STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345410	A. BUILDING _____ B. WING _____	04/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

(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 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to post the notice of location and availability of the facility's survey results. Findings included: During a tour of the facility on 4/9/18 at 11:51 AM an observation was made that survey results were located in a notebook binder on a bookshelf	F 577	The facility did not have the correct posting notice of location and availability of the facility's survey results. On 4/12/18, after being notified of the issue, the Administrator took immediate action in posting a notice of where the facility survey results were located. The posting was framed and placed in the front lobby which is an area that is prominent and accessible to the public.	5/11/18

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

Electronically Signed | 05/04/2018

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F 577	Continued From page 1 in the Chapel. An observation on 4/9/18 at 11:55 AM revealed there was no notice posted in the facility regarding the availability and location of recent survey results. On 4/10/18 at 3:45 PM the Resident Council interview was completed. During the meeting, the Resident Council members stated they had no knowledge of the location of the survey results notebook. An interview with the Resident Council President during the meeting revealed she didn't know what the survey results were, where they were located and had not seen any signage that directed residents to their location. An observation on 4/10/18 at 4:30 PM revealed there was no notice posted in the facility regarding the availability and location of recent survey results. An observation on 4/11/18 at 2:00 PM revealed there was no notice posted in the facility regarding the availability and location of recent survey results. An observation on 4/12/18 at 8:00 AM revealed there was no notice posted in the facility regarding the availability and location of recent survey results. An interview was completed with the Administrator on 4/12/18 at 10:05 AM. He stated the survey results were located in the Chapel. He said the facility did not have a notice posted that identified the location of the survey results notebook. The Administrator said he was unaware that posting a notice of the location of	F 577	The notice informs residents, family members, and legal representatives of residents where they can find the survey results book, which contains survey certifications, and complaint investigations during the 3 preceding years, and any plan of corrections available for any individual to review upon request. Residents, family members, and legal representatives will be educated on where the survey results and postings are located through the monthly newsletter, the monthly resident council, and will also be put in to the admission packet. The Administrator will ensure the correct signage is in place to the public by doing weekly checks for 4 weeks and thereafter monthly to ensure the signage stays in the correct location. The facility had the correct posting updated and posted in a prominent and accessible location on 4/12/18. Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	

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F 577	Continued From page 2 survey results was part of the regulation but that going forward he would expect a notice be posted that directed residents and families to the location of the survey results.	F 577		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		5/11/18

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F 578	Continued From page 3 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, facility staff and hospice staff interviews the facility failed to communicate one of two Residents ' request for a do not resuscitate (DNR) in the facility orders for one of two residents receiving hospice services. Resident #26. The findings included: Resident #26 was admitted to the facility on 3/3/17 with diagnosis that included congestive heart failure, Alzheimer ' s dementia and diabetes. Review of the "Initial Physician Certification of Terminal Illness" (hospice admission) dated 1/20/18 indicated Resident #26 was admitted to hospice with dementia. "Family wish for patient to be a DNR and wish for her not to go to hospital." The primary care physician at the facility electronically signed the admission certification on 1/30/18. This form was maintained in a notebook labeled "hospice" located on the facility chart rack for residents' medical records. Review of the "Advance Directives/Medical Treatment Decisions" dated 1/20/18 for Resident #26 revealed the family member signed for the	F 578	Resident #26 was admitted to Hospice services on 1/20/2018. A Do Not Resuscitate order was obtained and documented on the Hospice chart by the Hospice admission nurse. The order was not communicated to the facility via a written order for the facility□s medical record/chart. On 4/10/18, upon discovery of this issue, actions were taken to immediately rectify the gap in the communication of this issue. The medical records staff audited every chart to ensure the accurate code status was current for all residents. Each Hospice chart was audited by the facility□s medical record staff as well as by the Hospice medical records staff. A list of all residents was initiated that included up to date code statuses for each. This list is maintained by the medical records staff and updated with any changes to code status as communicated by physician, clinical nursing staff, or Hospice. Upon admission to either the facility or newly admitted to Hospice services, all DNR orders will be written in the facility□s chart and communicated with the medical records staff for updating the list as well as for	

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F 578	Continued From page 4 DNR. This form was maintained in a notebook labeled "Hospice" located on the facility chart rack for residents ' medical records. Review of a significant change Minimum Data Set (MDS) dated 1/20/18 revealed Resident #26 had severe impairment with long and short-term memory and cognition. The MDS indicated Resident #26 had a prognosis for life expectancy of less than six months. The instructions for this information included documentation by a physician. Record review revealed no orders for a DNR on a telephone order or on the monthly re-cap orders. Interview on 04/10/18 at 3:15 PM with the Director of Nursing (DON) revealed the clinical supervisor would be responsible for obtaining orders/forms for DNR. She was currently on bereavement leave. Follow up interview with the DON verified Resident #26 was a full code. She further explained the nursing staff would go by the regular chart in case of an emergency. Further interview revealed she would check with hospice to find out about their documentation. Interview with the Hospice Supervisor on 04/10/18 at 4:21 PM revealed since last summer in 2017, hospice started a notebook with their information from hospice. This was a separate notebook that was kept due to the large volume of paper records in the facility ' s medical records. The on-call hospice nurse did the admission for resident #26. Part of the process included writing a verbal telephone order in the facility ' s medical record after obtaining the DNR request from the resident and/or family member. The physician signed the DNR order for the hospice orders.	F 578	initiating color coded identification to the facility□s medical record, resident□s chart and to the individual resident (via armband/identification bracelet). An email was sent to all Hospice nurses from the Director of Patient Services at Mountain Valley Hospice. The email included the specific instruction to write DNR orders on the facility chart if the order is requested upon admission. The admitting nurse came to the facility and wrote an order based on the information she received during the admission on 1/20/18. This particular nurse is employed on a PRN basis. Both she and the full time Hospice nurse were educated on the importance of communication of orders between the Hospice staff and the facility staff. All involved staff have been educated, as of 4/27/2018, on communicating orders as well as maintaining the procedure for prevention of this issue. Weekly audits will be conducted by the Hospice medical record clerk for two weeks to ensure all orders are accurate and in the Hospice chart. The medical records clerk will verify that patients with a DNR order have that in their chart. The medical records clerk will then conduct chart audits every two weeks to make sure all signed orders are on the chart. The fulltime Hospice Nurse Case Manager will look at charts daily to verify any new orders on Hospice patients. And will also verify that patient is either a full code or DNR. The Hospice nurse will communicate any new orders or changes to existing orders to the clinical nurse supervisor. The code status of every	

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F 578	Continued From page 5 The hospice nurse did not write the order in the facility chart. Interview with the DON on 04/10/18 at 4:28 PM revealed the hospice notebook was the "hospice chart" and not the facility's chart. Further interview revealed the facility staff did not reference the hospice notebook. Interview with MDS nurse #1 on 04/11/18 10:48 AM revealed the hospice nurse attends the care plan meetings. She did not routinely add advanced directives to the care plan. They did review the hospice plan of care. Usually the hospice nurse would inform them if the code status changed, signed the form or MOST forms. The missed DNR was a lack of communication.	F 578	Hospice patient at the facility will be discussed at regularly scheduled facility care plan meetings and during Hospice interdisciplinary group meetings held every 14 days. The Hospice medical records clerk, the full time Hospice Nurse Case Manager and the Hospice Supervisor will be responsible for implementing and maintaining the initiation of Hospice orders, communication of those orders, and auditing of Hospice charts and orders. The facility medical records clerk and unit secretary clerk are responsible for audits on facility charts to be overseen by the Assistant Director of Nursing. The clinical nurse supervisor is responsible for implementation of all physician orders. The entire procedure is overseen by the Director of Nursing. Inservices for all nursing staff will be conducted by the Director of Nursing during the week of April 30th. After that, the procedure information will be added to the upcoming nursing department staff meeting to be held on May 9th and May 14th. The information will also be added to the facility□'s quick reference guide for nurses. Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		5/11/18

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F 584	Continued From page 6	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable

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F 584	Continued From page 7 sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain two of two sit to stand patient lifts in good condition on two of the four hallways. The findings included: Observations during initial tour on 4/9/18 at 10:10 AM on the 100 hall revealed a sit to stand lift in the hall. The lift was missing the protective covering and padding on the corners of the footboard. The lift was #6. Observations during the day shift and evening shift revealed the #6 lift continued to have the missing protective covering and padding on the footboard. Observations on 4/11/18 at 4:09 PM revealed a sit to stand lift, #7 was located on the 200 hall. The #7 lift had missing protective covering and padding missing on one corner of the footboard. The arm rests had pieces of the edges of the armrests missing. Interview on 4/11/18 at 4:09 PM with the Maintenance Director revealed he was not aware of any issues with the sit to stand lifts. The #7 lift had one side of the base missing. The ridge that would hold the resident's foot in place had worn off, with the foam and bottom of the base exposed. Both arm rests were torn on the sides. It was not sharp, but was jagged and rough which could cause skin tears. He indicated he had not been informed by staff the repairs were needed. He checked the lifts for functioning, and not "asthetics." Further interview revealed he would	F 584	Two sit to stand lifts were identified as being in poor condition with protective covering and padding missing. On 4/11/18, facility maintenance director was made aware by state surveyors that lifts #6 and #7 was not in a safe, clean, comfortable and homelike environment condition. Lift #6 was missing a protective covering and padding on the corners of the footboard. Lift # 7 was missing protective covering and padding on one corner of the footboard and the arm rests had pieces of the armrest's edges missing. As of 4/11/18 the maintenance director ordered a new footboard for lift #6. As of 4/11/18 the maintenance director ordered a new footboard for lift # 7, he also ordered a new arm rest for lift # 7. On 4/19/18, the arm piece for lift #7 came in and the maintenance director installed/assembled the arm piece to lift # 7. On 4/20/18, the brand new footboards came in and the maintenance director installed/assembled the new footboards for lifts # 6 and # 7. Staff will be educated on keeping a safe, clean, comfortable, and homelike environment through bi-monthly general staff meetings that will be continuous. Staff will be re-educated on how they should write a yellow maintenance slip up for any equipment issues and take any problems to the maintenance director to be handled. The maintenance director will monitor weekly for 4 weeks and then thereafter	

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F 584	Continued From page 8 order the parts for lifts. Observations on 4/12/18 at 1:48 PM of the #7 sit to stand lift with a resident in room 208B revealed the resident ' s arms rested on the arm rests and her feet remained on the footboard. Interview with Nursing Assistant #1 on 4/12/18 at 2:00 PM revealed she had not had any problems with using the sit to stand lifts. She had not had a resident's foot slip off the base. She had not had a resident receive skin tears from the jagged arm rests. She further explained she was not sure the purpose of the built-up edge on the base. She could see how the exposed base and metal could cause an injury. She had not informed maintenance of the issue.	F 584	monthly to ensure all equipment stays in a safe, clean, and comfortable setting. Housekeeping and maintenance services will be maintained in a sanitary, orderly, and comfortable environment. The facility corrected and fixed the two sit to stand patient lifts by 4/20/18. Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	
F 622 SS=B	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	F 622		5/11/18

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F 622	Continued From page 9	F 622		

appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. 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

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F 622	Continued From page 10 be met, facility attempts to meet the resident needs, and the service available at the receiving 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 and family member interviews, the facility failed to provide the resident representative a written notification of the transfer to the hospital and did not send a copy of the notice to the Ombudsman for 1 of 1 residents (Resident #28) reviewed for hospitalization. Findings included: Resident # 28 was admitted to the facility on	F 622	The facility did not provide a written notification of transfer to resident #28 or their representative, and the Ombudsman was not provided a notification. On 4/30/18, a transfer/discharge letter was sent resident # 28 with all the appropriate information needed. Upon any planned discharge, the social worker will send the appropriate transfer/discharge letter with the resident, if the discharge is either home or to	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 11 1/3/2018 with a diagnosis of dementia. A review of the medical record review of the most recent comprehensive Minimum Data Set (MDS) assessment dated 1/10/18 revealed Resident #28 was cognitively impaired. A medical record review revealed on 4/5/18, Resident #28 suffered a fall and was transferred to the Emergency Department. Resident #28 was subsequently admitted to the hospital with a fractured hip. A record review revealed Resident #28's representative was a family member. An interview on 4/13/18 at 9:04 AM with the residents' representative revealed the nurse did call her on the morning of 4/5/18 to inform her of the fall and transfer to the Emergency Department, but she did not receive a written notification of the transfer. An interview on 4/13/18 at 9:28 AM with the Admissions Director revealed the facility was not sending written notices of transfer/discharge to resident representatives or sending a copy of the written notices to the Ombudsman. She revealed she did not know about the requirement. An interview on 4/13/18 at 9:38 AM with the Administrator revealed he was not aware of the requirement to send written notification to the resident or resident representative and a copy to the Ombudsman of a residents transfer/discharge.	F 622	another health care institution. For all unplanned discharges, the admissions coordinator will mail the appropriate transfer/discharge letter to the resident or his/her representative. At the beginning of each month the admissions coordinator will send a monthly summary list of all discharges to the local Ombudsman via email and mail. A copy of all letters will be kept on file that are sent or given to each resident or resident representative. A copy of the monthly summaries will also be kept on file that is sent to the local Ombudsman. All residents, families, and/or resident representatives will be educated on receiving a transfer/discharge notice, through the monthly newsletters, resident council, and will be discussed in the admission packet upon admission. The social worker will do weekly checks for 4 weeks and then monthly thereafter to ensure all residents discharged from the facility received the appropriate transfer/discharge letter. The corrective action was completed and put in policy form on 5/1/2018. Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		5/11/18

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F 656	Continued From page 12 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

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F 656	Continued From page 13 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to complete a comprehensive care plan for the restorative maintenance program for one resident (Resident # 82) in a sample of two residents with restorative nursing services. The findings included: Resident #82 was admitted to the facility on 11/8/2016 with diagnosis that included Alzheimer ' s dementia, Parkinson ' s and arthritis. The "Restorative Referral" dated 3/9/18 included "Current Functional Status" for the resident to tolerate orthotic (anti-contracture knee orthotic) and hip abductor wedge up to 6 hours. The "Goals" included the resident would tolerate contracture bracing 4-6 hours per day. The "Program" indicated staff were to apply the orthotic for up to 6 hours. The frequency for the program was 3-5 days a week and application 1 time per day. Review of the significant change Minimum Data Set (MDS) dated 3/9/18 indicated Resident #82 had severe impairment with memory and cognition, required total assistance of two staff for bed mobility, transfers, and toileting, was not able to walk, and had functional limitation in range of motion of both upper and lower extremities on both sides of her body. Review of the Care Area Assessments (CAA ' s)	F 656	The restorative maintenance program for Resident #82 was not addressed on the comprehensive care plan. On 4/11/18, the MDS team revised the ADL care plan to reflect and incorporate restorative goals, to include Resident # 82□s contracture management goals. All long term care resident's charts will be audited to ensure all comprehensive person-centered care plans for each resident are consistent with resident rights and includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. When the therapy department recommends restorative maintenance, the therapy staff initiates a restorative referral form. This form details current functional status goals and the program itself with instructions for carrying out this program for direct care staff. The therapy department provides education with the direct care staff regarding the implementation for the program. The MDS team receives a restorative program/referral form from therapy. The comprehensive care plan will be updated at that time to reflect and incorporate restorative goals/interventions by the MDS nurse. At the same time, the ADON will receive a restorative program/referral form from therapy. The ADON will write a restorative program flow sheet, place it in	

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F 656	Continued From page 14 dated 3/14/18 indicated the area of activities of daily living (ADLs) required assessment and interventions. The CAA documentation indicated Resident #82 would wear an anti-contracture orthotic up to 6 hours per day for 3 - 5 days per week by restorative nursing. The decision to proceed to care plan was made by the team. Interview with MDS nurse #2 on 4/11/18 at 3:49 PM revealed she added the use of orthotic devices to the ADL care plan. She further explained she did not have a specific focus/problem, or goal for contracture management and use of orthotic devices. Interview with MDS nurse #1 on 4/11/18 at 3:51 PM revealed she added orthotic devices per resident specific and usually with the ADL care plan. When asked if contractures and management would have a goal and approaches, she explained it would depend on the resident and why they had the splints, etc. If there would not be any improvement of the contracture, it would be used for skin integrity management. For Resident #82, she explained she did not know the reason for the orthotic devices, as she did not do the MDS assessment. Interview with the Director of Nursing on 4/13/18 at 9:22 AM revealed she would expect communication between therapy and nursing to formulate the plan of care and follow the instructions.	F 656	the ADL flow book and distribute to the direct care staff. The DON, ADON and MDS team were educated on this process 5/1/18. The MDS team will do weekly audits continuously for any resident on therapy caseload. The ADON will maintain a binder with all restorative referral. This binder will be audited weekly and regularly thereafter on an ongoing basis. The ADON will monitor documentation in the CNA ADL flow book to ensure accuracy. Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance. The corrective action will be completed and put in policy form by 5/10/18.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		5/11/18

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F 657	Continued From page 15 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to update the care plan for Resident #93 for use of nectar thick liquids for 1 of 29 sampled residents for care plan review. The findings included: Resident #93 was readmitted to the facility on 12/26/17 with diagnosis of Parkinson ' s disease and dementia. The Speech Therapist (ST) discharge plan dated	F 657	The care plan for Resident #93 was not updated in regards to the use of nectar thick liquids. On 4/11/18, the MDS team added nectar thick liquid intervention to resident # 93□'s comprehensive care plan. All residents will be audited to ensure all comprehensive care plans are up to date with current interventions. The MDS team will receive all updated orders by way of carbon copy slips from the telephone orders to ensure all orders communicated to the MDS/Care plan	

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F 657	Continued From page 16 12/16/17 indicated the resident safely consumed nectar thick liquid utilizing cup while exhibiting mild impairment. The resident was not upgraded due to an unexpected discharge to the hospital. The ST recommendations included continuation of puree and nectar thick liquids. The care plan dated 1/9/18 with a problem of potential for weight loss due to dysphagia secondary to Parkinson's disease included the approach to provide diet as ordered: Puree with thin liquids. A second problem dated 1/9/18 indicated potential for fluid volume deficit related to trouble swallowing, limited intake and use of a diuretic. The update of 3/22/18 indicated no changes in the type of diet. The approaches included keep small cup at bedside that the resident could utilize during the day between meals or a straw as tolerated. The care plan did not mention use of nectar thick liquids. Review of a telephone order dated 1/30/18 indicated Resident #93 was to have nectar thick liquids. Interview with the MDS nurse on 4/13/18 at 9:31 AM revealed the care plan was not updated, because it must have been missed and was human error.	F 657	staff. The MDS nurses will update the comprehensive care plan accordingly. Other members of the comprehensive care plan team will be educated on the importance of keeping all resident care plans updated and continuously communicating all updated information. Education was provided 5/2/2018 to the interdisciplinary care plan team regarding this process. The MDS team will do weekly audits for 4 weeks and then monthly thereafter to ensure all comprehensive care plans are up to date and the appropriate changes have been made. Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance. The corrective action will be completed by 5/10/18.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		5/11/18

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F 658	Continued From page 17 by: Based on staff and physician assistant (P.A.) interviews and medical record review, the facility failed to follow a physician order for weekly weights for 1 of 2 residents (Resident #18) reviewed for nutrition. Findings included: Resident #18 was admitted to the facility on 10/30/17 with diagnoses that included, in part, Alzheimer's disease, Parkinson's disease and pressure ulcer of left heel. A review of the Significant Change Minimum Data Set (MDS) assessment dated 10/30/17 revealed Resident #18 weighed 243 pounds and had no significant weight loss. He received a diuretic (a medication that increases the excretion of water from the body through the urine) daily. A review of a physician order dated 1/15/18 revealed, "Weekly weights every week; re-check in four weeks." A review of weights from 1/15/18 through 4/12/18 revealed the following: 1/22/18- 238.9 pounds 1/29/18- 238.2 pounds 2/4/18- 235.6 pounds 2/5/18- 242.4 pounds 3/2/18- 242.8 pounds 4/2/18- 227.8 pounds 4/4/18- 229.1 pounds A review of the physician order sheet for February 2018, March 2018 and April 2018 revealed weekly weights were ordered.	F 658	Resident #18 had an order for weekly weights, recheck in four weeks, written 1/15/18. Weekly weights were obtained for three weeks then discontinued from the daily vital sheet indicating which weights are due. At this time, the weights were changed to monthly by the unit clerk. There was no stop order for weekly weights and this was not communicated by the unit clerk to the nursing staff therefore the weekly weights remained on the Medication Administration Record (MAR). The nurses are informed of the need for weights via the daily staff sheet provided to them by the unit clerk. Since the weekly weight for this resident had been removed from the daily vital sign sheet, the nurses did not obtain weekly weights despite this being written on the MAR and having an order. All weight orders will be written with a discontinue date. Once a weight order is received, the clinical nurse supervisor will give the order to the hall nurse who will then transcribe it onto the current MAR. The clinical nurse supervisor will then give the unit clerk a copy of the order. That copy will be placed in the weight binder maintained by the unit clerk. The daily vital sign sheet will be highlighted specific to each resident with a weight order and given to the hall nurse to pass on to the CNAs assigned to the hall. Education regarding this process was provided on 4/11/18 to the unit clerk, her supervisor, the nursing staff, and the Medical Director and Physician Assistant. The prescriber will indicate a discontinue date on all	

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F 658	Continued From page 18 A review of a P.A. note dated 1/15/18 revealed, "Chief complaint: Weight evaluation/bilateral edema. On rounds today for weight gain/lower extremity edema. Weight is now 234, up from 226. On physical examination resident had plus two edema bilateral lower extremities. Diagnosis: peripheral edema. Plan: increase Lasix (a diuretic) dose to 40 milligrams (mg) every morning. Check weights every week and re-assess in four weeks." A review of a P.A. note dated 2/15/18 revealed, "Chief complaint: Weight evaluation. On rounds today for weight gain/lower extremity edema. Weight is now 235, down from 238. Recent increased Lasix. On physical examination resident had plus two edema bilateral lower extremities. Plan: Monitor weights for fluctuations. Continue all medications and plan of care. Monitor for changes." An interview was completed with the Unit Clerk/Nurse Aide (NA) on 4/11/18 at 3:42 PM. The Unit Clerk reported that the NAs on the halls weighed the residents and that there was no specifically designated staff member who weighed all of the residents. The Unit Clerk said she kept a calendar of when each resident was scheduled to be weighed. She stated orders for weights were given to her by the nurse or supervisor and she placed them on the calendar. The Unit Clerk said Resident #18 was on weekly weights in January and thought it was only for four weeks. She stated that currently, Resident #18 was scheduled to be weighed monthly. A follow up interview was completed with the Unit Clerk/NA on 4/11/18 at 3:50 PM. She stated per	F 658	weight orders beginning 4/11/2018. The CNAs will be educated through in servicing during the week of April 30, 2018. This education will include increasing awareness of weight needs by referring to the daily vital sign sheet. For nurses, education will be provided during the week of April 30, 2018 regarding following all orders as prescribed as well as transcribing the orders appropriately. The education will also focus on following orders on MARs. The Medical Records Supervisor and Unit Clerk will conduct weight order audits on a weekly basis continuously. The Assistant Director of Nursing will oversee completion and accuracy.Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	

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F 658	Continued From page 19 the physician order dated 1/15/18, Resident #18 was supposed to be weighed weekly for four weeks then re-check. She reported there was no new order that stated to resume monthly weights. An interview was completed with the Director of Nursing (DON) on 4/11/18 at 4:08 PM. She said Resident #18 was supposed to be re-evaluated four weeks after the order for weekly weights was written 1/15/18 but that it didn't appear to have been addressed by the provider four weeks after the initial order was written. She further stated since there wasn't an order to discontinue the weekly weights, staff should have either continued to weigh the resident weekly or followed up with the provider regarding the frequency of weights. The DON said she was not sure why the weekly weights weren't being done on Resident #18. An interview was completed with Resident #18's P.A. on 4/12/18 at 7:16 AM. He said he placed Resident #18 on weekly weights due to two plus edema in his lower extremities and weight gain. The P.A. stated when he re-assessed Resident #18 four weeks later his weight was down due to the increased dosage of Lasix. The P.A. reported that he hadn't addressed in his plan whether staff should resume monthly weights or continue with weekly weights and hadn't written an order. He said since the weekly weights were being carried over onto the physician order sheet he would have expected staff to contact him to clarify if he wanted weekly weights continued or switched back to monthly weights.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		5/11/18

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F 684	Continued From page 20 § 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 observations, record review and staff interviews the facility failed to provide the restorative maintenance program according to therapy discharge instructions for one resident (Resident # 82) in a sample of two residents with restorative nursing services. The findings included: Resident #82 was admitted to the facility on 11/8/2016 with diagnosis that included Alzheimer ' s dementia, Parkinson ' s and arthritis. Review of a telephone order dated 3/8/18 to discharge Resident #82 from Physical Therapy (PT) and transfer to Restorative Nursing Program. The "Restorative Referral" dated 3/9/18 included "Current Functional Status" for the resident to tolerate orthotic (anti-contracture knee orthotic) and hip abductor wedge up to 6 hours. The "Goals" included the resident would tolerate contracture bracing 4-6 hours per day. The "Program" indicated staff were to apply the orthotic for up to 6 hours. The frequency for the program was 3-5 days a week and application 1 time per day. This form included signatures of the PT, and 5 nursing assistants (NA). One of	F 684	On 3/8/18, there was a telephone order to discharge Resident #82 from Physical Therapy and transfer to Restorative Nursing Program. The order included Current Functional Status for the resident to tolerate anti-contracture knee orthotic and hip abductor wedge up to 6 hours. The goals of this intervention indicate the resident would tolerate contracture bracing 4-6 hours per day. 3-5 days a week with application of 1 time per day. Another telephone order dated 3/16/18 written by Occupational Therapy included wearing a T-bar splint on the left hand, to be worn on first shift: use a carrot to the right hand during first shift. There was another order written by Physical Therapy on 3/16/18 for use of an anti-contracture orthotic to the left knee and abduction orthotic to bilateral lower extremities to be work 4-6 hours per day. The orders were not transcribed to the TAR. The treatment nurse noted the resident utilizing the equipment based on the restorative program initiation. Because she was unaware of the restorative order, she discussed the situation with the therapy staff to clarify the intended orders. Once	

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F 684	Continued From page 21 the NA ' s was NA#2. Review of the significant change Minimum Data Set (MDS) dated 3/9/18 indicated Resident #82 had severe impairment with memory and cognition, required total assistance of two staff for bed mobility, transfers, and toileting, was not able to walk, and had functional limitation in range of motion of both upper and lower extremities on both sides of her body. Review of the Care Area Assessments (CAA ' s) dated 3/14/18 indicated the area of activities of daily living (ADLs) required assessment and interventions. The CAA documentation indicated Resident #82 would wear an anti-contracture orthotic up to 6 hours per day for 3 - 5 days per week by restorative nursing. The decision to proceed to care plan was made by the team. Review of a telephone order dated 3/16/18 written by Occupational Therapy (OT) for wearing of a T-bar splint on the left hand, to be worn on first shift; use a carrot to the right hand during the first shift. Review of a telephone order dated 3/16/18 written by PT for use of an anti-contracture orthotic to the left knee and abduction orthotic to bilateral lower extremities. Devices were to be worn 4-6 hours per day. Review of the care plan dated 3/21/18 for a problem with ADL decline included an approach for use of anti-contracture orthotic device. Observations on 4/09/18 at 10:39 AM revealed Resident #82 had the left knee orthortic brace, the left hand/wrist splint, and a rolled wash cloth	F 684	clarified, the treatment nurse rewrote the restorative order. This order did not match the original order written by therapy. When an order is written for restorative nursing services that involves equipment such as splinting devices, the therapy department will will write an order in the resident's chart. The therapy department staff will educate the direct care staff regarding the process and goals for the specific resident. The therapy staff will make 3 copies of the restorative referral and give one to MDS and one to the ADON, the therapy department will keep a copy in their RNA log book while the original will be placed in the resident□s chart. The order will be written via telephone order with one copy going to the nurse on the assigned hall. The nurse will transcribe the order to the Treatment Record (TAR) if the order is specific to equipment or assistive devices. The treatment nurse will monitor compliance from direct care staff and document accordingly on the TAR. A review of all residents on a restorative maintenance program was conducted by the therapy director and the Assistant Director of Nursing on 5/1/2018. The Assistant Director of Nursing compared the list of current restorative orders to the orders in the CNA ADL flow books. All orders were verified. The ADON will maintain a binder with all restorative referral. This binder will be audited weekly on and on an ongoing basis. The ADON will monitor documentation in the ADL flow book to ensure accuracy.	

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	345410	A. BUILDING _____ B. WING _____	04/13/2018

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CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

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F 684	Continued From page 22 in the right hand were in place. Observations on 4/09/18 at 11:18 AM revealed the abductor wedge was loose at the resident ' s ankle. The wedge cushion was not between Resident #82 ' s ankles and the straps were loose at her feet. Observations on 4/11/18 at 9:00 AM revealed the abductor wedge was positioned at the resident's calves. Interview on 4/11/18 at 9:50 AM with the treatment nurse revealed the abductor wedge was to be placed between the resident ' s lower legs to try to prevent her from crossing her left leg over the right leg. Interview on 4/11/18 at 2:00 PM with NA #2 revealed she provided care for Resident #82 on 4/ 9/18 and 4/10/18 on day shift. NA#2 explained she would apply the t-bar wrist splint to the left arm, a carrot in her right hand, the left leg knee brace and the abductor wedge. She explained the carrot was in laundry and a rolled wash cloth was used in the right hand. Further interview revealed she had been instructed by therapy to The documentation on days that had a zero with a line through it meant she did not apply the wedge abductor. She explained it took 2 staff to get her legs straight to apply the device. She was unable to apply the device. She further explained the resident does not lay down after meals except for a check and change of her brief. She is up in the chair during day shift. Interview on 4/11/18 at 2:09 PM with the OT revealed she had written the order dated 3/16/18 for restorative to use the t- bar splint for first shift	F 684	Education was provided to the Assistant Director of Nursing, Treatment Nurse and therapy staff on 5/1/2018 by the Director of Nursing, MDS staff, and Administrator. The Assistant Director of Nursing, the nursing supervisor, the treatment nurse, and the therapy department manager will have responsibility for compliance. Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	

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F 684	Continued From page 23	F 684		

only. She had no knowledge about the order re-written to be on in the AM and off at HS.

Interview with the treatment nurse on 4/12/18 at 1:13 PM revealed she was in the room of Resident #82 on 3/16/18 and was asking therapy what the splints/braces were, and when to don and doff them. She explained she was informed by therapy to put them on in the am and take them off at HS.

Interview with PT#1 and #2 on 4/12/18 at 1:14 PM revealed they do written inservices for the aides with their signatures. The resident started therapy with PT in November 2017 and was discharged in March 2018. Resident #82 had been wearing the leg brace 4-6 hours. During the interview, neither PT were aware the resident was wearing the brace 8 to 16 hours per day. PT #1 explained the knee brace was a new device for the resident. The purpose of the brace was to stretch out the left leg to prevent further contracture of the knee. The abductor was to be placed at the resident's ankles to keep the legs separated. Review of the restorative referral revealed NA#2 had attended the training. The inservice instructions were to use the brace up to 6 hours a day.

Interview on 4/11/18 at 3:52 PM with the Nurse Supervisor, who supervises the restorative program, revealed she writes the restorative program according to the therapy discharge instructions to restorative. She was not aware of any changes to the order/s. She further explained the treatment nurse was supposed to supervise the aides to ensure the devices were on correctly as ordered. She did the sheets, (restorative program) and that was all she did

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F 684	Continued From page 24 with restorative. Interview on 4/12/18 at 3:54 PM with NA#3, on 3-11 who usually works on 100 hall revealed she would take the brace and splint off around 7:00 or 8:00 PM. She knew what to do by the restorative book that was kept on the hall. Interview with the Director of Nursing on 4/13/18 at 9:22 AM revealed she would expect communication between therapy and nursing to formulate the plan of care and follow the instructions.	F 684		
F 842 SS=B	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,	F 842		5/11/18

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regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted 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

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F 842	Continued From page 26 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, observations and staff interviews the facility failed to maintain accurate physician orders on the monthly recertification orders for 2 of 21 sampled residents. Residents #93 and 82. The findings included: 1. Resident #93 was readmitted 12/26/17 with diagnosis of Parkinson ' s disease and dementia. The Speech Therapist (ST) discharge plan dated 12/16/17 indicated the resident safely consumed nectar thick liquid utilizing cup while exhibiting mild impairment. The resident was not upgraded due to an unexpected discharge to the hospital. The ST recommendations included continuation of puree and nectar thick liquids. Review of a telephone order dated 1/30/18 indicated Resident #93 was to have nectar thick liquids. Review of the April 2018 physician monthly orders included thin liquids with the diet order. Further review of the orders revealed a "Medication" section which listed the resident was to receive nectar thick liquids. Interview with a nurse on 4/11/18 at 11:11 AM revealed the process for checking the monthly orders and the MARs (Medication Administration Record) included using the current monthly MAR and check against the new monthly orders for the	F 842	An order was obtained 1/30/2018 for nectar thick liquids for Resident # 93. The right side of the physician□s order form indicated the consistency of liquids was thin. However, the left side of the record indicated the most recent order for nectar thick liquids. Resident #82 had orders on the April physician monthly orders that were not current. At the end of every month, a Medication Administration Record check is performed by Linda Moore, RN. This check involves comparing the current MAR and orders with the new physician order sheet for the upcoming month. Once the physician or physician assistant sign the monthly orders, no changes can be made to the order sheet. Any new order obtained after the provider□s signature is communicated via fax to the pharmacy who then adds the information to the right side of the monthly physician order sheet. This will ensure all orders are printed on the physician order form. A complete review of all physician □s orders was conducted by the Director of Nursing and the contract pharmacist. Changes were made to the pre-printed order template. Those changes include discontinuing certain ancillary orders, lab orders, and miscellaneous orders from print in an effort to simplify the information included on the physician□s orders sheet. A list of current diets was immediately	

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F 842	Continued From page 27 medications. She explained she did not check any orders on the right side of the monthly orders. The orders on this side included "Orders" diet, code status, treatments, therapy, lab, orders. Review of Resident #93's April orders revealed she did not check the diet order which indicated "thin liquids" and checked the "medications" side and added "nectar thick liquids." Interview with the Director of Nursing on 4/13/18 at 9:14 AM revealed the first of month MAR checks were completed by one person. The process included taking the current MAR, and review the new MAR as a check. She explained any order after that check, the nurse on floor would be responsible for the update. The telephone orders went to the pharmacy, and the pharmacy did the diet orders. 2. Resident #82 was admitted to the facility on 11/8/16 with diagnosis of Alzheimer ' s, Parkinnson ' s and arthritis. The following orders on the April physician monthly orders were no longer current: - Treatments: "Don hand/palm protector to R (right) hand qd (every day) and check skin upon removal, do not place palm protectors until after morning meds and remove at bedtime. - Diets: Thin Liquids. - Ancillary orders: bedside rails up as needed for safety. The following telephone orders had been changed: - dated 3/21/18 nectar thick liquids due to dysphagia. - dated 3/16/18 apply anticontracture orthotic to left knee and abduction orthotic to BLEs (bilateral	F 842	provided by the dietary manager to the pharmacy to ensure all diets will be updated on the physician order sheet. Any diet order obtained after May 1, 2018 will be faxed to the pharmacy when the order is received. The order will be transcribed on the current MAR until the next month when the new month□s MARs are printed by the pharmacy. A current list of code statuses was provided to the pharmacy as well. Any order received after May 1, 2018 will be manually written in on the MAR and faxed to the pharmacy to be added to the next month□s MAR. Any other non-medication order will be communicated to the pharmacy via fax. These orders will be transcribed onto the left side of the MAR under the medication section until they can be appropriately assigned to the right side of the physician order sheet by the pharmacy for the next month□s MAR. Nurses will be educated immediately and ongoing regarding this process. The nurse completing MAR checks will transfer any information on the left side of the order sheet to the right side during monthly checks. All right side orders will be referenced and checked prior to completion of the monthly check. The Assistant Director of Nursing will assist Linda Moore for monthly Physician order/MAR checks. There will be 2 checks performed on all physician order forms during the last week of each month, in preparation for the upcoming month□s orders. When an order is written for restorative nursing services, the therapy department will educate the direct care staff regarding	

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F 842	Continued From page 28 lower extremities) 4-6 hours per day per PT (physical therapy) - dated 3/16/18 by occupational therapy to wear t-bar splint in left hand during first shift. Observations on 4/11/18 at 9:00 AM revealed the resident did not have side rails on the bed. Interview with a nurse supervisor on 4/11/18 at 11:11 AM revealed the process for checking the monthly orders and the MARs (Medication Administration Record) included using the current monthly MAR and check against the new monthly orders for the medications. She explained she did not check any orders on the right side of the monthly orders. The orders on this side included "Orders" diet, code status, treatments, therapy, lab, orders. Review of Resident #82's April orders revealed she did not check the diet order which indicated "thin liquids" and checked the "medications" side and added "nectar thick liquids". She explained she did the medication checks, but did not check the therapy, or ancillary orders. Interview with the Director of Nursing on 4/13/18 at 9:14 AM revealed the first of month MAR checks were completed by one person. The process included taking the current MAR, and review the new MAR as a check. She explained any order after that check, the nurse on floor would be responsible for the update. The telephone orders went to the pharmacy, and the pharmacy did the diet orders.	F 842	the process and goals for the specific resident. The therapy staff will make 3 copies of the restorative referral and give one to MDS and one to the ADON, one to the therapy department for their RNA log, while the original will be placed in the resident□'s chart. The order will be written via telephone order with one copy going to the nurse on the assigned hall. The nurse will transcribe the order to the Treatment Record (TAR) if the order is specific to equipment or assistive devices. The treatment nurse will monitor compliance from direct care staff and document accordingly on the TAR. The treatment nurse will perform TAR checks during the last week of the month. The checks include verifying orders from current TAR orders to the upcoming month TAR orders. The treatment nurse will then compare the physician□s order form to the upcoming month TAR to ensure all orders are accurate and transcribed appropriately. Education was provided to the Assistant Director of Nursing, the nursing supervisor, the treatment nurse, and therapy on 4/30/2018. All nurses will be educated regarding the process via monthly staff meeting to be held 5/9/2018. The Assistant Director of Nursing, the nursing supervisor, the treatment nurse, and therapy staff will have responsibility for compliance. The Director of Nursing will ensure compliance. Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for	

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F 842	Continued From page 29	F 842	overall compliance.	