician had seen Resident #37 on 4/6/17 and 8/10/17.</p> <p>During an interview with Medical Records on 10/11/17 at 2:10 PM she stated the facility had a computer program which would let her know who was to be seen by each physician weekly. After each physician visited weekly they would dictate their progress notes and then two of three physicians would fax their notes and one physician would either bring his notes to the facility or have the facility pick them up after notifying the facility. She stated after she received the physician ' s progress notes she placed them in the resident ' s charts. She stated to date, everything she had received had been filed on the medical records. She stated she did not know why all notes were not in the medical record.</p>	F 514			

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F 514	<p>Continued From page 30</p> <p>During an interview with the Director of Nursing on 10/11/17 at 2:15 PM she stated the physician ' s office who had missing progress notes had been called and the physician stated he would get the facility his progress notes as soon as he could.</p> <p>During an interview with the Administrator on 10/11/17 at 3:08 PM she stated she would expect the physician progress notes to be on the medical record.</p> <p>8. Resident #88 was admitted to the facility on 9/8/17, with diagnoses including Multiple Myeloma, Hypertension, and Dementia without Behavior Disturbance.</p> <p>Review of the Medical Record physician list revealed Resident #88 was seen by the physician on 9/14/17. Review of Resident #88's medical record revealed there was no MD notes were found.</p> <p>During an interview with Medical Records on 10/11/17 at 2:10 PM she stated the facility had a computer program which would let her know who was to be seen by each physician weekly. After each physician visited weekly they would dictate their progress notes and then two of three physicians would fax their notes and one physician would either bring his notes to the facility or have the facility pick them up after notifying the facility. She stated after she received the physician ' s progress notes she placed them in the resident ' s charts. She stated to date, everything she had received had been filed on the medical records. She stated she did not know why all notes were not in the medical</p>	F 514			

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F 514	<p>Continued From page 31 record.</p> <p>During an interview with the Director of Nursing on 10/11/17 at 2:15 PM she stated the physician ' s office who had missing progress notes had been called and the physician stated he would get the facility his progress notes as soon as he could.</p> <p>During an interview with the Administrator on 10/11/17 at 3:08 PM she stated she would expect the physician progress notes to be on the medical record.</p> <p>9. Resident #90 was originally admitted to the facility on 3/17/17 and was readmitted on 4/21/17, with diagnoses including Hypertension, Osteoarthritis and Spinal Stenosis.</p> <p>Review of the Medical Record physician visit list revealed Resident #90 was seen by the physician on 4/6/17, 4/23/17, 4/30/17, and 6/10/17. Review of Resident #90's medical record revealed the last MD visit was on 3/18/17.</p> <p>During an interview with Medical Records on 10/11/17 at 2:10 PM she stated the facility had a computer program which would let her know who was to be seen by each physician weekly. After each physician visited weekly they would dictate their progress notes and then two of three physicians would fax their notes and one physician would either bring his notes to the facility or have the facility pick them up after notifying the facility. She stated after she received the physician ' s progress notes she placed them in the resident ' s charts. She stated to date, everything she had received had been</p>	F 514			

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F 514	<p>Continued From page 32</p> <p>filed on the medical records. She stated she did not know why all notes were not in the medical record.</p> <p>During an interview with the Director of Nursing on 10/11/17 at 2:15 PM she stated the physician 's office who had missing progress notes had been called and the physician stated he would get the facility his progress notes as soon as he could.</p> <p>During an interview with the Administrator on 10/11/17 at 3:08 PM she stated she would expect the physician progress notes to be on the medical record.</p>	F 514			