

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

PRINTED: 01/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2015
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 245 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p>	F 272		1/9/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/09/2016

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

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record reviews the facility failed to accurately assess the dental condition for 1 of 3 residents (Resident #29) reviewed for dental services. The findings included: Resident #29 was admitted to the facility on 08/12/15 with diagnoses that included diabetes, atrial fibrillation, and pacemaker placement among others. Review of the admission Minimum Data Set (MDS) dated 08/19/15 revealed Resident #29 was cognitively intact and required limited to extensive assistance with most activities of daily living including personal hygiene. No dental issues were indicated on the MDS. No issues were identified as related to a resident with no natural teeth. Review of the Care Area Assessment dated 06/03/15 revealed dental issues were not triggered and received no further assessment or care planning. Review of Resident #29's care plan dated 08/12/15 indicated no dental issues were identified, and no goals or interventions were provided. On 12/15/15 at 11:30 AM an observation of Resident #29 revealed he had no teeth. On 12/16/15 at 3:50 PM an interview was conducted with Resident #29. He stated he did not have any teeth when he was admitted to the facility. Resident #29 indicated he had dentures at one time, but they were broken and not replaced. He stated no one had asked him about his teeth, or if he needed to see a dentist. Resident #29 denied difficulty eating or swallowing and stated he currently had no issues with his oral care. On 12/17/15 at 10:10 AM an interview was conducted with the MDS Coordinator. She stated	F 272	Macon Valley Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Macon Valley Nursing and Rehabilitation Center response to the statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Macon Valley Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution or formal appeals procedure and or any other administrative or legal proceeding. F272 01/14/2016 The resident identified, resident #29		

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F 272	Continued From page 2 she was aware Resident #29 had no teeth. She stated she was responsible for assessing and documenting Resident #29's dental status. The MDS Coordinator stated she made a mistake when she failed to document his lack of natural teeth. On 12/17/15 at 3:20 PM an interview was conducted with the Director of Nursing. She stated it was her expectation that assessments of dental issues were correctly documented.	F 272	comprehensive assessment has been modified to reflect the appropriate response for the area identified related to dental services. The care plan/care guide has been reviewed, revised as applicable. Upon the next comprehensive assessment of all residents when schedule to be completed, the review will include ensuring the completion of the identified section dental services to ensure that the section is completed in its entirety to include completion of the section which may include the response edentulous as applicable. The MDS Coordinator and the MDS Nurse both have received in-service education training by an RN/RAC-CT, Consultant in relation to the completion of the comprehensive assessments in which included the completeness of the Dental section on the comprehensive assessments to include as appropriate edentulous. In addition education was provided to ensure that this information is placed on the care plan/care guide as applicable. The monitoring of accuracy/completeness of the MDS comprehensive assessments will occur by the Director of Nursing or designee, QI, SFC one time weekly for three months for 100% of all comprehensive assessment completed, then twice monthly for three months on 75% of all comprehensive assessment completed; then one time per month for six months on 50% of all comprehensive		

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F 272	Continued From page 3	F 272	assessment completed. An audit tool has been developed to record the required information to ensure completeness for the identified section of the dental section. The findings of the audits will be reported monthly to the QAPI committee to reflect identification of patterns, additional concerns, and analysis of the progress of training and tools to ensure compliance. The LNHA is responsible to ensure communication and implementation of any Quality Assurance and Performance Improvement Committee recommendations.		
F 387 SS=E	<p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident, family and staff interviews the facility failed to ensure that residents were seen by the physician every 30 days during the first 90 days after admission and every 60 days for residents who had been in the facility longer than 90 days for 9 of 29 residents (Residents #13, #49, #63, #74, #79, #102, #104, #120 and #139).</p>	F 387	<p>F387 01/14/2016</p> <p>The attending physician(s) have been contacted for any additional information they may provide to the facility related to the progress notes identified that were not available during the survey, for (Residents #13, #49, #63, #74, # 79, # 102, #104,</p>	1/9/16	

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F 387	<p>Continued From page 4</p> <p>The findings included:</p> <p>1. Resident #74 was admitted to the facility on 06/02/13 with diagnosed including depressive disorder. A quarterly Minimum Data Set (MDS) assessment dated 09/21/15 indicated Resident #74 was cognitively intact for daily decision making and had no memory impairment.</p> <p>Review of Resident #74's medical record revealed a progress note signed by her physician (Physician #1) dated 02/08/15. Progress notes dated 04/27/15, 06/30/15 and 08/24/15 were signed by a nurse practitioner. There was no documentation that indicated Resident #74 had been seen by the physician or nurse practitioner after 08/24/15.</p> <p>An interview on 12/17/15 at 3:45 PM was conducted with the Director of Nursing (DON) and Administrator about the facility's system for tracking when physician visits were due revealed there was a system in Point Click Care (PCC), the facility's electronic medical record system, that generated a report for each physician on a monthly basis of when a visit was due for each resident. The Administrator stated the Medical Records Director (MRD) sent the report to each physician at the beginning of each month.</p> <p>An interview on 12/17/15 with Physician #1 revealed he saw newly admitted residents for the first visit then rotated subsequent visits every 30 days with the nurse practitioner. Physician #1 stated residents were seen every 60 days after the first 90 days. He stated the MRD gave him a list at the beginning of every month of which residents needed to be seen. Physician #1 stated he rotated visits with the nurse practitioner based</p>	F 387	<p>#120 and #139).</p> <p>The attending physician(s) and physician extenders have been provided information on the requirement of frequency and timeliness of physician visits.</p> <p>The Medical Records Clerk will continue to provide the required monthly physician visits report to the attending physician. In addition the Medical Record Clerk will complete an audit to ensure physician visits are occurring as required.</p> <p>The Medical Record Clerk has received in-service education training on the requirement of physician frequency and timeliness of physician visits and to audit for compliance and the reporting protocol when a deficient practice has been identified.</p> <p>The audits will be performed one time weekly for three months for 100% of all residents, then twice monthly for three months for 75% of all residents, then one time per month for six months for 50% of all residents. An audit tool will be utilized to record the findings to ensure compliance.</p> <p>The findings of the audits will be reported monthly to the QAPI committee to reflect identification of patterns, additional concerns, and analysis of the progress of training and tools to ensure compliance. The LNHA is responsible to ensure communication and implementation of any Quality Assurance and Performance Improvement Committee</p>		

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F 387	<p>Continued From page 5 on where the resident lived in the facility.</p> <p>An interview on 12/17/15 at 7:47 PM with the MRD revealed she pulled a list every month from PCC of physician visits that were due for that month. She stated she faxed the list to the physician's office and also put the list in the physician's mail box. She stated she didn't keep a copy of the list that was sent to the physicians. She stated the list was based on information in the electronic medical record of when the resident was last seen by the physician. She stated the information about the last physician visit wasn't always current because it could take 30 - 45 days to get a physician progress note following the visit. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them and did not have any additional physician progress notes for Resident #74. When asked who monitored physician visits to ensure that residents were being seen, she stated no one was monitoring the physician visits.</p> <p>An interview on 12/17/15 at 8:15 PM with the Administrator about his expectation for physician visits revealed he expected the physicians to be aware of the regulations and to be compliant with the regulations about the frequency of physician visits. The Administrator stated he thought progress notes by the physician should be provided to the facility within 30 days from the date of the visit. When asked what the facility's process was for monitoring that physician visits were being made as required, he stated the facility did not currently have a process for monitoring the physician visits but he thought the MRD should be monitoring the visits to ensure they were made in a timely manner.</p>	F 387	recommendations.		

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F 387	<p>Continued From page 6</p> <p>2. Resident #79 was admitted to the facility on 01/26/15 with diagnoses which included bipolar disorder, hypertension and cerebrovascular accident. A quarterly MDS assessment dated on 10/23/15 indicated Resident #79 had moderate cognitive impairment of skills for daily decision making and impaired short term and long term memory.</p> <p>Review of Resident #79's medical record revealed progress notes signed by Resident #79's physician dated 01/30/15, 02/19/15, 06/03/15, 07/24/15 and 10/13/15. There was no documentation that Resident #79 had been seen by the physician between 02/19/15 and 06/03/15 or between 07/24/15 and 10/13/15.</p> <p>An interview on 12/17/15 at 3:45 PM Interview with the DON and Administrator about the facility's system for tracking when physician visits were due revealed there was a system in PCC, the facility's electronic medical record system, generated a report for each physician on a monthly basis of when a visit was due for each resident. The Administrator stated the MRD sent the report to each physician at the beginning of each month.</p> <p>Resident #79's physician was not available for interview.</p> <p>An interview on 12/17/15 at 7:47 PM with the MRD revealed she pulled a list every month from PCC of physician visits that were due for that month. She stated she faxed the list to the physician's office and also put the list in the physician's mail box. She stated she didn't keep a copy of the list that was sent to the physicians.</p>	F 387			

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F 387	<p>Continued From page 7</p> <p>She stated the list was based on information in the electronic medical record of when the resident was last seen by the physician. She stated the information about the last physician visit wasn't always current because it could take 30 - 45 days to get a physician progress note following the visit. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them and did not have any additional physician progress notes for Resident #79. When asked who monitored physician visits to ensure that residents were being seen, the MRD stated no one was monitoring the physician visits.</p> <p>An interview on 12/17/15 at 8:15 PM with the Administrator about his expectation for physician visits revealed he expected the physicians to be aware of the regulations and to be compliant with the regulations about the frequency of physician visits. The Administrator stated he thought progress notes by the physician should be provided to the facility within 30 days from the date of the visit. When asked what the facility's process was for monitoring that physician visits were being made as required, he stated the facility did not currently have a process for monitoring the physician visits but he thought the MRD should be monitoring the visits to ensure they were made in a timely manner.</p> <p>3. Resident #49 was admitted to the facility on 05/22/09 with diagnoses including Alzheimer's disease, hypertension and diabetes mellitus. A quarterly MDS dated 11/02/15 indicated Resident #49 had severe cognitive impairment as well as short term and long term memory impairment.</p> <p>Review of Resident #49's medical record</p>	F 387			

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F 387	<p>Continued From page 8</p> <p>revealed progress notes signed by her physician (Physician #1) dated 04/26/15 and 09/20/15. Progress notes dated 02/27/15, 03/04/15, 06/30/15 and 08/24/15 were signed by a nurse practitioner. There was no documentation that indicated Resident #49 had been seen by Physician #1 or the nurse practitioner after 08/24/15.</p> <p>An interview on 12/17/15 at 3:45 PM Interview with the DON and Administrator about the facility's system for tracking when physician visits were due revealed there was a system in PCC, the facility's electronic medical record system, that generated a report for each physician on a monthly basis of when a visit was due for each resident. The Administrator stated the MRD sent the report to each physician at the beginning of each month.</p> <p>An interview on 12/17/15 with Physician #1 revealed he saw newly admitted residents for the first visit then rotated subsequent visits every 30 days with the nurse practitioner. Physician #1 stated residents were seen every 60 days after the first 90 days. He stated the Medical Records Director gave him a list at the beginning of every month of which residents needed to be seen. Physician #1 stated he rotated visits with the nurse practitioner based on where the resident lived in the facility.</p> <p>An interview on 12/17/15 at 7:47 PM with the Medical Records Director revealed she pulled a list every month from PCC of physician visits that were due for that month. She stated she faxed the list to the physician's office and also put the list in the physician's mail box. She stated she didn't keep a copy of the list that was sent to the</p>	F 387			

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F 387	<p>Continued From page 9</p> <p>physicians. She stated the list was based on information in the electronic medical record of when the resident was last seen by the physician. She stated the information about the last physician visit wasn't always current because it could take 30 - 45 days to get a physician progress note following the visit. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them and did not have any additional physician progress notes for Resident #49. When asked who monitored physician visits to ensure that residents were being seen, she stated no one was monitoring the physician visits.</p> <p>An interview on 12/17/15 at 8:15 PM with the Administrator about his expectation for physician visits revealed he expected the physicians to be aware of the regulations and to be compliant with the regulations about the frequency of physician visit. The Administrator stated he thought progress notes by the physician should be provided to the facility within 30 days from the date of the visit. When asked what the facility's process was for monitoring that physician visits were being made as required, he stated the facility did not currently have a process for monitoring the physician visits but he thought the MRD should be monitoring the visits to ensure they were made in a timely manner.</p> <p>4. Resident #104 was admitted to the facility on 05/05/14 with diagnoses including psychosis,</p>	F 387			

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F 387	<p>Continued From page 10</p> <p>delusional disorder, and dementia. A quarterly MDS assessment dated 11/04/15 indicated Resident #104 was severely cognitively impaired and received antipsychotic, antidepressant, and anti-anxiety medications 7 days a week.</p> <p>Review of Resident #104's medical record revealed progress notes signed by his physician (Physician #1) since February of 2015 dated 07/05/15 and 09/20/15. There was no documentation that indicated Resident #104 had been seen by Physician #1 after 09/20/15.</p> <p>An interview on 12/17/15 at 3:45 PM with the Director of Nursing (DON) and Administrator about the facility's system for tracking when physician visits were due, revealed there was a system in Point Click Care (PCC), the facility's electronic medical record system, that generated a report for each physician on a monthly basis of when a visit was due for each resident.</p> <p>An interview on 12/17/15 with Physician #1 revealed he saw newly admitted residents for the first visit then rotated subsequent visits every 30 days with the nurse practitioner. Physician #1 stated residents were seen every 60 days after the first 90 days. He stated the Medical Records director gave him a list at the beginning of every month of which residents needed to be seen. Physician #1 stated he rotated visits with the nurse practitioner based on where the resident lived in the facility. When asked how he made sure that he saw residents every other visit, Physician #1 stated he wasn't aware that he was required to see the resident every other visit.</p> <p>An interview on 12/17/15 at 7:47 PM with the Medical Records Director revealed she pulled a</p>	F 387			

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F 387	<p>Continued From page 11</p> <p>list every month from PCC of physician visits that were due for that month. She stated she faxed the list to the physician's office and also put the list in the physician's mail box. She stated she didn't keep a copy of the list that was sent to the physicians. She stated the list was based on information in the electronic medical record of when the resident was last seen by the physician. She stated the information about the last physician visit wasn't always current because it could take 30 - 45 days to get a physician progress note following the visit. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them and did not have any additional physician progress notes for Resident #104. When asked who monitored physician visits to ensure that residents were being seen, she stated no one was monitoring the physician visits.</p> <p>An interview on 12/17/15 at 8:15 PM with the Administrator about his expectation for physician visits revealed he expected the physicians to be aware of the regulations and to be compliant with the regulations about the frequency of physician visit. The Administrator stated he thought progress notes by the physician should be provided to the facility within 30 days from the date of the visit. When asked what the facility's process was for monitoring that physician visits were being made as required, he stated the facility did not currently have a process for monitoring the physician visits but he thought the MRD should be monitoring the visits to ensure they were made in a timely manner.</p>	F 387			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 387	Continued From page 12 5. Admission Minimum Data Set (MDS) dated 10/22/15 indicated Resident #13 was admitted to the facility on 10/15/15 and was cognitively intact. Resident #13 diagnoses were coded as cancer, arthritis, hip fracture, and cardiopulmonary disease. Resident #13 required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. A review of Resident #13's medical record revealed a history and physical assessment dated 10/28/15 and was signed by Physician #1. There was no documentation in the medical record that indicated Resident #13 had been seen by Physician #1 after 10/28/15. On 12/17/15 at 3:45 PM an interview was conducted with the Director of Nursing (DON) and Administrator about the facility's system for tracking when physician visits were due revealed there was a system in Point Click Care (PCC), the facility's electronic medical record system, that generated a report for each physician on a monthly basis of when a visit was due for each resident. On 12/17/15 at 7:47 PM an interview was conducted with the MRD who revealed she generated a list every month from PCC of physician visits that were due for the month and provided the list to the physician. The MRD stated the physician list included dates of when the physician list was last generated and the list did	F 387			

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F 387	<p>Continued From page 13</p> <p>not indicate that the resident was actually seen by the physician on the previous date. She stated the list was based on information in the electronic medical record of when the resident was supposed to have been last seen by the physician. The MRD stated the list of monthly residents that the Physician was supposed to see was not saved and the facility had no system in place to determine if residents on the list were actually seen by the physician. The MRD stated Physician #1 made initial visits and follow up visits on residents and then after that Physician #1 split the monthly resident visit list with the nurse practitioner. The MRD stated Physician #1 may not see a resident on a scheduled basis because he was splitting the resident list with the nurse practitioner. The MRD stated the physician visit information wasn't always current because it could take 30 - 45 days from the actual date of physician's visit to get a physician progress note. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them. MRD stated she had placed on the medical record all physician visit information for Resident #13. When asked who monitored physician visits to ensure that residents were being seen, she stated no one was monitoring the physician visits.</p> <p>On 12/17/15 at 8:15 PM an interview was conducted with the Administrator who stated currently there was no facility process in place to monitor if a resident on the monthly physician list was actually seen by the physician. The Administrator revealed he thought the MRD should be monitoring the physician visits to ensure they were made in a timely manner. The Administrator stated his expectations were that Physician #1 would have been aware of the</p>	F 387			

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F 387	<p>Continued From page 14</p> <p>regulations and would have been compliant with the regulations about the frequency of physician visit and further revealed Physician #1 had been at the facility for 28-29 years. The Administrator stated his expectations were that physician progress notes would be returned to the facility within 30 days after physician visit if the physician used a dictation service.</p> <p>6. Significant change MDS dated 10/28/15 revealed Resident #102 was admitted to the facility on 10/21/15 and was cognitively intact. Resident #102's diagnoses were coded as orthostatic hypotension, end stage renal disease, diabetes mellitus, hyperkalemia, and seizure disorder. Resident #102 required extensive assistance with bed mobility, transfers, dressing, and personal hygiene. Resident #102 required limited assistance with toileting.</p> <p>A record review of Resident #102's medical record revealed a history and physical assessment dated 10/28/15 and signed by Physician #1. There was no documentation in the medical record that indicated Resident #102 had been seen by Physician #1 after 10/28/15.</p> <p>On 12/17/15 at 3:45 PM an interview was conducted with the Director of Nursing (DON) and Administrator about the facility's system for tracking when physician visits were due revealed there was a system in Point Click Care (PCC), the facility's electronic medical record system, that generated a report for each physician on a monthly basis of when a visit was due for each resident.</p> <p>On 12/17/15 at 7:47 PM an interview was</p>	F 387			

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F 387	<p>Continued From page 15</p> <p>conducted with the MRD who revealed she generated a list every month from PCC of physician visits that were due for the month and provided the list to the physician. The MRD stated the physician list included dates of when the physician list was last generated and the list did not indicate that the resident was actually seen by the physician on the previous date. She stated the list was based on information in the electronic medical record of when the resident was supposed to have been last seen by the physician. The MRD stated the list of monthly residents that the Physician was supposed to see was not saved and the facility had no system in place to determine if residents on the list were actually seen by the physician. The MRD stated Physician #1 made initial visits and follow up visits on residents and then after that Physician #1 split the monthly resident visit list with the nurse practitioner. The MRD stated Physician #1 may not see a resident on a scheduled basis because he was splitting the resident list with the nurse practitioner. The MRD stated the physician visit information wasn't always current because it could take 30 - 45 days from the actual date of physician's visit to get a physician progress note. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them. MRD stated she had placed on the medical record all physician visit information for Resident #102. When asked who monitored physician visits to ensure that residents were being seen, she stated no one was monitoring the physician visits.</p> <p>On 12/17/15 at 8:15 PM an interview was conducted with the Administrator who stated currently there was no facility process in place to monitor if a resident on the monthly physician list</p>	F 387			

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F 387	<p>Continued From page 16</p> <p>was actually seen by the physician. The Administrator revealed he thought the MRD should be monitoring the physician visits to ensure they were made in a timely manner. The Administrator stated his expectations were that Physician #1 would have been aware of the regulations and would have been compliant with the regulations about the frequency of physician visit and further revealed Physician #1 had been at the facility for 28-29 years. The Administrator stated his expectations were that physician progress notes would be returned to the facility within 30 days after physician visit if the physician used a dictation service.</p> <p>7. Resident #139 was admitted to the facility on 07/28/15 with diagnoses including Parkinson's disease, diabetes, and aural vertigo.</p> <p>An admission Minimum Data Set (MDS) assessment dated 08/04/15 indicated Resident #139 was cognitively impaired.</p> <p>Review of Resident #139's medical record revealed an admission history and physical assessment dated 08/07/15 signed by Physician #1, a progress note dated 08/26/15 signed by a nurse practitioner, and a progress note dated 09/20/15 signed by Physician #1. There was no documentation that indicated Resident #139 had been seen by the physician or nurse practitioner after 09/20/15.</p> <p>An interview on 12/17/15 at 3:45 PM with the Director of Nursing (DON) and Administrator about the facility's system for tracking when physician visits were due revealed there was a</p>	F 387			

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F 387	<p>Continued From page 17</p> <p>system in Point Click Care (PCC), the facility's electronic medical record system, that generated a report for each physician on a monthly basis of when a visit was due for each resident. The Administrator stated the Medical Records Director (MRD) sent the report to each physician at the beginning of each month.</p> <p>An interview on 12/17/15 with Physician #1 revealed he saw newly admitted residents for the first visit then rotated subsequent visits every 30 days with the nurse practitioner. Physician #1 stated residents were seen every 60 days after the first 90 days. He stated the Medical Records Director gave him a list at the beginning of every month of which residents needed to be seen. Physician #1 stated he rotated visits with the nurse practitioner based on where the resident lived in the facility.</p> <p>An interview on 12/17/15 at 7:47 PM with the MRD revealed she pulled a list every month from PCC of physician visits that were due for that month. She stated she faxed the list to the physician's office and also put the list in the physician's mail box. She stated she didn't keep a copy of the list that was sent to the physicians. She stated the list was based on information in the electronic medical record of when the resident was last seen by the physician. She stated the information about the last physician visit wasn't always current because it could take 30 - 45 days to get a physician progress note following the visit. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them and did not have any additional physician progress notes for Resident #139. When asked who monitored physician visits to ensure that residents were</p>	F 387			

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F 387	<p>Continued From page 18</p> <p>being seen, she stated no one was monitoring the physician visits.</p> <p>An interview on 12/17/15 at 8:15 PM with the Administrator about his expectation for physician visits revealed he expected the physicians to be aware of the regulations and to be compliant with the regulations about the frequency of physician visits. The Administrator stated he thought progress notes by the physician should be provided to the facility within 30 days from the date of the visit. When asked what the facility's process was for monitoring that physician visits were being made as required, he stated the facility did not currently have a process for monitoring the physician visits but he thought the MRD should be monitoring the visits to ensure they were made in a timely manner.</p> <p>8. Resident #120 was admitted to the facility on 07/13/15 with diagnoses including dysphagia, malignant neoplasm of the colon, abnormal results of kidney function, overactive bladder, hypertension, cachexia, and dehydration.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 10/07/15 indicated Resident #120 was cognitively impaired.</p> <p>Review of Resident #120's medical record revealed an admission history and physical assessment dated 07/13/15 and a progress noted dated 08/22/15 signed by physician #1, and a progress noted dated 09/24/15 signed by a nurse practitioner. There was no documentation that indicated Resident #120 had been seen by the physician or nurse practitioner after 09/24/15.</p> <p>An interview on 12/17/15 at 3:45 PM with the</p>	F 387			

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F 387	<p>Continued From page 19</p> <p>Director of Nursing (DON) and Administrator about the facility's system for tracking when physician visits were due revealed there was a system in Point Click Care (PCC), the facility's electronic medical record system, that generated a report for each physician on a monthly basis of when a visit was due for each resident. The Administrator stated the Medical Records Director (MRD) sent the report to each physician at the beginning of each month.</p> <p>An interview on 12/17/15 with Physician #1 revealed he saw newly admitted residents for the first visit then rotated subsequent visits every 30 days with the nurse practitioner. Physician #1 stated residents were seen every 60 days after the first 90 days. He stated the Medical Records Director gave him a list at the beginning of every month of which residents needed to be seen. Physician #1 stated he rotated visits with the nurse practitioner based on where the resident lived in the facility.</p> <p>An interview on 12/17/15 at 7:47 PM with the MRD revealed she pulled a list every month from PCC of physician visits that were due for that month. She stated she faxed the list to the physician's office and also put the list in the physician's mail box. She stated she didn't keep a copy of the list that was sent to the physicians. She stated the list was based on information in the electronic medical record of when the resident was last seen by the physician. She stated the information about the last physician visit wasn't always current because it could take 30 - 45 days to get a physician progress note following the visit. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them and did not</p>	F 387			

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F 387	<p>Continued From page 20</p> <p>have any additional physician progress notes for Resident #120. When asked who monitored physician visits to ensure that residents were being seen, she stated no one was monitoring the physician visits.</p> <p>An interview on 12/17/15 at 8:15 PM with the Administrator about his expectation for physician visits revealed he expected the physicians to be aware of the regulations and to be compliant with the regulations about the frequency of physician visits. The Administrator stated he thought progress notes by the physician should be provided to the facility within 30 days from the date of the visit. When asked what the facility's process was for monitoring that physician visits were being made as required, he stated the facility did not currently have a process for monitoring the physician visits but he thought the MRD should be monitoring the visits to ensure they were made in a timely manner.</p> <p>9. Resident #63 was admitted to the facility on 07/02/15 with diagnoses including dementia with behavioral disturbances and diabetes.</p> <p>An admission Minimum Data Set (MDS) assessment dated 07/19/15 indicated Resident #63 was cognitively intact.</p> <p>Review of Resident #63's medical record revealed there was no documentation that indicated Resident #63 had been seen by the physician or nurse practitioner since admission.</p> <p>Resident #63's physician was not available for interview.</p> <p>An interview on 12/17/15 at 3:45 PM with the</p>	F 387			

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F 387	<p>Continued From page 21</p> <p>Director of Nursing (DON) and Administrator about the facility's system for tracking when physician visits were due revealed there was a system in Point Click Care (PCC), the facility's electronic medical record system, that generated a report for each physician on a monthly basis of when a visit was due for each resident. The Administrator stated the Medical Records Director (MRD) sent the report to each physician at the beginning of each month.</p> <p>An interview on 12/17/15 with Physician #1 revealed he saw newly admitted residents for the first visit then rotated subsequent visits every 30 days with the nurse practitioner. Physician #1 stated residents were seen every 60 days after the first 90 days. He stated the Medical Records Director gave him a list at the beginning of every month of which residents needed to be seen. Physician #1 stated he rotated visits with the nurse practitioner based on where the resident lived in the facility.</p> <p>An interview on 12/17/15 at 7:47 PM with the MRD revealed she pulled a list every month from PCC of physician visits that were due for that month. She stated she faxed the list to the physician's office and also put the list in the physician's mail box. She stated she didn't keep a copy of the list that was sent to the physicians. She stated the list was based on information in the electronic medical record of when the resident was last seen by the physician. She stated the information about the last physician visit wasn't always current because it could take 30 - 45 days to get a physician progress note following the visit. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them and did not</p>	F 387			

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F 387	Continued From page 22 have any additional physician progress notes for Resident #63. When asked who monitored physician visits to ensure that residents were being seen, she stated no one was monitoring the physician visits. An interview on 12/17/15 at 8:15 PM with the Administrator about his expectation for physician visits revealed he expected the physicians to be aware of the regulations and to be compliant with the regulations about the frequency of physician visits. The Administrator stated he thought progress notes by the physician should be provided to the facility within 30 days from the date of the visit. When asked what the facility's process was for monitoring that physician visits were being made as required, he stated the facility did not currently have a process for monitoring the physician visits but he thought the MRD should be monitoring the visits to ensure they were made in a timely manner.	F 387			
F 388 SS=E	483.40(c)(3)-(4) PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced	F 388		1/9/16	

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F 388	<p>Continued From page 23</p> <p>by: Based on record review and resident, family and staff interviews the facility failed to ensure that physician visits were alternated between the physician and nurse practitioner so that residents were seen by the physician every other visit for 4 of 29 residents (Residents #49, #74, #97 and # 104).</p> <p>The findings included:</p> <p>1. Resident #74 was admitted to the facility to a dually certified bed (a bed that was certified for both Medicare and Medicaid) on 06/02/13 with diagnoses including multiple sclerosis and depressive disorder. A quarterly Minimum Data Set (MDS) assessment dated 09/21/15 indicated Resident #74 was cognitively intact for daily decision making and had no memory impairment.</p> <p>Review of Resident #74's medical record revealed a progress note signed by her physician (Physician #1) dated 02/08/15. Progress notes dated 04/27/15, 06/30/15 and 08/24/15 were signed by a nurse practitioner.</p> <p>An interview on 12/17/15 at 3:45 PM with the Director of Nursing (DON) and Administrator about the facility's system for tracking when physician visits were due revealed there was a system in Point Click Care (PCC), the facility's electronic medical record system, that generated a report for each physician on a monthly basis of when a visit was due for each resident. The Administrator stated the Medical Records Director (MRD) sent the report to each physician at the beginning of each month.</p> <p>An interview on 12/17/15 with Physician #1</p>	F 388	<p>F388 01/14/2016</p> <p>The attending physician(s) identified have been contacted and advised of the findings and ask for any additional information related to physician visits/progress notes for (Residents #49, #74, #97 and #104).</p> <p>The attending physician(s) have been provided information as it relates to required physician visits and when the alternate PA/NP may visit.</p> <p>The Medical Records Clerk will continue to provide the required monthly physician visits report to the attending physician. In addition the Medical Record Clerk will complete an audit to ensure physician visits are occurring as required and when applicable authorized alternate PA/NP visits may occur.</p> <p>The Medical Record Clerk has received in-service education training on the requirement of physician frequency and timeliness of physician visits and on the audit process for compliance and the reporting protocol when a deficient practice has been identified.</p>		

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F 388	<p>Continued From page 24</p> <p>revealed he saw newly admitted residents for the first visit then rotated subsequent visits every 30 days with the nurse practitioner. Physician #1 stated residents were seen every 60 days after the first 90 days. He stated the Medical Records Director gave him a list at the beginning of every month of which residents needed to be seen. Physician #1 stated he rotated visits with the nurse practitioner based on where the resident lived in the facility. When asked how he made sure he saw residents every other visit, Physician #1 stated he wasn't aware that he was required to see the resident every other visit.</p> <p>An interview on 12/17/15 at 7:47 PM with the MRD revealed she pulled a list every month from PCC of physician visits that were due for that month. She stated she faxed the list to the physician's office and also put the list in the physician's mail box. She stated she didn't keep a copy of the list that was sent to the physicians. She stated the list was based on information in the electronic medical record of when the resident was last seen by the physician. She stated the information about the last physician visit wasn't always current because it could take 30 - 45 days to get a physician progress note following the visit. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them and did not have any additional physician progress notes for Resident #74. When asked who monitored physician visits to ensure that residents were being seen, she stated no one was monitoring the physician visits.</p> <p>An interview on 12/17/15 at 8:15 PM with the Administrator about his expectation for physician visits revealed he expected the physicians to be</p>	F 388	<p>The audits will be performed one time weekly for three months for 100% of all residents, then twice monthly for three months for 75% of all residents, then one time per month for six months on 50% of all residents. An audit tool will be utilized to record the findings to ensure compliance. The findings of the audits will be reported monthly to the QAPI committee to reflect identification of patterns, additional concerns, and analysis of the progress of training and tools to ensure compliance. The LNHA is responsible to ensure communication and implementation of any Quality Assurance and Performance Improvement Committee recommendations.</p>		

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F 388	<p>Continued From page 25</p> <p>aware of the regulations and to be compliant with the regulations about the frequency of physician visits. The Administrator stated he thought progress notes by the physician should be provided to the facility within 30 days from the date of the visit. When asked what the facility's process was for monitoring that physician visits were being made as required, he stated the facility did not currently have a process for monitoring the physician visits but he thought the MRD should be monitoring the visits to ensure they were made in a timely manner.</p> <p>2. Resident #49 was admitted to the facility on 05/22/09 to a dually certified bed (a bed that was certified for both Medicare and Medicaid) with diagnoses including Alzheimer's disease, hypertension and diabetes mellitus. A quarterly Minimum Data Set (MDS) dated 11/02/15 indicated Resident #49 had severe cognitive impairment as well as short term and long term memory impairment.</p> <p>Review of Resident #49's medical record revealed progress notes signed by her physician (Physician #1) dated 04/26/15 and 09/20/15. Progress notes dated 02/27/15, 03/04/15, 06/30/15 and 08/24/15 were signed by a nurse practitioner. There was no documentation that indicated Resident #49 had been seen by Physician #1 or the nurse practitioner after 08/24/15.</p> <p>An interview on 12/17/15 at 3:45 PM with the Director of Nursing (DON) and Administrator about the facility's system for tracking when physician visits were due revealed there was a system in Point Click Care (PCC), the facility's electronic medical record system, that generated</p>	F 388			

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F 388	<p>Continued From page 26</p> <p>a report for each physician on a monthly basis of when a visit was due for each resident. The Administrator stated the Medical Records Director (MRD) sent the report to each physician at the beginning of each month.</p> <p>An interview on 12/17/15 with Physician #1 revealed he saw newly admitted residents for the first visit then rotated subsequent visits every 30 days with the nurse practitioner. Physician #1 stated residents were seen every 60 days after the first 90 days. He stated the Medical Records Director gave him a list at the beginning of every month of which residents needed to be seen. Physician #1 stated he rotated visits with the nurse practitioner based on where the resident lived in the facility.</p> <p>An interview on 12/17/15 at 7:47 PM with the Medical Records Director revealed she pulled a list every month from PCC of physician visits that were due for that month. She stated she faxed the list to the physician's office and also put the list in the physician's mail box. She stated she didn't keep a copy of the list that was sent to the physicians. She stated the list was based on information in the electronic medical record of when the resident was last seen by the physician. She stated the information about the last physician visit wasn't always current because it could take 30 - 45 days to get a physician progress note following the visit. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them and did not have any additional physician progress notes for Resident #49. When asked who monitored physician visits to ensure that residents were being seen, she stated no one was monitoring the physician visits.</p>	F 388			

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F 388	Continued From page 27 An interview on 12/17/15 at 8:15 PM with the Administrator about his expectation for physician visits revealed he expected the physicians to be aware of the regulations and to be compliant with the regulations about the frequency of physician visit. The Administrator stated he thought progress notes by the physician should be provided to the facility within 30 days from the date of the visit. When asked what the facility's process was for monitoring that physician visits were being made as required, he stated the facility did not currently have a process for monitoring the physician visits but he thought the MRD should be monitoring the visits to ensure they were made in a timely manner. 3. Resident #97 was admitted to the facility to a dually certified bed (a bed that was certified for both Medicare and Medicaid) on 10/24/13 with diagnoses including major depressive disorder, hypertension and atrial fibrillation. A quarterly Minimum Data Set (MDS) assessment dated 11/13/15 indicated Resident #97 had severe cognitive impairment as well as short term and long term memory impairment. Review of Resident #97's medical record revealed progress notes signed by his physician dated 02/23/15 and 08/22/15. Progress notes dated 04/27/15, 06/22/15 and 10/21/15 were signed by a nurse practitioner. There were no progress notes signed by Resident #97's physician between 02/23/15 and 08/22/15. An interview on 12/17/15 at 3:45 PM with the Director of Nursing (DON) and Administrator about the facility's system for tracking when physician visits were due revealed there was a	F 388			

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F 388	<p>Continued From page 28</p> <p>system in Point Click Care (PCC), the facility's electronic medical record system, that generated a report for each physician on a monthly basis of when a visit was due for each resident. The Administrator stated the Medical Records Director (MRD) sent the report to each physician at the beginning of each month.</p> <p>An interview on 12/17/15 with Physician #1 revealed he saw newly admitted residents for the first visit then rotated subsequent visits every 30 days with the nurse practitioner. Physician #1 stated residents were seen every 60 days after the first 90 days. He stated the Medical Records director gave him a list at the beginning of every month of which residents needed to be seen. Physician #1 stated he rotated visits with the nurse practitioner based on where the resident lived in the facility.</p> <p>An interview on 12/17/15 at 7:47 PM with the Medical Records Director revealed she pulled a list every month from PCC of physician visits that were due for that month. She stated she faxed the list to the physician's office and also put the list in the physician's mail box. She stated she didn't keep a copy of the list that was sent to the physicians. She stated the list was based on information in the electronic medical record of when the resident was last seen by the physician. She stated the information about the last physician visit wasn't always current because it could take 30 - 45 days to get a physician progress note following the visit. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them and did not have any additional physician progress notes for Resident #49. When asked who monitored physician visits to ensure</p>	F 388			

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F 388	<p>Continued From page 29</p> <p>that residents were being seen, she stated no one was monitoring the physician visits.</p> <p>An interview on 12/17/15 at 8:15 PM with the Administrator about his expectation for physician visits revealed he expected the physicians to be aware of the regulations and to be compliant with the regulations about the frequency of physician visit. The Administrator stated he thought progress notes by the physician should be provided to the facility within 30 days from the date of the visit. When asked what the facility's process was for monitoring that physician visits were being made as required, he stated the facility did not currently have a process for monitoring the physician visits but he thought the MRD should be monitoring the visits to ensure they were made in a timely manner.</p> <p>4. Resident #104 was admitted to the facility on 05/05/14 with diagnoses including psychosis, delusional disorder, and dementia. A quarterly MDS assessment dated 11/04/15 indicated Resident #104 was severely cognitively impaired and received antipsychotic, antidepressant, and antianxiety medications 7 days a week. Resident</p>	F 388			

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F 388	<p>Continued From page 30</p> <p>#104 lived in a room that was both Medicare and Medicaid certified</p> <p>Review of Resident #104's medical record revealed progress notes signed by his physician (Physician #1) since February of 2015 dated 07/05/15 and 09/20/15. Progress notes dated 03/25/15 and 05/27/15 were signed by a nurse practitioner. There was no documentation that indicated Resident #104 had been seen by Physician #1 or the nurse practitioner after 09/20/15. There was no documentation Resident #104 was seen on an alternating schedule between February of 2015 and July of 2015- seen only by the nurse practitioner; and was seen only one time between 07/05/15 and 12/17/15- that by Physician #1.</p> <p>An interview on 12/17/15 at 3:45 PM with the Director of Nursing (DON) and Administrator about the facility's system for tracking when physician visits were due revealed there was a system in Point Click Care (PCC), the facility's electronic medical record system, that generated a report for each physician on a monthly basis of when a visit was due for each resident.</p> <p>An interview on 12/17/15 with Physician #1 revealed he saw newly admitted residents for the first visit then rotated subsequent visits every 30 days with the nurse practitioner. Physician #1 stated residents were seen every 60 days after the first 90 days. He stated the Medical Records director gave him a list at the beginning of every month of which residents needed to be seen. Physician #1 stated he rotated visits with the nurse practitioner based on where the resident lived in the facility. When asked how he made sure that he saw residents every other visit,</p>	F 388			

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F 388	<p>Continued From page 31</p> <p>Physician #1 stated he wasn't aware that he was required to see the resident every other visit.</p> <p>An interview on 12/17/15 at 7:47 PM with the Medical Records Director revealed she pulled a list every month from PCC of physician visits that were due for that month. She stated she faxed the list to the physician's office and also put the list in the physician's mail box. She stated she didn't keep a copy of the list that was sent to the physicians. She stated the list was based on information in the electronic medical record of when the resident was last seen by the physician. She stated the information about the last physician visit wasn't always current because it could take 30 - 45 days to get a physician progress note following the visit. The MRD stated she scanned physician progress notes into each resident's medical record as soon as she received them and did not have any additional physician progress notes for Resident #104. When asked who monitored physician visits to ensure that residents were being seen, she stated no one was monitoring the physician visits.</p> <p>An interview on 12/17/15 at 8:15 PM with the Administrator about his expectation for physician visits revealed he expected the physicians to be aware of the regulations and to be compliant with the regulations about the frequency of physician visit. The Administrator stated he thought progress notes by the physician should be provided to the facility within 30 days from the date of the visit. When asked what the facility's process was for monitoring that physician visits were being made as required, he stated the facility did not currently have a process for monitoring the physician visits but he thought the MRD should be monitoring the visits to ensure</p>	F 388			

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F 388	Continued From page 32 they were made in a timely manner.	F 388		