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MILSON PINES NURSING AND REHABILITATION CENTER WILSON PINES NURSING AND REHABILITATION CENTER WILSON, No. 27893 SIBMAMY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION (RACH CONNECTIVE ACTION SHOULD BE PRECEDED BY PILL REQUILATION OF DEFICIENCY) AND 15 DE PRECEDED BY PILL RECOULATION OF DEFICIENCY SIMMARY STATEMENT OF DEFICIENCE ACTION SHOULD BE PRECEDED BY PILL RECOULATION OF DEFICIENCY SIMMARY STATEMENT OF DEFICIENCE ACTION SHOULD BE COMPETCION OF TAKE STATEMENT OF DEFICIENCY STATEMENT OF DEFI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCT	TION	(X3) DATE SURVE COMPLETED		
INME OF PROVIDER OR SUPPLIER WILSON PINES NURSING AND REHABILITATION CENTER UICACH DEPICIONEY WILST ENTECEDED BY FULL GEACH DEPICIONEY WILST ENTECEDED BY FULL GEACH DEPICIONEY WILST ENTECED BY FULL FREDIX GEACH DEPICIONEY WILST ENTECED BY FULL GEACH DEPICIONEY WILST ENTECED BY FULL FREDIX FREDIX GEACH DEPICIONEY WILST ENTECED BY FULL GEACH DEPICIONEY WILST ENTECED BY FULL GEACH DEPICIONEY WILST ENTECH BY TAG CFR(s): 483.20(f)(5), 483.70(f)(1)-(5) S483.20(f)(5), 483.70(f)(1)-(5) S483.20(f)(5), 483.70(f)(1)-(5) S483.20(f)(5), 88sident-identifiable information, (i) A facility may not release information that is resident-identifiable to the public, and accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility wilst sie is permitted to do so. \$483.70(f)(1) 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 S483.70(f)(2) The facility must keep confidential all information contained in the resident's records, regardess 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) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 145.406; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, or organ donation purposes, research to coroners,			345372	B. WING _	B. WING				
FREFIX TAG RECULATORY OR ISC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR ISC IDENTIFYING INFORMATION PREFIX TAG RESIDENCE TO THE APPROPRIATE DATE DAT					403 CRESTVIEW AVENUE				
SS=D 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, or to coroners,	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		EACH CORRECTIVE ACTION SHOU OSS-REFERENCED TO THE APPR	JLD BE	COMPLETION	
medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	SS=D	CFR(s): 483.20(f)(5) §483.20(f)(5) Reside (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use or except to the extent to do so. §483.70(i) Medical residentifiable accordance with a cagrees not to use or except to the extent to do so. §483.70(i) Medical residentifiable accordance with a cagrees not to use or except to the extent to do so. §483.70(i) Medical residentifiable accordance with accordance with a cagrofessional standar must maintain medicate that are- (i) Complete; (ii) Accurately docurately docurately docurately docurately docurately occurately occurately occurately occurately occurately occurately occurately occurately occurately accept when (ii) Readily accessible (iv) Systematically of the for records, except when (ii) To the individual, representative when (ii) Required by Law (iii) For treatment, particular poperations, as permitted with the complex of the formation activities, judicial and law enforcement pur purposes, research medical examiners, a serious threat to head the control of the co	ent-identifiable information. release information that is to the public. elease information that is to an agent only in ontract under which the agent disclose the information the facility itself is permitted ecords. ordance with accepted rds and practices, the facility cal records on each resident enented; ole; and rganized cility must keep confidential ined in the resident's records, m or storage method of the n release is- or their resident e permitted by applicable law; cayment, or health care itted by and in compliance 6; n activities, reporting of abuse, eviolence, health oversight d administrative proceedings, rposes, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted		42				

07/12/2018

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.

Electronically Signed

Facility ID: 923039

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
						C 6/28/2018	
NAME OF PROVIDER OR SUPPLIER WILSON PINES NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 403 CRESTVIEW AVENUE WILSON, NC 27893		0/20/2010	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	§483.70(i)(3) The factorecord information agunauthorized use. §483.70(i)(4) Medica for- (i) The period of time (ii) Five years from the there is no requiremed (iii) For a minor, 3 years legal age under State (iii) For a minor, 3 years legal age under State (iii) A record of the result of the re	e with 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or I records must be retained required by State law; or see date of discharge when ent in State law; or ars after a resident reaches e law. cidical record must containtion to identify the resident; sident's assessments; ever plan of care and services by preadmission screening evaluations and cucted by the State; e's, and other licensed so notes; and logy and other diagnostic equired under §483.50. This is not met as evidenced riews and record reviews, the ment a physician 's order to edule for the administration ance medication for 1 of 3 esident #2); and, failed to	F8	The process that led to this d was facility failed to document physician's order to change a schedule for the administration controlled substance medicati sampled residents (resident # to completely and accurately of the administration of a prescrimedication on the Medication Administration Record (MAR)	t a dosing n of a on for 1 of 3 2) and failed document bed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345372	B. WING			C 06/28/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	•	00/20/2010	
				403 CRESTVIEW AVENUE			
WILSON F	PINES NURSING AND R	EHABILITATION CENTER		WILSON, NC 27893			
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F 842	Continued From pag	ge 2	F 84	2			
	2/1/17 from a hospit included a history of diabetes, and demended a history of Resident Set (MDS) assisted as revealed the resident cognitive skills for day a sessive and the resident set of Daily Live A review of the resident set of Daily Live A review of the residence on 5/4/18 physician orders revealed Resident procedure on 5/4/18 physician orders reverseived to initiate 3 acetaminophen with medication which into for pain relief) on 5/5 by mouth every six here in the revealed of MAR) reveascheduled to be given 12:00 PM, and 6:00 the 6:00 AM dose or Further review of the revealed a handwritt administration of acetal set of the revealed a handwritt administration of acetal s	t #2 's quarterly Minimum essment dated 3/14/18 It had severely impaired aily decision making. Section sment indicated the resident to total assistance for all of his ring (ADLs). The tent 's medical record 2 underwent a surgical 2. A review of the resident 's ealed a telephone order was 00/30 milligrams (mg) codeine (a combination cluded a controlled substance 5/18 as one tablet to be given and the second and the second and the second and the eresident 's May 2018 MAR ten notation indicated the estaminophen with codeine		On 7/12/18, a 100% audit of a physician's orders and Medic Administration Records (MAF past 30 days to include reside completed by the Director of Nurse Supervisors, Resource Quality assurance Nurses, M Set nurse, Staff Facilitator an Nurses to ensure all medicati were accurately transcribed to and provided as ordered. Any noted were addressed immed Director of Nursing, Nurse Su Quality Assurance Nurses, M set nurse, Staff Facilitator and Nurses to include staff retrain assessment of residents with medications, to include physic notification and implementation orders as applicable. On 7/12/18, a 100% audit was by the Director of Nursing, Nurse assurance Nurses, Minimum nurse, Staff Facilitator and Tr Nurses of all progress notes are ensure all documentation of resident #2 were accuranscribed to the MAR and pordered. All areas of concernimmediately addressed by the	ation Rs) for the ent #2 was Nursing, e Nurse, inimum Data d Treatment on orders to the MAR omissions diately by the apervisors, inimum Data d Treatment ing, omitted cian on of new s completed arse e, Quality Data Set eatment a 30 days to new orders to arately provided as were		
	6:00 AM dose on 5/s handwritten notation the administration of with codeine as one hours on an as need	was discontinued after the 0/18. The MAR included a (not dated) which initiated 300/30 mg acetaminophen tablet by mouth every 6 led basis (versus scheduled evealed one dose of 300/30		immediately addressed by the Nursing, Nurse Supervisors, Nurse, Quality Assurance Nu Minimum Data Set nurse, Sta and Treatment Nurses to include retraining, assessment of res omitted medications, to include	Resource rses, aff Facilitator ude staff idents with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345372	B. WING	B. WING		C 06/28/2018
NAME OF P	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, S	STATE. ZIP CODE	06/26/2016
				403 CRESTVIEW AVENUE		
WILSON F	PINES NURSING AND RI	EHABILITATION CENTER		WILSON, NC 27893	_	
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F 842	Continued From pag	e 3	F 8	42		
		dent #2 on 5/15/18, one ed on 5/17/18, and one dose		orders as applica On 7/12/18 a 100	0% audit of all MARs x	30
	A review of Resident revealed no order was scheduled dosing of with codeine initiated was written to initiate acetaminophen with (versus scheduled do An interview was cor PM with Nurse Supe the facility 's Directo Supervisor #1 was id handwritten the chand 's acetaminophen with an as needed basi Upon review of the re Supervisor stated sh	#2's physician's orders as written to discontinue the 300/30 mg acetaminophen on 5/5/18; and, no order the administration of the codeine on as needed basis osing). Inducted on 6/28/18 at 12:15 rvisor #1 in the presence of or of Nursing (DON). Nurse lentified as having the indexing for Resident #2 with codeine from a scheduled is on the resident's MAR. Resident's records, the Nurse the recalled talking with the		days to include recompleted by the Nurse Supervisor Quality Assurance Set nurse, Staff F Nurses to ensure were completely a documented by nomissions were in by the Director of Supervisors, Qua Minimum Data se and Treatment Nuretraining, assess omitted medication notification and in orders as applica	esident #2 was EDirector of Nursing, rs, Resource Nurse, e Nurses, Minimum Da Facilitator and Treatmer e all medications given and accurately nursing staff. All mmediately addressed f Nursing, Nurse ality assurance Nurse, et nurse, Staff Facilitato urses to include staff sment of residents with ons, to include physicia inplementation of new ible.	nt nt or
	the resident 's order codeine to be given of scheduled dosing. changed the dosing must have forgotten the resident 's medic DON stated her expensive been written." 2) Resident #2 was			by the licensed noted to have me determine if any a present. The Medof any adverse fir assessment. The utilize a resident all residents with and ensure an as completed and th adverse findings.		ed e
		#2 ' s quarterly Minimum		licensed nurses a	0% in-service for all and medication aides w irector of Nursing, Staff	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SURVEY COMPLETED	
345372	B. WING _	B. WING		C 5/28/2018	
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REHABILITATION CENTER		WILSON, NC 27893			
STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
age 4 ent had severely impaired daily decision making. Section essment indicated the resident to total assistance for his living (ADLs). ident 's medical record an 's order (based on the orders) was written on 5/9/18 sia (a laxative, frequently DM) 30 milliliters (ml) by mouth stipation; MOM, add 17 grams Miralax and the daily times two doses; may try Fleets enema (a bowel be) for one dose. Int #2's Nursing Notes a dated 5/9/18 at 7:00 PM. This he resident 's physician was a Magnesia was administered be have a bowel movement in 3 a review of Resident #2's May dministration Record (MAR) alose of Milk of Magnesia was a resident on 5/9/18 for relief of conducted with the facility 's a (DON) on 6/28/18 at 11:35 a the DON stated she would administration of the Milk of ent #2 on 5/9/18 to have been a resident 's MAR.	F8	Facilitator, Quality Assuran Nurse Supervisors, Resour Minimum Data Set Nurse, a Nurses in regards to docun medications on MAR to ensemedications are administer with documentation in the Market To reduce confusion with with the following recommendated developed: 1) Verbal communication orders should be limited to where immediate written, facommunication is not feasil 2) Long term care facilities promote a culture in which acceptable, and strongly enursing staff to question prothere are any questions or about verbal orders. Quest verbal orders should be resourced that the transcription, dispensin administration of the medical market include: *Name of patient *roon name *Dosage form (e.g., tablets inhalants) *Exact strength or concentration of medication the individual transmitting to the individual transmitting to the medical market individual transmitting to the individual transmitting to the surface of the surface of the individual transmitting to the surface of	ace Nurses, rce Nurse, and Treatment mentation of sure all red as ordered MAR. erbal orders, tions have been of medication situations ax, or electronic ble. es should it is incouraged, for escribers when disagreements cions about solved prior to ag, or cation. be included in a om number *drug s, capsules, ration e rrapy d the name of the order, if		
	REHABILITATION CENTER STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) age 4 ent had severely impaired daily decision making. Section essment indicated the resident to total assistance for his iving (ADLs). ident 's medical record an 's order (based on the orders) was written on 5/9/18 sia (a laxative, frequently M) 30 milliliters (ml) by mouth stipation; MOM, add 17 grams Miralax and the daily times two doses; may try Fleets enema (a bowel be) for one dose. Int #2 's Nursing Notes and dated 5/9/18 at 7:00 PM. This has resident 's physician was a may make a may	REHABILITATION CENTER STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) age 4 Inthe had severely impaired daily decision making. Section resonant indicated the resident to total assistance for his iving (ADLs). Ident's medical record an's order (based on the orders) was written on 5/9/18 Isia (a laxative, frequently by M) 30 milliliters (ml) by mouth stipation; MOM, add 17 grams Miralax (th daily times two doses; may try Fleets enema (a bowel e) for one dose. Int #2's Nursing Notes and dated 5/9/18 at 7:00 PM. This had resident's physician was a Magnesia was administered on have a bowel movement in 3 review of Resident #2's May diministration Record (MAR) lose of Milk of Magnesia was a resident on 5/9/18 for relief of conducted with the facility's (DON) on 6/28/18 at 11:35 the DON stated she would administration of the Milk of ent #2 on 5/9/18 to have been	REHABILITATION CENTER REHABILITATION CENTER REHABILITATION CENTER REHABILITATION CENTER STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL PRESS (CITY, STATE, ZIP C 403 CRESTVIEW AVENUE WILSON, NC 27893 DEPRETIX TAG DEPROVIDERS PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCY AND THE PRECED TO 1 DEFICIENCY TAG CROSS-REFERENCED TO 1 TAG CROSS-REFERENCED TO 1 DEFICIENCY TAG CROSS-REFERENCED TO 1 DEFICIENCY TAG CROSS-REFERENCED TO 1 DEFICIENCY TAG CROSS-REFERENCED TO 1 TA	A BUILDING 345372 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 403 CRESTVIEW AVENUE WILSON, NC 27893 STATEMENT OF DEFICIENCIES NOT MUST SE PRECEDED BY FULL RESC IDENTIFYING INFORMATION) FRESH ABILITATION CENTER STATEMENT OF DEFICIENCIES NOT MUST SE PRECEDED BY FULL RESC IDENTIFYING INFORMATION) FRESH ABILITATION CENTER STATEMENT OF DEFICIENCIES NOT MUST SE PRECEDED BY FULL RESC IDENTIFYING INFORMATION) FRESH FRECH ADDRESS, CITY, STATE, ZIP CODE 403 CRESTVIEW AVENUE WILSON, NC 27893 FROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROM IT AND INTERPRETATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FROM IT AND INTERPRETATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE Nurses Supervisors, Resource Nurses, Nurses in regards to documentation of medications and MAR to ensure all medications and MAR to ensure all medications are administered as ordered with documentation in the MAR. To reduce confusion with verbal orders, the following recommendations have been developed: 1) Verbal communication of medication orders should be limited to situations where immediate written, fax, or electronic communication is not feasible. 2) Long term care facilities should promote a culture in which it is acceptable, and strongly encouraged, for nursing staff to question prescribers when there are any questions or disagreements about verbal orders should be resolved prior to the transcription, dispensing, or administration of the medication. 3) Elements that should be included in a verbal order should be resolved prior to the transcription, dispensing, or administration of the medication. 3) Elements that should be included in a verbal order include: Name of patient "room number "drug name *Dosage form (e.g., tablets, capsules, inhalants) "Exact strength or concentration 'dose, frequency, and route 'duration of medication therapy 'indication or diagnosis	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345372 B. W				C 06/28/2018	
NAME OF PROVIDER OR SUPPLIER WILSON PINES NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 403 CRESTVIEW AVENUE WILSON, NC 27893			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)		
F 842	Continued From pag	ge 5	F	4) The content of the clearly communica *The name of the drug confirmed by spelling indication back to the *In order to avoid confirmed as "five zero numbers, a dose such repeated as "five zero Instructions for use swithout abbreviations. tab tid" should be commone tablet three times 5) The entire vert repeated back to the principles outlined about the principles	sted: g should be the drug and the prescriber fusion with spoken as 50mg should be milligrams" should be provided. For example, "1 municated as "giv daily" bal order should be prescriber, or se order, using the ove. ers should be to writing, he d to the medication (MAR) and prescriber per facil R should be signed ven. It for signatures pric resident. During sh ving report both should check each atures so this can be sted at that time medication aides k until in-service is hired licensed n aides will by	be e e e e e e e e e e e e e e e e e e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345372 B. W		. WING			C 06/28/2018	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			28/2018	
					3 CRESTVIEW AVENUE			
WILSON PINES NURSING AND REHABILITATION CENTER					ILSON, NC 27893			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	EIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE	
F 842	Continued From page	e 6	F	342	orientation in regards to documentation medications on MAR. All MARs to include resident #2 will be reviewed by the Director of Nursing and Nurse Supervisors, Resource Nurse, Quality assurance Nurse, Minimum Da Set nurse, Staff Facilitator and Treatmed Nurses weekly for 8 weeks, then month for 1 month, utilizing an MAR Audit Toolensure all orders to include verbal orders are written and transcribed accurately the MAR and that all licensed nurses and medication aides completely and accurately document the administration a prescribed medication on the Medication Administration Record (MA All areas of concern will be immediately addressed by the Director of Nursing, Nurse Supervisors, Resource Nurse, Minimum Data Set nurse, Quality Assurance Nurses, Staff Facilitator and Treatment Nurses to include staff retraining and assessment of residents with omitted medications to include physician notification and implementation of new orders as applicable. The DON review and initial the MAR for completion weekly for twelve weeks. The Administrator will present the finding the MAR Audit Tool to the Executive committee monthly for 3 months. The Executive QI Committee will meet month for 3 months and review the MAR Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	d/or ta ent hly l to ers to n of R). y d on will on hgs QI thly t		

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