STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING ______ B. WING ______	C 04/20/2018

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BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

(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 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to protect the private health	F 583	The process that lead to the deficiency was based on observation and staff	5/18/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/09/2018

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 583	Continued From page 1 information of 13 out of 13 residents (Resident #'s 55, 94, 7, 83, 8, 137, 51, 24, 85, 40, 17, 112, and 108) by leaving confidential medical information unattended and exposed in an area accessible to the public. Findings included: A continuous observation was made on 4/20/18 from 9:38 AM through 10:00 AM of a medication cart with a clipboard which had a form titled "Automatic Reorder Sheet" exposed. The bottom of the form read, in part, "The information contained in the facsimile message is Confidential Information intended only for the use of the individual or entity named as recipient." The form contained photocopied labels of 13 resident names and medications. The cart was located in the hallway outside Room 307, was unattended, and no staff or visitors were visible in the hallway from 9:38 AM until Nurse #5 approached the cart from a closed medical supply room at 9:45 AM. Nurse #5 re-stocked the cart and then entered Room 307 at 9:46 AM. Nurse #5 returned to the medication at 9:50 AM, prepared medications, and left the cart unattended from 9:52 AM through 9:57 AM. An interview was conducted on 4/20/18 at 9:57 AM with Nurse #5. He stated he received training on patient confidentiality annually and as needed to make sure resident information was secure and protected. He also stated, "The information on the reorder sheet should have been covered or turned over, but that's night shift's clipboard." An interview was conducted on 4/20/18 at 10:00 AM with Nurse #2. She stated the reorder sheet should not have been left uncovered or face up because it was clearly marked on the bottom that the information was confidential. She agreed it had been left exposed and unattended. An interview was conducted with the Director of	F 583	interviews, the facility failed to protect the private health information of 13 out of 13 residents (Resident #'s 55, 94, 7, 83, 8, 137, 51, 24, 85, 40, 17, 112 and 108) by leaving confidential medical information unattended and exposed in an area accessible to the public. 100% audit will be completed by 5/18/18 by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Quality Improvement (QI) nurse, Resource nurses, LPN Resident Liaison, Minimum Data Set (MDS) nurse, and/or the Facility Consultants of the residents private health information including any fax/electronic transmittal from outside physicians' offices and pharmacy that contains the message " The information contained in the facsimile message is confidential intended only for the use of the individual or entity named as recipient" to ensure the private information is not unattended and exposed in an area accessible to the public. 100% observations will be conducted by 5/18/18 by the Director of Nursing (DON), Assistant Director of Nursing (ADON), QI nurse, Resource nurses, LPN Resident Liaison, MDS nurse, and/or the Facility Consultants with all staff to include license nurses to ensure that residents private health information are not left on med cart, treatment cart, counter top and other accessible areas in all nurse stations. 100% in-service will be completed by 5/18/18 by Facility Consultant, DON, ADON, Resource nurses, MDS nurse,	

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F 583	Continued From page 2 Nursing on 4/20/18 at 12:30 PM. She stated patient information was to be protected from public view and the staff were trained annually and as needed. She stated she had an in service last week related to HIPAA (Health Insurance and Portability Accountability Act - a law which provides data privacy and security provisions for safeguarding personal medical information). She also stated her expectation was confidential resident information would be covered and protected.	F 583	and/or QI nurse with all staff to include CNAs, dietary staff, license nurses, housekeeping department, maintenance department, central supply, receptionist, agency staff, department managers (social workers, therapy, medical records, activities, bookkeeping, payroll) regarding the data privacy and security provisions for safeguarding personal medical and health information, Confidential resident information would be covered and protected at all times. 10% of all staff in each department to include CNAs, dietary department, license nurses, housekeeping department, maintenance department, central supply, receptionist, agency staff, and department managers will be observed by the ADON, QI nurse, Resource nurses, treatment nurses, LPN Resident liaison, and/or MDS nurse, weekly x 8 weeks then monthly x 1 month to ensure that any resident's (including Resident #s 55, 94, 7, 83, 8, 137, 51, 24, 85, 40, 17, 112, and 108) private health information is not left unattended or exposed in public accessible area utilizing a Resident Medical Information Audit Tool. Any concerns will be immediately addressed by the ADON, QI nurse, Resource nurses, treatment nurses, LPN Resident Liaison, and/or MDS with reeducation of staff during the time of the audit. The DON or Administrator will review and initial the Resident Medical Information Audit Tools weekly x 8 weeks then monthly x 1 month for completion and to	

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F 583	Continued From page 3	F 583	ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the Resident Care Audit Tools and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 3. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.	F 622		5/29/18

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F 622	Continued From page 4 Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving	F 622		

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F 622	Continued From page 5 facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide complete and/or legible resident information to an acute care facility for 10 of 11 residents (Resident #'s: 88, 98, 57, 15, 393, 131, 113, 13, 239, and 17) transferred for evaluation and treatment. Findings included: An electronic mail (e mail) message provided by the Director of Nursing (DON) and sent to the facility on 7/3/17 by the Corporate Clinical Program and Regulatory Director with the subject "Residents' Medication Information to Receiving Hospital Upon Transfer/Discharge" read, in part,	F 622	F 622 The process which led to this deficiency was that the facility failed to provide complete and legible information for resident #s 88, 98, 57, 15, 393, 131, 113, 13, 239, and 117 that were transferred to an acute care facility for evaluation and treatment. 100% in-service was initiated to all licensed nurses and Certified Nursing Assistants and agency nurses to ensure	

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F 622	Continued From page 6 "Beginning today, to provide this information in a standard format, will you please ensure your nurses follow the procedure as outlined below? 1) Residents' current medications to include the administration of the last dose. 2) To provide this information, copies of resident's MARs (Medication Administration Record) are to be made as follows: Copy the front of each MAR page only by: a) completely covering all documentation boxes on the right had (hand) side with a sheet of plain paper; b) upon covering these areas on the front of each MAR, make necessary copies of each MAR page; and c) write in to the right of each medication appearing on the copied MARs the date of the last dose administered, the time the last dose administered and if applicable, the route of administration." An in service training report provided by the Director of Nursing (DON) and dated 3/5/18 read, in part, "MAR - when making a copy to send residents to the emergency room ensure necessary medical information is displayed and given to include, but not limited to, medication names, dosages, times given, allergies, and diagnoses." An additional in service training report provided by the DON and dated 3/19/18 read, in part, "A copy of the MAR must be sent /c (with) resident. A second copy must be made a (and) placed in the DON box /c your signature." Copies of the MAR sent to the receiving acute care facility at the time of transfer for each of the following residents were reviewed and revealed: A. Resident #88 was transferred to an acute care facility on 3/28/18 and 4/8/18. A review of a copy of the MAR sent with the resident to the acute care facility had no resident name, diagnoses or allergies listed on page 1, illegible medications, allergies, diagnoses and administration times on	F 622	following procedure is followed as outlined below: 1) Residents current medications to include the administration of the last dose 2) To provide this information, copies of residents MARs (Medication Administration Record) are to be made as follows: Copying the front of the MAR ensuring that all pertinent information is legible to the receiving facilities; this includes but not limited to resident name, diagnosis, allergies, current medications, and scheduled times to be administered, b) after copying the MAR staff is to review that MAR entirely to ensure all medications including when the last does was given is legible to the receiving facilities. Upon transfer to the hospital or outside agency, a licensed nurse will review the discharging nurses documentation (MAR/TAR, MD orders) to validate for readability and completeness. Upon finding a 100% audit was initiated on residents that were transferred to the hospital in the past 30 days to an acute care facility to ensure copies of the MAR and other pertinent information was sent to with the resident by Assistant Director of Nursing, Resident Liaison, Quality Improvement Nurse and Minimum data set nurse, and Facility consultant will be completed by 5/18/2018. 10% of all transferred residents to an acute care facility will be audited by the Quality Improvement Nurse/Assistant Director of Nursing/Nursing supervisors/Liaison Nurse weekly x 8 weeks, then monthly x 1 month, utilizing a Hospital Transfer Audit tool to ensure	

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F 622	Continued From page 7 page 2, illegible medications and doses, no resident name, no allergies or diagnoses on page 3, illegible medications, allergies, diagnoses and administration times on page 4, and page 5 had no diagnoses listed and listed "multiple" as allergies. B. Resident #98 was transferred to an acute care facility on 3/19/18. A review of a copy of the MAR sent with the resident to the acute care facility had no diagnosis listed and the last page contained no resident information or name. C. Resident #57 was transferred to an acute care facility on 3/26/18. A review of a copy of the MAR sent with the resident to the acute care facility had no diagnoses listed, illegible allergies on page 1, and no indication of the last dose of Humalog insulin given or the last blood glucose reading prior to transfer. D. Resident #15 was transferred to an acute care facility on 3/21/18. A review of a copy of the MAR sent with the resident to the acute care facility had the medication names cut off from the left side of the page, and had no date or time listed for the last dose received. E. Resident #393 was transferred to an acute care facility on 4/8/18. A review of a copy of the MAR sent with the resident to the acute care facility had no diagnoses listed and no date the last dose was administered. F. Resident # 131 was transferred to an acute care facility on 3/24/18. A review of a copy of the MAR sent with the resident to the acute care facility had no resident name and no date or time listed for the last dose received. G. Resident #113 was transferred to an acute care facility on 3/21/18. A review of a copy of the MAR sent with the resident to the acute care facility had illegible diagnoses and no allergy information on 2 of 4 pages.	F 622	complete and legible resident information is sent. The nurse responsible for the residents□ transfer will ensure the copies are legible and all pertinent information is provided. The nurse will make an additional copy and place in in the Director of Nursing office for the Director of Nursing to complete the audit. Additional training will be provided by the Director of Nursing if any concerns are identified on the submitted documents. The Director of Nursing will provide the audit tool to the Administrator to validate the transfer process and the Executive QI committee will meet monthly and review the Hospital Transfer Audit tool and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 3.	

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F 622	Continued From page 8 H. Resident # 13 was transferred to an acute care facility on 4/13/18. A review of a copy of the MAR sent with the resident to the acute care facility had no date or time listed for 6 medications (Levaquin, Protonix, Hydrocortisone 2.5 % (percent), Remeron, and Senna-docusate). I. Resident #17 was transferred to an acute care facility on 3/30/18. A review of a copy of the MAR sent with the resident to the acute care facility had no blood glucose readings or last date and time dosages for 5 medications (Colace 100 mg (milligrams) by mouth at 2 PM/8 PM; Lispro Insulin 6 units with each meal; Novolin insulin 20 units every AM; and Senokot 8.6 mg-4 by mouth daily). J. Resident #239 was transferred to an acute care facility on 4/12/18. A review of a copy of the MAR sent with the resident to the acute care facility had no diagnoses, allergies or last date and times doses were received. An interview was conducted on 4/17/18 at 9:45 AM with a nursing assistant (NA #2). She stated residents go to the hospital with paperwork the nurse prepared. The NAs copied medical records if the nurse requested them to, but the nurses were ultimately responsible for the paperwork. An interview was conducted on 4/17/18 at 9:53 AM with Nurse # 5. He stated paperwork that accompanied the resident to the emergency department included the MAR, discharge summary, progress notes, physician orders, pertinent labs and demographics. He also stated the nurse or NA made copies to send with the resident. An interview was conducted with the Director of Nursing (DON) on 4/17/18 at 9:55 AM. She stated if a resident was sent to the emergency room the facility sent a face sheet, physician orders, a copy of the MAR, demographics, allergies, emergency	F 622		

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F 622	Continued From page 9 contacts, and progress notes. The staff made a copy to give to the emergency department and a copy was provided to the DON. She stated she had completed an in-service with all the staff related to information on the MARS being sent to the hospital with pertinent information covered. She stated, "This company has a practice of not displaying employee signatures, that's why we write only the last dose next to the medication. The signature boxes are covered. The MAR for (Resident #131) was a blatant disregard of the in-service we did so the employee is no longer here. It is my expectation that the MAR information is legible and present for the emergency department. I agree some of these records are still not completed correctly." An interview was conducted on 4/17/18 at 11:30 AM with the facility nurse consultant. She stated, "We are only required to provide a list of medications with the last dose given."	F 622		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 41 MDS assessments reviewed (Resident #62 for wounds and Resident #73 for falls). Findings included: 1. Resident #62 had been admitted on 11/17/17. His diagnoses included heart failure, atrial	F 641	The MDS assessment was corrected by appropriate code to reflect Resident # 62 for wounds and Resident # 73 for falls. 100% audit will be completed by 5/18/18 on all MDS assessments done in last 30 days by MDS Consultant for proper coding to reflect residents changes and needs. Any identified issues will be corrected by facility MDS nurses.	5/18/18

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F 641	Continued From page 10 fibrillation, hypertension, diabetes, kidney failure, muscle weakness and Alzheimer's disease. Resident #62's Admission Minimum Data Set (MDS) assessment was dated 11/24/17. The assessment indicated three Stage II pressure ulcers (a partial thickness loss of the upper layers of skin which present as a shallow open ulcer with a red or pink wound bed) had been present upon admission. The 2/7/18 Wound Flow Sheet for pressure ulcer #2 on the right heel indicated the wound had been present upon admission. Pressure ulcer #2 had been noted as unstageable with 95% granulation tissue (new connective tissue and microscopic blood vessels that form on the surface of a wound during the healing process) and 5% eschar (a patch of dead tissue covering part the wound) on this assessment. The 2/7/18 Wound Flow Sheet for pressure ulcer #3 on the left heel indicated the wound had been a Stage II, present upon admission. The wound continued to heal as a Stage II with 100% granulation tissue. A Quarterly MDS assessment dated 2/11/18 indicated Resident #62 continued to have one Stage II pressure ulcer which had been present upon admission, and one unstageable pressure ulcer which had not been present upon admission. The MDS also did not indicate one of the pressure ulcers had healed. An interview with the treatment nurse was conducted on 4/18/18 at 12:28 PM. The nurse stated upon admission, Resident #62 had three pressure ulcers. She stated a pressure ulcer on his buttock had healed in January, and the ulcers	F 641	An inservice will be conducted by 5/18/18 by MDS Consultant and Facility Consultant to include MDS nurses, treatment nurses and QI nurse to ensure residents change of condition, incidents are communicated and documented appropriately and in a timely manner to capture during different MDS assessments. 10% audit will be performed on all the assessments by the MDS nurse and validated by the DON (Director of Nursing) weekly x 8 weeks then monthly x 1 month to ensure appropriate coding for change in residents status. The Executive QI committee will meet monthly and review the MDS Coding Audit Tool and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 3.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

(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 641	Continued From page 11	F 641		

on his heels continued and were improving. She also stated Resident #62 had not developed any new pressure wounds since admission.

An interview with MDS nurse #1 was conducted on 4/18/18 at 1:47 PM. The nurse stated she reviewed the treatment nurse's documentation before coding the MDS. The nurse stated she coded the Stage II pressure ulcer correctly but should have coded the unstageable wound as present upon admission and should have indicated the third wound had healed.

An interview with the Director of Nursing (DON) was conducted on 04/19/18 at 9:36 AM. The DON stated she would expect the MDS assessment to accurately reflect the resident's condition.

2. Resident #73 was admitted to the facility on 9/9/10 with diagnoses that included Dementia and Difficulty in Walking.

Review of Resident #73's MDS (Minimum Data Set) dated 3/30/18, coded as a scheduled 60-day assessment, indicated that resident had experienced no falls since the prior assessment.

Review of resident's medical record revealed a progress note dated 3/15/18. The note documented that the resident had been observed on the floor on his left side. A skin tear was documented on his left hand.

A second progress note dated 3/20/18 documented follow up from an incident on 3/12/18 in which the resident had been heard by staff yelling and was found on his knees beside

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F 641	Continued From page 12 his wheelchair. The note read in part: resident sustained fall from presumed transfer. During an interview with MDS Nurse #1 on 4/19/18 at 12:08 PM she stated that the assessment should reflect the falls on 3/12/18 and 3/15/18. MDS Nurse #1 stated that she would complete a correction to this assessment. When interviewed on 4/19/18 at 3:36 PM, the Director of Nursing stated that the falls on 3/12/18 and 3/15/18 should have been recorded on the assessment. She further indicated it is her expectation that assessments are completed accurately.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow physician's orders by giving lactulose once a day for six days when it was ordered three times a day, failed to provide the appropriate form of liquid per orders during medication pass, and failed to have a nurse assess a resident prior to a med aid administering an as needed pain medication for 1 of 28 residents reviewed for quality of care	F 684	Resident # 338 no longer resides in the center. 100% audit will be done by ADON, Resource Nurses, QI nurse, LPN Resident Liaison by 5/18/18 on all MARs to ensure physicians' orders are reflected on MARs as ordered, and MARs are appropriately documented following all the	5/18/18

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	345237	A. BUILDING ______ B. WING ______	C 04/20/2018

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F 684	Continued From page 13 (Resident #338). Findings included: a. Resident #338 was admitted to the facility on 10/24/17. His active diagnoses included coronary artery disease, hypertension, diabetes mellitus, nonalcoholic steatohepatitis (a type of fatty liver disease, characterized by inflammation of the liver with concurrent fat accumulation in liver), and dysphagia. Review of Resident #338's minimum data set assessment dated 12/31/17 revealed the resident was assessed as cognitively intact. Resident #338 was assessed to require a mechanically altered diet. Review of Resident #338's care plan dated 11/12/17 revealed Resident #338 was care planned for the potential for or actual electrolyte imbalance related to decompensated hepatic cirrhosis and the interventions included to provide medications as ordered. Review of a physician's order dated 12/15/17 revealed Resident #338 was ordered to receive lactulose 30 milliliters by mouth three times a day. Review of Resident #338's medication administration record for December 2017 revealed from 12/15/17 through 12/21/17, Resident #338 received lactulose once a day. During an interview on 4/17/18 at 1:27 PM Physician #1 stated it was his expectation that the orders for lactulose dated 12/15/17 to be followed and they were not. He further stated there were no negative outcomes for the resident regarding	F 684	rules of medication administration. 100% Observation will be done by ADON, Resource Nurses, QI nurse, LPN Resident Liaison by 5/18/18 on Medication pass to ensure appropriate form of liquid per orders are provided during medication pass, also to ensure to have a nurse assess a resident prior to a med aid administering an as needed pain medication or anything similar that requires a nurse oversight. 100% in-service will be completed by 5/18/18 by Facility Consultant, DON, ADON, Resource nurses, MDS, and/or QI nurse with all nursing staff including Medication Aides, agency nurses on each and every step of medication administration procedure, appropriate and timely documentation on MAR (Medication Administration Record) as well as seeking nurses oversight by medication aid during medication pass as par facility policy. 10% audit will be performed weekly x 8 weeks then monthly x 1 month on MARs by ADON, Resource nurses, MDS, and/or QI nurse to ensure physicians orders, change of orders are reflected on the MARs and medications are given accordingly and in a timely manner with appropriate form of liquid and with nurses oversight if medication are administered by Medication Aid. The audit tool will be validated by the DON. DON will provide the audit tool to the Executive QI committee who will meet	

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	345237	A. BUILDING ______ B. WING ______	C 04/20/2018

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F 684	Continued From page 14 his ammonium levels as a result of not receiving lactulose as ordered for six days. He stated a possible negative outcome would be the ammonium levels to creep up depending on how severe the liver disease was and diet. During an interview on 4/18/18 at 9:30 AM Nurse #4 stated she was Resident #338's house supervisor. She further stated there was an issue with an order not being transcribed correctly from the physician orders to the medication administration record. She stated the night nurses would do chart audits and it had not been caught by any of the night nurses and she was unsure how the concern was identified. She further stated the resident was ordered to have laculose three times a day on the 15th and from the 15th to the 21st the resident did not receive his medication as ordered. During an interview on 4/18/18 at 11:58 AM the Director of Nursing stated that it was her expectation that the medication administration record should correctly reflect the resident's current orders. She further stated it was her expectation that medications be administered according to physician orders. She further stated that for the six days of 12/15/17 through 12/21/17 Resident #338's medication administration record was incorrect and the resident did not received laculose on those six days according to the physician orders. b. Resident #338 was admitted to the facility on 10/24/17. His active diagnoses included coronary artery disease, hypertension, diabetes mellitus, nonalcoholic steatohepatitis, and dysphagia. Review of Resident #338's minimum data set	F 684	monthly and review the MAR Audit Tool and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 3.	

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BARBOUR COURT NURSING AND REHABILITATION CENTER	**515 BARBOUR ROAD** **SMITHFIELD, NC 27577**

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F 684	Continued From page 15 assessment dated 12/31/17 revealed the resident was assessed as cognitively intact. Resident #338 was assessed to require a mechanically altered diet. Review of Resident #338's diet order change history revealed on 12/4/18 Resident #338 was ordered to have nectar thick fluids. This order was not changed until 1/2/18 to thin fluids. During an interview on 4/17/18 at 3:28 PM Med Aid #1 stated on 12/31/18 he gave Resident #338 his evening medications. He further stated he gave Resident #338 Tylenol and regular water from the pitcher on the medication cart and observed him take the medication. He stated he left the cup of regular water with the resident so he could finish it. He further stated he did not use nectar thick liquids because he did not believe the resident was ordered to have nectar thick liquids. He continued to state about fifteen minutes after he left the room he heard Resident #338 coughing from his room and asked Nurse Aide #1 to go check on Resident #338. He stated the nurse aide returned a few minutes later and told him the resident had been coughing but was okay. During an interview on 4/17/18 at 4:00 PM Nurse Aid #1 stated on 12/31/18 she was passing Resident #338's room and his friend was in the room and yelling to her and Med Aid #1 was standing at his cart preparing medications and asked her to check on Resident #338. She stated she went into the room and Resident #338 was coughing and while he was coughing Resident #338 told the nurse aid "I'm choking." She stated this caused her to realize he was not chocking as he could breathe and speak, but he was coughing	F 684		

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F 684	Continued From page 16	F 684		

and panicking. She further stated Resident #338's friend was hitting Resident #338 on his back and the nurse aid politely requested the friend stop because she was concerned it might cause something to get stuck in his airway if he continued to hit his back. She stated the friend stopped and she told Resident #338 to hold his hands up really high. When Resident #338 held his hands up and sat up straight he stopped coughing, calmed down, and was okay. He was able to verbalize to the nurse aid that he was okay and did not have any further complaints at that time. She further stated he did not have any complaints of pain. She stated she did not see Resident #338 cough up any pills during this episode. She stated Resident #338 was on either nectar thick or honey thick liquids at that time but had a cup of normal water with him which she replaced.

During an interview on 4/18/18 at 9:30 AM Nurse #4 stated she was Resident #338's house supervisor. She further stated that Resident #338 was on nectar thick liquids on 12/31/18. She stated he should not have been given regular water with his medication. She stated when she did rounds on Resident #338 around 10 or 10:30 PM he had stated he had choked earlier in the shift from medication pass.

During an interview on 4/18/18 at 11:58 AM the Director of Nursing stated that Resident #338's was ordered nectar thick liquids and nectar thick liquids should have been used with medication pass for Resident #338. She further stated it was her expectation Med Aid #1 use nectar thick liquids when he performed the evening medication pass on 12/31/18 and he did not.

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F 684	Continued From page 17 c. Resident #338 was admitted to the facility on 10/24/17. His active diagnoses included coronary artery disease, hypertension, diabetes mellitus, nonalcoholic steatohepatitis, and dysphagia. Review of Resident #338's minimum data set assessment dated 12/31/17 revealed the resident was assessed as cognitively intact. Resident #338 was assessed to require a mechanically altered diet. During an interview on 4/17/18 at 3:28 PM Med Aid #1 stated he entered Resident #338's room with his evening medications. Resident #338 reported to the med aid that he had some pain. The med aid then asked Resident #338 if he would like one of his as needed narcotics. He further stated he could not remember which narcotic it was that he offered Resident #338. He further stated Resident #338 refused the narcotic because he told the med aide he did not want to get addicted to the narcotic. He stated he then asked Resident #338 if he would like Tylenol for his pain and the resident said yes. The med aid stated he then got permission from a nurse to give as needed Tylenol after the nurse assessed Resident #338. The med aid stated he could not remember which nurse this was. During an interview on 4/18/18 at 9:30 AM Nurse #4 stated she was Resident #338's house supervisor on 12/31/17. She stated that when she did rounds on Resident #338 around 10 or 10:30 PM he had stated he had choked earlier in the shift from medication pass. She further stated at that time he had no complaints of pain or discomfort and that was the first she heard of the incident and had not assessed him prior to the administration of the medications on 12/31/17.	F 684		

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F 684	Continued From page 18 During an interview on 4/19/18 at 9:08 AM Facility Nurse Consultant stated that Nurse #4 was the nurse who was responsible for covering Med Aid #1 if he needed to administer an as needed medication or narcotic. She further stated no other nurses had stated they assessed Resident #338 prior to an as needed medication being administered on 12/31/18. During an interview on 4/19/18 at 10:13 AM the Director of Nursing stated that if the medication is an as needed medication, med aids are required by the facility to get a nurse to assess the resident prior to administering the as needed medication. She further stated that it was her expectation that Med Aid #1 get a nurse to assess Resident #338 prior to administering the as needed Tylenol and it did not appear it was done as there was no documentation of an assessment, no reason documented on the medication administration record for the as needed Tylenol being dispensed, and no nurse had stated they had assessed the resident prior to the administration of the Tylenol on the evening of 12/31/17.	F 684		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		5/18/18

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	345237	A. BUILDING ______ B. WING ______	C 04/20/2018

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BARBOUR COURT NURSING AND REHABILITATION CENTER	**515 BARBOUR ROAD SMITHFIELD, NC 27577**

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F 761	Continued From page 19 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to lock an unattended treatment cart for 1 of 3 treatment carts observed (300 hall treatment cart), failed to monitor and report out of range temperatures in a medication refrigerator for 1 of 2 medication storage refrigerators observed (station 1 medication refrigerator), and failed to lock an unattended medication cart for 1 of 8 medication carts observed (200 hall medication cart). Findings included: 1. During observation on 4/16/18 at 9:58 AM the 300 hall treatment cart was observed to be unlocked and unattended on the 300 hall. At 9:58 AM a visitor was observed to walk by the unlocked treatment cart. At 9:59 AM a house keeper was observed to walk by the unlocked treatment cart. At 9:59 AM a resident was observed to pass the unlocked treatment cart. At	F 761	1 of 3 treatment carts observed unlocked (300 hall treatment cart) was locked. The medication storage refrigerator was replaced with a new one and the medication were also replaced for their efficacy, staff started log in the temperatures on the temperature log to monitor the optimum range. 1 of 8 medication carts observed unlock (200 hall medication cart) was locked. 100% audit will be done by ADON, Resource Nurses, QI nurse, LPN Resident Liaison by 5/18/18 on all medication carts (8) and treatment carts (3) to ensure the nurse locks the carts while they are unattended. Also, 100% observation will be done by ADON, Resource Nurses, QI nurse, LPN Resident Liaison by 5/18/18 on all cart medication carts (8) and treatment carts	

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	345237	A. BUILDING ______ B. WING ______	C 04/20/2018

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F 761

Continued From page 20

10:00 AM a nurse aide was observed to walk by the unlocked treatment cart. At 10:02 AM a maintenance assistant was observed to walk by the unlocked treatment cart. At 10:06 AM Nurse #1 was observed to return to the treatment cart.

During an interview on 4/16/18 at 10:06 AM Nurse #1 stated the treatment cart should be locked when not attended but she did not have a key. She stated because of this she had to leave the cart unlocked this morning. She further stated that the treatment cart contained Bactraban, Benadryl, skin prep, normal saline, Nystatin powder, zinc oxide, and Proderm.

During an interview on 4/19/18 at 11:58 AM the Director of Nursing stated it was her expectation treatment carts be locked when unattended. She further stated Nurse #1 should have notified someone she did not have a key for her cart and she did not.

2. Review of the facility's policy for storage of refrigerated medications dated 11/1/17 revealed the temperatures of all refrigerators containing medications were to be maintained between 36 degrees and 46 degrees Fahrenheit.

Review of the temperature chart for refrigerators and freezers for April 2018 revealed the last temperature logged on the temperature chart was 36 degrees Fahrenheit on the evening of 4/17/18. The temperature had not been recorded on the morning of 4/16/18, 4/17/18, 4/18/18, and 4/19/18. The temperature had not been recorded on the evening of 4/18/18. On 4/2/18, 4/3/18, 4/4/18, 4/5/18, 4/6/18, 4/7/18, 4/8/18, 4/10/18, 4/11/18, 4/12/18, 4/14/18, and 4/15/18 the medication refrigerator temperature was

F 761

(3) while they pass the medication or perform the treatment to ensure the carts are locked while unattended. 2 of the medication storage refrigerator (100%) will be audited by ADON, Resource nurses, QI nurse, LPN Resident Liaison by 5/18/18 to ensure the temperature is logged twice a day and is maintained within the optimum ranges, if reviewing the temperature log does not reveal appropriate ranges, then an work order will be done immediately for Maintenance to look at the refrigerator for its function.

100% in-service will be completed by 5/18/18 by Facility Consultant, DON, ADON, Resource nurses, MDS, and/or QI nurse with all staff to include CNAs, dietary staff, license nurses, housekeeping department, maintenance department, central supply, receptionist, agency staff, department managers (social workers, therapy, medical records, activities, bookkeeping, payroll) regarding observation of the treatment and medication carts to ensure they are locked while nurses and medication aides responsible for those carts are not attending those carts. All licensed nurses (100%) will be in-serviced by 5/18/18 18 by Facility Consultant, DON, ADON, Resource nurses, MDS, and/or QI nurse regarding refrigerated medication storage policy, to monitor the temperature and log in daily basis as well as to report if temperatures are not in optimal ranges. An in-service will be done with Maintenance staff (100%) by 5/18/18 by the Administrator to ensure the work order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

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F 761

Continued From page 21

documented to be at 34 degrees Fahrenheit.

During observation on 4/19/18 at 11:47 AM the medication refrigerator in the station 1 medication storage room was observed to be at a temperature of 30 degrees Fahrenheit.

During an interview on 4/19/18 at 11:47 AM Nurse #2 stated the refrigerator in the station 1 med room was observed to have a temperature of 30 Fahrenheit. She further stated that Nurse #3 should have done the temperatures and had not. She stated that there had been no maintenance requests placed for the refrigerator in question.

During an interview on 4/19/18 at 11:57 AM Nurse #3 stated that she had not checked the refrigerator temperature on the mornings of the 16th, 17th, 18th, and 19th. She further stated she did not check them because the state was in the building and she had been very busy. She further stated she had not reported any low temperatures to the pharmacy or maintenance because she had been busy.

During an interview on 4/19/18 at 11:58 AM the Director of Nursing stated it was her expectation that refrigerator temperatures be monitored daily and that they had not been monitored correctly. She further stated if any temperatures were out of range such as the 12 days that the refrigerator temperature was out of range at 34 degrees, she would expect the staff to notify maintenance and contact pharmacy for guidance and it was not done. She further stated Nurse #3 should have identified that the refrigerator temperature was below freezing and stated that due to the lack of checking temperatures she could not say how long the refrigerator in station 1 had been below

F 761

is done promptly if nurses report the temperatures of the medication storage refrigerators are not within optimal ranges.

10% audit of med carts by ADON, Resource nurses, MDS, and/or QI nurse will be done weekly x 8 weeks then monthly x 1 month to ensure carts are locked at all times while unattended. Also, 10% audit will be done on both medication storage refrigerators weekly x 8 weeks then monthly x 1 month by ADON, Resource nurses, MDS, and/or QI nurse to ensure the temperatures are logged in and are within optimal ranges.

Audit tools will be provided to DON or Administrator to validate the finding. Administrator will provide the audit tool to the Executive QI committee who will meet monthly and review the Audit Tool and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING ______ B. WING ______	C 04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 22 freezing. During an interview on 4/19/18 at 12:08 PM Pharmacist #1 stated it was her expectation to store refrigerated medications between 36 and 46 degrees Fahrenheit. She further stated that the temperatures should be checked daily. She further stated that the staff should have notified maintenance about the refrigerator's temperatures and the pharmacy to discuss the effected medications. She further stated that based on the manufacture ' s recommendations, the Bydureon, Flu Vaccines, Vctoza, Basaglar, Hep B Vaccine, Phenergan suppositories, Gabapentin solution, and Tuberlin should have all been discarded and that she would recommend the facility do so immediately. She further stated that because the refrigerator was not checked daily the medications may have been frozen for the past day. During an interview on 4/20/18 at 9:08 AM the Maintenance Manager stated he had not received any maintenance requests for the station 1 medication room refrigerator prior to the survey bringing the out of range temperatures to the facility ' s attention. 3. On 4/20/18 at 10:19 AM the 200 hall medication cart was observed parked outside of room 212. The medication cart lock was observed in the unlocked position (a red dot is visible on the lock mechanism when in the unlocked position). No nursing staff were observed in the hallway. An interview was conducted with nurse #6 on 4/20/18 at 10:20 AM. The nurse stated when she left the medication cart, she should have locked it. She then activated the medication cart lock.	F 761		

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	345237	A. BUILDING ______ B. WING ______	C 04/20/2018

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F 761	Continued From page 23 An interview was conducted with the Director of Nursing (DON) on 4/20/18 at 12:09 PM. The DON stated medication carts should be locked when the nurse walks away.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		5/18/18

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F 842	Continued From page 24 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain accurate medication administration records by failing to document eight medications given to 1 of 6 residents	F 842	Resident # 338 no longer resides in the center. 100% audit will be done by ADON,	

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F 842	Continued From page 25 reviewed for medication administration (Resident #338). Findings included: Review of the physician's orders for December 2017 revealed Resident #338 was ordered to receive cipro 500 milligrams, eliquis 5 milligrams, colace 100 milligrams, xifaxan 550 milligrams, and lantus 15 units at 8 PM. He was also ordered melatonin 3 milligrams at 9 PM and coreg 3.125 milligrams at 5 PM. Resident #338 was also ordered tylenol 325 milligrams as needed every four hours for pain. Review of the medication administration record for December 2017 revealed cipro 500 milligrams, eliquis 5 milligrams, colace 100 milligrams, xifaxan 550 milligrams, lantus 15 units, melatonin 3 milligrams, and coreg 3.125 milligrams were not documented as being given on 12/31/17 on their respective times. Tylenol 325 milligrams was also not documented to have been given on 12/31/17. During an interview on 4/19/18 at 2:56 PM Med Aid #1 stated he did give the medications as ordered on 12/31/17 as well as the as needed Tylenol because the resident had a complaint of pain at 8 PM. He stated when medications are given that they are marked on the medication administration record as being given by initialing in the correct spot. He further stated he forgot to sign the medication off on the medication administration record and he should have documented that he gave them. During an interview on 4/19/18 at 3:34 PM the Director of Nursing stated that it was her	F 842	Resource Nurses, QI nurse, LPN Resident Liaison by 5/18/18 on all MARs to ensure physicians' orders are reflected on MARs as ordered, and MARs are appropriately documented following medication administration. 100% Observation will be done by ADON, Resource Nurses, QI nurse, LPN Resident Liaison by 5/18/18 to ensure timely documentation of medication administration is done on Medication Administration Record (MAR) after medication pass. 100% in-service will be completed by 5/18/18 by Facility Consultant, DON, ADON, Resource nurses, MDS, and/or QI nurse with all nursing staff including Medication Aides, agency nurses on each and every step of medication administration procedure, appropriate and timely documentation on MAR (Medication Administration Record) as par facility policy. 10% audit will be performed weekly x 8 weeks then monthly x 1 month on MARs by ADON, Resource nurses, MDS, and/or QI nurse to ensure physicians orders, change of orders are reflected on the MARs and medications are given accordingly and in a timely manner with appropriate documentation of medication pass on MAR (Medication Administration Tool). The audit tool will be validated by the DON. DON will provide the audit tool to the	

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F 842	Continued From page 26 expectation that the medication administration record be signed out once a medication is given. She stated this ensures accurate documentation of the treatments received by the resident. She further stated that Med Aid #1 did not chart that he had provided the medications on 12/31/17 at their respective times. She further stated the medication administration record for Resident #338 was inaccurate.	F 842	Executive QI committee who will meet monthly and review the MAR Audit Tool and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 3.	