STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	C 11/07/2019

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CHATHAM NURSING & REHABILITATION	**700 JOHNSTON RIDGE ROAD ELKIN, NC 28621**

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 11/4/19 to 11/7/19. The facility was in compliance with requirement CFR 483.73, Emergency Preparedness. Event ID # 8LDK11.	E 000		
F 000	INITIAL COMMENTS A recertification with complaint investigation survey was conducted from 11/4/19-11/7/19. 2 of the 7 complaint allegations were substantiated resulting in deficiencies F583 and F658.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure	F 583		12/5/19

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

Electronically Signed | 11/22/2019

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F 583	Continued From page 1 and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, the facility failed to protect private health information for 1 of 1 resident (Resident #288) by including their confidential medical and personal information into another resident's file (Resident # 279). Findings included: Resident #279 was discharged from the facility and admitted to the hospital on 10/19/19. The facility provided the resident face sheet and medication administration record (MAR) to the resident's family member who was present at the facility at the time of transfer. An interview was conducted with Resident #279's family member via phone who advised that she opened the envelope given to her by facility staff and found a face sheet with personal information for Resident #288 included with the pertinent medical information for Resident #279. The face sheet information included the home address, medications, billing and insurance numbers, current diagnoses, most recent vital signs, and emergency contact information for Resident #288. This information matched the information	F 583	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice • Resident #288 was informed via telephone and by formal letter of breach of protected health information in regards to facesheet and items pertained on facesheet on 11.19.19 by Social Services Director and Executive Director. 2) Address the facility will identify other residents having the potential to be affected by the same deficient practice: • All residents have the potential for possible breach of private personal and medical information. • All staff in-serviced on HIPAA, Confidentiality, and Privacy Notice policies and procedures to ensure confidentiality of residents personal and health information by Executive Director/Director of Nursing/designee. All staff will be in-serviced by 11.22.19 or by next scheduled shift. 3) Address what measures will be put into place or systemic changes made to	

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F 583	Continued From page 2 in the facility's computer system for Resident #288. The family member stated that the folder did contain the necessary paperwork for Resident # 279 but the extra face sheet for Resident # 288 was also included. The family member did not notify the hospital or facility and stated that she removed it from the envelope and placed it in her purse before turning it over to hospital personnel. Interview with Nurses #1 and # 2 was conducted together on 11/6/2019 at 9:15 am. Each nurse was able to verbalize each resident's face sheet and medication administration record was sent with them when they were discharged to the hospital. Each nurse also verbalized that it is not just one staff member's job to complete that task and that whomever is available will "go ahead at do it." No one was able to explain how another resident's medical information could have ended up in another resident's outgoing envelope. Neither nurse specifically remembered preparing Resident #279 for transfer or getting her envelope together and stated that anyone can do that task. An interview was conducted on 11/7/2019 at 1:30 pm with the Director of Nursing who stated that she will, at times, help the staff during emergency transfers by gathering necessary paperwork. She stated she was unaware that Resident #288's information was found in the envelope for Resident #279. Both the Administrator and Director of Nursing stated that they were not aware of any privacy issues or concerns prior to hearing about this incident. Both verbalized that it was their expectation that staff maintain the confidentiality of each resident's personal and medical information.	F 583	ensure that the deficient practice will not recur • All staff in-serviced on HIPAA, Confidentiality, and Privacy Notice policies and procedures to ensure confidentiality of residents personal and health information by Executive Director/designee. All staff will be in-serviced by 11.22.19 or by next scheduled shift. • Residents personal and health information will be checked by two staff members before being sent out of the facility to verify correct information is being sent. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained • An audit tool titled Confidentiality Audit, has been developed to monitor performance. Random Audits will be conducted by the DON/designee weekly x4 weeks, monthly x 3 months, and as needed to ensure compliance with accuracy. • Audit Compliance will be discussed weekly by the DON/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. • The DON/designee will bring results of Confidentiality Audit at the facility monthly QA meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to	

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F 583	Continued From page 3	F 583	the monitoring plan will require re-in servicing by the DON/designee and monitoring to begin again at the weekly audits until compliance is met. The outlined plan above will be implemented and monitored by the facility ED (Executive Director). The Director of Nursing Service (DNS) will be responsible for plan in the ED's absence.	
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 a Minimum Data Set assessment in the area of continence for 1 of 3 (Resident #40) reviewed for pressure ulcers. The findings included: Resident #40 was admitted to the facility on 4/21/15 with diagnoses that included, in part, vascular dementia, transient cerebral ischemic attack and polyneuropathy. A review of a quarterly Minimum Data Set assessment dated 10/18/19 revealed Resident #40 had severely impaired cognition, required extensive assistance of two people for bed mobility, transfers and toileting and was frequently incontinent of bowel. A care plan updated last on 6/12/19 indicated a	F 641	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice • CNA who charted continent in error corrected documentation to reflect incontinent for date of 10/18/19. Date of correction 11/18/19 • Resident #40 MDS assessment was corrected on 11/18/19 and transmitted with incontinent reflected for 10/18/19. 2) Address the facility will identify other residents having the potential to be affected by the same deficient practice: • A 100% audit was conducted of assessments by the Director of Clinical Reimbursement (DCR)/ designee on all assessments transmitted since 10/14/19 to ensure accurately reflects resident's current status.	12/5/19

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F 641	Continued From page 4 problem of incontinence not new onset of bowel and bladder at risk for further decline and for complications associated with incontinence. The goal was for Resident #40 to have no preventable decline to continence. The interventions included: offer frequent toileting opportunities if appropriate, identify any environmental barriers to toileting and minimize or eliminate and ensure pathway to toilet is clear for resident and staff convenience/safety. A review of bowel and bladder data collection by nursing assistants during the look back period of 10/12/19 through 10/18/19 revealed Nursing Assistant (NA) #2 documented Resident #40 had a bowel movement on 10/18/19 at 2:29 PM and was continent. An observation on 11/7/19 at 8:30 AM of Resident #40 in bed revealed the resident was awake and not verbally responsive. An interview was conducted on 11/7/19 at 10:04 AM with the Minimum Data Set Nurse #1. She stated she gets information for the assessment from many ways. She watches the residents, talks to the nursing assistants and family members of residents, does resident interviews and knows the residents. She stated she also uses the nursing assistant data collection tool. An interview on 11/7/19 at 11:55 AM with NA #2 revealed Resident #40 is always incontinent of bowel and bladder and if she documented continence, that was in error. An interview on 11/7/19 at 1:03 PM with Nurse #1 revealed she had been working at the facility for about 2 years and Resident #40 had been	F 641	• Any inaccuracies identified on the assessments during the audit were corrected by the DCR/designee. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur • The RN MDS Coordinators will ensure that assessments accurately reflect the resident's status. • The Interdisciplinary team (IDT) received in-service training by the DCR on the MDS requirements by RAI Manual to ensure compliance with MDS accuracy on 11/19/19. • Direct Care staff in-serviced on ADL coding and documentation ensuring accuracy. All Direct Care staff will be in-serviced by 11/22/19 or by next scheduled shift. • The MDS coordinator will participate in daily administrative nurse and IDT meetings to ensure that as interventions and changes are made, they are immediately transcribed to the careplan and updated on the next scheduled MDS assessment. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained • An audit tool titled MDS Coordination/Certification and Accuracy Audit, has been developed to monitor performance. Random Audits will be conducted by the DCR/designee weekly x4 weeks, monthly x 3 months, and as needed to ensure compliance with accuracy. • Audit Compliance will be discussed	

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F 641	Continued From page 5 incontinent of bowel and bladder for that time period. She stated she couldn ' t ask for assistance to be toileted.	F 641	weekly by the ED/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. • The ED/designee will bring results of MDS Coordination/Certification and Accuracy Audit at the facility monthly QA meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DCR/designee and monitoring to begin again at the weekly audits until compliance is met. The outlined plan above will be implemented and monitored by the facility ED (Executive Director). The Director of Nursing Service (DNS) will be responsible for plan in the ED's absence.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		12/5/19

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F 657	Continued From page 6 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise care planned interventions for 1 of 3 (Resident #40) reviewed for pressure ulcers. The findings included: Resident #40 was admitted to the facility on 4/21/15 with diagnoses that included, in part, vascular dementia, transient cerebral ischemic attack and polyneuropathy. A review of a quarterly Minimum Data Set assessment dated 10/18/19 revealed Resident #40 had severely impaired cognition, required extensive assistance of two people for bed mobility and transfers. A review of a care plan dated 6/12/19 for risk of skin impairment with a goal to maintain skin integrity without noted skin problems and staff to implement interventions to reduce risk for skin	F 657	1) Corrective action for affected resident(s) For Resident #40 Care plan meeting was held on 11/19/19 to include and advise the resident and resident representative of any changes in the plan of care. Resident #40 plan of care was updated to reflect appropriate problems, goals, and interventions. 2) Corrective action for resident(s) with the potential to be affected. • All residents have the potential for interventions and revisions not being included on the plan of care or updated in a timely manner. Upon next MDS Assessment, care plans will be reviewed by the IDT. • The IDT (Interdisciplinary Team) were re-educated by the Management Company's Director of Clinical Reimbursement on 11/19/19 as to the purpose and process of developing	

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F 657	Continued From page 7 impairment through next review included interventions of right boot when up in wheelchair on 4 hours a day dated 6/12/19, monitor skin pre and post boot application dated 6/12/19 and left arm position on pillow under arm and elbow. An observation on 11/4/19 at 10:29 AM revealed Resident #40 out of bed to her wheelchair. There was not a boot to the resident ' s right foot observed. An observation on 11/4/19 at 3:02 PM revealed Resident #40 lying in bed. There was not a pillow under the left arm and elbow. An observation on 11/5/19 at 1:49 PM revealed Resident #40 out of bed to wheelchair. There was not a boot to the right foot. An observation on 11/5/19 at 2:37 PM revealed Resident #40 lying in bed with no pillow observed under the left arm and elbow. An interview was conducted on 11/7/19 at 3:10 PM with Med Aide #1. He stated the Kardex is where the nursing assistants would look to find out the residents needs. He stated the Kardex for Resident #40 did indicate a pillow was to be placed under her left arm and elbow. He did not know about Resident #40 having a boot. An interview was conducted on 11/7/19 at 3:17 PM with the treatment nurse. She stated Resident #40 had interventions in place to prevent pressure ulcers including low air loss mattress, barrier cream and hand splints. She stated she didn ' t know about a boot. She stated Resident #40 didn ' t have a wound to the foot.	F 657	person- centered plans of care and the importance of keeping the problems, goals, and interventions up-to-date in order to reflect the current status of the resident. 3) What measures/systems will be put into place to ensure the deficient practice does not occur again • A member of the facility MDS team will attend the weekly meetings applicable to residents' care (e.g. wounds, weights, accident/incident, restorative, etc.) and update the residents' plan of care as needed at the time of the meeting and developed intervention or discontinue interventions no longer be utilized. • IDT members will meet weekly to review care plans as required by the MDS assessment schedule and/or care plan goals. a. How will performance be monitored and how often • 50% of residents discussed in the weekly meetings (see list above) will be audited by Executive Director/designee on a weekly basis X 4 weeks, and as needed. • Results of audits will be brought to the morning facility administrative meeting, where QAA members are present, by Executive Director weekly X 4weeks. Any non-compliance will be corrected at the time of discovery. • Results of audits will continue to be brought by Executive Director to the facility monthly QAA meeting x 3 months, and as needed. • All discussion by QAA committee members will be recorded in the meeting	

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F 657	Continued From page 8 An interview was conducted on 11/7/19 at 3:52 PM with the Assistant Director of Nursing. She stated Resident #40 was on the restorative nursing program beginning in June of 2019 and the boot was to be worn for 6 weeks. She stated the care plan should have been updated.	F 657	minutes to include but not limited to continuing with stated plan or to identify any needed revisions. • Any revision to the above state plan will require re-in servicing of involved staff by the Management Team Director of Clinical Reimbursement/designee and for the monitoring to begin again at 3(a) and continue as outlined above. 4) The outlined plan above will be implemented and monitored by the facility ED (Executive Director). The Director of Nursing Service (DNS) will be responsible for plan in the ED's absence.	
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 observations, staff interviews and record review the facility failed to give a supplement as ordered by the physician for 1 of 3 residents (Resident #73) reviewed for nutrition. Findings included: Resident #73 was admitted to the facility on 9/4/18 with diagnoses that included vascular dementia and anorexia. The quarterly Minimum Data Set (MDS) assessment dated 10/15/19 revealed Resident #73 had severely impaired cognition and needed	F 658	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice • Resident #73 supplement order and medication administration record reviewed. Special requirement for fluid intake in milliliters initiated to order to document how much consumed with each administration of supplement on 11.15.19 by Assistant Director of Nursing. • Resident #73 meal ticket was reviewed and updated by Registered Dietician on 11.5.19 to remove ensure	12/5/19

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F 658	Continued From page 9 limited assistance with one person for eating. The resident's weight was 73 pounds. A care plan problem updated 7/22/19 included nutrition. A care plan intervention revealed "supplement meal intake with between meal/nourishing snacks." The care plan further revealed the discipline responsible for the task was dietary and nursing assistant. A physician's order dated 8/27/19 revealed "Ensure (a nutritional supplement), three times a day, weight loss." The November medication administration record (MAR) indicated Ensure was scheduled to be given daily at 10:00 AM, 4:00 PM and 10:00 PM. Documentation on the MAR revealed Ensure was signed off as having been given three times daily each day in November. On 11/4/19 from 12:29 PM-1:13 PM a continuous observation was made of Resident #73 when she ate lunch in the main dining room. The meal ticket that accompanied Resident #73's lunch tray indicated she was on a mechanical soft diet and the lunch meal included a "Supplement: Ensure Chocolate." An observation of the meal tray revealed there was no Ensure on the tray that had been delivered to Resident #73. Resident fed herself the lunch meal. Throughout the dining process, staff opened food containers for the resident and encouraged resident to eat her meal. At 1:13 PM the Social Services Director escorted Resident #73 from the dining room. The resident had not received the chocolate Ensure during the consumption of the lunch meal. An observation of Resident #73 on 11/4/19 at	F 658	supplement due to supplement given between meals reflected on the medication administration record. • Executive Director and Director of Nursing interviewed Nurse #4 on 11.7.19 in regards to resident #73 supplement administration. Nurse #4 reveals she administered resident #73 Ensure supplement as reflected on medication administration record (MAR). MAR reflects supplement given by Nurse #4 on 11.4.19 at 10:00AM and 3:00PM, 11.5.19 at 10:07AM and 3:53PM, and 11.6.19 at 10:48AM and 3:15PM. • Affirmation Statement of Nurse #4 completed. 2) Address the facility will identify other residents having the potential to be affected by the same deficient practice: • 100% audit completed on residents and supplement orders in facility to ensure reflected on medication administration record and special requirement of fluid intake in milliliters attached to order. Audit completed 11.15.19 by Assistant Director of Nursing. • 100% audit of resident meal tickets reviewed by registered dietician to ensure no supplements reflected on meal tickets due to supplements reflected on medication administration record and given during medication passes as scheduled on 11.5.19. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur • All direct care staff in-serviced on supplement procedure/protocol in regards	

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F 658	Continued From page 10 3:25 PM revealed she was in her room, asleep in the bed. No nutritional supplements were observed to be in her room. During an interview with Nurse #4 on 11/5/19 at 2:18 PM, she explained if there was an order for Ensure to be given three times a day the supplement came out on the meal tray and the nurse or nurse aide checked if the resident received it on the meal tray. Nurse #4 said if a resident ate in the dining room she asked the nurse aide if the resident received the Ensure, and if so, asked how much the resident drank and then documented the resident received the supplement. On 11/6/19 at 8:12 AM an observation was made of Resident #73 seated in the main dining room, eating breakfast. There was no Ensure on the breakfast tray. The breakfast tray ticket revealed no supplement was listed on the ticket. An interview was completed with Personal Care Assistant (PCA) #1 on 11/6/19 at 9:17 AM. She stated she worked in the main dining room during meal times and assisted residents to set up meal trays, cut up food, opened drink cartons and checked on residents throughout the meal and asked if they needed anything. PCA #1 confirmed the meal tickets came out with the meal trays for each resident. She added when she checked on a resident she looked at the tray ticket to see if it matched what was on the meal tray. PCA #1 verified she worked in the main dining room on 11/4/19 during the lunch meal and indicated she had not looked for the nutritional supplement for Resident #73, "I honestly probably looked more at the food than the supplement."	F 658	to who, how, and when supplements are given. All direct care staff will be in-serviced by 11.22.19 or by next scheduled shift. • Supplement orders will be entered under “supplement” classification and have special requirement of fluid intake in milliliters attached to order in MAR for consistency and ensure amount of supplement consumed is tracked. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained • An audit tool titled Supplement Audit, has been developed to monitor performance. Random Audits will be conducted by the DON/designee weekly x4 weeks, monthly x 3 months, and as needed to ensure compliance with accuracy. • Audit Compliance will be discussed weekly by the DON/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. • The DON/designee will bring results of Supplement Audit at the facility monthly QA meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DON/designee and monitoring to begin again at the weekly audits until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING _____ B. WING _____	C 11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 11 An observation of Resident #73 on 11/6/19 at 9:43 AM revealed she was in her room and asleep. No nutritional supplements were observed to be in her room. On 11/6/19 at 10:10 AM an interview was completed with the Registered Dietician (RD) during which she said Resident #73 had been in the facility over a year, had lost weight and was placed on a nutritional supplement of Ensure. The RD explained the Ensure was supposed to be given in between meals and not with the meal in order that the resident was encouraged to eat the meal or food first. RD said the Ensure was not to be placed on the meal tray and was unsure why it was listed on the tray ticket, "The Ensure being on the tray ticket is an error." She reported the Ensure was kept in a refrigerator in the medication room and the nurse was supposed to give the Ensure to Resident #73. An interview was completed with Nurse Aide (NA) #1 on 11/6/19 at 10:27 AM. She recalled she had worked with Resident #73 on 11/5/19 and said she had not given the resident any Ensure during her shift. A second interview was completed with Nurse #4 on 11/6/19 at 10:31 AM during which she confirmed she worked with Resident #73 11/4/19-11/6/19. Nurse #4 stated she had not given any Ensure to Resident #73 during the shifts she worked with the resident. An observation of Resident #73 on 11/6/19 at 10:38 AM revealed she was in her room, asleep in a wheelchair. No nutritional supplements were observed to be in her room.	F 658	The outlined plan above will be implemented and monitored by the facility ED (Executive Director). The Director of Nursing Service (DNS) will be responsible for plan in the ED's absence.	

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F 658	Continued From page 12	F 658		

An observation of Resident #73 on 11/6/19 at 3:50 PM revealed she was in her room, asleep in bed. No nutritional supplements were observed to be in her room.

The MAR for 11/6/19 indicated the nurse documented that Ensure was given to Resident #73 at 10:00 AM and 4:00 PM.

In an interview with the Director of Nursing (DON) on 11/7/19 at 11:11 AM, she explained when a nutritional supplement was ordered for a resident it was typically given in between meals and not with a meal. The ordered supplement was listed on the MAR and either the medication aide or nurse was responsible to give the supplement to the resident or make sure the resident received it. The DON added the supplements had been placed on the meal tray until recently (8/27/19). She reported Nurse #4 was new to the facility and had completed a medication pass for the first time during the week of 11/4/19. The DON expressed if a supplement was ordered and was on the MAR she expected the medication aide or nurse ensured the supplement was provided to the resident.

On 11/7/19 at 12:30 PM an interview was completed with Nurse #4, the DON and Administrator. During the interview Nurse #4 stated she gave Ensure to Resident #73 when she gave her medication, "I gave it to her on every med pass that I have for her this week."

An interview with the Administrator on 11/7/19 at 1:01 PM revealed Nurse #4 had been suspended pending an investigation related to the administration and documentation of the Ensure.