STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.	E 036		11/15/19

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

Electronically Signed | 11/08/2019

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E 036	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and maintain an annual emergency preparedness training program for facility staff. Findings included: A review of the facility's emergency preparedness manual was conducted on 10/17/2019 and the manual did not include information on training or testing of the emergency preparedness plan for the facility staff. An interview was conducted with the maintenance director on 10/17/2019 at 6:45 PM and he reported the facility had drills over the past year (fire and tornado drills), but there was no specific emergency preparation training program in place for the facility. The maintenance director went on to explain the staff were given information on various subjects during the quarterly drills, but the facility had not developed an annual emergency preparation training program. The Administrator was interviewed on 10/17/2019 at 6:45 PM and she reported the former Administrator had developed the emergency preparation plan and she was not aware there was not an annual training program established.	E 036	POC for E036 An emergency preparedness training program calendar for the next 12 months was implemented on 11/1/19. Administrator reviewed the past 12 months of Maintenance related In-Services on 11/7/19 to identify any months that did not have a facility wide training program initiated. Maintenance Director and/or Assistant Maintenance Director will conduct a mandatory biannual emergency preparedness training for facility staff. All active staff will sign an attendance sheet that they attended and understand what to do during that emergency. The Maintenance Director and/or Assistant maintenance director will report all findings to the QAPI meeting. The Maintenance Director and/or Assistant Maintenance Director is responsible for implementing the acceptable plan of correction.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For	F 637		11/15/19

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F 637	Continued From page 2 purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after the resident fell and sustained a hip fracture for 1 of 9 residents reviewed for accidents (Resident #55). Findings included: Resident #55 had been admitted 7/11/19 with diagnoses including diabetes, arthritis, peripheral vascular disease and anxiety. Resident #55's admission MDS dated 7/18/19 indicated she was cognitively intact, required supervision with bed mobility and transfers, had been independent with walking and locomotion, and used a walker. Facility documentation dated 7/26/19 indicated Resident #55 had sustained a fall and had fractured her right hip. Resident #55's Quarterly MDS assessment dated 8/22/19 indicated she was cognitively intact, she required extensive assistance with bed mobility, transfers and locomotion, did not walk, and used a wheelchair. On 10/15/19 at 10:26 AM an interview was conducted with Resident #55. She stated she had originally been admitted to the facility for therapy related to a foot problem and had been using a	F 637	POC for F637 A complete audit of Resident #55's chart was completed, and corrections made by 11/8/19. A review of all current residents that have had a fall with fracture within the last 6 months was completed by the Director of Nursing on 11/7/19 to identify that a significant change in status MDS assessment has been completed within 14 days of the incident. The regional MDS nurse educated the MDS department on correctly coding a significant change when related to a fall with fracture on 10/17/19. The regional MDS nurse will audit Section J for falls with fracture to identify all have been coded with a significant change. An audit will be conducted weekly times 4 weeks and then monthly for 3 months. Data obtained from the audit process will be analyzed for patterns and trends and reported to QAPI by the MDS coordinator monthly times 3 months. At that time the QAPI team will evaluate the effectiveness of the interventions to determine if continued auditing is necessary.	

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F 637	Continued From page 3 knee scooter to get around. She stated she had fallen since being admitted to the facility, broke her hip and had surgery. She explained that she had continued with therapy but was still unable to walk and had to use a wheelchair to get around. On 10/16/19 at 8:23 AM an interview with the 200-hall Assistant Director of Nursing (ADON) was conducted. The ADON stated Resident #55 had been independent with mobility with a knee scooter when she fell and now required the use of a wheelchair because she cannot bear weight on the leg with the hip repair. On 0/17/19 at 2:15 PM an interview was conducted with MDS nurse #1. She stated Resident #55 had a decline in her abilities since her admission to the facility due to the fractured hip. She further stated Resident #55 had been in and out of the hospital several times and a significant change in status MDS assessment should have been completed to reflect the resident's fall with fracture and multiple declines since the completion of the resident's 07/18/19 admission MDS but it had been overlooked. On 10/17/19 at 3:08 PM an interview with the Administrator was conducted. The Administrator stated it would be her expectation that staff would conduct significant changes in status assessments when a change in condition is identified.	F 637	MDS will be responsible for implementing the acceptable plan of correction.	
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.	F 641		11/15/19

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F 641	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interviews, and facility and hospital record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to indicate a resident ' s history of falls and the routine use of an antipsychotic medication for 1 of 3 residents reviewed for Accidents (Resident #119). The findings included: 1) Resident #119 was admitted to the facility on 9/21/17 with re-entry 6/24/18 from a hospital. Her cumulative diagnoses included Parkinson ' s disease, schizophrenia, and difficulty in walking. A review of Resident #119 ' s quarterly Minimum Data Set (MDS) assessment dated 8/13/19 was conducted. Section J of the MDS assessment reported Resident #119 did not experience any falls since the prior assessment. Review of a Fall Incident Report dated 9/1/19 at 11:10 AM revealed Resident #119 experienced an unwitnessed fall to the floor in her room on 9/1/19. She was observed by the nurse to have a laceration and hematoma above her right eye and her right wrist appeared to be bruised. The resident was transferred to the hospital related to her injuries. A review of the hospital Emergency Department notes dated 9/1/19 reveals the resident had experienced a fall with a fracture of her right ulna (the thinner and longer of the two bones in the forearm) and radius (the thicker and shorter of the two bones in the forearm). She was discharged back to the facility. Resident #119 ' s most recent quarterly MDS	F 641	POC for F641 A complete audit of Resident 119's chart was completed, and corrections made by 10/18/19. A review of all residents that have had a history of falls and the routine use of antipsychotic medications to identify that the MDS assessment was accurately coded for history of falls and the routine use of an antipsychotic medication was completed by the Director of Nursing and Unit Managers on 11/8/19. The regional MDS nurse educated the MDS department on 10/17/19 regarding accurately coding MDS assessments for history of falls and the routine use of an antipsychotic medication. The regional MDS nurse will audit Section J for falls and Section N for antipsychotic medications. A minimum of 5 per week for 4 weeks and then 5 per month for 3 months. Data obtained from the audit process will be analyzed for patterns and trends and reported to QAPI by the MDS coordinator monthly times 3 months. At that time the QAPI team will evaluate the effectiveness of the interventions to determine if continued auditing is necessary. MDS nursing is responsible for implementing the acceptable plan of correction.	

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F 641	Continued From page 5	F 641		

assessment was dated 9/28/19. Section J of the MDS assessment revealed Resident #119 had two or more falls since the prior assessment with injury (not major). No falls resulting in a major injury were reported to have occurred since the prior assessment.

An interview was conducted on 10/17/19 at 10:55 AM with MDS Nurse #1. Upon request, the nurse reviewed Section J of Resident #119 ' s quarterly MDS dated 9/28/19 and confirmed it reported the resident experienced 2+ falls with injury (not major). When asked if fractures of the ulna and radius would be considered a major injury from a fall, the MDS nurse stated, "Yes." She reported a modification would need to be submitted to correct this MDS assessment.

An interview was conducted on 10/17/19 at 3:50 PM with the facility ' s Director of Nursing (DON). During the interview, the MDS coding error for Resident #119 was discussed. When asked, the DON stated she would expect the MDS assessments to be accurate in submissions. Upon further inquiry about the MDS coding for the 9/1/19 fall (when this resident fractured her ulna and radius), the DON stated she would expect a wrist fracture to be coded as a major injury from a fall.

2) Resident #119 was admitted to the facility on 9/21/17 with re-entry 6/24/18 from a hospital. Her cumulative diagnoses included Parkinson ' s disease, schizophrenia, and difficulty in walking.

Resident #119 ' s most recent quarterly Minimum Data Set (MDS) assessment was dated 9/28/19. Section N of the MDS indicated the resident received an antipsychotic medication on 7 out of

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F 641	Continued From page 6 7 days during the look back period. However, section N0450 of the MDS reported no antipsychotics were received by the resident during the look back period. A review of the resident ' s September 2019 Medication Administration Record (MAR) revealed she received the following medications as scheduled on each of the 7 days during the MDS look back period: 50 milligrams (mg) quetiapine to be given as one tablet by mouth three times daily; 25 mg quetiapine to be given as 0.5 tablets by mouth every evening at bedtime; and, 0.5 mg risperidone to be given as one tablet by mouth every evening at bedtime. An interview was conducted on 10/17/19 at 10:55 AM with MDS Nurse #1. Upon request, the nurse reviewed Section N of Resident #119 ' s quarterly MDS dated 9/28/19. She also reviewed the resident ' s September 2019 MAR and confirmed the resident did receive an antipsychotic medication on 7 out of 7 days during the look back period. When asked what the correct response for N0450 would have been, the MDS nurse reported it should have indicated Resident #119 received antipsychotic medication(s) on a routine basis. An interview was conducted on 10/17/19 at 3:50 PM with the facility ' s Director of Nursing (DON). During the interview, the MDS coding error for Resident #119 was discussed. When asked, the DON stated she would expect the MDS assessments to be accurate in submissions.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		11/15/19

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F 656	Continued From page 7 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 8 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan which addressed pain management as triggered by his comprehensive Minimum Data Set (MDS) assessment. This occurred for 1 of 3 residents (Resident #327) reviewed for pain. The findings included: Resident #327 was admitted to the facility on 2/28/19 with re-entry from a hospital on 5/23/19. His cumulative diagnoses included chronic pain syndrome. The resident left on a leave of absence from the facility on 7/1/19 and did not return. A review of Resident #327 ' s admission Minimum Data Set (MDS) assessment dated 3/7/19 revealed the resident had intact cognitive skills for daily decision making. He required supervision only for his Activities of Daily Living (ADLs), with the exception of being independent with transfers. He was reported to walk in his room or corridor only 1-2 times during the 7-day look back period. Section J of the assessment revealed the resident received medications on an "as needed" basis for frequent pain rated as a 6 out of 10 (0 was indicative of no pain and 10 indicative of the most severe pain). Section N of the MDS assessment reported the resident received an opioid pain medication on 7 out of 7 days during the look back period. A review of the resident ' s Care Area Assessment (CAA) Worksheets for the	F 656	POC FOR F656 Resident #327 has discharged and therefore a modification cannot be completed. A review of all current residents that have a chronic pain syndrome diagnosis was completed by the DON and unit managers by 11/8/19 to ensure that they have a pain management care plan. The regional MDS nurse educated the MDS department on accurately code a pain management care plan on any resident with a chronic pain syndrome diagnosis. The regional MDS nurse will audit Section J for completion of pain management care plans. Data obtained from the audit process will be analyzed for patterns and trends and reported to QAPI by the MDS coordinator monthly times 3 months. At that time the QAPI team will evaluate the effectiveness of the interventions to determine if continued auditing is necessary. MDS Nurse's Tammy Wilhite and/or Rachel Herion are responsible for implementing the acceptable plan of correction.	

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F 656	Continued From page 9	F 656		

Assessment Reference Date (ARD) of 3/7/19 revealed the care area for Pain was triggered by his admission MDS assessment. The nature of the problem or condition indicated the resident had chronic complaints of pain with his knees and received pain medications as needed. The CAA Worksheet indicated pain would be addressed in Resident #327 ' s care plan.

A review of Resident #327 ' s most recent quarterly MDS assessment dated 5/23/19 was also conducted. Section J of the MDS revealed the resident received medications on an "as needed" basis for frequent pain rated as a 7 out of 10. Section N reported the resident continued to receive an opioid pain medication on 7 out of 7 days during the look back period.

A review of Resident #327 ' s comprehensive care plan (last revised 6/3/19) was conducted. The care plan did not address pain management.

An interview was conducted on 10/17/19 at 10:55 AM with MDS Nurse #2. During the interview, the nurse reviewed Resident #327 ' s CAA Worksheets from the ARD of 3/7/19 and confirmed the care area for Pain had been triggered for review. The CAA Worksheets also indicated the resident would be care planned with a focus area related to pain. When asked, MDS Nurse #2 also reviewed the resident ' s care plan and medication history. The nurse reported Resident #327 received oxycodone (an opioid pain reliever used to treat severe pain) and should have been care planned for pain. MDS Nurse #2 confirmed Resident #327 was not care planned for pain during his stay at the facility.

An interview was conducted on 10/17/19 at 11:30

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F 656	Continued From page 10 AM with the facility ' s Director of Nursing (DON). During the interview, the CAA Worksheets and care plan information for Resident #327 was discussed. When asked, the DON reported she would have expected a care plan related to pain to have been completed for this resident.	F 656		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to	F 732		11/15/19

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F 732	Continued From page 11 exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of the daily nurse staffing forms, nursing schedules and staff interviews, the facility failed to accurately report care hours provided by licensed and unlicensed personnel for 9 out of 9 daily posted nurse staffing forms reviewed. Findings included: 1. Review of the facility ' s daily nursing staffing forms and daily nursing schedules for 8/6/2019, 8/7/2019, 8/8/2019, 9/26/2019, 9/27/2019, 9/28/2019, 10/1/2019, 10/2/2019, and 10/3/2019 revealed the daily nursing staffing forms were not accurate on the following 9 of 9 days: a. The nursing schedule for 1st shift (6:00 AM to 2:00 PM) for 8/6/2019 was reviewed and 1 Registered Nurse (RN), 15 Nursing Assistants (NA) and 4 Medication Technicians (MT) were scheduled to work 1st shift. The daily posted nurse staffing form for 8/6/2019 reported 2 RNs had provided 16 hours of care, 9 NA had provided 72 hours of care and no MTs were noted on the daily posted nurse staffing form. The nursing schedule for 2nd shift (2:00 PM to 10:00 PM) noted no RNs and 4 MTs were scheduled. The daily posted nurse staffing form for 2nd shift on 8/6/2019 indicated that 1 RN provided 8 hours of care and no MTs were on the posted nursing	F 732	POC for F 732 Staffing The staffing form that was being used has been discontinued and a new form has been initiated. The DON trained the staffing coordinator and the staff development coordinator on 10/18/19 on the utilization of the new staffing form. The new form will include the number of CMAs per shift. The Staffing Coordinator was instructed on how to complete the new form and what licensed personnel should be included. All nurses will be educated on the requirements of the daily staffing sheet by 11/15/19 by the director of nursing and the staff development coordinator. DON or designee will review staffing sheets daily till 100% achieved for 5 consecutive days; than reviews will be done 2 random days a week for 4 weeks till 100% accuracy achieved; then monthly times 3. The DON will findings to the QAPI and will be reviewed and discussed in monthly QAPI meetings. The DON and/or staffing coordinator will be responsible for implementing the acceptable plan of correction.	

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staffing form. The nursing schedule for 3rd shift (10:00 PM to 6:00 AM) was reviewed and 10 NA were scheduled to work. The daily posted nurse staffing form reported 9 NA had provided 72 hours of care.

b. The nursing schedule for 1st shift on 8/7/2019 indicated 13 NAs and 4 MTs had worked that date. The daily posted nurse staffing form reported 14 NAs had provided 112 hours of care and no MTs were on the posted daily nurse staffing form. The nursing schedule for 2nd shift on 8/7/2019 was reviewed and 1 RN 2 Licensed Practical Nurses (LPN), 11 NAs and 4 MTs were scheduled to work. The daily posted nurse staffing form did not indicate any RN or MT had worked that shift, 3 LPNs provided 24 hours of care, and 12 NA provided 96 hours of care. The nursing schedule for 3rd shift on 8/7/2019 reported 11 NAs were scheduled to work. The daily posted nurse staffing form indicated 9 NAs had provided 72 hours of care.

c. The nursing schedule for 1st shift 8/8/2019 was reviewed and 1 RNs, 14 NAs and 4 MTs were scheduled to work 1st shift. The daily posted nurse staffing form for 8/8/2019 indicated 2 RNs had provided 16 hours of care, 13 NAs provided 104 hours of care and no MT was noted on the daily posted nurse staffing form. The nursing schedule for 2nd shift on 8/8/2019 was reviewed and it reported 12 NAs and 4 MTs were scheduled to work. The daily posted nurse staffing form did not indicate any MT had worked that shift and 11 NAs had provided 88 hours of care.

d. The nursing schedule for 1st shift 9/26/2019 was reviewed and 1 RNs, 3 LPNs and 4 MTs

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were scheduled to work 1st shift. The daily posted nurse staffing form for 9/26/2019 indicated 2 RNs had provided 16 hours of care, 3 LPNs provided 32 hours of care, and no MTs were noted on the daily posted nurse staffing form. The nursing schedule for 2nd shift on 9/26/2019 was reviewed and it showed no RNs were scheduled to work, 3 LPNs and 4 MTs were scheduled to work. The daily posted nurse staffing form indicated 2 RNs provided 20 hours of care, 2 LPNs provided 16 hours of care and no MT had worked that shift. The nursing schedule for 3rd shift on that date reported 11 NAs were scheduled to work. The daily posted nurse staffing form indicated 10 NAs provided 75 hours of care.

e. The nursing schedule for 1st shift 9/27/2019 was reviewed and 2 LPNs, 14 NAs and 4 MTs were scheduled to work 1st shift. The daily posted nurse staffing form for 9/27/2019 indicated 3 LPNs provided 24 hours of care, 13 NAs provided 97.5 hours of care and no MTs were noted on the daily posted nurse staffing form. The nursing schedule for 2nd shift on 9/27/2019 was reviewed and it revealed 1 RN, 2 LPNs, 9 NAs and 4 MTs were scheduled to work. The daily posted nurse staffing form indicated 4 LPNs provided 32 hours of care, 10 NAs provided 75hours of care and no MT had worked that shift. The nursing schedule for 3rd shift that date reported 10 NAs were scheduled to work. The daily posted nurse staffing form indicated 9 NA had provided 67.5 hours of care.

f. The nursing schedule for 1st shift 9/28/2019 was reviewed and no RN, 12 NAs and 4 MTs were scheduled to work 1st shift. The daily posted nurse staffing form for 9/28/2019 indicated

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1 RN provided 8 hours of care, 10 NAs provided 75 hours of care and no MTs were noted on the daily posted nurse staffing form. The nursing schedule for 2nd shift on 9/28/2019 was reviewed and it showed 4 MTs were scheduled to work. The daily posted nurse staffing form indicated no MTs had worked that shift. The nursing schedule for 3rd shift revealed 11 NAs were scheduled to work on that date. The daily posted nurse staffing form indicated 10 NAs had provided 75 hours of care.

g. The nursing schedule for 1st shift 10/1/2019 was reviewed and 1 RN, 2 LPNs, 14 NAs and 4 MTs were scheduled to work 1st shift. The daily posted nurse staffing form for 10/1/2019 indicated 2 RNs provided 16 hours of care, 4 LPNs provided 32 hours of care, 11 NAs provided 75 hours of care and no MTs were noted on the daily posted nurse staffing form. The nursing schedule for 2nd shift on 10/1/2019 was reviewed and it showed no RNs were scheduled to work, 3 LPNs, 10 NAs and 4 MTs were scheduled to work. The daily posted nurse staffing form indicated 3 RNs had provided 24 hours of care, 2 LPNs had provided 16 hours of care, 12 NAs had provided 90 hours of care and no MT had worked that shift. The nursing schedule for 3rd shift was reviewed and 1 RN, 2 LPNs and 12 NAs were scheduled to work. The daily posted nurse staffing form for that shift indicated no RN worked, 3 LPNs provided 24 hours of care, and 8 NA provided 60 hours of care.

h. The nursing schedule for 1st shift 10/2/2019 was reviewed and 1 RN, 2 LPNs, 12 NAs and 4 MTs were scheduled to work 1st shift. The daily posted nurse staffing form for 10/1/2019 indicated 2 RNs provided 16 hours of care, 3 LPNs

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provided 24 hours of care, 11 NA provided 82.5 hours of care and no MTs were noted on the daily posted nurse staffing form. The nursing schedule for 2nd shift on 10/2/2019 was reviewed and it showed 1 RN, 12 NAs and 4 MTs were scheduled to work. The daily posted nurse staffing form indicated 3 RNs had provided 24 hours of care, 10 NAs had provided 105 hours of care and no MT had worked that shift. The nursing schedule for 3rd shift was reviewed, and 12 NAs were scheduled to work. The daily posted nurse staffing form for that shift indicated 9 NAs provided 72 hours of care.

i. The nursing schedule for 1st shift 10/3/2019 was reviewed and 1 RN, 2 LPNs, 14 NAs and 4 MTs were scheduled to work 1st shift. The daily posted nurse staffing form for 10/3/2019 indicated 2 RNs provided 16 hours of care, 3 LPNs provided 24 hours of care, 10 NAs provided 75 hours of care and no MTs were noted on the daily posted nurse staffing form. The nursing schedule for 2nd shift on 10/3/2019 was reviewed and it showed 1 RN, 2 LPNs, 12.5 NAs and 3.5 MTs were scheduled to work. The daily posted nurse staffing form indicated 3 RNs had provided 24 hours of care, 3 LPNs had provided 16 hours of care, 11 NAs had provided 82.5 hours of care and no MT had worked that shift. The nursing schedule for 3rd shift was reviewed and 1 RN, 2 LPNs and 11 NAs were scheduled to work. The daily posted nurse staffing form for that shift indicated no RN worked, and 3 LPNs provided 24 hours of care, and 8 NAs provided 60 hours of care.

The facility scheduler was interviewed on 10/17/20019 at 10:57 AM and she reported she counted the Director of Nursing (DON) in the RN

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F 732	Continued From page 16 totals for the day at times and stated she was not aware she should not count the DON towards staffing totals. The scheduler reported she was not aware the MTs should be listed on the daily posted nurse staffing form. The scheduler reported the DON and the wound care nurse helped to manage the daily posted staffing form, as well as the 3rd shift nurse, and she reviewed the forms each morning for accuracy. The Administrator was interviewed on 10/17/2019 at 4:47 PM and she reported she expected the daily posted staffing forms to be accurate and reflect the daily staffing of the facility.	F 732		
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 observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 25 medication opportunities, resulting in a medication error rate of 8% for 1 of 8 residents (Resident #126) observed during medication pass. The findings included: 1) Resident #126 was admitted to the facility on 10/9/19. Her cumulative diagnoses included dementia with behavioral disturbance, disorder of	F 759	POC for F759 Medication Error Resident 126 had a complete review of medication orders and electronic Medication Administration Record. An audit of all residents on that unit was conducted on 10/19/19 by the ADON and/or Director of Nursing for accuracy of Medication Administration instructions. Employee 1 was educated on 10/15 by ADON for proper access to order instructions on eMAR/PCC. All nurses, including current agency, were in-serviced on accessing further instructions on	11/15/19

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F 759	Continued From page 17 the peripheral nervous system, and low back pain. On 10/15/19 at 9:21 AM, Nurse #1 was observed as she prepared and administered to Resident #126. The medications included one - 5% Lidoderm topical patch (a topical analgesic) applied to the resident ' s lower back. A review of the resident ' s medication orders included the following: "Lidoderm Patch 5% (lidocaine). Apply to skin topically in the morning related to low back pain. Place 2 patches onto skin daily. Remove and discard after 12 hours and remove per schedule" (Start date 10/10/19 at 9:00 AM). An interview was conducted on 10/15/19 at 9:55 AM with Nurse #1. During the interview, Resident #126 ' s electronic Medication Administration Record (eMAR) was reviewed. Upon review of the eMAR, the nurse reported the portion of the order she looked at during the med pass administration did not indicate two patches needed to be applied to the resident ' s back. Upon further review of the eMAR, Nurse #1 found that only a portion of the medication order had been visible during the med pass. The nurse discovered she needed to click on or scroll over the word "more" (located next to the order on the eMAR) to enable her to view the entire medication order. When the entire med order was visible, the nurse was able to view instructions which indicated two Lidoderm patches needed to be applied to Resident #126 ' s back. Nurse #1 reported she had not been aware of the need to expand her view of the instructions on the eMAR to ensure an entire medication order could be seen.	F 759	eMAR/PCC by 11/15/19. A medication observation of Employee 1 was conducted on 10/19, 10/22, 10/29, 10/30, and 11/5 totaling 5 days by the Director of Nursing and achieved 100% accuracy. A medication observation will be conducted by the Unit Manager for Employee 1 twice weekly for 4 weeks to maintain accuracy. A random audit of med passes on 100 Hall and/or 200 Hall will be conducted twice weekly for 4 weeks to ensure facility-wide accuracy. The findings will be reported and discussed in our monthly QAPI meetings. DON is responsible for implementing the acceptable plan of correction.	

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An interview was conducted on 10/15/19 at 10:11 AM with Unit Manager #1. During the interview, the Unit Manager reviewed Resident #126 ' s eMAR and reported nursing staff needed to view the entire order when administering medications. She stated the phrase, "hover to discover" referred to scrolling over the word "more" when looking at the eMAR to enable the nurse to see a medication order in its entirety.

An interview was conducted on 10/16/19 at 4:05 PM with the facility ' s Director of Nursing (DON). During the interview, the facility ' s medication errors and medication error rate were discussed. When asked what her expectations were the DON stated, "They (nurses and medication aides) should know how to read the entire order and follow that order."

2) Resident #126 was admitted to the facility on 10/9/19. Her cumulative diagnoses included dementia with behavioral disturbance, disorder of the peripheral nervous system, and low back pain.

On 10/15/19 at 9:21 AM, Nurse #1 was observed as she prepared and administered to Resident #126. The medications included one - 100 milligram (mg) tablet of Vitamin B-1 administered by mouth.

A review of the resident ' s medication orders included the following: "Vitamin B-1 tablet (thiamine) Give 100 mg by mouth one time a day for supplement. Give 2 tablets (200 mg) by mouth every day" (Start date 10/10/19 at 9:00 AM).

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An interview was conducted on 10/15/19 at 9:55 AM with Nurse #1. During the interview, Resident #126 ' s electronic Medication Administration Record (eMAR) was reviewed. Upon review of the eMAR, the nurse reported the portion of the order she looked at during the med pass administration did not indicate two tablets of Vitamin B-1 (for a total dose of 200 mg) needed to be given to the resident. Upon further review of the eMAR, Nurse #1 found that only a portion of the medication order had been visible during the med pass. The nurse discovered she needed to click on or scroll over the word "more" (located next to the order on the eMAR) to enable her to view the entire medication order. When the entire med order was visible, the nurse was able to view instructions which indicated two tablets of Vitamin B-1 (for a total dose of 200 mg) needed to be given to Resident #126. Nurse #1 reported she had not been aware of the need to expand her view of the instructions on the eMAR to ensure an entire medication order could be seen.

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F 759	Continued From page 20 should know how to read the entire order and follow that order."	F 759		