STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345182	A. BUILDING _____ B. WING _____	C 02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-SEALEVEL	468 HIGHWAY 70 EAST SEALEVEL, NC 28577

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F 156		2/19/16

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

Electronically Signed | 02/18/2016

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F 156	Continued From page 1 under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and	F 156		

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F 156	Continued From page 2 applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to post State client advocacy groups and Medicare/Medicaid information in a prominent location in the facility for three consecutive days of the survey. The findings included: During a tour of the facility on 2/2/16 at 7:13 AM, there were no numbers posted for State client advocacy services such as the State survey and certification agency, the State licensure office, the Medicaid Fraud Unit, and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. There was no written information posted about how to apply for Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. During an observation on 2/3/16 at 3:30 PM, there were no numbers posted for State client advocacy services such as the State survey and certification agency, the State licensure office, the Medicaid Fraud Unit, and a statement that the resident may file a complaint with the State survey and certification agency concerning	F 156	Corrective action for resident affected: The facility posted State client advocacy groups and Medicare/Medicaid information in a prominent location in the facility on 2-5-16. Corrective action to prevent recurrence for other potential residents: The facility posted State client advocacy groups and Medicare/Medicaid information in a prominent location in the facility on 2-5-16. Measure put into place to ensure that deficient practice will not occur: The facility posted State client advocacy groups and Medicare/Medicaid information in a prominent location in the facility. The Facility in-serviced nursing staff and department managers on documents required to be visible at all times in the facility. In-servicing was completed on 2-18-16 with 14 of 16 nursing staff members in-serviced. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The facility will assure thru daily	

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F 156	Continued From page 3 resident abuse, neglect, and misappropriation of resident property in the facility. There was no written information posted about how to apply for Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. During an observation on 2/4/16 at 1:57 PM, there were no numbers posted for State client advocacy services such as the State survey and certification agency, the State licensure office, the Medicaid Fraud Unit, and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. There was no written information posted about how to apply for Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. During an observation on 2/5/16 at 2:33 PM, there were no numbers posted for State client advocacy services such as the State survey and certification agency, the State licensure office, the Medicaid Fraud Unit, and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. There was no written information posted about how to apply for Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. During an observation on 2/5/16 at 3:24 PM the Administrator looked through the facility for the advocacy numbers and the Medicare and Medicaid information, however he was not able to	F 156	compliance rounds that required documents are posted in a prominent location in the facility. This will be monitored during our QAPI Meetings for 3 months or until a pattern of compliance is achieved.	

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F 156	Continued From page 4 find the information. During an interview on 2/5/16 at 3:28 PM, the Administrator stated he located the information. He said the maintenance man removed the information prior to painting and he had not replaced the information.	F 156		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews, the facility failed administer an antibiotic medication for one of five residents reviewed for medications (#76). The findings included: Resident #76 was admitted to the facility on 12/16/2015 with diagnosis of cirrhosis of the liver with portal hypertension, ascites and diabetes. An order written by the Resident ' s Physician on 12/31/15 included " Cipro(Ciprofloxacin) 500 mg 1 (one) po (by mouth) QD (daily). " Ciprofloxacin is an antibiotic. Review of the Medication Administration Record (MAR) showed documentation that Resident #76 received Ciprofloxacin 500 mg once a day by mouth on 1/1/16 through 1/4/16 (4 days). Review of the facility ' s Standing Orders revealed no standing order for Ciprofloxacin. Review of the weekly vital sign sheet for 1/13/16 and 1/21/16 documented the Resident had a normal temperature. Review of the nurse ' s notes revealed no sudden onset of severe pain in	F 333	Corrective action for resident affected: The order for the Cipro was corrected on 2-5-16 for resident #76, to verify that the Cipro was to be given for an indefinite period of time. Corrective action to prevent recurrence for other potential residents: The nursing staff has been in-serviced to ensure that each order will have a completed order, including drug dose, route, frequency, and stop date if applicable. All orders are to be reviewed by the DHS and CCC every Monday thru Friday during morning clinical rounds to check for accuracy, weekend supervisor will monitor for accuracy of orders on Saturday and Sunday. All orders have been audited with no additional errors noted.	2/19/16

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F 333	Continued From page 5 abdomen. The Director of Nursing (DON) stated in an interview on 2/4/16 at 9:40 AM, the Physician meant to give 5 days of Cipro (Ciprofloxacin) and even though the order does not say it, the nurses knew that the Physician treated urinary tract infections (UTI) for 5 days and the Resident had a history of UTI. She stated she did not understand why the staff only gave the Resident 4 days of antibiotic and the facility did not have a standing order for Ciprofloxacin. The DON stated the staff should have clarified the order with the Physician since it was written to be given daily without an end date and it was not done. The Physician who wrote the order stated in an interview on 2/5/16 at 4:59 PM that Resident #76 had liver cirrhosis with portal hypertension and ascites and he had prescribed the daily dose of Ciprofloxacin to prevent a condition the Resident was at risk for called Spontaneous Bacterial Peritonitis (SBP is an infection of ascetic fluid in the abdomen) and not to treat a UTI. The Physician further stated he intended the Resident to be on the medication continuously and if she did not receive the Ciprofloxin more than 4 days she would be only at a low to moderate risk of SBP but he did want her started back on the antibiotic that day. The DON stated in an interview on 2/5/16 at 5:05 PM the Physician had just told her that the Ciprofloxacin should have been given daily to prevent SBP and not to treat UTI and she had written a clarification order.	F 333	Measure put into place to ensure that deficient practice will not occur: The nursing staff has been in-serviced to ensure that each order will have a completed order including drug dose, route, frequency, and stop date if applicable. All orders are to be reviewed by the DHS and CCC every Monday thru Friday during morning clinical rounds, rounds to check for accuracy, weekend supervisor will monitor for accuracy of orders on Saturday and Sunday. 100% of orders have been audited with no additional errors noted. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The nursing staff has been in-serviced to ensure that all orders are completed including drug dose, route, frequency, and stop date if applicable. All orders are to be reviewed by the DHS and CCC every Monday thru Friday during morning clinical rounds, rounds to check for accuracy, weekend supervisor will monitor for accuracy of orders on Saturday and Sunday. Consulting Pharmacists will monitor during monthly visits. The facility will review findings monthly during QAPI meetings for 3 months or until a pattern of compliance is achieved.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		2/19/16

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F 356	Continued From page 6 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post accurate daily staffing in a prominent location in the facility for two days of the survey. The findings include:	F 356	Corrective action for resident affected: The facility posted Daily Nursing Staffing Hours in a prominent location in the facility on 2-5-16.	

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F 356	Continued From page 7 During an interview on 2/2/16 at 7:10 AM the Director of Nursing revealed the staff posting was posted on a bulletin board in the dietary area of the facility. During an observation on 2/2/16 at 7:13 AM after passing through double doors with a sign posted " Restricted Area, Authorized Access Only " the Daily Staff Posting was located on a communication board in the dietary area. The date posted on the Daily Staff Posting was 1/31/16. During an observation on 2/3/16 at 4:00 PM after passing through double doors with a sign posted " Restricted Area, Authorized Access Only, " the Daily Staff Posting dated 2/2/16 was located on a communication board in the dietary area. A Dietary Staff person asked, " May I help you? " During an interview on 02/04/2016 at 4:07 PM with the Director of Nursing and the Nurse Consultant, the Nurse Consultant revealed the previous Administrator had the staff posting in the back area of the facility and the Interim Administrator started last week and the staff posting was put up today. During an interview on 02/05/2016 at 4:30 PM, the Director of Nursing revealed when the Nurse arrived in the morning she would usually post the Staff Posting and the night nurse would make adjustments to the Staff Posting. She said there was a bulletin board near her office and the information was shifted to another area in the process of painting being done.	F 356	Corrective action to prevent recurrence for other potential residents: Nursing Daily Staffing Report is posted daily by Charge Nurse beginning with morning shift and will be updated by night supervisor if status changes. Measure put into place to ensure that deficient practice will not occur: The nurses and department managers have been in-serviced to ensure that each day during compliance rounds the posting of nursing staff is visible at the nursing station. In-servicing was completed on 2-18-16 with 14 of 16 nursing staff members in-serviced. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The nurses and department managers have been in-serviced to ensure that each day the posting of nursing staff is visible at the nursing station. The facility will review findings monthly during QAPI meetings for 3 months or until a pattern of compliance is achieved.	
F 387	483.40(c)(1)-(2) FREQUENCY & TIMELINESS	F 387		2/19/16

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F 387 SS=E	Continued From page 8 OF PHYSICIAN VISIT 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. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to ensure a resident was seen by a physician within 30 days of admission (Resident #53) and failed to ensure residents were seen every 30 days thereafter by a physician or physician ' s assistant for the first 90 days after admission and every 60 days for residents who had been in the facility longer than 90 days for 5 of 26 residents reviewed (Resident #53, #9, #27, #36 and #42. The findings included: 1a. Resident # 53 was admitted to the facility on 10/21/15 and had a diagnosis of Anemia, Atrial Fibrillation, Hypertension, Hemiplegia, Seizures and Depression. Review of the clinical record revealed a physician ' s Admission History and Physical dated 10/30/15 signed by a physician ' s assistant. There were no physician ' s progress notes on the chart. On 2/4/16 at 4:01 PM, the MDS (Minimum Data Set) Nurse stated in an interview that she had called the physician ' s office and they had no other documentation of physician ' s visits for the resident. The Clinical Care Coordinator (CCC) stated in an interview on 2/4/16 at 4:21 PM the physician ' s	F 387	Corrective action for resident affected: Resident # 53 is no longer a resident. Resident # 9 had a progress note completed 1-27-16. Resident # 27 had a progress note completed 1-27-16. Resident # 36 had a progress note completed 2-3-16. Resident # 42 had a progress note completed 1-27-16. The DHS has reviewed all progress notes for all 54 residents. Each resident in the facility has been seen by the physician between the dates of 1-20-16 to 2 -17-16. Corrective action to prevent recurrence for other potential residents: The Director of Health Services or Clinical Competency Coordinator will maintain a log of all active residents to ensure that each resident is seen at a minimum of the required regulations. New admission will be added to the log upon admission to ensure that MD visit is completed within	

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F 387	Continued From page 9 assistant (PA) made rounds on Mondays and the physician made rounds on Wednesday evening. The CCC stated the facility had a list of new admissions, residents with new concerns and family members that wanted to talk with the physician. The CCC stated if a resident had an acute problem they called the physician at that time. The CCC stated the physician would dictate his visit in a computer and print out the progress notes at his office and the office was supposed to fax the notes to the facility. The CCC stated the facility had a difficult time getting the notes from the physician ' s office. The Director of Nursing (DON) stated in an interview on 2/4/16 at 4:31 PM that the physician always saw new admissions and there should be a physician ' s note somewhere. The DON was not able to provide documentation to show the physician had seen the resident within the first 30 days of admission. The MDS (Minimum Data Set) Coordinator stated in an interview on 2/5/16 at 12:54 PM that she had been assigned to make rounds with the physician and the PA. The MDS Coordinator stated they had a communication book for the physician and the staff would write non-emergent resident concerns in the book. The MDS Coordinator stated when the current Director of Nursing (DON) started the DON took over the role of rounding with the physician. On 2/5/16 at 1:31 PM the DON stated in an interview they recently realized they had an issue with progress notes not being where they needed to be. The DON stated she had been making rounds with the physician for the past 3 weeks and it was a work in progress. The DON stated the physician had seen every resident in the building in the past 2 weeks. The DON stated she did not have a written plan of correction.	F 387	30 days. The Director of Health Services or Clinical Competency Coordinator will review log weekly with Medical Director. Measure put into place to ensure that deficient practice will not occur: The Director of Health Services or Clinical Competency Coordinator will maintain a log of all active residents to ensure that each resident is seen at a minimum of the required regulations. New admission will be added to the log upon admission to ensure that MD visit is completed within 30 days The Director of Health Services or Clinical Competency Coordinator will review log weekly with Medical Director. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The facility will review findings of the log of all residents monthly during QAPI meetings for 3 months or until a pattern of compliance is achieved.	

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The facility ' s Physician stated in an interview on 2/5/16 at 1:45 PM that on his visits to the facility the staff provided a list of residents to be seen and he saw the residents on that list.
On 2/5/16 at 1:43 PM the Interim Administrator stated the previous administrator had notified him on 1/21/16 that there was a problem with physician ' s visits and progress notes that were not being done. The Administrator stated he had been at the facility for 2 weeks and had not yet met the physician who was also the medical director. The Administrator stated the corporation had a medical director to oversee all their facilities and this person had been contacted to speak with their physician regarding the problem. The Administrator stated they were looking at the issue but did not have a written plan of correction.
1b. Resident # 53 was admitted to the facility on 10/21/15 and had a diagnosis of Anemia, Atrial Fibrillation, Hypertension, Hemiplegia, Seizures and Depression.
Review of the clinical record revealed the resident was seen by a physician ' s assistant on 10/30/15. There were no additional progress notes to show the resident had been seen by a physician or a physician ' s assistant prior to the resident ' s discharge on 1/14/16.
On 2/4/16 at 4:01 PM, the MDS (Minimum Data Set) Nurse stated in an interview that she had called the physician ' s office and they had no other documentation of physician ' s visits for the resident while in the facility.
The Clinical Care Coordinator (CCC) stated in an interview on 2/4/16 at 4:21 PM the physician ' s assistant made rounds on Mondays and the physician made rounds on Wednesday evening. The CCC stated the facility had a list of new admissions, residents with new concerns and family members that wanted to talk with the

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physician. The CCC stated if a resident had an acute problem they called the physician at that time. The CCC stated the physician would dictate his visit in a computer and print out the progress notes at his office and the office was supposed to fax the notes to the facility. The CCC stated the facility had a difficult time getting the notes from the physician ' s office.

The MDS (Minimum Data Set) Coordinator stated in an interview on 2/5/16 at 12:54 PM that she had been assigned to make rounds with the physician and the PA. The MDS Coordinator stated they had a communication book for the physician and the staff would write non-emergent resident concerns in the book. The MDS Coordinator stated when the current Director of Nursing (DON) started the DON took over the role of rounding with the physician.

On 2/5/16 at 1:31 PM the DON stated in an interview they recently realized they had an issue with progress notes not being where they needed to be. The DON stated she had been making rounds with the physician for the past 3 weeks and it was a work in progress. The DON stated the physician had seen every resident in the building in the past 2 weeks. The DON stated she did not have a written plan of correction.

The facility ' s Physician stated in an interview on 2/5/16 at 1:45 PM that on his visits to the facility the staff provided a list of residents to be seen and he saw the residents on that list.

On 2/5/16 at 1:43 PM the Interim Administrator stated the previous administrator had notified him on 1/21/16 that there was a problem with physician ' s visits and progress notes that were not being done. The Administrator stated he had been at the facility for 2 weeks and had not yet met the physician who was also the medical director. The Administrator stated the corporation

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PRUITTHEALTH-SEALEVEL	468 HIGHWAY 70 EAST SEALEVEL, NC 28577

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had a medical director to oversee all their facilities and this person had been contacted to speak with their physician regarding the problem. The Administrator stated they were looking at the issue but did not have a written plan of correction.
2. Resident #9 was admitted to the facility on 6/20/14 and had a diagnosis of Hypertension, Intracranial Hemorrhage, Hemiplegia, Seizures, Congestive Heart Failure, Hyperlipidemia and Dementia.
Review of the clinical record for 2015/2016 revealed physician ' s progress notes dated 3/30/15 and 10/22/15. The facility was unable to provide additional progress notes for the resident.
The Clinical Care Coordinator (CCC) stated in an interview on 2/4/16 at 4:21 PM the physician ' s assistant made rounds on Mondays and the physician made rounds on Wednesday evening. The CCC stated the facility had a list of new admissions, residents with new concerns and family members that wanted to talk with him. The CCC stated if a resident had an acute problem they called the physician at that time. The CCC stated the physician would dictate the visit in a computer and print out the progress notes at his office and the office was supposed to fax the notes to the facility. The CCC stated the facility had a difficult time getting the notes from the physician ' s office.
The MDS (Minimum Data Set) Coordinator stated in an interview on 2/5/16 at 12:54 PM that she had been assigned to make rounds with the physician and the PA. The MDS Coordinator stated they had a communication book for the physician and the staff would write non-emergent resident concerns in the book. The MDS Coordinator stated when the current Director of Nursing (DON) started the DON took over the role of rounding with the physician.

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F 387	Continued From page 13 On 2/5/16 at 1:31 PM the DON stated in an interview they recently realized they had an issue with progress notes not being where they needed to be. The DON stated she had been making rounds with the physician for the past 3 weeks and it was a work in progress. The DON stated the physician had seen every resident in the building in the past 2 weeks. The DON stated she did not have a written plan of correction. The facility ' s Physician stated in an interview on 2/5/16 at 1:45 PM that on his visits to the facility the staff provided a list of residents to be seen and he saw the residents on that list. On 2/5/16 at 1:43 PM the Interim Administrator stated the previous administrator had notified him on 1/21/16 that there was a problem with physician ' s visits and progress notes that were not being done. The Administrator stated he had been at the facility for 2 weeks and had not yet met the physician who was also the medical director. The Administrator stated the corporation had a medical director to oversee all their facilities and this person had been contacted to speak with their physician regarding the problem. The Administrator stated they were looking at the issue but did not have a written plan of correction. 3. Resident #27 was admitted to the facility on 8/22/14 and had diagnoses of Hypertension, Hyperlipidemia, Dementia, Anemia, Peripheral Vascular Disease, Abdominal Aortic Aneurysm and Major Depressive Disorder. Review of the clinical record for 2015/2016 revealed a physician ' s progress note dated 2/18/15. On 2/4/16 at 11:29 AM the Director of Nursing (DON) provided physician ' s progress notes faxed to the facility by the physician ' s office dated 2/18/15 and stated these were the most recent notes on file. The Clinical Care Coordinator (CCC) stated in an	F 387		

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interview on 2/4/16 at 4:21 PM the physician ' s assistant made rounds on Mondays and the physician made rounds on Wednesday evening. The CCC stated the facility had a list of new admissions, residents with new concerns and family members that wanted to talk with him. The CCC stated if a resident had an acute problem they called the physician at that time. The CCC stated the physician would dictate the visit in a computer and print out the progress notes at his office and the office was supposed to fax the notes to the facility. The CCC stated the facility had a difficult time getting the notes from the physician ' s office.

The MDS (Minimum Data Set) Coordinator stated in an interview on 2/5/16 at 12:54 PM that she had been assigned to make rounds with the physician and the PA. The MDS Coordinator stated they had a communication book for the physician and the staff would write non-emergent resident concerns in the book. The MDS Coordinator stated when the current Director of Nursing (DON) started the DON took over the role of rounding with the physician.

On 2/5/16 at 1:31 PM the DON stated in an interview they recently realized they had an issue with progress notes not being where they needed to be. The DON stated she had been making rounds with the physician for the past 3 weeks and it was a work in progress. The DON stated the physician had seen every resident in the building in the past 2 weeks. The DON stated she did not have a written plan of correction.

The facility ' s Physician stated in an interview on 2/5/16 at 1:45 PM that on his visits to the facility the staff provided a list of residents to be seen and he saw the residents on that list.

On 2/5/16 at 1:43 PM the Interim Administrator stated the previous administrator had notified him

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on 1/21/16 that there was a problem with physician ' s visits and progress notes that were not being done. The Administrator stated he had been at the facility for 2 weeks and had not yet met the physician who was also the medical director. The Administrator stated the corporation had a medical director to oversee all their facilities and this person had been contacted to speak with their physician regarding the problem. The Administrator stated they were looking at the issue but did not have a written plan of correction.
4. Resident #36 was originally admitted to the facility with diagnoses including Heart Failure, Cardiomegaly, Peripheral Vascular disease and Chronic Obstructive Pulmonary Disease.
Review of the clinical record revealed an Admission History and Physical dated 7/22/15, which was signed by the physician. There were no other physician progress notes in the resident's chart.
On 2/4/16 at 4:01 PM, the MDS (Minimum Data Set) Nurse stated in an interview that she had called the physician ' s office and they had no other documentation of physician's visits for the resident.
The Clinical Care Coordinator (CCC) stated in an interview on 2/4/16 at 4:21 PM the physician ' s assistant (PA) made rounds on Mondays and the physician made rounds on Wednesday evening. The CCC stated the facility had a list of new admissions, residents with new concerns and family members that wanted to talk with the physician. The CCC stated if a resident had an acute problem they called the physician at that time. The CCC stated the physician would dictate his visit in a computer and print out the progress notes at his office and the office was supposed to fax the notes to the facility. The CCC stated the facility had a difficult time getting the notes from

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the physician ' s office.
The DON was not able to provide documentation to show the physician had seen the resident within the first 30 days of admission.
The MDS (Minimum Data Set) Coordinator stated in an interview on 2/5/16 at 12:54 PM that she had been assigned to make rounds with the physician and the PA. The MDS Coordinator stated they had a communication book for the physician and the staff would write non-emergent resident concerns in the book. The MDS Coordinator stated when the current Director of Nursing (DON) started the DON took over the role of rounding with the physician.
On 2/5/16 at 1:31 PM the DON stated in an interview they recently realized they had an issue with progress notes not being where they needed to be. The DON stated she had been making rounds with the physician for the past 3 weeks and it was a work in progress. The DON stated the physician had seen every resident in the building in the past 2 weeks. The DON stated she did not have a written plan of correction.
The facility's Physician stated in an interview on 2/5/16 at 1:45 PM that on his visits to the facility the staff provided a list of residents to be seen and he saw the residents on that list.
On 2/5/16 at 1:43 PM the Interim Administrator stated the previous administrator had notified him on 1/21/16 that there was a problem with physician's visits and progress notes that were not being done. The Administrator stated he had been at the facility for 2 weeks and had not yet met the physician who was also the medical director. The Administrator stated the corporation had a medical director to oversee all their facilities and this person had been contacted to speak with their physician regarding the problem. The Administrator stated they were looking at the

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issue but did not have a written plan of correction.
5. Resident #42 was originally admitted to the facility with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) with acute exacerbation, Muscle Weakness (Generalized) and Hypothyroidism.
Review of the clinical record revealed an Admission History and Physical dated 10/15/15, which was signed by the physician. There were no other physician progress notes in the residents chart.
On 2/4/16 at 4:01 PM, the MDS (Minimum Data Set) Nurse stated in an interview that she had called the physician ' s office and they had no other documentation of physician ' s visits for the resident.
The Clinical Care Coordinator (CCC) stated in an interview on 2/4/16 at 4:21 PM the physician ' s assistant (PA) made rounds on Mondays and the physician made rounds on Wednesday evening. The CCC stated the facility had a list of new admissions, residents with new concerns and family members that wanted to talk with the physician. The CCC stated if a resident had an acute problem they called the physician at that time. The CCC stated the physician would dictate his visit in a computer and print out the progress notes at his office and the office was supposed to fax the notes to the facility. The CCC stated the facility had a difficult time getting the notes from the physician ' s office.
The MDS (Minimum Data Set) Coordinator stated in an interview on 2/5/16 at 12:54 PM that she had been assigned to make rounds with the physician and the PA. The MDS Coordinator stated they had a communication book for the physician and the staff would write non-emergent resident concerns in the book. The MDS Coordinator stated when the current Director of

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F 387	Continued From page 18 Nursing (DON) started the DON took over the role of rounding with the physician. On 2/5/16 at 1:31 PM the DON stated in an interview they recently realized they had an issue with progress notes not being where they needed to be. The DON stated she had been making rounds with the physician for the past 3 weeks and it was a work in progress. The DON stated the physician had seen every resident in the building in the past 2 weeks. The DON stated she did not have a written plan of correction. The facility ' s Physician stated in an interview on 2/5/16 at 1:45 PM that on his visits to the facility the staff provided a list of residents to be seen and he saw the residents on that list. On 2/5/16 at 1:43 PM the Interim Administrator stated the previous administrator had notified him on 1/21/16 that there was a problem with physician ' s visits and progress notes that were not being done. The Administrator stated he had been at the facility for 2 weeks and had not yet met the physician who was also the medical director. The Administrator stated the corporation had a medical director to oversee all their facilities and this person had been contacted to speak with their physician regarding the problem. The Administrator stated they were looking at the issue but did not have a written plan of correction.	F 387		