

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

PRINTED: 06/24/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2019
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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	
E 000	Initial Comments	E 000			
F 000	INITIAL COMMENTS	F 000			
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585	6/20/19		

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

TITLE

(X6) DATE

Electronically Signed

06/17/2019

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 585	Continued From page 1 to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by	F 585			

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F 585	<p>Continued From page 2</p> <p>anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;</p> <p>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, resident, and staff interview the facility failed to report a resident's concern of missing personal items to the Administrator (grievance coordinator) for 1 of 1 resident investigated for personal property (Resident #12).</p> <p>The findings included:</p> <p>Review of facility policy title Grievances read in part, "any grievance alleging neglect, any form of abuse, injuries of unknown origin or</p>	F 585	<p>This plan of correction is submitted as required under Federal and State Regulation and statutes applicable to long term care providers. This plan of correction does not constitute an agreement by the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' finding or conclusion are accurate, that the findings constitute a deficiency, or that the scope and severity</p>		

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F 585	<p>Continued From page 3</p> <p>misappropriation requires immediate intervention to prevent any potential future violation while the grievance is being investigated. These allegations must be immediately reported to the Administrator and Director of Nursing."</p> <p>Resident #12 was admitted to the facility on 08/21/13 and her diagnoses included: heart disease, hypertension, diabetes, major depressive disorder and others.</p> <p>Review of Resident #12's most recent comprehensive Minimum Data Set (MDS) dated 03/04/19 revealed that Resident #12 was cognitively intact and required limited assistance with activities of daily living. No behaviors were identified on the MDS.</p> <p>An interview was conducted with Resident #12 on 05/21/19 at 9:59 AM. Resident #12 stated that about a month ago she had 2 small trinket owls that were teal in color that she had won as a prize in a game of bingo that disappeared from her room. She stated that she had been on the look out for them but had not found them and stated that she reported the missing trinket owls to Nursing Assistant (NA) #1.</p> <p>An interview was conducted with NA #1 on 05/22/19 at 12:35 PM with the Director of Nursing (DON) present. NA #1 confirmed that Resident #12 reported to her the missing trinket owls. She stated that one minute they were there and the next minute they were gone. NA #1 could not recall when Resident #12 reported it to her but stated that she had not reported it to anyone. She added that she thought it was just a "fluke thing" and she had been keeping her eyes open for them but had not seen them. NA #1 stated that</p>	F 585	<p>regarding any of the deficiencies are correctly applied.</p> <ol style="list-style-type: none"> Resident #12 missing items were replaced after an investigation was completed by the Administrator. The outcome of the investigation was reviewed with resident #12 by the administrator. The resident was in satisfied with the outcome. All residents have the potential to be affected by the alleged deficient practice. The Social Worker interviewed facility resident to ascertain if there were any other missing items. No other concerns regarding missing items were voiced. The Administrator re-educated all staff on the Policy and Procedure regarding Grievance Forms and missing items. All staff have been re-educated on utilizing the Grievance form for missing resident items on 6/12/19. Social worker will ensure Grievance Forms accessible for all staff and residents. Social Worker to randomly interview 5 resident weekly for 4 weeks, then 2 residents weekly for 4 weeks, and then 1 time a week for 1 month. Administrator to ensure compliance via verification of audit accuracy. Data obtained during audits will be analyzed for patterns and trends by the Administrator. This information will be reported during the Quality Assurance and Process Improvement (QAPI) for 3 months. The committee will make recommendations or changes as needed. 		

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F 585	<p>Continued From page 4</p> <p>she could not recall if she reported it to the Nurse on duty that day or not.</p> <p>An interview was conducted with Nurse #1 on 05/22/19 at 12:43 PM. Nurse #1 confirmed that she routinely worked the unit where Resident #12 resided. She stated that no one had reported any missing trinket owls to her or any other missing items.</p> <p>An interview was conducted with the DON on 05/22/19 at 3:04 PM. The DON stated that no one had reported to her that Resident #12 had missing trinket owls. She stated that the first time she was made aware of it was earlier in the day during the interview with NA #1. The DON stated if a resident reported a concern of missing personal items to a staff member, the staff member should report it to the Social Worker (SW) and the SW would report it to the Administrator and the investigation would begin. The DON confirmed that she was unaware that Resident #12 was missing 2 teal trinket owls and had just became aware.</p> <p>An interview was conducted with the Administrator on 05/22/19 at 3:49 PM. The Administrator stated that she was unaware of Resident #12's missing trinket owls. She stated the DON informed her earlier in the day and she had begun the investigation. The Administrator stated that Resident #12 was cognitively intact, and they had questioned her and started the full investigation. The Administrator stated that NA #1 should have immediately reported the missing items to the SW or herself. She added that when she spoke to NA #1 she reported she thought "she would find them, and it would be fine."</p>	F 585			

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F 585	Continued From page 5 A follow up interview was conducted with the Administrator on 05/23/19 at 12:35 PM. The Administrator stated that all resident concerns for missing items should be brought to her attention and placed on a grievance form, so the investigation could begin and from there she would determine if the missing items were also misappropriation of resident property. The Administrator stated that either way the investigation would be the same. The Administrator again confirmed that NA #1 should have reported the resident concern of missing items to the SW or herself a grievance completed, and the investigation initiated. An interview was conducted with the SW on 05/23/19 at 3:25 PM. The SW stated that she was not aware of any concerns that Resident #12 was missing some personal items. She stated that she learned about it on 05/22/19 and started the investigation. THE SW confirmed that NA #1 should have reported Resident #12's concerns to her immediately so she could have let the Administrator know and they could have started the investigation.	F 585			
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		6/20/19	

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F 761	<p>Continued From page 6</p> <p>§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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to remove expired medications (100 hall cart and 300/500 hall cart) and undated insulin (200 hall cart) from 3 of 3 medication carts reviewed during medication storage (100 hall cart, 200 hall cart, and 300/500 cart).</p> <p>The findings included:</p> <p>Review of a facility policy titled "Medication Storage in the Facility" and dated April 2018 read in part, "all expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner."</p> <p>a. An observation was made of the 100-hall medication cart on 05/23/19 at 10:37 AM with Nurse #2 present. The following medications were found in the first large drawer of the</p>	F 761	<p>This plan of correction is submitted as required under Federal and State Regulation and statutes applicable to long term care providers. This plan of correction does not constitute an agreement by the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' finding or conclusion are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied.</p> <ol style="list-style-type: none"> 1. All outdated and undated medication were immediately disposed upon discovery. 2. All residents have the potential to be affected by the alleged deficient practice. The Director of Nursing/ Unit Manager audited all medication carts for outdated and undated medication. 		

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F 761	<p>Continued From page 7</p> <p>medication cart and were available for use:</p> <p>-Zofran 4 milligrams (mg) 6 tablets that expired on 01/16/19.</p> <p>-Tramadol 50 mg 22 tablets that expired on 04/24/19</p> <p>An interview was conducted with Nurse #2 on 05/23/19 at 10:43 AM. Nurse #2 confirmed that she was responsible for the 100-hall medication cart and had just gone through the cart last week. Nurse #2 stated that when she went through the medication cart she really only checked eye drops and insulin because she assumed if staff were giving out medication correctly then they would not have time to expire. Nurse #2 also stated that the pharmacy representative was at the facility on 05/20/19 and reported she had gone through the medication carts while in the facility. Nurse #2 was given the expired medication and stated she would dispose of them properly.</p> <p>b. An observation of the 200 hall medication cart was made on 05/23/19 at 10:19 AM with Nurse #2 present. There was an opened Levemir insulin pen that contained no date as to when it was opened in the top left-hand drawer of the cart and available for use.</p> <p>An interview was conducted with Nurse #2 on 05/23/19 at 10:43 AM. Nurse #2 confirmed that she was responsible for the 200-hall medication cart and had just gone through the cart last week. She stated that she could not answer when the Levemir pen was opened. Nurse #2 stated that when she went through the medication cart she really only checked eye drops and insulin and had not caught the Levemir pen that was undated. She stated that she had not used the Levemir</p>	F 761	<p>3. Director of Nursing/ Unit Manager to re-educated licensed nursing staff on proper storage of medication on 6/12/19</p> <p>4. Director of Nursing/ Unit Manager to audit all medication carts weekly to ensure there are no undated or outdated medications for 1 month, then 2 random carts weekly for 1 month, then 2 times monthly for 1 month.</p> <p>Administrator to ensure compliance via verification of audit accuracy. Data obtained during audits will be analyzed for patterns and trends by the Administrator. This information will be reported during the Quality Assurance and Process Improvement (QAPI) for 3 months. The committee will make recommendations or changes as needed.</p>		

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F 761	<p>Continued From page 8</p> <p>pen that morning and she would dispose of the Levemir pen properly.</p> <p>c. An observation of the 300/500 hall medication cart was made on 05/23/19 at 11:11 AM with Nurse #1. There was an open bottle of Vitamin C 500 milligrams in the top drawer of the cart that was available for use. The expiration date on the bottle of Vitamin C tablets was 04/19.</p> <p>An interview was conducted with Nurse #1 on 05/23/19 at 11:11 AM. Nurse #1 confirmed that she was responsible for the 300/500 hall medication cart. She stated that she had gone through the medication cart the previous day and looked at the open dates on the medication bottles but had not checked the expiration dates of the medication. She stated she would dispose of the Vitamin C tablets now.</p> <p>An interview was conducted with the Director of Nursing (DON) on 05/23/19 at 11:26 AM. The DON stated that on 05/15/19 she identified an issue with medication storage during a routine audit of the carts. She explained that she found expired medication and items that were stored together that should not have been stored together and a number of other things that concerned her. The DON stated that she did education to all the nurses and even assigned each nurse an area that they were responsible for. The DON stated that she handed each nurse the assignment sheet and was very clear with her expectation of what she wanted. They were to go through the carts and ensure proper medication cart management. The DON stated that Nurse #2 was responsible for the 100-hall medication cart and she now has to find out what part of the education Nurse #2 and the other staff did not</p>	F 761			

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F 812	<p>Continued From page 10</p> <p>hair was covered in the kitchen.</p> <p>Findings Included:</p> <p>1. During an initial tour of the facility's kitchen on 05/20/19 at 10:23 AM, an observation of ½ of an onion and ½ of a head of lettuce to be in a preparation refrigerator, with the head of lettuce and onion wrapped in plastic wrap with no date of use visible.</p> <p>During an interview with the Dietary Manager on 05/20/19 at 10:23 AM, he reported the unused portion of the onion and the head of lettuce should have been dated before being stored in the refrigerator.</p> <p>2. During a follow up visit to the kitchen on 05/22/19 at 12:27 PM to observe food temperatures, an observation was made of a shallow tub with 9 milk cartons set aside for service. The observation of the tub revealed no ice in it to keep the milk at a safe temperature. Upon request, a sample temperature of one of the milk cartons was taken. The temperature of the milk was observed to be 47.1 degrees Fahrenheit (F). Another milk from the same tub was tested for temperature and revealed the milk to have an internal temperature of 46.8 degrees F.</p> <p>During an interview on 05/22/19 at 12:27 PM with the Dietary Manager, he verified the milk tested was intended to be delivered to residents and had the temperature not been requested, the milk would have been served at an unacceptable temperature. He reported the milk in the tub should have been sitting in or covered in ice to</p>	F 812	<p>correction does not constitute an agreement by the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' finding or conclusion are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied.</p> <p>1. The head of lettuce and onion were immediately disposed.</p> <p>The 2 cartons of milk were immediately disposed.</p> <p>Hair nets and beard guards have been provided for all dietary staff to utilize.</p> <p>2. All residents have the potential to be affected by the alleged deficient practice. Kitchen storage areas have been audited and staff wearing beard guards</p> <p>3. Administrator has re-educated Dietary staff on the proper procedure of food storage to include items being dated and remaining at an acceptable temperature per policy. Dietary have also been re-educated on the wearing of beard guards for any facial hair on 6/12/19</p> <p>4. Random audits to be performed by the Administrator/ Dietary Manager 4 times weekly for 1 month, 2 times weekly for 1 month, weekly for 1 month.</p> <p>Administrator to ensure compliance via verification of audit accuracy. Data obtained during audits will be analyzed for patterns and trends by the Administrator. This information will be reported during the Quality Assurance and Process Improvement (QAPI) for 3 months. The committee will make recommendations or</p>		

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F 812	Continued From page 11 assist in keeping it within a safe, servable temperature range. 3. During an observation on 05/23/19 at 12:49 PM, the Dietary Manager was observed to be in the kitchen during meal service with no hair covering over his beard. During an interview with the Dietary Manager on 05/23/19 at 2:01 PM he reported hair coverings for hair and facial hair should always be worn in the kitchen. He reported he had not worn a beard covering because he did not believe his beard was long enough to warrant wearing one. He further reported he only expected beard coverings to be worn if the staff's beard extended off the face ½ inch or more. During an interview with the Administrator on 05/23/19 at 4:25 PM, she reported it was her expectation that all left over food be dated before being stored for further use. She also reported it was her expectation that milk served to residents should be kept on ice and at a safe temperature. She also stated it was her expectation that all hair be covered including beards, no matter how long the hair.	F 812	changes as needed.		
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	F 842		6/20/19	

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NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 842	Continued From page 12 to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted 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	F 842			

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F 842	<p>Continued From page 13</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to accurately document a physician's order for a follow up appointment after discharge and failed to complete documentation on a resident's discharge plan and summary for 1 of 3 residents reviewed for discharge (Resident #254).</p> <p>Findings included:</p> <p>Resident #254 was admitted to the facility on 10/02/18 with diagnoses which included high blood pressure, rheumatoid arthritis, chronic pain, generalized muscle weakness, depression and anxiety.</p> <p>A review of a nursing admission assessment dated 10/02/18 indicated Resident #254 was alert, oriented to person, place and time and her cognition was intact. Further review of the assessment revealed Resident #254 required</p>	F 842	<p>This plan of correction is submitted as required under Federal and State Regulation and statutes applicable to long term care providers. This plan of correction does not constitute an agreement by the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' finding or conclusion are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied.</p> <p>1. On 10/12/2018 the Discharge Summary for resident # 254 was not completely and accurately documented. The discharge summary and plan did not match the physician order. The resident or representative did not sign and date the</p>		

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F 842	<p>Continued From page 14</p> <p>substantial or maximal assistance with activities of daily living but only required set up assistance with eating.</p> <p>A review of a physician's order dated 10/12/18 indicated to discharge Resident #254 to home per resident's request. The order also indicated home health services for medication management, wound care and therapy and to follow up with a primary care physician in 1-2 weeks and the name of a physician was documented.</p> <p>A review of a discharge plan and summary dated 10/12/18 revealed a family member was indicated as Resident #254's representative. A section labeled medication reconciliation further indicated a post discharge medication list was provided to resident and family but a section to specify who was provided the medication list and the date the medications were provided was blank. A section labeled signatures and date revealed the resident representative and resident signatures were blank.</p> <p>During an interview on 05/23/19 at 2:47 PM, the social worker explained the discharge plan and summary was a multidisciplinary process and nursing, therapy and activities completed parts of the document and she completed sections for post discharge follow up. After review of Resident #254's discharge plan and summary she recalled Resident #254's medications were sent with her at discharge and the discharge summary should have specified who the medications were given to. She further stated after review of the physician's discharge order she had put the wrong physician name on the physician's order for follow up but recalled</p>	F 842	<p>discharge summary and plan.</p> <p>2. All residents have the potential to be affected by the alleged deficient practice. The Medical Records Manager/ Social Worker have audited the past 30 days of discharge summaries and plans from the facility. No further concerns have been noted.</p> <p>3. The interdisciplinary team to have been re-educated on the importance of a residents discharge summary and plan to be correct and accurate by the Administrator. Licensed staff have been re-educated on ensuring the resident or representative have signed the discharge summary and plan on 6/12/19</p> <p>4. Random audits on discharged residents to be performed by the Administrator/ Director of Nursing 4 times weekly for 1 month, 2 times weekly for 1 month, weekly for 1 month. Administrator to ensure compliance via verification of audit accuracy. Data obtained during audits will be analyzed for patterns and trends by the Administrator. This information will be reported during the Quality Assurance and Process Improvement (QAPI) for 3 months. The committee will make recommendations or changes as needed.</p>		

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

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F 842	<p>Continued From page 15</p> <p>Resident #254's representative had requested to make a follow up physician appointment with a physician of their choice. She explained the discharge summary and plan should match physician's orders and the resident or representative should have signed and dated the discharge plan and summary.</p> <p>During an interview on 05/23/19 at 3:49 PM, the Director of Nursing stated she was a Unit Manager when Resident #254 was discharged from the facility. She explained she recalled Resident #254's medications were sent with her when she was discharged. She stated it was her expectations for documentation to have the facts and nothing but the facts and the documentation on the discharge plan and summary needed to include everything to tell the story.</p> <p>During an interview on 05/23/19 at 4:30 PM, the Administrator stated it was her expectation for documentation to be complete and accurate.</p>	F 842		