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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345232	A. BUILDING ______ B. WING ______	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHABI HICK	3031 TATE BOULEVARD SE HICKORY, NC 28602

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E 000	Initial Comments A recertification survey was conducted on 07/08/19 through 07/11/19 by the Division of Health Service Regulation, Nursing Home Section. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID #RSJR11	E 000		
F 000	INITIAL COMMENTS On 07/11/19 the Division of Health Service Regulation, Nursing Home Certification Section, conducted an annual recertification survey and complaint investigation. There were 3 complaint allegations and they were unsubstantiated. Event ID# RSJR11.	F 000		
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 bowel incontinence for one of 2 residents reviewed for pain management (Resident #57). The Findings Included: A review of Resident #57's medical record revealed he was admitted to the facility on 04/04/19 with diagnoses that included pain in unspecified joint, history of falling, gastrostomy, vascular dementia without behaviors, polyneuropathy, sciatica, and gout. A review of Resident #57's most recent Minimum	F 641	F641 Accuracy of Assessments SS=D Criteria 1 The Resident Care Management Director modified and resubmitted assessment for Resident #57 to reflect correct coding of his bowel incontinence on 7/11/2019 Criteria 2 The Director of Nursing or Unit Managers will complete a 100% audit of MDS assessments completed for 90 days prior to 7/11/2019 to ensure bowel and bladder incontinence were coded correctly by	8/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 08/02/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641	Continued From page 1 Data Set (MDS) Assessment dated 05/16/19 and coded as a quarterly revealed resident was coded as not having an ostomy, was always incontinent of bladder but his bowel incontinence was coded as "not rated". During an interview with NA #1 on 07/11/19 at 4:04 PM, she reported Resident #57 was mostly incontinent of bowel and verified he did not have an ostomy. She reported Resident #57 required assistance with toileting. She also verified she charted bowel movements in Resident #57's electronic chart. During an interview with Nurse #2 on 07/11/19 at 4:09 PM, she reported Resident #57 was frequently incontinent of bowel and had always been. She verified that Resident #57 did not have an ostomy. She verified that resident had 3 bowel movements that were charted during the period reviewed for the completion of his Minimum Data Set Assessment dated 05/16/19. During an interview with MDS Nurse #1 on 07/11/19 at 4:16 PM, she verified that Resident #57 had bowel movements charted on 05/12/19, 05/14/19 & 05/15/19. She reported she could not determine why Resident #57's assessment coded him as "not rated" for bowel continence. She stated that information is automatically pulled from information charted in his electronic medical record and there must have been a software error that caused the information to be coded inaccurately. MDS Nurse #1 also reported she typically reviewed the information that pulled onto the assessment but must have overlooked the inaccuracy of coding for Resident #57's bowel continence.	F 641	7/26/2019. Opportunities that are identified will be corrected by RCMD by 7/26/2019 Criteria 3 The Director of Nursing or Unit Managers will re-educate MDS nurses on ensuring correct coding for bowel and bladder incontinence by 7/31/2019. The Director of Nursing or RCMD will perform random audits of 5 completed assessments 3 times per week for 4 weeks, then weekly for 8 weeks to validate correct documentation in Bowel and Bladder section. Opportunities identified as a result of these audits will be corrected by the Director of Nursing or RCMD Criteria 4 The results of the audits will be reported by the Director of Nursing in the monthly Quality Assurance Performance improvement meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of compliance will be August 8, 2019	

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F 641	Continued From page 2 During an interview with the Director of Nursing on 07/11/19 at 4:31 PM, she reported it was her expectation that MDS Assessments be completed accurately. She reported if Resident #57 had a documented bowel movement during the period of time reviewed for an assessment, then the MDS Nurses should have verified the information was correct and made a correction.	F 641		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to provide Podiatry services to a resident who had requested to see a Podiatrist for 1 of 1 resident sampled for foot care (Resident #64). Findings included: Resident #64 was admitted to the facility on 01/04/18 with diagnoses which included type 2 diabetes, heart disease, abnormal gait and mobility, difficulty walking, and lack of coordination.	F 687	F687 Foot Care SS=D Criteria 1 Resident #64 was scheduled for podiatry appointment on 7/17/2019 and her toenails were trimmed by Podiatrist at the visit. Criteria 2 The Director of Nursing or Unit Managers completed a 100% audit on 7/26/2019 of	8/8/19

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F 687	Continued From page 3 A review of a physician's order for consults dated 01/04/18 indicated Resident #64 may be seen and treated by a Podiatrist. A review of a quarterly Minimum Data Set (MDS) dated 04/05/19 revealed Resident #64 was cognitively intact for daily decision making. The MDS also indicated was Resident #64 required limited assistance with dressing and hygiene. A review of a Physician's Assistant (PA) progress note dated 04/11/19 revealed in part Resident #64 complained of painful toenails and consults were reviewed but the PA did not see that she had seen a Podiatrist. A section labeled physical exam indicated Resident #64 had long, deformed and thickened toenails and the plan was to refer to in-house Podiatrist due to thickened, long, deformed toenails. A review of a physician's order dated 04/11/19 indicated in part to refer to in-house Podiatrist for trimming of thickened, long, deformed nails. A review of a care plan with a revised date of 05/21/19 revealed Resident #64 had diabetes and the goal indicated she would have no complications related to diabetes. The intervention was listed in part to refer to the Podiatrist/foot care Nurse to observe and document foot care needs and to cut long nails. A review of a facility document labeled Appointments dated 06/11/19 indicated a list of residents who were scheduled to see the Podiatrist. A review of the names on the list revealed Resident #64's name was not on the list.	F 687	referrals to Podiatrist during the last 60 days to verify that any resident with a referral to Podiatry were either seen or had scheduled appointment. Any opportunities identified will be corrected by The Director of Nursing or Unit Managers. Criteria 3 The Director of Nursing or Unit Managers will re-educate all Licensed Nurses regarding need to complete in house communication form for referrals and to provide copies to Unit Managers, Van Driver, if needed and Social Services by 7/26/2019. Social Services were educated by The Director of Nursing to ensure all residents with referrals were placed on the list to see the Podiatrist and to verify that list with Unit Managers prior to Podiatrist visit to ensure all residents with referrals are on the list on 7/26/2019. The Director of Nursing, Unit Managers and Social Workers will review the orders from the previous day to ensure all residents with podiatry referrals are placed on list for in house Podiatry or has appointment with outside Podiatrist weekly for 12 weeks. Opportunities identified as a result of these audits will be corrected by the Director of Nursing or designee. Criteria 4 The results of the audits will be reported	

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F 687	Continued From page 4 A review of a facility document labeled Appointments dated 07/02/19 indicated a list of residents who were scheduled to see the Podiatrist. A review of the names on the list revealed Resident #64's name was not on the list. A review of a Nurse's note with a created date of 07/03/19 at 2:56 PM by Unit Manager #1 revealed new orders were received to refer Resident #64 to an outside Podiatrist for thick deformed diabetic toenails. An interview was conducted on 07/09/19 at 8:57 AM with Resident #64 and she stated she had been asking to see the Podiatrist since April 2019 but had not seen them. She further stated her toes were bothering her and her toenails needed to be trimmed. An interview was conducted on 07/11/19 at 3:20 PM with Unit Manager #1 and she explained she tried to help the Social Workers stay current with consults and appointments. She confirmed the Podiatrist was at the facility on 03/24/19 but Resident #64 was not on the list to be seen. She explained the Podiatrist did not come to the facility in April 2019 or May 2019 because they typically came every 3 months and conducted a 2-day clinic in order to see residents who were on the appointment list to be seen. After review of Resident #64's medical record, she confirmed the PA saw Resident #64 on 04/11/19 and wrote an order for her to see the Podiatrist. She stated the expectation was that Resident #64 would be seen on the next Podiatrist visit. She verified the Podiatrist saw residents on 06/11/19 and 07/02/19 but Resident #64 was not on the appointment list for 06/11/19 or 07/02/19 and had not seen the Podiatrist. She stated she was not	F 687	in the monthly Quality Assurance Performance Improvement meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of compliance August 8, 2019	

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F 687	Continued From page 5 sure why Resident #64 had not been seen by the Podiatrist. An interview on 07/11/19 at 3:31 PM with Social Worker #1 revealed she was on leave in April 2019 and was not sure why Resident #64 was not seen by the Podiatrist. An interview on 07/11/19 at 4:29 PM with the Director of Nursing revealed several staff had been out of work in recent months and they were trying to do everything for everyone at that time to keep things going. An interview on 07/11/19 on 4:29 PM with the Administrator revealed she thought one of the social workers was out in April 2019 and staff were wearing different hats and were doing different jobs. She stated she felt they needed to put better systems in place to cover absences and she wanted to cross train more people so they could cover jobs when staff were out. She confirmed the Podiatrist was at the facility twice since April 2019 but Resident #64 had been missed.	F 687		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		8/8/19

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F 761	Continued From page 6 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to label an insulin pen when opened for Resident #65 in 1 of 4 medication carts (medication cart #1 on the 300 hall). Findings included: Resident #65 was admitted to the facility on 04/23/19 with diagnoses which included heart disease and diabetes. A review of the most recent annual Minimum Data Set (MDS) dated 04/05/19 indicated Resident #65 was cognitively intact for daily decision making. The MDS also indicated Resident #65 had received insulin during the 7 day look back period. A review of monthly Physician's orders dated 07/01/19 through 07/31/19 indicated to administer Novolog Flex pen 2 units subcutaneously before	F 761	F761 Label/Store Drugs and Biologicals SS=d Criteria 1 The Unit Manager discarded resident #65 undated insulin pen and replaced with a new insulin pen labeled and dated on 7/11/2019. Criteria 2 The Director of Nursing completed a 100% audit of insulin pens on Medication Carts to ensure they were labeled and dated on 7/22/2019 Any opportunities will be corrected as identified as result of these audits by the Director of Nursing. Criteria 3	

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F 761	Continued From page 7 meals. An observation on 07/11/19 at 2:30 PM of medication cart #1 on the 300 hall revealed a Novolog Insulin Flex pen lying in a drawer in the cart. The pen had a sticker with Resident #65's name on it but there was no date when the pen had been opened. An interview on 07/11/19 at 2:45 PM with Nurse #3 revealed she had been giving medications from medication cart #1 on 07/11/19. She stated she did not know when the Novolog Insulin Flex pen for Resident #65 had been opened but she had given him 2 units of insulin from the pen earlier today at approximately 12:00 PM. She further stated she thought the pen had been in a plastic bag because she usually placed insulin pens in a bag and labeled the pen and the bag. She stated it was the expectation to label the insulin pen when opened and it should have the expired date written on the pen and bag. An interview on 07/11/19 at 2:49 PM with Unit Manager #1 revealed it was her expectation that insulin pens should be dated when opened. She further stated it was her expectation that insulin pens should be checked every shift for opened dates and expiration dates. An interview on 07/11/19 at 2:52 PM with the Director of Nursing revealed it was her expectations for insulin pens to be dated and labeled when opened. She further stated Resident #65's insulin pen should have had the date written on a label on the pen and should have been stored in a plastic bag with the residents name and opened date on the bag.	F 761	The Director of Nursing will educated all Licensed Nurses on ensuring all insulin's are labeled and dated when opened, this education will be completed by July 22, 2019. The Director of Nursing or Unit Managers will audit medication carts weekly to ensure all insulin pens are labeled and dated when opened weekly for 12 weeks. Opportunities identified as a result of these audits will be corrected by the Director of Nursing or Unit Managers. Criteria 4 The results of the audits and observations will be reported by the Director of Nursing in the monthly Quality Assurance Performance Improvement meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of compliance August 8, 2019	

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F 812	Continued From page 8	F 812		
F 812 SS=E	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 observations, staff interviews, and record review the facility failed to store serving pans under sanitary conditions, ensure a deep fryer was clean and failed to cover facial hair during 1 of 1 lunch meal service. These practices had the potential to affect the food being served to residents. The findings included: On 07/11/19 at 11:40 AM observations were made of the lunch meal service with the Dietary Manager (DM). Additional observations were made of the sanitary conditions of the kitchen. A metal rack used to store clean pots and pans for	F 812	F812 1. All items were removed from the drying rack. All items that had been stored on the rack were re-washed and sanitized. The rack was deep cleaned and the shelves were lined prior to any items being returned to the shelf. The sides of the deep fryer were scrubbed and all grease residue was removed. The male dietary aide covered his facial hair with a proper restraint. 2.All Residents in the facility receiving PO intake have the potential to be affected. All drying racks were inspected to insure	8/2/19

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F 812 Continued From page 9
food service was noted to have accumulated dust on the shelves. The clean pots and pans were stored in contact with the dust.

On 07/11/19 at 11:45 AM observations were also made of the deep fryer that revealed the deep fryer had dried splattered grease on the exterior. The accumulation of grease was so extensive, there were formed grease sickles hanging from the bottom of the deep fryer.

On 07/11/19 at 11:50 AM the lunch meal tray was in process and a male dietary aid was working on the tray line handling desserts and assisting with tray set up. Observations of the male dietary aide revealed he had facial hair that was different lengths, ranging from approximately ½ inch long to an inch long. The facial hair was not covered.

On 07/11/19 at 2:34 PM the Dietary Manager (DM) and District Manager were interviewed. The Dietary Manager reported that it was not okay for pans to be stored on a dusty shelf. The DM explained that basic cleaning was to be done daily in the kitchen and then weekly items such as the deep fryer were to be cleaned. The DM provided the weekly cleaning schedule that specified the deep fryer was to be cleaned on Thursdays. The schedule did not specify when the deep fryer was last cleaned. The DM stated she thought the deep fryer was cleaned last Thursday but was not certain. The DM was asked about hair coverings and stated hair was supposed to be covered. She added that she did not have beard guards for dietary aides with facial hair and that she didn't think that hair would get in the food. The District Manager stated that it was the expectation that hair, including facial hair should be covered.

F 812

there was no dust or debris in contact with clean pots and pans. The deep fryer was inspected by the dietary manager and district manager to insure there was no grease present. All male dietary staff members were observed as having facial hair covered.

3. The dietary staff was in-serviced to thoroughly complete daily cleaning assignments as scheduled. The dietary staff was also in-serviced that all facial hair is to be covered during meal preparation and service. The dietary manager or assigned supervisor will monitor the cleaning schedule for completion daily for twelve weeks. The dietary manager or assigned supervisor will inspect all staff twice per day to insure facial hair is covered.

4. The dietary manager will provide a copy of cleaning schedules and facial hair monitoring tool to the Executive Director to be reviewed at the monthly QAPI meeting. The committee will evaluate and make further recommendations as indicated.

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		8/8/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 11 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to maintain accurate information on an electronic medication administration record for 1 of 5 residents reviewed for unnecessary medications (Resident #224). The findings included: Resident #224 was admitted to the facility on 07/03/19 with diagnoses which included cardiovascular disease and pneumonia.	F 842	F842 Resident Records- Identifiable Information SS=D Criteria 1 Medication error was completed by Unit Manager on resident #224, Physician was notified and order was clarified on 7/10/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345232	A. BUILDING ______ B. WING ______	C 07/11/2019

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F 842	Continued From page 12 Resident #224 did not have a completed admission Minimum Data Set assessment. Review of Resident #224's admission medication Physician's orders dated 07/03/19 included medications for Lisinopril 5 milligrams (mg) by mouth once a day and Metoprolol Tartrate 25 mg twice a day. Review of Resident #224's Medication Administration Record (MAR) dated 07/01/19 - 07/31/19 revealed, effective date 07/05/19 give Lisinopril 5 mg by mouth once a day, hold if systolic blood pressure was less than 110, and give Metoprolol Tartrate 25 mg by mouth twice a day, hold if systolic blood pressure was less than 110. Review of Resident #224's medical record revealed no orders to hold the Lisinopril or the Metoprolol Tartrate if the systolic blood pressure was less than 110 had been written or given verbally by the resident's provider since his admission to the facility. Further review of Resident #224's electronic MAR indicated, on 07/04/19 Nurse #1 had added the parameter to hold the medication if the systolic blood pressure was less than 110 to both of the medication orders. An interview with the Unit Manager (UM) #1 on 07/11/19 at 11:13 AM revealed, that through her research of the history of Resident #224's medication orders she found that the systolic blood pressure parameter had been set up by Nurse #1 who then confirmed she had changed the orders for the Lisinopril and Metoprolol	F 842	Criteria 2 The Director of Nursing performed a 100% of all blood pressure medication with parameters to ensure they were ordered by the physician on 7/10/2019. Any opportunities will be corrected as identified as result of these audits by the Director of Nursing. Criteria 3 The Director of Nursing or Unit Managers will re-educate all Licensed Nursing Staff on ensuring all orders are entered correctly, parameters are only entered if ordered by Provider by July 26, 2019. The Director of Nursing or Unit Manager will audit Blood Pressure medication orders daily, Monday through Friday for 12 weeks to verify orders entered appropriately and parameters are in place if ordered by the Physician. Parameters on blood pressure medication will be added in capital letters to ensure nurses identify the need to assess vital signs before administering the medication by August 8, 2019. All newly hired nurses, during orientation will complete modules on entering ordered and supplementary documentation successfully on the new PCC training site before entering physician orders on their assigned unit. The DON or Unit Managers will ensure training is completed prior to newly hired nurses entering physician orders on the unit. Opportunities identified as a result	

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F 842	Continued From page 13 Tartrate to demonstrate to a new Nurse of how to add parameters to blood pressure medications. The UM stated Nurse #1 explained that after she had demonstrated the procedure to a new Nurse she was immediately called away from the medication cart and forgot to go back to Resident #224's electronic MAR and change the orders back to how they were originally written. An interview with the Director of Nursing (DON) was conducted on 07/11/19 at 11:36 AM who also explained the parameters had been set up on Resident #224's Lisinopril and Metoprolol Tartrate during a training session for a new Nurse. The DON stated, currently that was the only way for the facility to train the new staff on how to link parameters to medications was to manually do it with existing residents and their medications. The DON stated that with this situation she could see where the incident could happen again and realized the facility needed a system for training which did not involve using active residents. The DON stated she had already reached out to the Corporation for advice on the training system. During an interview with Nurse #1 on 07/11/19 at 4:10 PM she explained on 07/04/19 she was tasked with training a new Nurse and during the training session she used Resident #224's medications to demonstrated how to set up parameters for when to hold medications that effect the blood pressure. Nurse #1 stated, after she had demonstrated the procedure to the new Nurse she was called away from the electronic MAR and forgot to change the medications back to the original orders. An interview was conducted with the Administrator on 07/11/19 at 4:48 PM. The	F 842	of these audits will be corrected daily by the Director of Nursing or Unit Managers. Criteria 4 The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting for 3 months and then quarterly. The committee will evaluate and make further recommendations as indicated. Date of compliance August 8, 2019	

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F 842	Continued From page 14 Administrator explained, Nurse #1 has used Resident #224's medication record as a training tool to demonstrate to a new Nurse how to set up parameters and was interrupted but forgot to go back and change the orders back. The Administrator stated currently that was the only way the facility had to demonstrate to the new Nurses but that she had reached out to her Corporation for the need of a different system. The Administrator also stated it was always her expectation for the Residents' medical records to be accurate.	F 842		