STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING _____ B. WING _____	C 03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

(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 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		4/13/18

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

Electronically Signed | 04/06/2018

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F 842	Continued From page 1 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately document and record the distribution of a controlled medication to 1 of 1 residents sampled (Resident #1). The Findings included: Resident #1 was admitted to the facility on 2/27/18 with diagnoses that included: repeated falls, essential hypertension, heart disease, heart failure and chronic kidney disease among others.	F 842	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers	

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F 842	Continued From page 2 A review of Resident #1's most recent comprehensive assessment (MDS) dated 2/27/18 indicated he was cognitively impaired while requiring limited assistance with bed mobility and transfer, extensive assistance with locomotion and toilet use, supervision while walking in his room and was independent with eating. Resident #1 was coded as being occasionally incontinent of bladder and always continent of bowel. A review of physician orders revealed an orders for "oxycodone-acetaminophen 5/325mg: Give one tablet by mouth every 4 hours as needed for pain" and "acetaminophen suppository 650mg: insert one tablet rectally every 4 hours as needed for general discomfort". A review of Resident #1's electronic medication administration record (MAR) revealed neither of the two ordered pain medications were given on 2/27/18 or 2/28/18. Per the MAR, the medications were to be given every 4 hours as needed. Further review of MAR revealed Pain Assessments occurring on 2/27/18 on 2nd, 3rd shifts and again on 2/28/18 on 1st shift. The pain levels were documented as level 2 by Nurse #1; level 8 by Nurse #2; and level 7 by Nurse #3 on 2/27 2nd and 3rd shift and 2/28 on 1st shift respectively. Review of Grievance logs revealed one grievance filed by resident on 2/28/18. Further review of the grievance revealed concern regarding resident "was admitted on 2/27. Pt states he did not receive his pm meds on 2/27 - nurse stated meds were not available." Action taken - DON pulled med admin 54 records. Pain medication not given when resident asked for it. Medications are	F 842	allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The plan for correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited. Narcotic removed from the Omni-cell indicated the medication was pulled for the resident, but the nurse failed to document the administration on the Electronic Medication Administration Record. This a result of a lack of attention to an established professional process. The procedure for implementing the acceptable plan of correction for the specific deficiency cite; corrected and/or in compliance with the regulatory requirements. Director of nursing, Unit Manager and Weekend Supervisor educated all Licensed nurses on correct practice of documenting administration of narcotic medication to include “When signing out a prn narcotic for a resident from the Omni-cell you MUST document it on the Electronic Medication Administration Record, this no different than signing a narcotic out on a narcotic count sheet.” This education will be completed by April 13, 2018. Any nurse that did not receive the education and training material on this date will not be allowed to work until education and material is received. All New Licensed nurses will receive education on correct practice of documenting administration of narcotic	

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F 842	Continued From page 3 available in the electronic medication dispenser. Staff nurse questioned and counseled regarding med availability and instruction if resident's request for pain medication." An interview with Nurse #1 on 3/21/18 at 7:36 PM revealed she did not remember Resident #1. She reported she no longer worked at the facility and would not be able to answer any questions regarding Resident #1 without looking at his chart. An interview with Nurse #2 on 3/22/18 at 10:07 AM revealed she remembered Resident #1 vividly and that he had complained loudly about having not received any pain medication when she came on shift. She reported her and another nurse (Nurse #4) went to the medication cart used for residents whose prescriptions had not yet come into the facility and pulled a pain medication for resident. She reported after providing the resident with the medications he relaxed and went to sleep. She reported resident was still sleeping when her shift ended and resident was not in the facility when she returned for her next shift. In an interview with Nurse #4 on 3/22/18 at 8:40 AM revealed she was informed in the middle of her report that resident had been admitted to the facility but his medications had yet to be received from the facility. She reported hearing Resident #1 call out in pain and reportedly left her meeting and subsequently provided Resident #1 with a pain medication which she believed was an oxycodone 5/325mg from the electronic medication dispenser. She further informed after giving Resident #1 his pain medication she did not go into the resident's electronic medication	F 842	medication in “When signing out a prn narcotic for a resident from the Omni-cell you MUST document it on the Electronic Medication Administration Record, this no different than signing a narcotic out on a narcotic count sheet.” How the facility plans to monitor and ensure correction is achieved and sustained. The Pharmacy will generate a report daily and email to the Director of Nursing of medications removed from the Omni-cell by Patient and those removals will be compared to the Electronic Medication Administration Record of any patient with a PRN narcotic ordered, this will be done for all PRN narcotics daily Monday – Friday X 4 weeks, then 10% of PRN Narcotics removed Weekly X 4 and Monthly X 1. Results of audits will be reviewed at weekly Quality Assurance Risk Meeting, and at Quarterly Quality Assurance meeting X 1 for further problem resolution if needed The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing will ensure that the implementation of the plan is followed.	

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F 842	Continued From page 4 administration record (MAR) and sign off that Resident #1 had received a pain medication. She stated she "did not know why" she did not sign off on the MAR and reported she should have per facility policy and reported "with everything going on I just forgot". An interview with the Director of Nursing on 3/21/18 at 10:15 AM revealed she expected that all medications that are given should "absolutely" be signed off on the MAR and the nurse that provided the medication should have completed the MAR, noting the time the medication was given. An interview with the Administrator on 3/22/18 revealed she expected regulations to be followed.	F 842		