STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	C 03/17/2021

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UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

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F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		4/12/21

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

Electronically Signed | 04/07/2021

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F 842	Continued From page 1 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview it was determined that facility staff failed to document medication administration in February and March 2021 for 3 of 4 residents reviewed (#1, #2, #4). Findings included: 1.Resident #1 was admitted to the facility with diagnosis including hypokalemia, vitamin D deficiency, hypertension, anxiety, pain, cerebral infarction, shortness of breath, herpes, neuropathy, skin cancer, and chronic kidney	F 842	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate	

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F 842	Continued From page 2 disease. Review of electronic and paper medication administration record (MAR)dated February 2021 revealed an order for Lisinopril tablet one time daily. There was no documentation of the medication having been given on February 19 or 22, 2010. Review of electronic and paper medication administration record dated February 2021 revealed orders for Lovastatin 40 mg tablet, Magnesium 250 mg tablet, Valtrex 500 mg caplet, and Gabapentin 300 mg capsule for neuropathy. There were no signatures on the MAR indicating that the medications had been given on February 1st, 3rd, 6th, 7th, 13th, 15th, 17th, or 18th. Review of electronic and paper medication administration record dated February 2021 revealed an order for Demadex 20 M tablet one daily for edema. There was no documentation of the medication having been given on February 1st, 3rd, 6th, 7th, or 21st. Review of electronic and paper medication administration record dated February 2021 revealed an order for Klor-con tablet for hypokalemia, one tablet by mouth daily. There was no documentation of the medication having been given on February 22 or 26th. Review of electronic and paper medication administration record dated February 2021 revealed an order for a multivitamin one tablet by mouth daily. There were signatures indicating the medication had been give on February 22, 2021. Review of electronic and paper medication administration record dated February 2021 revealed an order for zinc 50 mg caplet by mouth daily. There was no documentation of the medication having been given on February 22, 2021. Review of medication administration record dated	F 842	the good faith attempts by the provider to improve the quality of life of each resident. 1) Address how corrective action will be accomplished for residents(s) found to be affected: No adverse reactions were noted for Resident #1, #2 and #4. On 3/13/2021, Charge Nurse #2 was re-educated by the Director of Nursing (DON)and Assistant Director of Nursing (ADON) on the use of the hardcopy Medication Administration Record (MAR)/Treatment Administration Record (TAR) in the event of computer malfunctions. Additionally, education was given related to medication administration policy/expectations to include proper documentation. 2) Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be address: On 3/15/2021, an review of the previous 2 weeks was completed by Nursing Administration comparing the electronic MAR/TAR and hard copy MAR/TAR to identify documentation issues such as incomplete documentation (omissions). Any identified issues were addressed with Nursing Staff by providing education. From 3/15/2021 - 03/19/2021 and 3/25/2021, Licensed Nurses and Medication Aides were re-educated by the	

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F 842	Continued From page 3 February 2021 revealed physician orders for DHEA 1,000 mcg/ml, Duloxetine HCL 60 mg, Lidoderm 5% patch for pain, Lisinopril 10 mg for hypertension, supplement, Cyanocobalamin and Toprol XL for hypertension. There was no documentation of the medications having been given on February 22, 2021. Review of the electronic health record and the paper generated medication administration record dated March 2021 revealed no documentation of the following medications being given on March 3-5th or 7th-9th. The medications were KLOR-CON, Multivitamin, Zinc, MiraLAX for constipation, DHEA, Toprol XL for hypertension, Cyanocobalamin for vitamin B12 deficiency, Duloxetine HCL for anxiety, and Hydrea 500 mg 8 AM dose. Review of the electronic health record and the paper generated medication administration record dated March 2021 revealed no documentation of Lidoderm 5% patch being applied on March 3, 4,5,7, or 8th. Review of the electronic health record and the paper generated medication administration record dated March 2021 revealed no documentation of prescribed medication Gabapentin being given on March 1,3 4, or 7th. Review of the electronic health record and the paper generated medication administration record dated March 2021 revealed no documentation of Lisinopril being given on March 3, 4, 5, 7th or 8th. Review of the MAR revealed no documentation of Lovastatin, Magnesium or Valtrex being given on March 3-4th. 2. Resident #2 was admitted to the facility with diagnosis including hemiplegia, and peripheral vascular disease. Review of the electronic and paper medication	F 842	Administrator, DON, ADON, Staff Development Coordinator (SDC) on the facility medication administration policy, accurate documentation, notes and protocol to follow when computers are down due to technical difficulties. 3) Address what measures will be put in place or systemic changes made to ensue that the identified issue does not occur in the future: Beginning 3/18/2021, MAR/TAR documentation monitoring was initiated daily by Nurse Administration and discussed in clinical rounds. Effective 4/9/2021, an audit tool for MAR/TAR documentation will be completed by the DON, ADON or SDC weekly x 3 months. Nursing Administration will contact the Licensed Nurse or Medication Aide for any identified documentation issues and follow-up needed. At least quarterly and on an as needed basis, Nursing Staff will be re-educated on the facility medication administration policy, accurate documentation, notes and protocol to follow when computers are down due to technical difficulties by the DON, SDC or Nursing Administration. All new Licensed Nurses and Medication Aides will continue to be educated upon hire by the DON, SDC or Nursing Administration designee on medication administration, documentation requirements, and back up process to computer technical difficulties.	

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F 842	Continued From page 4 administration record dated February 2021 for Resident #2 revealed no documentation that Dilantin 100 mg for seizures, or Melatonin 3 mg for sleep were administered on February 1, 3, 6,7,11, 17, 18, or 27th. There was no documentation that Levetiracetam 1000 mg tab for seizures was administered on February 1,3,8,11,15,19 or 25th at 9am or 5PM on February 1st, 3rd, 6th,7th,11th,15th,17th,18th,20th or 27th. Review of Resident #2's electronic and paper medication administration record dated March 2021 revealed that Dilantin for seizures, melatonin for sleep, Flomax for benign prostatic hyperplasia, Aspirin for hypertension, and multivitamin for wound, were not documented as being administered on March 1st, 3rd, 4th, 5th, or 7th. 3.Resident #3 had diagnosis including diabetes type II, bipolar disorder, and muscle weakness. Review of Resident #'3 electronic and paper medication administration record (MAR) on 3/13/21 revealed no documentation of Atorvastatin for cholesterol and Melatonin for sleep administered on February 6th, 7th, 11th and 13th. Interview with the Director of Nurses (DON) at 3:41 PM revealed that the facility had some computer issues and that the concerns had been reported and concerns to the electronic health record staff. The DON provided an email dated February 3rd which stated that four of the medication cart laptops were not working. She received an email back which stated the laptops on medication cart 2, 4 and 6 should be good to go. Interview with nurse #1 at 4:12 PM on 3/13/21 revealed that If the computer was not working,	F 842	Any facility computer issues will by reported to Information Technology (IT) by the Administrator and/or DON via phone and/or email. Follow-up by the Administrator with IT will occur for any outstanding computer issues. The DON will review findings of the MAR/TAR audit tool with the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. The QAPI committee can modify this plan to ensure substantial compliance is maintained.	

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she used the MAR book.
Interview with the Director of Nurses at 5:54 PM revealed that if the staff can't click on the medication or get the medication to come up on the laptop, staff are then to try documenting on the tabletop computer. Procedurally they are supposed to copy to document medication pass when the computers aren't working. The DON further stated that they had been using LTC electronic health record for 6 years. She stated that the facility went through some upgrades and had to send computers back in the last 4 or 5 months. She stated that recently, in the last couple of months they had not been ben getting the computers back.
Interview with nurse #2 at 6:10 PM revealed that sometimes the computers don't work. She stated sometimes it depended on where you stood in the facility or if the wi-fi went off. She stated that if the laptop was not working, she would run back and catch it at the desktop. The nurse stated that they (facility staff) called and got the computers fixed in February, because nothing would come up on the laptop. She stated it felt like it took forever using some computers on the cart.
Interview with a nurse at 7 PM stated that sometimes the electronic system went down, and she did not use the paper MAR. She stated the whole thing goes down, sometimes until 4:30 and that she forgets to go back and document the medication pass.
The facility provided a QAPI action plan dated 2/3/21 via email on 3/16/21. Review of the plan revealed that IT was notified to trouble shoot and correct computer issues throughout building on 2/3/21 via computer and 2/4/21 via telephone follow-up. The QAPI included a policy titled, Medication administration general guidelines.
The document stated, "The individual who

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F 842	Continued From page 6 administers the medication dose records the administration on the resident's MAR directly after the medication is given at the end of each medication pass, the person the medications administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off duty without first recording the administration of any medications."	F 842		