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	345312	A. BUILDING _____ B. WING _____	C 08/22/2019

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BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

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E 000	Initial Comments An unannounced recertification survey was conducted on 08/19/19 through 08/22/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# D4LP11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 08/19/19 through 08/22/19. One allegation was investigated and unsubstantiated. Event ID# D4LP11.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal	F 576		9/8/19

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

Electronically Signed | 09/12/2019

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F 576	Continued From page 1 service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to provide residents with the right to receive mail when delivered on Saturdays. The findings included: Interview with Resident #14, the Resident Council President, on 08/21/19 at 10:45 AM revealed residents received unopened mail Monday through Friday but not on Saturdays. Interview with the Life Engagement Coordinator who was the Acting Activity Director on 08/21/19 at 1:53 PM revealed the activity department staff delivered mail to the residents Monday through Friday. The Activity Director explained the Weekend Nurse Supervisor on duty Saturday delivered mail to the residents. Interview with the Weekend Nurse Supervisor on 08/21/19 at 2:48 PM revealed she worked as the	F 576	How will corrective action be accomplished for those residents having the potential to be affected by the deficient practice? Resident #14 received his mail with no adverse outcome. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: The Receptionist was educated on 8/23/19 on the facility process of delivery of mail to the resident's by the LNHA. An Audit was conducted by the LNHA on mail delivery with no other residents identified to have been affected by the same deficient practice. What measures will be put into place or	

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F 576	Continued From page 2 Weekend Nurse Supervisor every Saturday. The Weekend Nurse Supervisor explained the mail delivered on Saturday was set aside for the Receptionist to sort on Monday before delivery to the residents. Residents did not receive mail delivered on Saturday. Interview with the Receptionist on 08/21/19 at 2:15 PM revealed she worked Monday through Friday and received the mail for the facility. She further stated she sorted the mail delivered Monday and Friday and gave all the residents' mail to the Activity Department for delivery to the residents. The Receptionist stated the weekend mail delivered on Saturday was placed on her desk and she sorted it on Monday and gave it to the Activity Director. Interview with the Administrator on 08/21/19 at 3:05 PM revealed residents should receive mail on Saturday when it was delivered.	F 576	systematic changes made to ensure the deficient practice does not recur: The Receptionist and the Inter-disclipnary Team was educated by the LNHA on the facilities mail delivery process of the residents on 8/23/19. On the weekends resident mail will be distributed by the Weekend Supervisor or Manager on Duty. The Weekend Supervisor was educated by the LNHA on 8/23/19 on obtaining the mail on the weekend and distributing to the residents in the absence of the Manger on Duty. Manager on Duty will obtain and deliver resident mail in the absence of the weekend supervisor. The LNHA/Business Office Director will assume role of mail collection in the absence of the Receptionist during the weekdays. How the corrective actions will be monitored to ensure the practice will not recur, i.e. what Quality assurance program will be put into place: To ensure ongoing compliance, LNHA/designee will conduct random audits on 10 resident’s mail delivery weekly for twelve (12) weeks to ensure mail delivery. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved.	

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F 576	Continued From page 3	F 576	The LNHA will be responsible for the implementation of the acceptable plan of correction.	
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 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 record review and staff interviews, the facility failed to review and/or revise the care plan	F 657	How will corrective action be accomplished for those residents having	9/8/19

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F 657	Continued From page 4 to reflect the individual care needs for 1 of 5 residents reviewed for unnecessary medications (Resident #46). Findings Included: Resident #46 was admitted to the facility on 10/24/17 and readmitted on 11/19/18 with diagnoses which included non-Alzheimer's dementia. Review of the care plan for Resident #46 with a revised date of 4/18/19 revealed interventions which included using a wanderguard (bracelet that sets off an alarm at exit doors) as ordered. Review of the quarterly Minimum Data Set (MDS) dated 7/05/19 indicated Resident #46 had severe cognitive impairment. Review of physician's orders revealed the wanderguard for Resident #46 had been discontinued on 7/22/19. Interview with the MDS Coordinator on 8/21/19 at 11:13 AM revealed the wanderguard interventions should have been removed from the care plan when the physician discontinued it, but it was not. She further stated she did not know how it had been missed but that it did not show up on her daily order printouts. The MDS Coordinator stated care plans should be updated when needed to reflect accurate resident care information and Resident #46's care plan should have been updated when the wanderguard was discontinued. Interview with the Administrator on 8/21/19 at 3:03 PM indicated she expected the care plans to	F 657	the potential to be affected by the deficient practice: Resident #46 wander guard bracelet was removed off the care plan by the MDS nurse on 8/21/19 with no adverse outcome. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An Audit was conducted on 8/28/19 by the Director of Nursing on residents with wander guards that had been discontinued to ensure the resident's care plan have been updated. No other residents were affected by the same deficient practice. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: The Nursing Administrative Team to include the Assistant Director Nursing and the Unit Manager were educated on 8/26/19 by DON on ensuring when wander guard orders have been discontinued that it is removed from the residents care plan. How the corrective actions will be monitored to ensure the practice will not recur, i.e. what Quality assurance program will be put into place: To ensure ongoing compliance, the	

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F 657	Continued From page 5 accurately reflect the care for each resident and for it to be revised as necessary to accurately reflect the resident's condition.	F 657	Director of Nursing or Unit Managers will conduct random audits on wander guards that have been discontinued weekly for twelve (12) weeks to ensure the wander guard has been removed from the residents care plan. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. The Director of Nursing will be responsible for the implementation of the acceptable plan of correction.	
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 by: Based on record review and Audiologist Office Manager, family and staff interviews, the facility failed to follow physician's orders for cerumen (earwax) removal for 1 of 1 resident reviewed who had impaired hearing (Resident #15). The findings included: Resident #15 was admitted to the facility on 05/12/17 with multiple diagnoses that included dementia and depression. Review of Resident #15's medical record	F 658	How will corrective action be accomplished for those residents having the potential to be affected by the deficient practice: An order was received on 9/5/19 for resident #15 for Debrox as recommended by the outside provider (audiologist). Resident # 15 has been scheduled on 10/9/19 for a follow up appointment by the Audiologist. How will corrective action be accomplished for those residents having	9/8/19

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F 658	Continued From page 6 revealed an Audiologist consult note dated 04/23/19 that read, "Otoscopic (visual exam of the ear canal using a lighted instrument) exam revealed impaction of cerumen (earwax) in the right ear canal with a near impaction of cerumen in the left ear canal. Cerumen must be removed before an accurate hearing evaluation can be obtained. Please reschedule hearing evaluation after cerumen is removed." Review of Resident #15's physician telephone orders revealed an order dated 04/23/19 which read, "Cerumen/earwax removal both ear canals." Review of the quarterly Minimum Data Set (MDS) dated 06/12/19 indicated Resident #15 had severe impairment in cognition and minimal impairment in hearing. A telephone interview on 08/19/19 at 2:34 PM with Resident #15's Family Member (FM) revealed Resident #15 was hard of hearing and while living independently at home, Resident #15 had routinely flushed her ears due to earwax buildup. The FM added Resident #15 was supposed to have her ears cleaned at the facility but was not sure if it had been done. A telephone interview was conducted on 08/21/19 at 1:51 PM with the Audiologist Office Manager (AOM). The AOM confirmed Resident #15 was seen on 04/23/19 but the Audiologist was unable to complete the hearing examination due to earwax buildup in both of her ears. The AOM added Resident #15 was sent back to the facility with orders for earwax removal and instructions to reschedule the hearing examination once the earwax was removed. The AOM verified until the	F 658	the potential to be affected by the same deficient practice: An Audit was conducted on 9/5/19 by the Director of Nursing on residents who received consultations for the last 30 days to ensure the resident's recommendations from the outside providers were followed thru with as recommended. No other residents were affected by the same deficient practice. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: The Assistant Director Nursing and the Unit Managers were educated on 9/5/19 by DON on ensuring outside provider recommendations were followed through with by the physician as recommended. How the corrective actions will be monitored to ensure the practice will not recur, i.e. what Quality assurance program will be put into place: To ensure ongoing compliance, the Director of Nursing/Designee will conduct random audits on resident's consultations with outside providers weekly for twelve (12) weeks to ensure the recommendations were followed thru with as recommended. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has	

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F 658	Continued From page 7 earwax was removed from both of Resident #15's ear canals, a hearing evaluation could not be completed. An interview was conducted with the Director of Nursing (DON) on 08/21/19 at 2:30 PM. The DON explained when physician orders were received, the nurse taking the order was responsible for entering it into the resident's electronic medical record for it to be followed. The DON reviewed the consult note and physician order dated 04/23/19 for Resident #15 and confirmed the physician's order was filed in Resident #15's medical chart without being entered into the system or completed by facility staff. The DON was unsure who received the physician's order for Resident #15 and filed it into her medical chart without being completed. The DON stated she would have expected for staff to follow the physician's order for earwax removal and reschedule Resident #15's hearing exam once the order was completed.	F 658	been achieved. The Director of Nursing will be responsible for the implementation of the acceptable plan of correction.	
F 712 SS=C	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.	F 712		9/8/19

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F 712	Continued From page 8 §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure Physician visits were alternated with the Physician Assistant visits every 60 days after the first 90 days of admission for 5 of 26 residents reviewed for rehab and restorative, unnecessary medications, accidents, and nutrition (Residents #15, #29, #51, #61, and #63). The Findings Included: 1. Resident #15 was admitted to the facility on 05/12/17 with multiple diagnoses that included dementia, hypertension, atrial fibrillation (irregular heartbeat), and depression. Review of Resident #15's medical record revealed she was seen by the Physician Assistant (PA) on 03/22/19, 05/13/19, 06/05/19, 06/24/19, 07/25/19 and 08/07/19. Further review revealed she was seen by the Physician on 08/06/19 for an acute (sudden onset or of short duration) visit. There was no other documentation that indicated she was seen by the physician after 03/22/19 or prior to 08/06/19. An interview was conducted with the Director of Nursing (DON) on 08/21/19 at 9:31 AM. The DON verified Resident #15 was seen by the physician on 08/06/19. She was unable to locate	F 712	How will corrective action be accomplished for those residents having the potential to be affected by the deficient practice: Resident #61 was seen by the physician Dr. Holl on 8/22/19. Resident #61 had no adverse outcome. Resident #63 was seen by the physician Dr. Holl on 8/22/19. Resident #63 had no adverse outcome. Resident #51 was seen by the physician Dr. Holl on 8/27/19. Resident #51 had no adverse outcome. Resident #29 was seen by the physician Dr. Holl on 9/7/19. Resident #29 had no adverse outcome. Resident #15 was seen by the physician Dr. Holl on 8/6/19. Resident #15 had no adverse outcome. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An audit was conducted by the Health Information Manager and DON on 8/30/19 of current resident's physician visits to ensure that all current residents are in	

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F 712	Continued From page 9 any additional physician progress notes for Resident #15 and confirmed routine physician visits for Resident #15 were not alternated with the PA every 60 days as required. The DON stated the medical records person was responsible for providing the physician with a list of residents who needed to be seen for routine visits. The DON explained the facility had been without a stable medical records person since November 2018 and the physician was not notified Resident #15 needed to be seen for a routine visit. An interview was conducted with the Administrator on 08/22/19 at 9:49 AM. The Administrator stated the physician was required to see residents within 30 days of admission and every 60 days thereafter. She verified Resident #15 was seen by the physician on 08/06/19 but was unable to locate any additional progress notes to indicate the physician's visits were alternated with the PA visits as required. The Administrator stated the medical records person was responsible for providing the physician with a list of residents who needed to be seen for routine visits and added the facility had been without a steady medical records person since October 2018. The Administrator stated a system failure was identified on 08/21/19 that the physician was not being provided with a list of residents who needed to be seen for routine visits. She added after the system failure was identified, the facility developed a method in the electronic medical record that would keep track of when physician visits were due so the physician could be notified. A telephone interview was conducted with the Physician on 08/22/19 at 9:54 AM. The Physician	F 712	compliance of having been seen by the physician. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Dr. Holl was educated on frequency of physician visits on 8/23/19 by LNHA on ensuring that residents are seen by the physicians as per regulations. The Nursing Administrative Team to include the Assistant Director of Nursing and the Unit Manger were educated on 8/23/19 by the LNHA on frequency of physician visits. The DON will track physician visits of the residents to ensure continued compliance with frequency of physician's visits. How the corrective actions will be monitored to ensure the practice will not recur, i.e. what Quality assurance program will be put into place: To ensure ongoing compliance, the Director of Nursing/Designee will conduct weekly audit on residents required physician visits weekly for twelve (12) weeks to ensure the residents received a physician's visits to maintain regulatory compliance. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. The Director of Nursing will be	

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explained he was required to see residents every 120 days for a routine visit and stated he relied on the medical records person in the facility to inform him when the visits were due. He stated he was seeing residents for acute concerns because they were listed in the physician's communication book but had not had not been receiving a list of residents who were due to be seen for a routine visit. He indicated he would do a better job of tracking residents in the facility who were required to be seen by him for routine visits. The Physician verified the facility notified him on 08/21/19 that he had not been seeing residents as required and the facility had put a system in place on 08/21/19 to notify him when required resident visits were due.

An interview was conducted with the Health Information Coordinator (HIC) on 08/22/19 at 11:44 AM. The HIC stated she began employment with the facility on 08/08/19 but was not informed at that time she was responsible for tracking the frequency of physician visits. The HIC confirmed she was informed on 08/21/19 that she would need to keep track of residents who required a routine visit from the physician and provide the physician with a list of residents needing to be seen.

2. Resident #29 was admitted to the facility on 04/21/10 with multiple diagnoses that included dementia, dysphagia (difficulty swallowing), pain, and depression.

Review of Resident #29's medical record revealed the most recent physician's progress note was dated 10/11/18. There was no other documentation in the medical record that indicated she was seen by a physician after

responsible for the implementation of the acceptable plan of correction.

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10/11/18. Further review revealed she was seen by the Physician Assistant (PA) on 01/31/19, 03/22/19, 06/06/19, 06/07/19, 06/21/19, 07/25/19, 08/05/19, and 08/21/19.

An interview was conducted with the Director of Nursing (DON) on 08/21/19 at 9:31 AM. The DON verified Resident #29 was seen by a physician on 10/11/18. She was unable to locate any additional physician progress notes for Resident #29 and confirmed routine physician visits for Resident #29 were not alternated with the PA every 60 days as required. The DON stated the medical records person was responsible for providing the physician with a list of residents who needed to be seen for routine visits. The DON explained the facility had been without a stable medical records person since November 2018 and the physician was not notified Resident #29 needed to be seen for a routine visit.

An interview was conducted with the Administrator on 08/22/19 at 9:49 AM. The Administrator stated the physician was required to see residents within 30 days of admission and every 60 days thereafter. She verified Resident #29 was last seen by the physician on 10/11/18 but was unable to locate any additional progress notes to indicate the physician's visits were alternated with the PA visits as required. The Administrator stated the medical records person was responsible for providing the physician with a list of residents who needed to be seen for routine visits and added the facility had been without a steady medical records person since October 2018. The Administrator stated a system failure was identified on 08/21/19 that the physician was not being provided with a list of

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residents who needed to be seen for routine visits. She added after the system failure was identified, the facility developed a method in the electronic medical record that would keep track of when physician visits were due so the physician could be notified.

A telephone interview was conducted with the Physician on 08/22/19 at 9:54 AM. The Physician explained he was required to see residents every 120 days for a routine visit and stated he relied on the medical records person in the facility to inform him when the visits were due. He stated he was seeing residents for acute concerns because they were listed in the physician's communication book but had not had not been receiving a list of residents who were due to be seen for a routine visit. He indicated he would do a better job of tracking residents in the facility who were required to be seen by him for routine visits. The Physician verified the facility notified him on 08/21/19 that he had not been seeing residents as required and the facility had put a system in place on 08/21/19 to notify him when required resident visits were due.

An interview was conducted with the Health Information Coordinator (HIC) on 08/22/19 at 11:44 AM. The HIC stated she began employment with the facility on 08/08/19 but was not informed at that time she was responsible for tracking the frequency of physician visits. The HIC confirmed she was informed on 08/21/19 that she would need to keep track of residents who required a routine visit from the physician and provide the physician with a list of residents needing to be seen.

3. Resident #51 was admitted to the facility on

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01/08/16 with multiple diagnoses that included Alzheimer's disease, diabetes, hypertension, atrial fibrillation, and depression.

Review of Resident #51's medical record revealed the most recent physician's progress note was dated 04/09/19. There was no other documentation in the medical record that indicated she was seen by a physician after 04/09/19. Further review revealed she was seen by the Physician Assistant (PA) on 06/17/19, 06/26/19, 07/03/19, 07/26/19, and 08/12/19.

An interview was conducted with the Director of Nursing (DON) on 08/21/19 at 9:31 AM. The DON verified Resident #51 was seen by a physician on 04/09/19. She was unable to locate any additional physician progress notes for Resident #51 and confirmed routine physician visits for Resident #51 were not alternated with the PA every 60 days as required. The DON stated the medical records person was responsible for providing the physician with a list of residents who needed to be seen for routine visits. The DON explained the facility had been without a stable medical records person since November 2018 and the physician was not notified Resident #51 needed to be seen for a routine visit.

An interview was conducted with the Administrator on 08/22/19 at 9:49 AM. The Administrator stated the physician was required to see residents within 30 days of admission and every 60 days thereafter. She verified Resident #51 was last seen by the physician on 04/09/19 but was unable to locate any additional progress notes to indicate the physician's visits were alternated with the PA visits as required. The

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Administrator stated the medical records person was responsible for providing the physician with a list of residents who needed to be seen for routine visits and added the facility had been without a steady medical records person since October 2018. The Administrator stated a system failure was identified on 08/21/19 that the physician was not being provided with a list of residents who needed to be seen for routine visits. She added after the system failure was identified, the facility developed a method in the electronic medical record that would keep track of when physician visits were due so the physician could be notified.

A telephone interview was conducted with the Physician on 08/22/19 at 9:54 AM. The Physician explained he was required to see residents every 120 days for a routine visit and stated he relied on the medical records person in the facility to inform him when the visits were due. He stated he was seeing residents for acute concerns because they were listed in the physician's communication book but had not had not been receiving a list of residents who were due to be seen for a routine visit. He indicated he would do a better job of tracking residents in the facility who were required to be seen by him for routine visits. The Physician verified the facility notified him on 08/21/19 that he had not been seeing residents as required and the facility had put a system in place on 08/21/19 to notify him when required resident visits were due.

An interview was conducted with the Health Information Coordinator (HIC) on 08/22/19 at 11:44 AM. The HIC stated she began employment with the facility on 08/08/19 but was not informed at that time she was responsible for

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tracking the frequency of physician visits. The HIC confirmed she was informed on 08/21/19 that she would need to keep track of residents who required a routine visit from the physician and provide the physician with a list of residents needing to be seen.

4. Resident #63 was admitted to the facility on 10/17/14 with multiple diagnoses that included Parkinson's disease, dementia and depression.

Review of Resident #63's medical record revealed the most recent physician's progress note was dated 03/11/19. There was no other documentation in the medical record that indicated she was seen by a physician after 03/11/19. Further review revealed she was seen by the Physician Assistant (PA) on 05/13/19, 06/05/19 and 08/12/19.

An interview was conducted with the Director of Nursing (DON) on 08/21/19 at 9:31 AM. The DON verified Resident #63 was seen by a physician on 03/11/19. She was unable to locate any additional physician progress notes for Resident #63 and confirmed routine physician visits for Resident #63 were not alternated with the PA every 60 days as required. The DON stated the medical records person was responsible for providing the physician with a list of residents who needed to be seen for routine visits. The DON explained the facility had been without a stable medical records person since November 2018 and the physician was not notified Resident #63 needed to be seen for a routine visit.

An interview was conducted with the Administrator on 08/22/19 at 9:49 AM. The

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Administrator stated the physician was required to see residents within 30 days of admission and every 60 days thereafter. She verified Resident #63 was last seen by the physician on 03/11/19 but was unable to locate any additional progress notes to indicate the physician's visits were alternated with the PA visits as required. The Administrator stated the medical records person was responsible for providing the physician with a list of residents who needed to be seen for routine visits and added the facility had been without a steady medical records person since October 2018. The Administrator stated a system failure was identified on 08/21/19 where the physician was not being provided with a list of residents who needed to be seen for routine visits. She added after the system failure was identified, the facility developed a method in the electronic medical record that would keep track of when physician visits were due so the physician could be notified.

A telephone interview was conducted with the Physician on 08/22/19 at 9:54 AM. The Physician explained he was required to see residents every 120 days for a routine visit and stated he relied on the medical records person in the facility to inform him when the visits were due. He stated he was seeing residents for acute concerns because they were listed in the physician's communication book but had not had not been receiving a list of residents who were due to be seen for a routine visit. He indicated he would do a better job of tracking residents in the facility who were required to be seen by him for routine visits. The Physician verified the facility notified him on 08/21/19 that he had not been seeing residents as required and the facility had put a system in place on 08/21/19 to notify him when required

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resident visits were due.

An interview was conducted with the Health Information Coordinator (HIC) on 08/22/19 at 11:44 AM. The HIC stated she began employment in the facility on 08/08/19 but was not informed at that time she was responsible for tracking the frequency of physician visits. The HIC confirmed she was informed on 08/21/19 that she would need to keep track of residents who required a routine visit from the physician and provide the physician with a list of residents needing to be seen.

5. Resident #61 was admitted to the facility on 06/09/18.

A quarterly Minimum Data Set (MDS) assessment dated 07/24/19 indicated Resident #61 was cognitively impaired and diagnoses included dementia, Parkinson's disease, and diabetes mellitus. He required extensive assistance with bed mobility, transfers, toileting, and personal hygiene and required limited assistance with dressing.

A review of Resident #61's medical record revealed a physician's progress note dated 03/15/19 and was signed by the physician. There was no other documentation in the medical record that indicated Resident #61 had been seen by the physician.

Resident #61 was seen by the Physician Assistant on 03/20/19, 05/30/19, 07/19/19, and 08/05/19.

On 08/22/19 at 9:31 AM an interview was conducted with the Director of Nursing (DON)

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who confirmed Resident #61 was seen by the physician on 03/15/19 and had not been seen by the physician for 5 months (over 120 days). The DON verified that the physician had missed seeing Resident #61 for the required routine visit. The DON stated the medical records person was responsible for providing a list of residents who were required to be seen for routine visits to the physician. The DON shared that the facility had been without a stable medical records person since November 2018 and the physician had not been notified that Resident #61 had been required to be seen for routine visit and was missed. The DON stated that she believed the failure of the physician to see Resident #61 was due to the facility not having a stable medical records person that would generate a list of residents who were required to be seen by the physician for routine visit.

On 08/22/19 at 9:49 AM an interview was conducted with the Administrator who verified the physician had not seen Resident #61 since 03/15/19 (over 120 days). The Administrator stated the physician was required to see the resident within 30 days of admission and every 60 days thereafter. The administrator stated the facility had been without a steady medical records person since October 2018. The Administrator stated the medical records person was responsible for generating a list of residents who were required to be seen by the physician for routine visit within 30 days of admission and every 60 days thereafter. The Administrator stated on 08/21/19 a system failure had been identified that the medical records person had not provided a list of residents who were required to be seen for routine visit to the physician. The Administrator stated after the system failure was

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identified the facility developed a method in the electronic medical record where the residents that required a routine visit would be tracked and the physician would be notified.

On 08/22/19 at 9:54 AM a telephone interview was conducted with the physician who stated he had not seen Resident #61 since 03/15/19. He stated he relied on the medical records person at the facility to inform him of residents who were required to be seen for routine visits. He stated he had not been receiving a list from medical records at the facility to notify him of residents who were required to be seen for routine visit. The physician indicated he had not been doing a very good job of keeping track of residents in the facility who were required to be seen for routine visits. The physician shared that he was required to see the resident for a routine visit every 120 days. The physician stated he was seeing residents for acute concerns because they were listed in the physician's communication book. The physician indicated that he would do a better job of tracking residents in the facility who were required to be seen by him for routine visit. The physician stated the facility notified him on 8/21/19 that he had not been seeing residents for the required routine visits. The physician shared that the facility had put in place on 08/21/19 a system to notify him of residents who were required to be seen by him for a routine visit.

On 08/22/19 at 11:44 AM an interview was conducted with the Health Information Coordinator (HIC) who stated she began employment in the facility on 08/08/19. She shared that she was not informed on hire that she was responsible to provide a list of residents who required a routine visit to the physician. The HIC

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F 712	Continued From page 20 stated she was informed on 08/21/19 that she would need to track residents who required a routine visit from the physician and provide a list of those residents to the physician.	F 712		