STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING _____ B. WING _____	C 04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		5/1/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/26/2018

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F 578	Continued From page 1 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to update its electronic medical records with a change in code status for 1 of 1 sampled residents (Resident #138) whose code status changed after admission to the nursing home. Findings included: Record review revealed Resident #138 was admitted to the facility from the hospital on 03/27/18 with a full code status. The resident's documented diagnoses included pulmonary fibrosis, fracture of the sacrum, multiple compression fractures of the vertebra, and hypertension. A 03/27/18 7:05 PM progress note documented, "Code Status: DNR (do not resuscitate)...Resident signed consent for treatment form and DNR form." On 03/28/18 Resident #138's care plan documented, "Resident has advanced directives. Resident is DNR." A 04/03/18 11:36 AM social service progress note documented, "ADVANCED DIRECTIVE/CODE STATUS: Full Code. Advanced directives have been reviewed and are located on the chart." On 04/03/18 at 3:18 PM review of Resident #138's electronic medical record revealed on the resident's profile page and on her elecronic medical administration record (e-MAR) it was documented her code status was "full code".	F 578	Process that led to deficiency cited: Facility failed to update the electronic medical record with change in code status. Procedure for implementing plan of correction: 100% audit of residents completed on 4-3-18 by Medical Records Director comparing current physician orders in the electronic medical record to Advance Directives Binder. 100% education for license nurses, Social Worker, and Admissions Department started on 4-3-18 by the Staff Development Nurse on procedure for updating Advance Directive/Code Status. Monitoring procedure: Weekly audit of 100% of resident's Advance Directive/Code Status comparing current orders in electronic medical record and Advance Directives Binder to be completed for four weeks starting 4-18-18 by the Medical Records Director. Monthly audit of 100% of resident's Advance Directive/Code Status comparing current orders in electronic medical record and Advance Directives Binder to be completed for three months starting 5-9-19 by the Medical Records Director. Results of weekly and monthly audits will	

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F 578	Continued From page 2 On 04/03/18 at 3:37 PM review of the code status notebooks kept at the nursing stations revealed the presence of a request form signed by Resident #138 on 03/27/18 to change her code status from full code to DNR, a 03/28/18 physician's order documenting the resident's code status was DNR, and a 03/28/18 golden rod DNR sheet documenting there was no expiration on the resident's DNR status. On 04/04/18 at 4:12 PM Nurse #1 (the Staff Development Coordinator) stated there were three places staff could quickly check a resident's code status. She reported there was a code status notebook at each nursing station, the e-MAR, and the electronic profile page. She commented nurses working on the hall who needed to know a code status would probably pull up the e-MAR or electronic profile page on their computers, but if were sitting at the nurse's station they might look in the code status notebook. On 04/04/18 at 4:32 PM Nurse #2 stated there was a problem because in the code status notebook documentation showed Resident #138's code status was DNR, but in the electronic medical record it was still documented the resident was full code status. She explained that if a nurse was passing medications on the hall when staff reported Resident #138 appeared to have stopped breathing, and the nurse checked in her computer quickly where it was documented the resident was full code, cardiopulmonary resuscitation (CPR) might be begun on the resident who did not wish to have such measures initiated. Nurse #2 reported the nurse who wrote Resident #138's order for a change in her code status should updated the information in the	F 578	be reviewed weekly/monthly by the QAPI Committee. Title of person responsible for implementing plan of correction: Staff Development Nurse Medical Records Director Date when corrective action will be completed: 5-1-19	

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F 578	Continued From page 3 electronic record. On 04/04/18 at 4:40 PM the Director of Nursing (DON) stated residents discharged from the hospital to the nursing home were frequently admitted to the nursing home with a full code status. She reported sometimes the residents or family members wanted the code status changed after the residents had resided in the nursing home for awhile. She explained the code status was changed by obtaining a physician order, and the nurse who wrote this order was also responsible for changing the code status in the electronic medical record. According to the DON, she also reviewed the code status notebooks to make sure the same code status that was documented in writing was also documented in the electronic record. She was unable to explain why Resident #138's code status in the notebook did not match the code status on the profile page and e-MAR in the resident's electronic medical record. On 04/04/18 at 4:45 PM Nurse #3 (a Nurse Supervisor) stated if a nurse was passing medications on the hall and needed to know a resident's code status the fastest way to determine that would be to go to the profile page or look on the e-MAR in her computer. She reported it was important to honor resident choices by making sure the code status was up-to-date and accurate, and the same code status was documented in both the electronic system and on paper.	F 578		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		5/1/18

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F 658	Continued From page 4 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, physician interview, resident interview, staff interview, and record review the facility failed to enter physician orders into its electronic medical system resulting in 1 of 1 sampled residents (Resident #79) not receiving the Ocuvite (vitamin to promote eye health) and Flomax (medication to promote healthy urine flow) which was to be continued from the hospital. The facility also failed to apply compression stockings for 2 of 4 sampled residents (Resident #64 and Resident #3) with orders for compression stocking application. Findings included: 1. A 03/12/18 hospital discharge summary documented the facility was to continue providing Resident #79 with Flomax 0.8 milligrams (mg) daily (QD) and Ocuvite one capsule QD. Record review revealed Resident #79 was admitted to the facility on 03/12/18 with diagnoses that included benign prostatic hyperplasia (BPH) and glaucoma. Review of the facility's 03/12/18 handwritten Admission Orders revealed on the second page of the document Resident #79 had physician orders for Flomax 0.8 mg QD and Ocuvite 1 capsule QD. A 03/12/18 2:45 PM admission progress note documented Resident #79 was alert and oriented x 3, was able to make his needs known, was	F 658	F-658 Process that led to deficiency cited: Facility failed to enter complete physician orders into electronic medical record due to not following the facilities triple audit process for entering physician orders for new admissions. Facility failed to apply compression stockings as per physician order due to ineffective validation by assigned nurse. Procedure for implementing plan of correction: 100% education for license nurses on procedure to be completed by facility Staff Development nurse starting 4-20-18 that includes an initial audit of signed physician orders and hospital discharge orders, and then a second audit that includes an audit of the electronic physician orders and signed physician orders, and lastly a third audit that includes audit of the electronic physician orders and signed physician orders. 100% audit of new admissions and return admissions beginning on 4-5-18 for the past 60 days by Director of Nursing or designee to ensure that the physician orders compared to the hospital discharge orders were transcribed properly. Physician orders were reviewed and	

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F 658	Continued From page 5 being admitted after a fall at home with multiple fractures, and was having constant pain at a 5 level on a scale of 1 - 10. "All orders approved by provider in house earlier....Pharmacy notified of admission." A 03/12/18 10:16 PM physician progress note documented Resident #79 had a diagnosis of glaucoma, was supposed to receive Ocuvite daily, and was receiving Flomax for BPH management. Review of Resident #79's electronic medical record revealed he did not have electronic physician orders for Flomax or Ocuvite, and review of his March 2018 and April 2018 electronic medication administration records (e-MARs) revealed he had not received any Flomax or Ocuvite since his nursing home admission on 03/12/18. On 04/04/18 at 2:45 PM Resident #79's primary physician stated the resident's health was not negatively affected due to not receiving the Flomax and Ocuvite which were supposed to be continued from his hospital stay. He reported the resident was receiving prescription eye drops to control the ocular pressure associated with his glaucoma, and the Ocuvite was only a proactive vitamin to promote eye health. He commented the risk of not receiving Flomax with a BPH diagnosis was increased difficulty in urinating, but he reported that during his many assessments of Resident #79 the resident did not complain of any urination problems. On 04/04/18 at 3:09 PM, after comparing the facility's handwritten Admission Orders against the e-MAR, the Director of Nursing (DON) stated	F 658	clarified for 100% of residents with compression stockings. 100% of nursing department educated on validating usage of compression socks as per physician orders starting on 4-3-18 by the Staff Development Nurse. Monitoring procedure: Audit of new admissions and return admissions beginning on 4-5-18 for the next 30 days by Director of Nursing or designee to ensure that the physician orders compared to the hospital discharge orders were transcribed properly. 100% audit of existing residents with physicians orders for compression socks to ensure compression socks were on as ordered completed by the Staff Development Nurse on 4-5-18. Daily audit of compliance with usage of compression socks as per physician orders starting on 4-5-18 by Staff Development Nurse or designee for next 30 days. Results of audits will be reviewed weekly beginning on 4-6-18 by the QAPI Committee. Weekly audit results will be reviewed in the May 2018 QAPI Committee Meeting. Title of person responsible for implementing plan of correction: Staff Development Nurse Director of Nursing Date when corrective action will be completed: 5-1-18	

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it appeared to her that the nurse who entered the handwritten physician orders into the electronic medical record forgot to enter the second page of the written orders. She explained the facility had a three-point check system to ensure the accuracy of orders with one nurse hand writing orders from the hospital discharge summary, a second nurse entering the orders into the electronic medical system, and a third nurse (usually herself or a unit manager) comparing the orders in the electronic system against the handwritten Admission Orders. She commented the nurse practitioner (NP), primary physician, or on-call physician reviewed the handwritten Admission Orders and made any changes, additions, or deletions before they were entered into the electronic system. According to the DON, if the reviewing physician or NP did not want an order continued or carried over from the hospital they would write a discontinue order. She reported she was unsure how the three-point check system for order accuracy failed, causing Resident #79 not to receive the Flomax and Ocuvite which had been ordered.

On 04/04/18 at 3:45 PM Nurse #2, who cared for Resident #79 from 7:00 AM to 7:00 PM, stated a nurse hand transcribed orders from the hospital discharge summary, submitted the handwritten list to the physician or NP for review and changes, entered or had another nurse enter the orders into the electronic system, and then a nurse from the next shift reviewed the orders a third time for accuracy.

On 04/05/18 at 10:25 AM Resident #79 stated he was being discharged home tomorrow. He reported his primary physician made him aware that he had missed some doses of Coumadin

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while he was in the facility and that he had not received his Flomax and Ocuvite. The resident commented his preference would have been to receive the Flomax and Ocuvite in the facility, and he would continue to take these medications at home because they were important to him. However, he commented he had not experienced any eye problems or increased problems with urination while residing in the nursing home.

2. a. Resident #64 was admitted to the facility on 02/02/18. The resident's documented diagnoses included cerebrovascular accident (CVA) with hemiplegia/aphasia/dysphagia/gastrostomy, chronic atrial fibrillation, and hypertension.

The resident's 02/09/18 admission minimum data set (MDS) documented the resident's cognition was moderately impaired, he exhibited no behaviors including resistance to care, and he required extensive assistance from staff with his activities of daily living (ADLs).

A 03/23/18 physician order for Resident #64 documented, "Apply TED (compression) stockings to both legs every morning and Remove TED stockings to both legs at bedtime."

Review of the resident's April 2018 medication administration record (MAR) documented at 6:00 AM on 04/03/18 Nurse #5 initialed that he had "appl(ied) TED stockings to both legs every morning for edema APPLY BEFORE GETTING OOB (out of bed)". (Multiple phone calls were made to interview Nurse #5, but he never returned the messages which were left for him).

On 04/03/18 at 3:48 PM Resident #64 was sitting up in his wheelchair with shorts, athletic anklet

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socks, and tennis shoes on. The resident did not have compression stockings on.

On 04/03/18 at 4:06 PM Resident #64 was still sitting up in his wheelchair with shorts, athletic anklet socks, and tennis shoes on. The resident did not have compression stockings on.

On 04/03/18 at 4:08 PM nursing assistant (NA) #1 entered Resident #64's room, and closed the door to provide care.

On 04/03/18 at 4:11 PM NA #1 stated she was not assigned to care for Resident #64, but was asked to re-apply the resident's compression stockings because they had been soiled earlier in the day, and no one had gotten around to putting clean ones back on the resident yet.

On 04/03/18 at 4:17 PM NA #2 and NA #3 stated Resident #64 had his compression stockings on earlier in the day, but they had removed them when they put the resident back to bed for a nap. They reported they had forgotten to reapply them, but the stockings in his room were the same stockings that he had on earlier in the day.

On 04/03/18 at 4:20 PM Nurse #4 stated she could not remember whether Resident #64 had compression stockings on when she began her shift earlier in the morning. She reported the resident wore them for edema, and they were supposed to be put on the resident in the mornings before he got out of bed and removed before the resident was put to bed at night.

On 04/04/18 at 3:08 PM the Director of Nursing (DON) stated it was her expectation that if a resident had a physician order for compression

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stockings that they be applied daily. She reported residents did not have to wear the stockings when they were in bed, but unless the residents were put to bed at night, the stockings should be re-applied when the staff got the residents up from shorter stays in bed such as naps.

On 04/04/18 at 3:45 PM Nurse #1 stated she, as a nurse, usually applied and removed compression stockings, but it was okay for NAs to also apply and remove them. She reported before she signed off that compression stockings were applied on the MAR she actually laid eyes on the residents to make sure the stockings were in place as ordered.

2.b. Resident #3 was admitted to the facility on 5/10/16 with diagnoses of heart failure.

The Minimum Data Set (MDS) dated 1/2/18 quarterly assessment revealed Resident #3 was severely cognitively impaired and required an extensive assist with the assistance of two staff members with bed mobility, transfers, and toileting and one staff assistance with all other activities of daily living (ADLs). Resident #3 had no impairments and used a walker and a wheelchair. Resident #3 exhibited no behaviors including resistance to care.

A review of Resident #3 ' s care plans included a plan of care updated on 4/4/18 to include self-care deficit related to history of falls and dementia with interventions to include bunny

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boots (off-loading soft boots) to both feet while in bed, proper foot wear, no powder, non-slip strips to floor in front of resident ' s recliner, nonskid socks when out of bed and TED stockings.

A record review of the physician ' s order written on 11/2/17 revealed an order for knee high TED stockings to be applied in the morning and removed in the evening.

An observation of Resident #3 on 4/3/18 at 9:01 AM and at 2:25 PM revealed Resident #3 was noted to be lying in bed with nonskid socks in place. Resident #3 was noted to have slight bilateral ankle edema and there were no TED stockings in place as ordered.

An interview was conducted with Nurse #4 on 4/3/18 at 2:35 PM. Nurse #4 revealed Resident #3 did not wear anything on her feet and stated "she just wore nonskid socks." Nurse #4 reviewed the Medication Administration Record (MAR) at this time and she noted there was no order for TED stockings on the MAR during the shift of 7:00 AM till 7:00 PM. Nurse #4 also reviewed the Treatment Administration Record (TAR). Nurse #4 stated there was no order on the TAR for the 7:00 AM till 7:00 PM shift. Nurse #4 stated she had not seen TED stockings on the resident, but she had seen the resident wear the bunny boots. Nurse #4 observed the resident's legs and feet at this time and it was noted Resident #3 had slight edema to her ankles and there were no TED stockings on her feet. Nurse #4 stated she did not know if the resident had TED stockings in her room and stated she had not seen them on her. Nurse #4 then reviewed the MAR for the 7:00 PM till 7:00 AM shift. The order to apply the TED stockings was on the

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MAR for the second shift. Nurse #4 stated the night shift nurse was to apply them in the morning and remove them in the evening before bed and that was why the order was not on her MAR or TAR for the first shift. Nurse #4 confirmed that the TED stockings should have been on Resident #3 at the start of her shift on 4/3/18.

A review of the MAR on 4/3/18 revealed that Nurse #5 signed the MAR indicating that TED stockings were applied as evidenced by a check mark and Nurse #5 ' s initials.

An interview was attempted via phone on 4/3/18 at 3:00 PM with Nurse #5 who, according to the schedule, worked 7:00 PM till 7:00 AM on 4/2/18 into 4/3/18 and whose initials were on the MAR indicating the TED stockings were applied A voicemail message was left for a returned call. Attempted to interview Nurse #5 a second time on 4/4/18 at 11:57 AM and left a voicemail message for a returned call. Nurse #5 did not return the phone calls and was not interviewed.

An interview with Nurse #2 on 4/4/18 at 3:49 PM revealed that nursing assistants (NAs) or nurses could apply the TED stockings, and if a NA put them on a resident, the nurse would need to check to be sure they were on before signing the MAR or TAR. Nurse #2 stated nurses are not supposed to sign off that they have done a task or administered a medication until they have actually done it.

An interview with the Director of Nursing (DON) on 4/4/18 at 4:00 PM revealed that her expectation of the nurses would be to complete the task as ordered then sign the MAR or TAR to indicate that it was done. The DON confirmed

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F 658	Continued From page 12 the order was to apply the TED stockings in the morning and remove them in the evening. The DON confirmed there were no parameters as to when to apply them. The DON stated if the order stated to apply TED stockings, then her expectation would be that the nurses ensure they followed the physician ' s order as written.	F 658		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		5/1/18

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F 755	Continued From page 13 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Certified Pharmacy Technician interviews the facility failed to provide medications to meet the needs of newly admitted residents for 1 of 3 residents (Resident #188) whose records were reviewed. Findings included: Resident #188 was admitted to the facility at approximately 4:40 PM on 06/19/17 and discharged home at family request at approximately 1:30 PM on 06/20/17. Review of the Hospitalist Discharge Summary dated 06/19/17 revealed Resident #188 had diagnoses of paroxysmal atrial fibrillation (a condition where the upper heart chambers lose their normal rhythm and beat chaotically occasionally and stop spontaneously), sepsis and insulin dependent diabetes mellitus. Resident #188 was to start taking Eliquis (a blood thinner) twice each day and Levaquin (an antibiotic) every night. Resident #188 was to continue taking Sotalol (a drug to help regulate the beating of the heart), Lantus insulin, Humalog insulin, Trulicity, and Hyzaar (a medication to reduce blood pressure.) Review of the Medication Administration Record (MAR) for 06/19/17 revealed Resident #188 received 25 units of Lantus insulin at bedtime, Levaquin 750mg (milligrams) at 8:00 PM and Eliquis 5mg at 9:00 PM. The Sotalol was not administered to Resident #188 on 06/19/17 at 9:00 PM as ordered.	F 755	F-755 Process that led to deficiency cited: Facility failed to follow process for obtaining medications from backup pharmacy for a new admission. Procedure for implementing plan of correction: Affected resident was discharged. 100% of license nurses to be educated on obtaining medications as ordered from backup pharmacy by calling the pharmacy to request medications are sent STAT to be completed by the Staff Development Nurse and Director of Nursing beginning 4-20-18. 100% audit of new admissions and return admissions for the past 60 days starting on 4-27-18 to be completed by the Director of Nursing or designee to ensure that residents received their medications timely. Monitoring procedure: 100% audit of new admissions and return admissions beginning on 4-5-18 for 30 days by Director of Nursing or designee to ensure medications are ordered from the pharmacy, to include backup pharmacy ordering procedure when needed, and received timely for medication administration.	

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F 755	Continued From page 14 Review of the MAR for 06/20/17 revealed Resident #188 did not receive the Humalog insulin, Eliquis, Sotalol or Trulicity which were ordered for that day. In an interview on 04/04/18 at 3:26 PM Nurse #2 stated when the hospital discharge orders were received, the orders were transcribed onto the admission order sheet and then were faxed to the pharmacy along with the hospital discharge orders. The orders were then transcribed by another nurse into the computer. She indicated that last June the facility had an emergency medicine kit (E-kit) which contained some common medications that could be used for residents until the medications were received from the pharmacy. She indicated if medications were not received in a timely manner from the pharmacy, a telephone call should be made to the pharmacy to let them know the medications were needed that day. If the medications were still not received the on-coming nurse should be told so that the nurse could follow-up with the pharmacy. She indicated there was also a local pharmacy that the consultant pharmacist could call so the medications could be delivered more quickly if needed. In an interview on 04/04/18 at 4:07 PM Nurse #1 stated admission orders should be faxed and called to the pharmacy and was the responsibility of the residents nurse. She indicated the pharmacy made deliveries sometime between midnight and 4:00 AM. If the medications were not received by that time the nurse needed to call the pharmacy so the local back-up pharmacy could be notified that the medications were needed.	F 755	Results of audits will be reviewed weekly by the QAPI Committee for 4 weeks. Title of person responsible for implementing plan of correction: Director of Nursing Staff Development Nurse Date when corrective action will be completed: 5-1-18	

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In an interview on 04/04/18 at 4:30 PM Nurse #3 stated the process for admission orders was to transcribe them from the hospital discharge orders and have them approved by the Physician or Nurse Practitioner. The orders were then faxed to the pharmacy and the E-kit was opened and any ordered medications that were available in the E-kit would be administered. She indicated the orders were transcribed into the electronic record and the pharmacy also received a copy of the electronic record. She indicated medications were delivered by the pharmacy between 9:00 PM and 10:30 PM or they could send out a special delivery if needed. Nurse #3 stated someone should have called the pharmacy to inform them that the ordered medications had not been received and requested a special delivery either from the consultant pharmacy or the local back-up pharmacy. She indicated she would expect the medications to be provided prior to the 9:00 AM medication administration time.

In a follow-up interview Nurse #1 stated she called the pharmacy the morning of 06/20/17 when she saw Resident #188's medications were not available but that she had not documented the call.

In a telephone interview on 04/04/18 at 7:45 PM Nurse #6 verified she was Resident #188's nurse on the 7:00 PM shift on 06/19/17. She stated when hospital discharge records were received the orders were transcribed and put in the computer. The orders were then faxed to the pharmacy and if past the cut-off time of 3:00 PM the Director of Nursing (DON) would be notified and the pharmacy should be called. The pharmacy would do a special delivery if the

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F 755	Continued From page 16	F 755		

medications were needed that evening. She indicated medications were received from the pharmacy between 6:00 AM and 7:00 AM and should have been available for the 9:00 AM medication administration. Nurse #6 stated she followed up with the pharmacy because the medications were not received and passed the information on to Nurse #2 in report and also informed the Nursing Supervisor although she could not recall which supervisor she told. She indicated she did not document that she had contacted the pharmacy for Resident #188's medications.

In an interview on 04/05/18 at 9:40 AM the DON indicated medications for new admissions were usually delivered the evening of the admission. She stated that when she did rounds the morning of 06/20/17 she discovered Resident #188's medications had not been delivered and that she placed a call to the pharmacy. She indicated the medications were delivered later that day in the afternoon. She indicated the pharmacy delivered medications twice each night to the facility and that Resident #188's medications were just missed. She indicated it was her expectation that the facility be able to provide medications to each resident when they were admitted. She stated she expected timely delivery of medications from the pharmacy and the use of the local back-up pharmacy when needed.

In a telephone interview on 04/05/18 at 10:20 AM the Certified Pharmacy Technician (CPT) stated the pharmacy received Resident #188's admission orders at 6:12 PM on 06/19/17. She indicated the pharmacy did not receive a telephone call from the facility to let them know the medications were needed that night for

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F 755	Continued From page 17 administration. She indicated it was understood that if the facility needed medications that night they needed to call and inform the pharmacy so the on-call Pharmacist could come in and fill the order. She indicated that Resident #188's medications were received by the facility from the pharmacy at 1:00 PM on 06/20/17. The CPT stated if the facility had faxed the orders and called the pharmacy to let them know the medications were needed then the facility would have received the medications. The CPT was unable to provide a list of the medications that would have been available in the facility E-kit.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on physician interview, resident interview, staff interview, and record review the facility failed to administer three doses of Coumadin (anticoagulant) as ordered by the physician for 1 of 2 sampled residents who were receiving anticoagulant medications. Findings included: A 03/12/18 hospital discharge summary documented the facility was to continue providing Resident #79 with Coumadin 7.5 milligrams (mg) every Tuesday and Saturday and Coumadin 5 mg every Monday, Wednesday, Thursday, Friday, and Sunday. The form also documented the resident's PT/INR (prothrombin time/international normalized ratio) was 22.1/2.04 on the morning of 03/12/18 prior to hospital discharge.	F 760	F-760 Process that led to deficiency cited: Facility failed to enter complete physician orders into electronic medical record due to not following the facilities triple audit process for entering physician orders for new admissions. Procedure for implementing plan of correction: 100% education for license nurses on procedure to be completed by facility Staff Development nurse starting 4-20-18 that includes an initial audit of signed physician orders and hospital discharge	5/1/18

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F 760	Continued From page 18 Record review revealed Resident #79 was admitted to the facility on 03/12/18 with diagnoses that included atrial fibrillation (heart rhythm irregularities), congestive heart failure, history of pulmonary embolism (blood clot), and fracture of the left wrist, hand, and pubis (pelvis). Review of the facility's 03/12/18 handwritten Admission Orders revealed on the second page of the document Resident #79 had a physician order for Coumadin 7.5 mg on Tuesday and Saturday and for Coumadin 5 mg on all other days. A 03/12/18 2:45 PM admission progress note documented Resident #79 was alert and oriented x 3, was able to make his needs known, was being admitted after a fall at home with multiple fractures, and was having constant pain at a 5 level on a scale of 1 - 10. "All orders approved by provider in house earlier....Pharmacy notified of admission." A 03/12/18 10:16 PM physician progress note documented Resident #79 was to receive Coumadin 7.5 mg on Tuesday and Saturday and Coumadin 5 mg on all other days. The physician documented the resident was receiving Coumadin therapy for atrial fibrillation. "INR goal 2 - 3. Check INR and adjust meds." Review of the facility electronic medication administration record (e-MAR) revealed Resident #79 did not receive Coumadin, scheduled for 5:00 PM administration, on 03/12/18 (Monday), 03/13/18 (Tuesday), and 03/14/18 (Wednesday). The facility's electronic orders documented on 03/15/18 a physician order initiated Coumadin 1	F 760	orders, and then a second audit that includes an audit of the electronic physician orders and signed physician orders, and lastly a third audit that includes audit of the electronic physician orders and signed physician orders. 100% audit of new admissions and return admissions beginning on 4-5-18 for the past 60 days by Director of Nursing or designee to ensure that the physician orders compared to the hospital discharge orders were transcribed properly. Monitoring procedure: Audit of new admissions and return admissions beginning on 4-5-18 for the next 30 days by Director of Nursing or designee to ensure that the physician orders compared to the hospital discharge orders were transcribed properly. Results of audits will be reviewed weekly by the QAPI Committee for 4 weeks. Title of person responsible for implementing plan of correction: Staff Development Nurse Director of Nursing Date when corrective action will be completed: 5-1-18	

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mg every Monday, Wednesday, Thursday, Friday, and Saturday for Resident #79. Review of the e-MAR revealed the resident received the Coumadin as ordered on 03/15/18.

Review of the electronic physician orders documented the order for Coumadin 1 mg was discontinued on 03/16/18, and a new physician order started the resident on Coumadin 5 mg every Monday, Wednesday, Thursday, Friday, and Sunday. Review of the e-MAR revealed the resident received the Coumadin as ordered on 03/16/18 and thereafter.

The facility's electronic orders documented on 03/17/18 a physician order also initiated Coumadin 7.5 mg every Tuesday and Saturday for Resident #79. Review of the e-MAR revealed the resident received the Coumadin as ordered on 03/17/18 and thereafter.

A 03/19/18 STAT (at once emergency lab) PT/INR, the first drawn by the facility since the resident's 03/12/18 hospital PT/INR, documented on 03/19/18 the resident's PT/INR was 13.6/1.26, with the INR out of the goal range of 2 - 3.

Resident #79's 03/19/18 admission minimum data set (MDS) documented his cognition was intact, he exhibited no signs and symptoms of delirium/mood issues/psychosis/behavior problems, he required extensive assistance from staff with most of his activities of daily living (ADLs), and he had only received anticoagulant medication on 5 of the 7 days of the look back assessment period.

On 03/27/18 Resident #79's care plan identified "The resident is on anticoagulant therapy r/t (due

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to) atrial fibrillation" as a problem. The goal for the problem was, "The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date." Interventions for the problem included, "Assess/document/report to nurse/MD (physician) s/sx (signs and symptoms) of anticoagulant complications, Labs as ordered. Report abnormal lab results to the MD, Review medication list for adverse interactions, Skin inspection with care and per routine. Report abnormalities to the nurse."

On 04/04/18 at 2:45 PM Resident #79's primary physician stated he never ordered for the resident's Coumadin to be held. He reported recalling his nurse practitioner (NP) catching that Coumadin was not being administered to Resident #79 although the resident had a physician order for it to be continued from the hospital. He commented the resident was receiving Coumadin for control of his atrial fibrillation, and explained the goal was to keep the resident's INR between 2 - 3. He explained that goal was reached when labs were drawn in the hospital on the morning of 03/12/18 with the resident having a documented INR of 2.04. The physician commented obviously by the time the resident's next PT/INR was drawn on 03/19/18 the resident's INR was out of range at 1.26, and missed doses of Coumadin contributed to this. According to statistics, the physician reported missed doses of Coumadin given for heart rhythm control increased the chance of a heart attack by 7%. The physician stated in the nursing home Resident #79 was very mobile in his wheelchair so his chances of a heart attack were probably decreased somewhat below the 7%. The physician commented during

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assessments of the resident the resident never exhibited or complained of signs and symptoms indicative of heart problems. (Review of progress notes also revealed there were no documented concerns or complaints from the resident that were of a cardiac nature). According to the physician, the NP who discovered the missing doses of Coumadin was on vacation and not available for interview.

On 04/04/18 at 3:09 PM the Director of Nursing (DON) reported she was not aware that Resident #79 had missed doses of Coumadin. After comparing the facility's handwritten Admission Orders against the e-MAR, she stated it appeared to her that the nurse who entered the handwritten physician orders into the electronic medical record forgot to enter the second page of the written orders. She explained the facility had a three-point check system to ensure the accuracy of orders with one nurse hand writing orders from the hospital discharge summary, a second nurse entering the orders into the electronic medical system, and a third nurse (usually herself or a unit manager) comparing the orders in the electronic system against the handwritten Admission Orders. She commented the NP, primary physician, or on-call physician reviewed the handwritten Admission Orders and made any changes, additions, or deletions before they were entered into the electronic system. According to the DON, if the reviewing physician or NP did not want an order continued or carried over from the hospital they would write a discontinue order. The DON commented missing doses of Coumadin increased the chance of developing a deep venous thrombosis (blood clot) and/or increased the chance of having a heart attack. She stated she had not been made aware that

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F 760	Continued From page 22 Resident #79 was exhibiting signs and symptoms of either of these conditions. She reported she was unsure how the three-point check system for order accuracy failed, causing Resident #79 to miss three doses of Coumadin. On 04/04/18 at 3:45 PM Nurse #2, who cared for Resident #79 from 7:00 AM to 7:00 PM, stated a nurse hand transcribed orders from the hospital discharge summary, submitted the handwritten list to the physician or NP for review and changes, entered or had another nurse enter the orders into the electronic system, and then a nurse from the next shift reviewed the orders a third time for accuracy. According to Nurse #2, Resident #79 had not complained to her about any signs of cardiac trouble during his nursing home stay. On 04/05/18 at 10:25 AM Resident #79 stated he was being discharged home tomorrow. He reported his primary physician made him aware that he had missed some doses of Coumadin while he was in the facility. However, he commented he had not experienced any signs or symptoms of heart rhythm problems or cardiac discomfort during his nursing home stay.	F 760		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical	F 773		5/1/18

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F 773	Continued From page 23 nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on physician interview, resident interview, staff interview, and record review the facility failed to obtain PT/INR (prothrombin time/international normalized ratio) results as ordered by the physician for 1 of 2 sampled residents who were receiving anticoagulant medications. Findings included: A 03/12/18 hospital discharge summary documented the facility was to continue providing Resident #79 with Coumadin 7.5 milligarms (mg) every Tuesday and Saturday and Coumadin 5 mg every Monday, Wednesday, Thursday, Friday, and Sunday. Discharge instructions included, "Continue Coumadin with INR goal 2 - 3 daily to help prevent blood clots while you are recovering from your injuries." The form also documented the resident's PT/INR was 22.1/2.04 on the morning of 03/12/18 prior to discharge from the hospital. Record review revealed Resident #79 was admitted to the facility on 03/12/18 with diagnoses that included atrial fibrillation (heart rhythm irregularities), congestive heart failure, history of pulmonary embolism (blood clot), and fracture of the left wrist, hand, and pubis (pelvis). Review of the facility's 03/12/18 handwritten Admission Orders revealed on the second page of the document Resident #79 had a physician order for Coumadin 7.5 mg on Tuesday and	F 773	F-773 Process that led to deficiency cited: Facility failed to enter complete physician orders into electronic medical record due to not following the facilities triple audit process for entering physician orders for new admissions. Procedure for implementing plan of correction: 100% education for license nurses on procedure to be completed by facility Staff Development nurse starting 4-20-18 that includes an initial audit of signed physician orders and hospital discharge orders, and then a second audit that includes an audit of the electronic physician orders and signed physician orders, and lastly a third audit that includes audit of the electronic physician orders and signed physician orders. 100% audit of new admissions and return admissions beginning on 4-5-18 for the past 60 days by Director of Nursing or designee to ensure that the physician orders compared to the hospital discharge orders were transcribed properly. Monitoring procedure: 100% audit of new admissions and return admissions beginning on 4-5-18 for the	

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F 773	Continued From page 24 Saturday and for Coumadin 5 mg on all other days and a physician order for "Labs: PT/INR Q (every) Thursday." A 03/12/18 2:45 PM admission progress note documented Resident #79 was alert and oriented x 3, was able to make his needs known, was being admitted after a fall at home with multiple fractures, and was having constant pain at a 5 level on a scale of 1 - 10. "All orders approved by provider in house earlier....Pharmacy notified of admission." A 03/12/18 10:16 PM physician progress note documented, "...(Atrial fibrillation) on coumadin therapy-INR goal 2-3. Check INR and adjust meds." Review of the facility electronic medication administration record (e-MAR) revealed Resident #79 did not receive Coumadin, scheduled for 5:00 PM administration, on 03/12/18 (Monday), 03/13/18 (Tuesday), and 03/14/18 (Wednesday). Review of the facility's lab notebook revealed Resident #79 was scheduled to have a PT/INR drawn on 03/15/18 (Thursday). However, the lab did not get drawn, and there were no PT/INR values documented on the resident's lab results page associated with a 03/15/18 lab draw. Review of the facility's lab notebook revealed Resident #79 was scheduled for a STAT (at once, emergency) PT/INR on 03/19/18. Results from the 03/19/18 lab draw documented the resident's PT/INR was 13.6/1.26, with the INR out of the goal range of 2 - 3. Resident #79's 03/19/18 admission minimum	F 773	past 60 days by Director of Nursing or designee to ensure that the physician orders compared to the hospital discharge orders were transcribed properly. Audit of new admissions and return admissions beginning on 4-5-18 for the next 30 days by Director of Nursing or designee to ensure that the physician orders compared to the hospital discharge orders were transcribed properly. Results of audits will be reviewed weekly by the QAPI Committee for 4 weeks. Title of person responsible for implementing plan of correction: Staff Development Nurse Director of Nursing Date when corrective action will be completed: 5-1-18	

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data set (MDS) documented his cognition was intact, he exhibited no signs and symptoms of delirium/mood issues/psychosis/behavior problems, he required extensive assistance from staff with most of his activities of daily living (ADLs), and he had only received anticoagulant medication on 5 of the 7 days of the look back assessment period.

On 03/27/18 Resident #79's care plan identified "The resident is on anticoagulant therapy r/t (due to) atrial fibrillation" as a problem. The goal for the problem was, "The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date." Interventions for the problem included, "Labs as ordered. Report abnormal lab results to the MD (physician)."

On 04/04/18 at 2:45 PM Resident #79's primary physician reported recalling his nurse practitioner (NP) catching that Coumadin was not being administered to Resident #79 although the resident had a physician order for it to be continued from the hospital. He commented the resident was receiving Coumadin for control of his atrial fibrillation, and explained the goal was to keep the resident's INR between 2 - 3. He explained that goal was reached when labs were drawn in the hospital on the morning of 03/12/18 with the resident having a documented INR of 2.04. The physician stated obviously by the time the resident's next PT/INR was drawn on 03/19/18 the resident's INR was out of range at 1.26, and missed doses of Coumadin contributed to this. He reported obtaining weekly PT/INR results was important for Resident #79 as he adjusted to a new nursing home environment and diet. According to the physician, weekly PT/INR

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values enabled the Coumadin dose to be adjusted quickly to keep the resident's INR in the goal range which made it less likely that the resident might develop a blood clot or have a heart attack. The physician commented during assessments of the resident the resident never exhibited or complained of signs and symptoms indicative of heart problems. (Review of progress notes also revealed there were no documented concerns or complaints from the resident that were of a cardiac nature). According to the physician, the NP who discovered the missing doses of Coumadin was on vacation and not available for interview.

On 04/04/18 at 3:09 PM the Director of Nursing (DON) reported she was not aware that Resident #79 had missed doses of Coumadin. After comparing the facility's handwritten Admission Orders against the e-MAR, she stated it appeared to her that the nurse who entered the handwritten physician orders into the electronical medical record forgot to enter the second page of the written orders which included the Coumadin and PT/INR lab orders. She explained the facility had a three-point check system to ensure the accuracy of orders with one nurse hand writing orders from the hospital discharge summary, a second nurse entering the orders into the electronic medical system, and a third nurse (usually herself or a unit manager) comparing the orders in the electronic system against the handwritten Admission Orders. She commented the NP, primary physician, or on-call physician reviewed the handwritten Admission Orders and made any changes, additions, or deletions before they were entered into the electronic system. According to the DON, if the reviewing physician or NP did not want an order continued or carried

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F 773	Continued From page 27	F 773		

over from the hospital they would write a discontinue order. The DON commented missing doses of Coumadin increased the chance of developing a deep venous thrombosis (blood clot) and/or increased the chance of having a heart attack. She stated she had not been made aware that Resident #79 was exhibiting signs and symptoms of either of these conditions. She reported she was unsure how the three-point check system for order accuracy failed, contributing to Resident #79's 03/15/18 PT/INR not getting drawn.

On 04/04/18 at 3:45 PM Nurse #2, who cared for Resident #79 from 7:00 AM to 7:00 PM, stated a nurse hand transcribed orders from the hospital discharge summary, submitted the handwritten list to the physician or NP for review and changes, entered or had another nurse enter the orders into the electronic system, and then a nurse from the next shift reviewed the orders a third time for accuracy. According to Nurse #2, Resident #79 had not complained to her about any signs of cardiac trouble during his nursing home stay.

On 04/05/18 at 10:25 AM Resident #79 stated he was being discharged home tomorrow. He reported his primary physician made him aware that he had missed some doses of Coumadin and a PT/INR lab draw while he was in the facility. However, he commented he had not experienced any signs or symptoms of heart rhythm problems or cardiac discomfort during his nursing home stay.

On 04/05/18 at 1:13 PM the DON sated the phlebotomist usually drew labs around 6:00 AM, but if there were problems and a facility nurse

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F 773	Continued From page 28 had to gather the bloodwork, then the labs would be drawn a little later in the morning. She reported part of the reason she thought Resident #79 did not get his 03/15/18 PT/INR drawn was because the nurse in charge of the lab process was out of the facility on that date due to an acute health problem.	F 773		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain cold salads made with mayonnaise at 41 degrees Fahrenheit or below, failed to air dry kitchenware before stacking it in storage, and failed to de-stain kitchenware and dispose of abraded kitchenware. Findings included:	F 812	Process that led to deficiency cited: Facility failed to maintain cold salads made with mayonnaise at 41 degrees Fahrenheit or below due to not handling cold salad as to maintain temperature of 41 degrees Fahrenheit or below. Facility failed to air dry kitchenware before	5/1/18

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F 812	Continued From page 29 1. At 11:18 AM on 04/04/18 five egg salad sandwich plates were covered with plastic wrap and sitting on a food preparation counter. A calibrated thermometer was used to check the temperature of the egg salad which remained in the tray pan after the sandwiches had been assembled. The thermometer registered 55 degrees Fahrenheit. At this time the dietary aide who prepared the sandwiches stated they were an alternate item for the lunch meal.. He reported he obtained left over egg salad from the walk-in refrigerator, but added three to four more eggs to make sure he had an adequate amount of egg salad to prepare five sandwiches. At this time the cook stated the trayline would begin operation at 11:30 AM. At 10:40 AM on 04/05/18 the assistant dietary manager (ADM) stated chilled salads made with mayonnaise should be kept at or below 41 degrees Fahrenheit. She reported she thought adding extra ingredients to the left over egg salad had caused temperature problems. She commented it was important to keep products containing mayonnaise at the appropriate temperature to avoid the chance of spoilage over an extended period of time which could make residents sick. At 10:46 AM on 04/05/16 the cook stated the facility made its own egg salad, and it contained eggs, pickle relish, mustard, mayonnaise, and salt and pepper. He reported chilled ingredients were supposed to be used when preparing cold salads, and the cold salads should be at 41 degrees Fahrenheit or below to lessen the chance that residents could get sick from bacterial contamination.	F 812	stacking it in storage due to not following air dry and storage procedure. Facility failed to de-stain kitchenware and dispose of abraded kitchenware due to not consistently auditing kitchenware for stains and replacement. Procedure for implementing plan of correction: 100% education for dietary staff on proper handling of cold salads to maintain temperature of 41 degrees Fahrenheit or below beginning on 4-12-18 by the Dietary Manager. 100% education for dietary staff on proper procedure for air drying kitchenware before it is stacked in storage beginning on 4-12-18 by the Dietary Manager. 100% education for dietary staff on de-staining of kitchenware schedule and procedure beginning on 4-12-18 by the Dietary Manager. 100% audit of kitchenware for de-staining completed on 4-5-19 by the Dietary Manager. 100% education for dietary staff on reviewing kitchenware for abrasions for disposal and replacement during the daily dishwashing process beginning on 4-12-18 by the Dietary Manager. 100% audit of kitchenware for abrasions completed on 4-5-19 by the Dietary Manager. Monitoring procedure: Audit of proper handling of cold foods by observation and temperature assessment 5 days a week, when cold foods are present on menu, by the Dietary Manager beginning on 4-12-18 for 4 weeks. Audit of proper procedure for air drying	

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F 812	Continued From page 30 2. During initial tour of the kitchen, beginning at 11:42 AM on 04/02/18, 14 of 18 tray pans stacked on top of one another on a storage rack were wet inside. During a follow-up tour of the kitchen, beginning at 7:55 AM on 04/04/18, 8 of 15 tray pans stacked on top of one another on a storage rack were wet inside. At 10:40 AM on 04/05/18 the assistant dietary manager (ADM) stated that several times prior to the survey the dietary staff had been in-serviced on making sure all kitchenware was air dried before stacking it in storage. She reported that stacking pieces of wet kitchenware of top of one another in storage promoted the growth of bacteria which could make residents sick. At 10:46 AM on 04/05/18 the cook stated it was important to have air circulating around drying kitchenware so stacking it wet on a storage rack was not a good practice since germs and mold could grow. He reported these could potentially make residents sick. 3. During an inspection of kitchenware, beginning at 10:20 AM on 04/04/18, 8 of 24 coffee mugs (33%) had dark brown stains inside of them, and 12 of 36 eight-ounce clear drinking cups (33%) were stained brown. In addition, the interior surfaces of 7 of 24 plastic soup/cereal bowls (29%) were abraded and rough to the touch. At 10:40 AM on 04/05/18 the assistant dietary manager (ADM) stated dietary staff were supposed to use a bleach-based solution to	F 812	kitchenware before it's stacked in storage beginning on 4-12-18, 5 days a week for 4 weeks by the Dietary Manager. Audit of de-staining schedule (every other week) beginning on 4-5-18 for 4 weeks by the Dietary Manager. Audit of kitchenware for abrasions beginning on 4-5-18, 5 days a week for 4 weeks by the Dietary Manager. Results of audits will be reviewed weekly by the QAPI Committee for 4 weeks. Title of person responsible for implementing plan of correction: Dietary Manager Date when corrective action will be completed: 5-1-18	

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F 812	Continued From page 31 de-stain kitchenware monthly, but because of a shortage of help it had been longer than a month since the procedure was last completed. She reported abraded kitchenware was supposed to be disposed of because pieces of plastic or other materials could slough off into resident food and the abraded surfaces were more apt to harbor bacteria. At 10:46 AM on 04/05/18 the cook stated the dietary staff de-stained kitchenware that was discolored weekly, but it had been awhile since that had occurred due to a shortage of staff. He reported kitchenware which was compromised with abrasions, cracks, and chips was supposed to be taken to the dietary manager or ADM so they could document the number of pieces requiring disposal. He explained this helped the manager know how much new kitchenware to order so he/she could replenish what was thrown away. He commented abraded surfaces making contact with food could contaminate the food with germs, bacteria, and materials from which the kitchenware was made.	F 812		
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.	F 842		5/1/18

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§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 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

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F 842	Continued From page 33 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 observations, record review and staff interviews, the facility inaccurately documented a task as completed on the Medication Administration Record for 1 of 2 residents (Resident #3) observed for the application of TED (compression) stockings to be applied to both legs every morning and removed at bedtime. Findings Included: Resident #3 was admitted to the facility on 5/10/16 with a diagnoses of heart disease. The Minimum Data Set (MDS) dated 1/2/18 quarterly assessment revealed Resident #3 was severely cognitively impaired and required an extensive assist with the assistance of two staff members with bed mobility, transfers, and toileting and one staff assistance with all other activities of daily living (ADLs). Resident #3 had no impairments and used a walker and a wheelchair. Resident #3 exhibited no behaviors including resisting care.	F 842	Process that led to deficiency cited: Facility inaccurately documented a task as completed on the Medication Administration Record due to the nurse not validating that the task was completed prior to recording completion of task on Medication Administration Record. Procedure for implementing plan of correction: 100% license nurse education on validating that tasks are completed prior documenting its completion on the Medication Administration Record beginning on 4-3-18 by the Staff Development Nurse. Monitoring procedure: Audit of resident's Medication Administration Record with compression socks to ensure compliance with accurately documenting completed tasks beginning on 4-5-18 for 30 days by the	

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F 842	Continued From page 34 A review of Resident #3 ' s care plans included a plan of care updated on 1/4/18 to include a self-care deficit related to history of falls and dementia with interventions to include bunny boots (off-loading soft boots) to both feet while in bed, proper foot wear, no powder, non-slip strips to floor in front of resident ' s reclining chair, nonskid socks when out of bed, and an order for TED stockings. A record review of the physician ' s order written on 11/2/17 revealed an order for knee high TED stockings to be put on in the morning and removed at night. An observation of Resident #3 on 4/3/18 at 9:01 am and at 2:25 pm revealed Resident #3 was noted to be lying in bed with nonskid socks in place. Resident #3 had slight bilateral ankle edema and there were no TED stockings in place as ordered. An interview was conducted with Nurse #4 on 4/3/18 at 2:15 pm. Nurse #4 revealed Resident #3 did not wear anything on her feet and stated "she just wore nonskid socks." Nurse #4 reviewed the Medication Administration Record (MAR) at this time and she noted there was no order for TED stockings on the MAR during the shift of 7:00 am till 7:00 pm. Nurse #4 also reviewed the Treatment Administration Record (TAR). Nurse #4 stated there was no order on the TAR for the 7:00 am till 7:00 pm shift. Nurse #4 stated she had not seen TED stockings on the resident, but she had seen her wear the bunny boots. Nurse #4 observed the resident's legs and feet at this time and it was noted Resident #3 had slight edema to her ankles and the resident did	F 842	Assistant Director of Nursing. Results of audits will be reviewed weekly by the QAPI Committee for 4 weeks. Title of person responsible for implementing plan of correction: Staff Development Nurse Assistant Director of Nursing Date when corrective action will be completed: 5-1-18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING _____ B. WING _____	C 04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 35	F 842		

not have the TED stockings on. Nurse #4 stated she did not know if the resident had TED stockings in her room and stated she had not seen them on her. Nurse #4 then reviewed the MAR for the 7:00 pm till 7:00 am shift. The order to apply the TED stockings was on the MAR for the second shift. Nurse #4 stated the night shift nurse was to apply them in the morning and remove them in the evening before bed and that was why the order was not on her MAR or TAR for the first shift. Nurse #4 stated if there was a check mark and initials in the box on the MAR or TAR, it would mean that the task was completed by the nurse with the initials that were indicated. Nurse #4 confirmed that the TED stockings should have been on Resident #3 at the start of her shift on 4/3/18.

A review of the MAR on 4/3/18 revealed that Nurse #5 signed off that TED stockings were applied on Resident #3 as evidenced by a check mark and Nurse #5 ' s initials.

An interview was attempted via phone on 4/3/18 at 3:00 pm with Nurse #5 who, according to the schedule, worked 7:00 pm till 7:00 am on 4/2/18 into 4/3/18 and whose initials were on the MAR indicating the TED stockings were applied. A voicemail message was left for a returned call.

An attempt was made to interview Nurse #5 via phone a second time on 4/4/18 at 11:57 am. A voicemail message was left for a returned call. Nurse #5 did not return the phone calls and was not interviewed.

An interview with Nurse #2 on 4/4/18 at 3:49 pm revealed that Nurse #2 stated nursing assistants (NAs) or nurses could apply the TED stockings,

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F 842	Continued From page 36	F 842		

and if a NA put them on a resident, the nurse would need to check to be sure they were on before signing the MAR. Nurse #2 stated if a check mark was on the MAR and there were initials under the task, it would mean the nurse completed the task. Nurse #2 stated nurses are not supposed to sign off that they have done a task or administered a medication until they have actually done it.

An interview with the Director of Nursing (DON) on 4/4/18 at 4:00 pm revealed that her expectation of the nurses would be to complete the task as ordered then sign off in the MAR or TAR that the task was done. The DON confirmed the order was to apply the TED stockings in the morning and remove them at night. The DON confirmed there were no parameters as to when to apply them. The DON stated if the order stated to apply TED stockings, then her expectation would be that the nurses ensured they were applied before signing the task off as completed.