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	345380	A. BUILDING _____ B. WING _____	C 05/11/2019

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VILLAGE GREEN HEALTH AND REHABILITATION	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

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E 000	Initial Comments The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness Event ID #P0LH11.	E 000		
F 000	INITIAL COMMENTS The Statement of Deficiencies was amended on 05/29/19 at tag F661 and tag F840 changed to F698. Tag F880 was deleted.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to implement their abuse policy and procedures by not interviewing potential witnesses during an investigation of a physical abuse allegation for 1 of 5 sampled residents reviewed for abuse. (Resident # 50) Findings included: A review of the facility policy and procedure titled "Abuse investigating and reporting", with a	F 607	Preparation and/or execution of this plan does not constitute admission or agreement by the Provider of the truth or facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed because it is required by the provisions of State and Federal Law. F607 The interviews of the potential witnesses during an investigation of a physical abuse allegation for Resident #50 were	6/8/19

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

Electronically Signed | 05/31/2019

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F 607	Continued From page 1 revised date of July 2017, read in part: "Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Reporting: 1). the individual conducting the investigation will, as a minimum: Interview staff members (on all shifts) who have had contact with resident during the period of the alleged incident. Witness reports will be obtained in writing. Either the witness will write his/ her statement and sign and date it, or the investigation may obtain a statement, read it back to the member and have him/ her sign and date." Resident # 50 was admitted to the facility on 3/18/2019 with diagnoses that included heart failure, hypertension, diabetes and hyperlipidemia. Review of the admission Minimum Data Set (MDS) dated 3/25/2019 indicated Resident # 50 was cognitively intact and required extensive assistance with bed mobility, transfer, and dressing, toileting and personal hygiene. The MDS revealed Resident # 50 was in pain occasionally. The review of the facility's investigation dated 4/10/2019 documented "the resident reported to staff on the morning of 4/5/2019 that he had tried to call the police the night prior due to the way Nurse Assistants (NA) treated him the night before. Resident # 50 stated that the NA's came in to do vital signs and "jerked his leg in the air."	F 607	documented and placed in the investigation file on 05/31/2019. The administrator completed an audit of all allegation investigation files from the last 6 months to ensure evidence of interviews were present. The Director of Nursing was provided education on documenting all interviews conducted during allegation investigations by the Administrator on 05/10/2019. The administrator will audit all allegation investigations prior to submission to ensure evidence of interviews conducted. Results of these audits will be reviewed in the QAPI (Quality Assessment Process Improvement)meetings monthly x 3 months, then quarterly x 2 quarters.	

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Resident was asked to give a description of the person. He stated it was a black woman, with maroon hair, medium build. There was no one that fit this description on duty that night. When Social Worker interviewed resident, his story had changes to that the NA's had "flipped him and knocked him out."

Review of the facility's investigation revealed no documentation of the interviews with the potential staff witnesses. The investigation revealed the following:

" The facility was notified of the allegation of abuse on 4/5/2019.
" Interviews with the Resident # 50, alert and oriented residents was completed on 4/5/2019.
" Staff was trained on abuse on 4/5/2019
" faxed return 4/5/2019 to a state agency
" police report completed 4/5/2019 on patient abuse
" investigation report - incident date was completed on - 4/5/2019

Observations and interview of the resident on 5/7/2019 at 10:00 AM revealed no bruising or injury on the resident's legs. The resident reported he did not want to be touched or repositioned because most staff were not careful when handling his legs. He further reported that Physical Therapist was working with him to help him walk again. The resident was asked about the physical abuse incident that happened on 4/15/2019. He stated that 2 staff members came to his room and pulled his legs hurting him. He reported the 2 staff members were no longer assigned to him because he had not seen them since she reported the physical abuse incident.

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Nurse Assistant (NA) #1 (who worked the 11:00 PM-7:00 AM shift) was interviewed on 5/8/2019 at 3:00 PM. NA # 1 reported that she was assigned to Resident # 50 during the night of 4/5/2019. She reported Resident # 50 regularly will not let staff touch him throughout the shift. She added on the 4/5/2019 she repositioned the resident with the assistance of NA# 2. She reported there were no concerns that were brought to her attention by Resident # 50 on the night of 4/5/2019. She further added The Director of Nursing (DON) had not interviewed or asked her to write a statement relating to Resident # 50's allegation of being physical abuse the night of 4/5/2019.

NA # 2 (who worked the 11:00 PM-7:00 AM shift) was interviewed on 5/9/2019 at 3:00 PM. NA # 2 reported she was not assigned to Resident # 50 on the night of 4/5/2019 but assisted NA # 1 to turn and repositioned the resident. She reported no concerns were brought to her attention with Resident # 50 on the night of 4/5/2019. NA # 2 reported the DON had not interviewed her or asked her to write statement in reference to the allegation of physical abuse by Resident # 50.

The DON was interviewed on 5/9/2019 at 4:00 PM. DON reported she investigated the alleged abuse allegation and unsubstantiated the allegation but did not interview or ask the Nurse Assistants who were potential witness to document their statements. She added Resident # 50 could not identify the staff who he alleged physically abuse him and also the resident changed his story about 3 times. DON reported she was in a hurry to complete the investigation and that is the reason the investigation did not have NA # 1 and NA # 2 statements.

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F 607	Continued From page 4 During an interview on 5/10/19 at 11:49 AM, the Administrator stated she was aware of the requirement of completing thorough investigation by interviewing all potential witnesses. Administrator reported moving forward she will make sure all the staff who were potential witnesses will be interviewed and documentation will be completed in reference to the alleged allegation of any abuse.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS, a tool used for resident assessment) for 5 of 28 resident assessments reviewed (Resident #102, Resident #37, Resident #116, Resident #61, Resident #42). The findings included: 1. Resident #102 was admitted to the facility on 11/16/18 with diagnoses which included anxiety disorder with behavioral disturbances. A review of Resident #102's quarterly MDS dated 04/29/19 revealed Resident #102 to be moderately cognitively impaired. The MDS had been coded as "antipsychotics had not been received." A review of Resident #102's Care Plan, last updated 04/29/19, indicated Resident #102 had	F 641	F641 Modifications of the Minimum Data Set (MDS) for Residents #102,#37, #116, #61, and #42, to correct the errors, were completed by the MDS Nurse, 5/11/2019. An audit of section A, G, I, and N was conducted on all current resident's last Minimum Data Set (MDS)by the Regional Reimbursement Manager, 6/05/2019. Any discrepancies were corrected with a modification assessment. MDS Nurses were in-serviced on completing the Minimum Data Set (MDS) accurately to reflect the resident. The Regional Reimbursement Manager will review 5 Minimum Data Set (MDS) assessments and correlating documentation for accuracy weekly x 4 weeks, then 2 Minimum Data Sets (MDS)	6/8/19

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F 641	Continued From page 5 been at risk for adverse effects related to the use of psychotropic medications. A review of Resident #102's physician orders revealed an order for Haldol decanoate (a monthly antipsychotic injectable medication) 100 milligrams (mg) per milliliter (ml), administer 1 ml intramuscularly on first day of month for recurrent anxiety and behavioral disturbances. During an interview with MDS Nurse #1 on 05/09/19 at 12:00 p.m., MDS Nurse #1 stated she had incorrectly coded the quarterly MDS assessment dated 04/29/19 as "antipsychotics had not been received". MDS Nurse #1 stated she had coded the assessment that way because his injection had been on the first day of the month and the first day of the month had not been a day in her 7-day assessment period. When asked if Resident #102 received antipsychotics on a routine basis, MDS Nurse #1 stated he had. MDS Nurse #1 stated she had made a mistake and had incorrectly coded the assessment. During an interview with the Administrator on 05/11/19 at 1:30 p.m., the Administrator stated it was her expectation all MDS assessments be coded accurately for all residents. 2. Resident #37 was admitted to the facility on 2/22/2019 with diagnoses of Alzheimer's disease, diabetes and Hypertension. A review of Resident #37's MDS dated 3/22/2019 was coded as a quarterly assessment. The assessment was coded as the resident had received antidepressants 7 out of 7 days of the assessment period. There was no diagnosis of	F 641	assessments and correlating documentation weekly x 4 weeks, then 5 Minimum Data Set (MDS)assessments and correlating documentation x 1 month. Results of the MDS audit will be reviewed in the Quality Assessment Process Improvement (QAPI) meeting monthly x 3 months, then quarterly x 1 quarter.	

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depression marked on the MDS

A review of Resident #37's most recent quarterly MDS dated 4/4/2019 revealed the resident had received antidepressants 3 out of 7 days of the assessment period. There was no diagnosis of depression marked on the MDS.

On 5/8/2019 at 1:29 PM, the MDS Nurse was interviewed. She acknowledged that Resident # 37 was on Zoloft medication for depression and the diagnoses of depression should have been checked on the MDS but they were not. She added that she missed to check the diagnoses on the quarterly MDS assessment dated 3/22/2019 and 4/4/2019.

During an interview on 5/9/2019 at 1:30pm with the DON (Director of Nursing), she indicated that depression should have been coded on Resident # 37's MDS dated 3/22/2019 and 4/4/2019. During Further interview with DON, she stated that it is her expectation that if a resident was receiving antidepressant medications, the diagnosis of Depression should be marked on the MDS.

3. Resident #116 was admitted to the facility on 2/22/2019 with diagnosis that included pneumonia, muscle weakness and hypertension.

Review of the discharge Minimum Data Set (MDS) dated 3/14/2019 indicated Resident #116 was discharged to acute hospital.

Review of the nurse and Social work notes dated 3/14/2019 indicated Resident #116 was discharged home with home health services.

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During the interview on 5/8/2019 at 1:29 PM, Minimum Data set (MDS) nurse reviewed the discharge MDS and confirmed it was inaccurate. The MDS nurse explained it was coded in error as Resident # 116 was discharged home not in acute hospital.

During an interview on 5/9/2019 at 1:30pm with the DON (Director of Nursing), she indicated that discharge to the community should have been coded on Resident # 116's MDS dated 3/14/2019. During Further interview with DON, she stated that it is her expectation that the MDS should be coded accurately.

4. Resident #61 was admitted to the facility on 12/13/18 with diagnoses that included chronic obstructive pulmonary disease, severe protein-calorie malnutrition and dysphagia.

Review of the Admission Minimum Data Set (MDS) dated on 12/20/18 revealed that the Resident #61 was coded as being total dependence for eating and tube fed.

Review of the Quarterly MDS dated on 04/17/19 revealed that the Resident #61 was coded as being extensive assistance for eating and tube fed.

During an interview with the MDS Nurse #1 on 05/09/19 at 10:35 AM, she stated that she coded the resident extensive assistance for eating based on the ADL sheet completed by the Nursing Assistant. She further stated that the Resident #61 is bolus fed and is NPO (nothing by mouth).

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During an interview with the Director of Nursing on 05/11/19 at 8:31 AM, she stated that it is her expectation that the MDS is coded accurately according to residents 7 day look back period.

During an interview with the Administrator on 05/11/19 at 10:26 AM, she stated that it is her expectation that the MDS is coded accurately to reflect the resident.

5. Resident #42 was admitted to the facility on 04/20/18 with diagnoses of anxiety disorder, delusional disorder, and vascular dementia.

A review of Resident #42's Minimum Data Set (MDS) dated 04/06/19 was coded as a quarterly assessment. The assessment was coded as the resident had received antianxiety medication 7of 7 days of the assessment period and had received antipsychotic medications 7 of 7 days of the assessment period. There were no diagnosis of anxiety disorder, delusional disorder, or vascular dementia marked on the quarterly MDS.

During an interview with MDS Nurse #1 on 05/10/19 at 2:52 PM, MDS Nurse #1 revealed Resident #42 had been receiving medications for anxiety, dementia, and delusion disorder. She acknowledged the diagnoses - dementia, anxiety disorder and delusional disorder should have been checked on the MDS.

During an interview with the Director of Nursing on 05/11/19 at 8:34 AM, the Director of Nursing stated she expected the MDS be coded

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F 641	Continued From page 9 according to guidelines for all residents. During an interview with the Administrator on 05/11/19 at 1:30 PM, the Administrator stated it was her expectation all MDS assessments be coded accurately for all residents.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		6/8/19

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F 655	Continued From page 10 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete an initial care plan within 48 hours of admission for 2 of 2 resident reviewed for baseline care plans. (Resident #177 and Resident #21). Findings included: 1. Resident #177 was admitted 05/02/19 with a diagnoses including Left leg/ankle fracture. The admission Minimum Data Set (MDS) dated 05/09/19 had resident coded as cognitively intact and needing limited and extensive assistance with her assisted daily living (ADL). Review of Resident #177's 48-hour care plan dated 05/07/19 had a focus of ADL decline R/t fracture of left leg/ankle, and impaired skin integrity R/T surgical wound. Review of the facility's care planning policy indicated a baseline care plan was to be initiated within 48 hours.	F 655	F655 The baseline care plan was completed for Resident #177 on 05/07/2019, reviewed and a copy given to the resident. The baseline care plan was reviewed with Resident #21 and a copy provided. An audit of the baseline care plan was completed on current residents admitted in the last 30 days by the MDS Nurse,06/03/2019. All nurses were in-serviced on completing the baseline care plan within 48 hours of admission by the Asst. Director of Nursing. Newly hired nurses will receive education on base line care plans in orientation. New admissions are audited daily, 5x per week by the nurse admin team for completion of the baseline care plan within 48 hours. Results of the baseline care plan audits will be reviewed daily, 5x per week, in the	

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F 655	Continued From page 11 During an interview with MDS Nurse #2 on 05/08/19 at 2:05 PM, MDS Nurse #2 stated she helps with the 48-hour care plans and was responsible for completing the 48-hour care plan for resident #177 on 05/07/19, which was not within the 48 hour time frame. During an interview with the Director of Nursing (DON) on 05/08/19 10:43 AM the DON revealed it was his expectation that the initial care plan be done with 48 hours of a resident being admitted to the facility. During an interview with the Administrator on 05/09/19 at 2:23 PM with the Administrator stated her expectation was that the initial care plan was done per the facility's policy and within the first 48 hours after the resident was admitted. 2. Resident #21 was admitted to the facility on 03/20/19 with diagnoses which included non-Alzheimer's dementia and encounter for orthopedic aftercare. A review of Resident #21's admission baseline care plan revealed it to have an observation date of 03/21/19 by Nurse #3 and a completion date of 03/25/19 by MDS Nurse #2. A review of Resident #21's admission Minimum Data Set (MDS) dated 03/27/19 revealed Resident #21 had been severely cognitively impaired and required extensive assistance with his Activities of Daily Living. During an interview with Resident #21's Responsible Party (RP) on 05/07/19 at 9:36 a.m., the RP stated she had not received a written	F 655	daily clinical meeting. Results of the audits will be reviewed in the Quality Assessment Process Improvement (QAPI) meeting monthly x 3 months, then quarterly x 2 quarters.	

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F 655	Continued From page 12	F 655		

summary of the initial baseline care plan. The RP stated she would have liked to have seen the initial baseline care plan.

During an interview with MDS Nurse #2 on 05/11/19 at 12:40 p.m., the MDS Nurse #2 stated she is one of the staff who makes sure residents' initial baseline care plans have been completed. The MDS Nurse #2 stated once an initial baseline care plan had been signed off by a Registered Nurse it went to the Social Worker (SW) for the Interdisciplinary team's initial 48-hour care plan meeting with the resident and/or RP.

During an interview with the SW on 05/11/19 at 11:23 a.m., the SW stated she remembered she had given Resident #21's RP a copy of Resident #21's initial baseline care plan when she met with her on 03/22/19. The SW stated she had not been in the habit of documenting that a summary of the initial baseline care plan had been given to a resident and/or their RP. The SW stated she understood the need of the documentation and planned to do so in the future.

During an interview with the Director of Nursing (DON) on 05/11/19 at 11:53 a.m., the DON stated it was her expectation the SW or nursing staff provide a resident and/or RP a copy of the initial baseline care plan within 48 hours of an admission.

During an interview with the Administrator on 05/11/19 at 11:58 a.m., the Administrator stated it was her expectation staff provide a resident and/or their RP a copy of the initial baseline care plan within 48-hours and document that it was given.

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VILLAGE GREEN HEALTH AND REHABILITATION	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

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F 658	Continued From page 13	F 658		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans 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 record review, resident and staff interviews the facility failed to assure a medication order was transcribed and administered per Physicians order causing missed doses for 1 of 1 resident reviewed for providing care according to professional standards. (Resident #177) Findings included: Resident #177 was admitted on 05/02/19 with diagnoses that included Fractured right lower leg. The admission Minimum Data Set (MDS) dated 05/09/19 had resident coded as cognitively intact and needing limited and extensive assistance with her assisted daily living (ADL). Review of Resident #177's 48-hour care plan dated 05/07/19 had a focus of ADL decline R/t fracture of left leg/ankle, and impaired skin integrity R/T surgical wound. Review of the discharge medication list dated 04/03/19 read: Metoclopramide 10mg, Metoprolol 25mg, Zolpidem 5mg, Aspirin 81mg, Atorvastin 40mg, Insulin lispro 5 units, Fluoxetine 20mg, Heparin 1ml, Oxycodone 5mg, Myfortic 180 mg bid, Prednisone 5mg, Sulfamethoxazole Trimethoprim 400mg/80mg, Tacrolimus Prograf	F 658	F658 The medication was initiated for resident #177 An audit of physician orders for all new admissions, over the last 30 days, currently in the facility to ensure physician orders were transcribed accurately was completed by the administrative Nurses on 5/20/2019. All nurses were in-serviced on transcribing and administering medications per physician's orders by the Assistant Director of Nursing,05/21/2019 All newly hired nurses will be in-serviced during orientation. All new admission orders will be reviewed by the Administrative Nurses in morning meeting to ensure all medication orders are transcribed accurately 5x per week x 4 weeks, weekly x 3 weeks, then monthly x 3 months. The results of the audit will be reviewed in the Quality Assessment Process Improvement (QAPI) meeting monthly x 2 months, then quarterly x 2 quarters.	6/8/19

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F 658	Continued From page 14	F 658		

(a medication used to prevent organ rejection) 3mg, and Tacrolimus Prograf 4mg.

Review of May 2019 Medication Administration Record (MAR) had Tacrolimus Prograf capsule; 1 mg administer 3 capsules orally at bedtime start date 05/02/19 given as ordered, Tacrolimus Prograf capsule; 1 mg administer 4 capsules once a day in the morning, start date 05/06/19, first dose administered 05/07/19. The Tacrolimus Prograf 1 mg 4 capsules once a day had missed four doses.

During an interview with Resident #177 on 05/06/19 at 3:56 PM, Resident #177 stated she had a kidney transplant in March of 2018, is taking antirejection medication and she received her evening dose of Tacrolimus Prograf but did not receive the day time dose.

During an interview with Resident #177 on 05/09/19 at 5:21 PM, Resident #177 stated, and she had just returned from visit with her kidney specialist and was tested to assure the medication was in her system and still working and was pleased to find out it was, and she was doing great.

During an interview with Nurse #4 on 05/07/19 at 11:05 AM, Nurse #4 stated the resident had a fixator on her ankle and she does most of her care. Nurse #4 also stated per the Physician Assistants order, she updated Resident #177's MAR on 5/6/19 to include the Tacrolimus Prograf 1mg cap to administer 4caps once a day every morning.

During an interview with Nurse #3 on 05/08/19 at 02:05 PM, Nurse #3 stated she was responsible

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F 658	Continued From page 15 for imputing the medication list that came from Resident #177's discharge instructions and did not know how she missed the second medication for Prograf 4mg that was supposed to be administered in the morning. Nurse #3 also stated it was an oversight and orders will be double checked in the future. During an interview with the Director of Nursing (DON) on 05/08/19 at 03:30 PM, the DON stated her expectations are for resident's medications to be completely transcribed into the medical records and to be administered per Physicians order. During an interview with the Administrator on 05/09/19 at 2:23 PM, the Administrator stated her expectations are for the nursing staff to transcribe orders completely in the medical records and administer medications according to Physicians orders. During an interview with the Physician Assistant (PA) on 05/8/19 at 3:54 PM, the PA stated he noticed the second order of Tacrolimus Prograf 4mg AM dose was missing from the MAR and ordered it to be included. The PA also stated he expects the orders to be administered as ordered and didn't believe there was any adverse effects from missing the AM medication due to the resident still receiving the evening daily dose of medication.	F 658		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		6/20/19

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F 698	Continued From page 16 with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have a dialysis contract in place to allow residents to receive dialysis at an outside dialysis center for 1 of 1 sampled resident (Resident #111) reviewed for dialysis. The findings included: Resident #111 was admitted to the facility on 02/18/19 with diagnoses that included acute kidney failure, end stage renal disease and dependence on renal dialysis. The Admission Minimum Data Set (MDS) dated on 03/14/19 revealed that Resident #111 was cognitively intact and coded as receiving dialysis. The care plan dated on 05/10/19 revealed that Resident #111 will receive dialysis three times a week. During an interview with the Director of Nursing (DON) on 05/11/19 at 8:32 AM, she stated that it was her expectation that the facility has contracts in place for dialysis services. The DON further stated that Resident #111 went to an outside dialysis center three times per week to receive dialysis. During an interview with Administrator on 05/11/19 at 10:28 AM, she stated that it was her expectation that the facility has contracts in place prior to a resident receiving dialysis at the dialysis center. The Administrator further stated that she	F 698	F698 A Memorandum of Understanding between the Veterans Affairs Dialysis Center and Village Green Health and Rehabilitation was obtained for Resident #111. An audit of all dialysis service provider contracts was completed by the administrator.6/3/2019 The administrator was in-serviced by the Regional Operations Manager on obtaining contracts/Service Agreements from outside providers. The administrator in-serviced the admissions director on checking for the presence of contracts/Service Provider Agreements prior to admitting a resident in need of contracted services. The administrator will maintain a copy of all contracts/service agreements from service providers. The administrator will audit the contracts quarterly x 2 quarters, then every 6 months x 1. The results of the audits will be reviewed in the Quality Assessment Process Improvement (QAPI) meeting quarterly x 2, then annually x 1.	

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F 698	Continued From page 17 could not find the signed dialysis contract for the dialysis center in which Resident #111was receiving services.	F 698		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review observation and staff interviews the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication error rate of 8% from 2 errors out of 25 attempts. (Resident #93 and #175) Findings included: 1. Resident #93 was admitted to the facility on 04/13/19 with diagnoses including Pneumonia. The admissions Minimum Data Set (MDS) dated 04/20/19 had Resident #93 coded as cognitively intact and needing extensive assistance with most activities of daily living (ADL's). Resident #93's physicians orders were reviewed, and listed Carbidopa-Levodopa tablet 25-100mg four times a day at 12:00 AM, 8:00 AM, 1:00 PM and 6:00 PM; Dofetilide capsule 125mg twice a day with breakfast and dinner, 8:00 AM and 6:00 PM; Pradaxa capsule 150mg twice a day with breakfast and dinner. On 05/08/19 at 10:05 AM, Nurse #1 was	F 759	F759 Nurse #1 and Nurse #2 were provided education on giving medications within one hour of their prescribed time. An audit of the medication pass times was completed by administrative nurses on 06/03/2019. All resident's medication pass times were adjusted to allow for passing medications within one hour of their prescribed time. All nurses/med aides were in-serviced on passing medications within one hour of their prescribed time by the Assistant Director Of Nursing. 05/31/2019 All resident's medication pass times were adjusted to allow for passing medications within one hour of their prescribed time. Medication pass times will be audited utilizing medication pass observations. Medication pass observations will be completed on 1 Nurse/Med Aide per unit, weekly x 4 weeks, monthly x 3 months, then quarterly x 2 quarters.	6/8/19

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F 759	Continued From page 18 observed during a medication pass for Resident #93. Nurse #2 administered Carbidopa-Levodopa 25-100mg, Dofetilide 125mg, and Pradaxa 150mg two hours later than the scheduled ordered time of 8:00 AM. A review of the facilities medication administration dated 2012 states medications must be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meals orders). During an interview with Nurse #1 on 05/09/19 at 10:57 AM, Nurse #1 stated she started passing medications at 8:00 AM from room 218 to 234 and by the time she finished it was 11:00 AM. Nurse #1 also stated that was the norm due to having to help with adl's for residents and the managers are aware of medication being late. Nurse #1 also stated she was aware of the medication 1 hour policy. During an interview with the Nurse #5 Manager (NM) on 05/09/19 at 11:04 AM, the NM stated she was not aware of nurses administering medications late and it is not okay, and staff will be educated. During an interview with the Director of Nursing (DON) on 05/08/19 at 10:43 AM, the DON stated her expectations are for the medications to be listed accurately and as scheduled. During an interview with the Administrator on 05/09/19 at 05:07 PM the administrator stated her expectations are for the nursing staff to administer medications as scheduled. 2. Resident #175 was admitted to the facility on	F 759	Results of the medication pass audits will be reviewed in the Quality Assessment Process Improvement (QAPI) meeting monthly x 3 months, then quarterly x 2 quarters.	

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F 759	Continued From page 19	F 759		

05/03/19 with diagnosis including Hypertension. The admissions Minimum Data Set (MDS) dated 05/10/19 had Resident #175 coded as cognitively intact and needing limited and extensive assistance with his activities of daily living (ADL).

Resident #175's Physicians order was reviewed and listed: Advair Diskus 250-50 mcg/dose 1 puff twice a day 8:00AM and 8:00PM; Ascorbic Acid 500mg three times a day8:00 AM, 2:00PM, and 8:00PM; Ferrous Sulfate 325mg/iron 65mg three times a day 8:00 AM, 2:00 PM, and 8:00 PM; Gabapentin capsule 400 mg twice a day; Metformin tablet 1000 mg twice a day 8:00 AM and 6:00 PM.

On 05/07/19 at 05:01 PM, Nurse #1 was observed during a medication pass for Resident #93. Nurse #3 administered Advair Diskus 250-50 mcg, Ascorbic Acid 500mg, Ferrous Sulfate 325/Iron 65 mg, Gabapentin 400 mg, and Metformin 1000 mg 3 hours before the scheduled ordered time.

A review of the facilities medication administration dated 2012 states medications must be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meals orders).

During an interview with Nurse #2 on 05/08/19 at 05:20 PM, Nurse #3 stated she is aware she administered the medication early and she was aware of the medication 1 hour policy but she stated she gave the medication early because resident doesn't like to get medication late, she will refuse it, has not reported the issue to the unit manager.

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F 759	Continued From page 20 During an interview with the Nurse #5 Unit Manager (NM) on 05/08/19 05:24 PM, the NM stated she was not aware nurse #2 was administering the medications for this resident early, it would have been care planned and times would have been adjusted, also stated she expects the nursing staff to administer medications within the i hour time frame according to policy. During an interview with the Director of Nursing (DON) on 05/08/19 at 10:43 AM, the DON stated her expectations are for the medications to be listed accurately and as scheduled. During an interview with the Administrator on 05/09/19 at 05:07 PM the administrator stated her expectations are for the nursing staff to administer medications as scheduled.	F 759		