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	345011	A. BUILDING ______ B. WING ______	C 11/20/2019

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E 000	Initial Comments An unannounced Recertification survey was conducted on 11/18/19 through 11/20/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 8NXD11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 11/18/19 through 11/20/19. Event ID# 8NXD11. 4 of the 31 complaint allegations were substantiated resulting in 2 defiencyies, F658 and F561.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		12/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/16/2019

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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§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observations, resident and staff interviews and record review the facility failed to assist a resident out of bed when requested. This was for 1 of 4 sampled residents reviewed for choices regarding significant aspects of life (Resident #67).

The findings included:

Resident #67 was admitted to the facility on 02/08/19 with diagnoses that included spinal stenosis and others. The most recent Minimum Data Set (MDS) dated 09/06/19 specified the resident's cognition was moderately impaired, he had clear speech, able to himself understood and understood others. The MDS also specified the resident required total dependence of two people for transfers.

A care plan was developed and revised on 10/31/19 for the needs of Resident #67. Interventions included: anticipate and meet the resident's needs.

On 11/18/19 at 9:39 AM Resident #67 was observed in bed and interviewed. He stated he had requested to get out of bed and was waiting for the nurse aide. Resident #67 also reported he was waiting to be changed from an incontinent episode.

F 561

The delay in staff assisting with Resident #67 allegedly was not assisted out of bed in a timely manner upon his request and waited 2 hours and 59 minutes.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

To correct the deficient practice, resident #67 was assisted by Nurse #4 and NA #1 via mechanical lift from his bed to his wheelchair on 11/18/2019 at 12:38pm.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Staff Development Coordinator educated Nurse #4 on residents rights with self determination to assure that the resident's preference time for getting out of bed is implemented as requested by the resident's preference with written understanding of education. The Staff Development Coordinator and/or Director of Nursing educated nursing staff on residents rights with self determination to assure that the resident's preference time for getting out of bed is implemented in a

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On 11/18/19 at 10:10 AM nurse #4 was interviewed and explained she was working as the nurse aide assigned to Resident #67. She stated that due to call-offs, she was asked to work the hall by herself. Nurse #4 was not aware Resident #67 was requesting to get out of bed but that she would assist him with morning care as soon as she could.

On 11/18/19 at 10:18 AM Resident #67 was in bed and interviewed again. He reported that a staff member had changed him, but he was still waiting to get out of bed. The Unit Manager was present for this request to get out of bed and replied to Resident #67, "just be patient."

On 11/18/19 at 10:52 AM Resident #67 was in bed and stated he was starting to get "stiff and aggravated" from having to wait for assistance to get out of bed. Resident #67 added that having to wait to get out of bed "happened more than it should."

On 11/18/19 at 12:19 PM nurse aide (NA) #1 and nurse #4 were together in the hallway with the mechanical lift. They were interviewed together and reported they would assist Resident #67 after the lunch meal because they had other residents waiting to be assisted.

On 11/18/19 at 12:38 PM Resident #67 was assisted out of the bed by two staff using the mechanical lift.

On 11/19/19 at 10:10 AM Nurse #4 was interviewed and explained that on 11/18/19 she was working as the only nurse aide on the 600 hall. She added that Resident #67 required a mechanical lift for transfers and it took two people

F 561

timely manner and not delayed with the resident's preference by 12/18/2019. Any nursing staff that was not educated prior to 12/18/2019 will be educated prior to working their next scheduled shift by the Staff Development Educator or the Director of Nursing. This education was not provided to NA #1 and the Unit Manager as they were no longer employed at this facility on 12/18/2019.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility.

The Director of Nursing and/or Staff Development Coordinator will randomly perform at least 8 resident interviews requesting if the resident did get out of bed as requested for at least x 12 weeks. Any negative findings will include interview questions with the resident to include the staff's name, reason given to resident for delay, and time of day as resident recalls to further identify any trends. All findings will be reported to the Administrator weekly. The Director of Nursing or Staff Development Coordinator will report the results of the Plan of Correction including the interviews and the trends to the QAPI committee for review in QAPI monthly for a period of at least 90 days, or until compliance is sustained.

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F 561	Continued From page 3 to operate the lift. As a result, she stated she had to wait to find a second person to assist her with the transfer. On 11/20/19 at 10:51 AM the Director of Nursing (DON) was interviewed and explained that the she was unaware of staffing concerns on 11/18/19; and that she expected staff to assist residents within a reasonable timeframe. The DON reported that it was unacceptable for Resident #67 to wait that long before being assisted out of bed.	F 561	Include dates when corrected action will be completed. The corrective action will be fully implemented by 12/18/2019.	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625		12/18/19

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F 625 Continued From page 4

hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, family interview, and staff interviews, the facility failed to provide written notification to the resident regarding the facility ' s bed hold information when the resident was hospitalized for 1 of 2 residents reviewed for hospitalization (Resident #92). Resident #92 was transferred to the hospital on 1/28/2019 and readmitted to the facility on 2/4/2019.

Findings included:

Resident #92 was admitted to the facility on 1/15/2019 and readmitted 2/4/2019 with diagnoses to include chronic obstructive lung disease, hypertension and atrial fibrillation. The most recent admission Minimum Data Set dated 1/22/2019 assessed Resident #92 to be cognitively intact and she did not have behaviors.

The demographic information for Resident #92 revealed Resident #92 was her own responsible party.
A nursing note dated 1/28/2019 at 4:50 PM written by Nurse #1 was reviewed and it documented that Resident #92 was sent to the hospital for evaluation.

A review of the electronic medical chart revealed there was not a scanned copy of a bed hold policy signed by the resident.

Resident #92 ' s family member was interviewed

F 625

Resident #92 was not provided a bed hold policy by the nurse upon transfer to the hospital .

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

To correct the deficient practice, one on one education was provided to Nurses # 1, #3 and #4 on providing a bed hold policy in the transfer packet with a resident upon transfer to a hospital by Staff Development Coordinator by 12/18/2019.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Licensed Nurses and Business Office Manager and Business Office Assistant to be educated by Staff Development Coordinator or Director of Nursing on the bed hold policy and providing a bed hold policy with the resident upon transfer to the hospital by 12/18/2019. Newly hired Licensed Nurses will be educated upon hire in class orientation on the bed hold policy and providing a bed hold policy with the resident upon transfer to the hospital

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F 625	Continued From page 5	F 625		

by phone on 11/18/2019 at 3:07 PM and she reported the facility staff member had called Resident #92 when she was in the hospital and explained the bed hold policy, but neither she nor Resident #92 had received a copy of the bed hold policy. The family member reported Resident #92 was readmitted to the facility on 2/4/2019 without issues.

The Unit Manager was interviewed on 11/19/2019 at 11:44 AM and she reported residents who were transferred to the hospital had a packet of papers to go with them and included in that packet was the bed hold policy.

An interview was conducted with Nurse #3 on 11/19/2019 at 2:56 PM and she reported she had not sent a copy of the bed hold policy with a resident when they were transferred to the hospital. Nurse #3 reported she was not aware she should send a bed hold policy with the resident when she sent them to the hospital.

An interview was conducted with Nurse #1 on 11/19/2019 at 2:28 PM and she reported she did not remember Resident #92 or sending her to the hospital on 1/28/2019. Nurse #1 further reported she was not aware of a bed hold policy to send with the resident when they were transferred to the hospital.

Nurse #4 was interviewed on 11/19/2019 at 3:00 PM and she reported she was aware of the bed hold policy, but she had not sent out the form with any resident transferred to the hospital.

The Director of Nursing was interviewed on 11/19/2019 at 5:47 PM and she reported the nurses should include a paper copy of the bed

by the Staff Development Coordinator or Registered Nurse.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The Plan of Correction (POC) is integrated into the quality assurance system of the facility.

The Director of Nursing or Staff Development Coordinator will audit for any residents that discharged to the hospital daily and notify the Business Office Manager or Business Office Assistant to call the Representative/Resident to review bed hold policy and send a written bed hold policy certified via mail the next business day following discharge to the Representative. The audit will be completed daily by the Director of Nursing or the Staff Development Coordinator by reviewing the daily census for all discharged residents to the hospital and the Director of Nursing or Staff Development Coordinator will report in the morning meeting (Monday- Friday) to the Administrator x 4 weeks, then monthly x 2 until compliance is achieved and sustained at which time frequency of monitoring will be determined by the Quality Assurance Performance Improvement(QAPI)Committee.
The results of the audits will be reviewed in the morning meeting Monday- Friday by

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F 625	Continued From page 6 hold policy in the packet of papers they send with a resident when the resident is transferred to the hospital. The Administrator was interviewed on 11/19/2019 at 5:50 PM and she reported it was her expectation that staff provided all residents with a copy of the bed hold policy upon transfer to the hospital.	F 625	the Director of Nursing or Staff Development Coordinator to the Administrator and results will be reviewed in Quality Assurance Performance Improvement(QAPI)Committee monthly for a period of at least 90 days until compliance is sustained. Include dates when corrected action will be completed. The corrective action will be fully implemented by 12/18/2019	
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 staff interviews and record review, the facility failed to document the use of a daily antianxiety medication on the Minimum Data Set (MDS) for 1 of 5 residents reviewed for unnecessary medications (Resident #84). The findings included: Resident #84 was admitted to the facility on 10/29/19 with diagnoses that included bipolar disorder. A physician's order dated 10/29/19 specified the resident was to have Buspar (antianxiety) medication every twelve hours daily for bipolar disorder.	F 641	Resident #84 MDS was not accurately coded with a current antianxiety medication. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; To correct the deficient practice, MDS Nurse immediately requested modification of resident #84 (MDS) Minimum Data Set Assessment to modify the assessment and resubmit for accuracy of the resident's assessment by correction of the antianxiety medication the resident was receiving on 11/19/19.	12/18/19

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F 641	Continued From page 7 Review of the Medication Administration Records (MAR) for October and November 2019 revealed the resident received Buspar twice daily as ordered. The most recent Minimum Data Set (MDS) dated 11/05/19 specified the resident's cognition was intact and she did not take an antianxiety medication. On 11/19/19 at 9:54 AM the MDS Nurse was interviewed and explained that when completing the medication section of the MDS she referenced the Medication Administration Record (MAR) to see how many days a resident had taken medications such as antianxiety. She added that if she was uncertain of a medication's classification, she would look it up in a reference guide. In the case of Buspar, she confirmed the medication was classified as an antianxiety medication and failed to accurately code the daily use of the medication. The MDS Nurse stated it was an oversight. On 11/20/19 at 10:51 AM the Director of Nursing (DON) was interviewed and reported she wanted MDS assessments to be correct.	F 641	The Clinical Reimbursement Specialist will educate The MDS Nurses regarding Federal and State regulation to ensure MDS Assessment of coding accuracy in the section of the antianxiety medications by 12/18/2019. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Residents that receive antianxiety medications currently in the facility will be reviewed by 12/18/2019 for accuracy on their most current MDS assessment. Any residents coded incorrect will be modified and will be re-summited immediately upon findings. The Clinical Reimbursement Specialist will educate newly hired MDS Nurses upon hire during training regarding Federal and State regulation to ensure MDS Assessment accuracy by RAI guidelines in the section for those residents that receive antianxiety medications. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility.	

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F 641	Continued From page 8	F 641	The Clinical Reimbursement Specialist will review the submissions of all newly completed comprehensive assessments for December 2019 & January 2020 residents weekly by the MDS Nurses and audit each submission for any resident currently receiving an antianxiety medication with accuracy with the MDS assessment to achieve desired results. Any identified issues with an assessment will be corrected at that time. The results of the audits will be reviewed in QAPI monthly for a period of 90 days until compliance is sustained. Include dates when corrected action will be completed. The corrective action will be fully implemented by 12/18/2019.	
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. (D) A member of food and nutrition services staff.	F 657		12/18/19

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F 657	Continued From page 9 (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 medical record review and staff interviews, the facility failed to review and revise the care plan for one of fifteen care plans reviewed for care plan revisions. Resident #91 ' s care plan was not updated to reflect the resident ' s pneumonia had resolved and the resident continued to have had a care plan focus title describing the resident having had a nutritional problem of obesity despite having had significant weight loss and a normal Body Mass Index (BMI). The findings included: Resident #91 was admitted to the facility 8/2/19. The resident ' s cumulative diagnoses included: Chronic bronchitis, Parkinson ' s Disease, dysphagia (difficulty swallowing), and muscle wasting. Review of the resident ' s progress notes in his medical record revealed a dietary/nutrition note dated 10/17/19 and timed 2:25 PM revealed resident 91 ' s most recent weight was 157.8	F 657	Resident #91 care plan was not updated to reflect that the resident's pneumonia had resolved and another care plan not corrected with a continued focus title under nutrition with a diagnosis of obesity although the resident had significant weight loss with a normal body mass index (BMI). Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; To correct the deficient practice, Resident #91 care plan was corrected by the MDS Nurse updating the pneumonia as resolved and updating the focus area to the resident having a potential nutritional problem of Parkinson progression, anemia, and dysphagia immediately on 11/20/2019.	

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F 657	Continued From page 10 pounds and the resident ' s Body Mass Index (BMI) (a measurement of height and weight used to measure body fat) was 22.6 (A normal BMI range is 18.6 to 24.9). The note further documented the resident had experienced a 7.9% significant weight loss in one month and the resident had experienced gradual weight loss since admission. A review completed of the Minimum Data Set (MDS) assessments for Resident #91 revealed the most recent completed assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 11/8/19. Review of the assessment revealed the resident was coded as having had moderately impaired cognition. The resident ' s weight was coded as having been 161 pounds and his height was 70 inches, which resulted in a BMI of 23.1. The resident was coded as having had a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. Resident #91 ' s November Medication Administration Record (MAR) from November 1, 2019 through November 20, 2019 was reviewed and there were no antibiotics or other medications discovered on the MAR regarding the treatment of an active pneumonia infection. Resident #91 ' s care plan was reviewed. The review revealed the care plan had been last revised on 11/13/19. The care plan was discovered to have had a focus area of the resident having had pneumonia. The goal listed for the resolving pneumonia was for the resident ' s pneumonia t have been resolved without complications by the review date. Further review revealed the resident had a focus area of the	F 657	Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Clinical Reimbursement Consultant educated the (IDT) Interdisciplinary Team on 12/18/2019 ensuring comprehensive care plans are updated and reviewed for residents that are on antibiotics and the residents that have a weight loss reviewing the focus title ensuring accuracy. Education will be provided by the Clinical Reimbursement Consultant regarding care plan timing and revision with long term care facilities per Federal and State regulation and the RAI manual on 12/18/2019. All other residents that are currently receiving antibiotics or have received antibiotics within the last 30 days were identified by an audit reviewing the order listing report on the Electronic Medical Record (EMR) by the Director of Nursing. All 13 residents identified by the order listing report had their care plans reviewed for accuracy by the Director of Nursing and Staff Development Coordinator and all 13 were updated on 12/17/2019. All residents that had current weight loss were identified by the weight exception report on the electronic medical record (EMR) by the Director of Nursing and the Staff Development Coordinator. Eight residents were identified with current weight loss on 12/17/2019 and their care plans were reviewed for accuracy in the Risk meeting by the Interdisciplinary team (IDT)including the Director of Nursing and	

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	345011	A. BUILDING ______ B. WING ______	C 11/20/2019

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Continued From page 11
resident had a nutritional problem due to obesity.

A dietary/nutrition progress note written on 11/15/19 and timed 11:48 AM documented Resident #91 had a weight of 161 pounds (11/7/19) and a BMI of 23.1 which was within normal limits for the resident ' s age. The note further documented the resident having lost 16% of his weight since his admission weight from 8/5/19 of 188.2 pounds. The note documented interventions for weight loss such as 120 milliliters (ml) of a house supplement three times a day and a health shake each day with lunch for nutritional support.

An interview was conducted on 11/20/19 at 11:01 AM with the MDS Nurse. The MDS Nurse stated Resident #91 was admitted to the facility with Pneumonia back in August and that was when she had created the care plan and the focus area for pneumonia. The MDS Nurse further stated she had most recently reviewed the resident ' s care plan on 11/8/19 and at that time he did not have pneumonia. The MDS Nurse stated she should have marked the focus area regarding pneumonia as resolved when she reviewed the care plan on 11/8/19. Regarding the focus which documented the resident having had a nutritional problem related to obesity, she stated the resident was no longer obese and had a significant weight loss. The MDS Nurse stated she would update the focus area to the resident had a potential nutritional problem due to Parkinson progression, anemia, and dysphagia.

An interview was conducted on 11/20/19 at 12:28 PM with the Administrator. The Administrator stated it was her expectations for care plans to updated to the resident ' s current diagnoses or

F 657

Staff Development Coordinator on 12/17/2019. Two resident's care plans were updated with current weight loss to reflect the recent weight loss during the risk meeting on 12/17/2019; while the other six were accurate.

Newly admitted residents will have their comprehensive assessment reviewed by the (IDT)Interdisciplinary Team for accuracy and updated as identified.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The Plan of Correction (POC) is integrated into the quality assurance system of the facility.

To ensure ongoing compliance, the care plans of the residents on antibiotics and the residents with weight loss will be reviewed weekly by reviewing the order listing report and the weight exception report on the Electronic Medical Record (EMR) for accuracy and updated as indicated by the Director of Nursing or the Staff Development Coordinator or a MDS Nurse with the Interdisciplinary Team (IDT) as present during the Risk Meeting x 12 weeks and findings reported to the Administrator. This plan of correction and the quality improvement monitoring findings of the antibiotic and weight loss care plan timing and revision will be submitted and reported in Quality

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F 657	Continued From page 12 status to provide an accurate picture of the resident and if a focus area, such as pneumonia, has been resolved, then the focus area should be resolved, and the focus area removed from the resident ' s active care plan.	F 657	Assurance Performance Improvement(QAPI) by the Director of Nursing monthly x 3, and if substantial compliance is achieved, the quality improvement monitoring will be discontinued. Include dates when corrected action will be completed. The corrective action will be fully implemented by 12/18/2019	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to transcribe admission orders for a diuretic medication for 1 of 6 residents reviewed for medications (Resident #92). Findings included: The Division of Medical Assistance form (a form used to determine a resident ' s level of care) dated 12/31/2018 was reviewed and a list of medication for Resident #92 included Torsemide (a diuretic) 20 milligrams (mg) two tablets by mouth daily. Resident #92 was admitted to the facility on 1/15/2019 with diagnoses to include chronic	F 658	Resident #92 torsemide that was ordered on admission and was not transcribed to the Electronic Medical Record(EMR) by the admission nurse no longer working at the facility. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The resident is no longer in the facility. Address how the facility will identify other residents having the potential to be	12/18/19

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F 658	Continued From page 13 obstructive lung disease, hypertension and atrial fibrillation. The admission orders dated 1/15/2019 for Resident #92 were reviewed and no order for Torsemide were noted. The resident ' s January 2019 medication administration record (MAR) was reviewed and no torsemide was administered from 1/15/2019 to 1/19/2019. Review of the physician ' s orders revealed an order for Torsemide 20 milligrams two tablets by mouth daily dated 1/20/2019. A review of the MAR revealed Resident #92 had received the torsemide as ordered on 1/20/2019 to 1/28/2019. The most recent admission Minimum Data Set dated 1/22/2019 assessed Resident #92 to be cognitively intact and she did not have behaviors. The medical record was reviewed and Resident #92 was noted to have gained 3 pounds between her admission weight on 1/16/2019 and 1/21/2019. The nurse whose signature was on the 1/15/2019 admission orders for Resident #92 was no longer employed by the facility. An attempt to contact her by phone call was made on 11/19/2019, but the phone number was no longer in service. Nurse #1 was interviewed on 11/19/2019 at 2:28 PM and she reported she did not remember Resident #92. Nurse #1 reported that the nursing staff worked together on admissions sometimes	F 658	affected by the same deficient practice; 26 Newly admitted and/or readmitted residents to the facility were reviewed had their (EMR) Electronic Medication Record reviewed since 11/17/2019 for accuracy by the Director of Nursing or Staff Development Coordinator with no negative findings of the 26 reviewed. Education was initially provided to all the Licensed Nurses by the Staff Development Coordinator on 11/13/2019-11/18/2019. The education that was provided stated that newly or readmitted residents must have their(EMR)Electronic Medical Record reviewed and signed by another second nurse for accuracy verifying medications are accurate with the residents discharge summary and/or FL2 and/or physician orders, with a Nurse Practitioner, Physician Assistant, or Medical Doctor verification prior to administering any medications to the resident. Additionally, Licensed Nurses were re-educated by the Staff Development Coordinator on 12/14/19. Any other Licensed Nurses were educated prior to working their next scheduled shift. Re-education was completed on 12/18/2019 by the Staff Development Coordinator. All newly hired Licensed nurses will be educated by the Staff Development Coordinator or the Director of Nursing that all newly admitted or readmitted residents must have their (EMR) Electronic Medical Record reviewed and signed by another	

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F 658	Continued From page 14 and she completed Resident #92 ' s admission assessment, but she had not called the physician to confirm the medication orders. A message was left for the Nurse Practitioner (NP) who completed the FL2 for Resident #92 on 11/20/2019 at 11:07 AM, but she did not return the phone call. The Director of Nursing (DON) was interviewed on 11/19/2019 at 5:47 PM and she reported she was not employed by the facility during the time Resident #92 was a resident. The DON reported the nursing staff who completed an admission were to call the physician to confirm medications and she was not certain why the Torsemide was not transcribed for Resident #92. The Administrator was interviewed on 11/19/2019 at 5:50 PM and she reported she expected the admission orders to be entered correctly into the electronic medical record and checked by the nurse with the physician or NP for accuracy.	F 658	second nurse for accuracy verifying medications are accurate with the residents discharge summary and/or FL2, with a Nurse Practitioner, Physician Assistant, or Medical Doctor verification prior to administering any medications to the resident. This education will be provided during the class orientation upon hire prior to any medication administration to the residents. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The Plan Of Care (POC) is integrated into the quality assurance system of the facility. The Director of Nursing or Staff Development Coordinator will be responsible for the review of each new admitted and/or readmitted resident daily (Monday- Friday) Electronic Medical Record (EMR) for accuracy and verification of 2 licensed nurse signatures and verification of Nurse Practitioner, Physician Assistant, or Medical Director with findings, any identified issues will be corrected at that time of each newly admitted resident's review. The review findings will be reported in morning meeting daily (Monday-Friday) weekly x 4 weeks to the Administrator, then monthly x 2 until compliance is achieved and sustained at which time frequency of	

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F 658	Continued From page 15	F 658	monitoring will be determined by the Quality Assurance Process Improvement (QAPI) committee. Include dates when corrected action will be completed. The corrective action will be fully implemented by 12/18/2019	