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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/3/17 through 10/4/17. One complaint was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 225 certified bed facility was 172 at the time of the survey. The survey sample consisted of 23 current resident reviews (Residents #1 through #23) and five closed record reviews (Residents #24 through # 28).	F 000		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive care plan. 483.21 (b) Comprehensive Care Plans (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 -	F 279		10/23/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/22/2017

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 279	Continued From page 1 (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 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 staff interview, facility document review	F 279	The statements made on the plan of	

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and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan for one of 28 residents in the survey sample, Resident #17.

The facility staff failed to develop a care plan for Resident #17 to address his receiving dialysis three times a week.

The findings include:

Resident #17 was admitted to the facility on 7/27/17 with a recent readmission on 9/21/17 with diagnoses that included but was not limited to: high blood pressure, gastroesophageal reflux, atrial fibrillation, low back pain, peripheral vascular disease, anemia, and end stage renal disease.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date (ARD) of 9/17/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating that the resident was cognitively intact to make daily decisions. The resident was coded as requiring supervision to limited assistance for all of his activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis. *

*Dialysis is a medical procedure for filtering waste products from the blood of some kidney-disease patients or for removing poisons or drugs. (1)

Review of the comprehensive care plan dated, 9/22/17, did not reveal any documentation of Resident #17's renal failure (the inability of the

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correction are not an admission to, and does not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State regulations, the facility has taken, or will take the action set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.

Our Date of Allegation of Compliance is 10/23/17.

1. Corrective Action

On 10/4/17, a comprehensive care plan was developed for resident #17 to address receiving Dialysis three times a week.

2. Other Residents Who Had The Potential to Be Affected:

Current patients who are receiving Dialysis had the potential to be affected.

3. Systemic Changes:

On 10/4/17, an audit of the Comprehensive Care Plans for residents receiving Dialysis was completed by the QA Nurses with no discrepancies noted.

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kidneys to excrete wastes and function in the maintenance of electrolyte balance (2)) and the need for dialysis.

An interview was conducted with LPN (licensed practical nurse) #3 on 10/4/17 at 3:30 p.m. LPN #3 was asked if a resident receives dialysis, should this be included in the care plan. LPN #3 stated, "Yes." LPN #3 was asked to review Resident #17's care plan. Once the care plan was reviewed, LPN #3 stated, "I don't see anything related to dialysis on it (the care plan)."

An interview was conducted with LPN #4, the nurse manager, on 10/4/17 at 4:00 p.m. When asked if the care plan should address if a resident is receiving dialysis, LPN #4 stated, "Yes." Resident #17's care plan dated 9/22/17 was reviewed with LPN #4. LPN #4 stated, "I already know, it's not on there."

The facility policy, "Care Plans, Comprehensive Person-Centered" documented in part, "1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident...8. The comprehensive, person -centered care plan will...b. Describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being...k. Reflect treatment goals, timetables and objectives in measurable outcomes. l. Identify the professional services that are responsible for each element of care."

The administrator (administrative staff member - ASM) #1, ASM #2, the director of nursing, ASM #5, the assistant administrator of clinical services

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Beginning 10/4/17, licensed nurses were provided refresher education by the QA Nurse regarding the importance of developing a Comprehensive Care Plan for Dialysis.

4. Monitoring

A monthly audit of all residents receiving dialysis services will be conducted by the QA Nurses for a period of 3 months to validate appropriate comprehensive care plans are in place.

Any areas of non-compliance will be immediately corrected and responsible staff will be counseled. The results of all audits will be forwarded to the QAPI committee for review and/or recommendations.

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F 279	Continued From page 4 and ASM #6, the medical director, were made aware of the above findings on 10/4/17 at 4:13 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman; page 164. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman; page 501	F 279		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (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 staff interview and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 28 residents in the survey sample, Resident #17. The facility staff failed to transcribe an order for dialysis onto Resident #17's current POS (physician order summary) during the recapitulation of orders for October 2017. The findings include:	F 281	1. Corrective Action: On 10/4/17, an order for Dialysis was resident #17, was transcribed and entered onto the current POS (Physician Order Summary)for October 2017. 2. Other Residents Who Had The Potential To Be Affected: Patients receiving dialysis services had the potential to be affected.	10/23/17

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Resident #17 was admitted to the facility on 7/27/17 with a recent readmission on 9/21/17 with diagnoses that included but was not limited to: high blood pressure, gastroesophageal reflux, atrial fibrillation, low back pain, peripheral vascular disease, anemia, and end stage renal disease.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 9/17/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating that the resident was cognitively intact to make daily decisions. Resident #17 was coded as requiring supervision to limited assistance for all of his activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis. *

*Dialysis is a medical procedure for filtering waste products from the blood of some kidney-disease patients or for removing poisons or drugs. (1)

Review of the physician order summary (POS) dated 9/21/17, documented, "Dialysis Q (every) M - W - F (Monday - Wednesday - Friday) @ (at)." There was nothing else documented after that.

Review of the October 2017 POS, signed by the physician on 10/2/17, did not reveal a physician order for dialysis.

An interview was conducted with LPN (licensed practical nurse) #3 on 10/4/17 at 3:30 p.m. When asked if a physician order was required for a resident to receive dialysis, LPN #3 stated, "Yes." Resident #17's October POS was reviewed with LPN #3. LPN #3 stated she did not see any order

F 281

3. Systemic Changes:

On 10/5/17, a 100% audit of patients receiving dialysis services was completed by the QA Nurse to ensure orders were transcribed to the POS (Physician Order Summary) for October 2017 with no discrepancies noted.

Beginning 10/8/17, licensed nurses were provided re-educated by the QA Nurse regarding the importance of transcribing orders for Dialysis onto the POS (Physician Order Summary).

4. Monitoring:

A 100% audit of all patients receiving dialysis services will be completed monthly by the QA Nurses for a period of 3 months to validate the presence of physician orders on the POS.

Any areas of non-compliance will be immediately corrected and responsible staff will be counseled. The results of all audits will be forwarded to the QAPI committee for review and/or recommendations.

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for dialysis. The September POS was reviewed with LPN #3. She stated that the order was on the September 2017 POS, but the order for dialysis didn't get carried over to the new POS (October 2017). When asked who does the monthly change over or recapitulation of the orders, LPN #3 stated the nurse managers do them.

An interview was conducted with LPN #4, the nurse manager, on 10/4/17 at 4:00 p.m. When asked about the process staff follows for the monthly change over or recapitulation of the monthly orders, LPN #4 stated that the nurse managers and the administrative nurses are responsible for doing them. Resident #17's October 2017 POS were reviewed with LPN #4, and LPN #4 was then asked whose signature was on the POS as having completed the review. LPN #4 stated, "That's my signature. I didn't carry it (the order for dialysis) over. I made the mistake."

The administrator (administrative staff member - ASM) #1, ASM #2, the director of nursing, ASM #5, the assistant administrator of clinical services and ASM #6, the medical director, were made aware of the above findings on 10/4/17 at 4:13 p.m.

On 10/4/17 at 5:05 p.m. ASM #2 stated they did not have a policy on the recapitulation of the orders.

In Potter-Perry, Fundamentals of Nursing, 6th edition, page 841, a noted standard of practice is: "When medications are first ordered, the nurse compares the medication recording form or computer orders with the prescriber's written

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F 281	Continued From page 7 orders." On page 852, regarding the administration of oral medications, "Check accuracy and completeness of each MAR or computer printout with prescriber's written medication order." No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman; page 164.	F 281		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is	F 309		10/23/17

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provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide care and services to maintain the highest practicable physical wellbeing for one of 28 residents in the survey sample, Resident #17.

The facility staff failed to provide the care and services for the care of a resident with dialysis, Resident #17.

The findings include:

Resident #17 was admitted to the facility on 7/27/17 with a recent readmission on 9/21/17 with diagnoses that included but was not limited to: high blood pressure, gastroesophageal reflux, atrial fibrillation, low back pain, peripheral vascular disease, anemia, and end stage renal disease.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date (ARD) of 9/17/17, coded Resident #17 as scoring a 15 on the BIMS (brief interview for mental status) score, indicating

F 309

1. Corrective Action:

On 10/5/17, dialysis care and services were provided for Resident #17.

2. Other Residents Who Had The Potential To Be Affected:

Patients receiving dialysis care and services had the potential to be affected.

3. Systemic Changes:

On 10/6/17, a 100% audit of physician orders for dialysis care and services was completed by the QA Nurse with no discrepancies noted.

Beginning 10/12/17, licensed nurses were re-educated by the QA nurse regarding the importance of obtaining physician orders and consistent documentation of dialysis care and services provided.

4. Monitoring:

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that the resident was cognitively intact to make daily decisions. The resident was coded as requiring supervision to limited assistance for all of his activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis. *

*Dialysis is a medical procedure for filtering waste products from the blood of some kidney-disease patients or for removing poisons or drugs. (1)

Review of the physician order summary (POS) dated 9/21/17, documented, "Dialysis Q (every) M - W - F (Monday - Wednesday - Friday) @ (at)." There was nothing else documented after that.

Review of the October 2017 POS, signed by the physician on 10/2/17, did not reveal a physician order for dialysis.

Review of the TAR (treatment administration record) for 9/21/17 through 9/30/17 did not reveal any documentation related to monitoring the resident's dialysis access.

Review of the TAR for 10/1/17 through 10/4/17 did not reveal any documentation related to monitoring the resident's dialysis access.

Review of the comprehensive care plan dated, 9/22/17, did not reveal any documentation of Resident #17's renal failure (the inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance (2)) and the need for dialysis.

The nurse's notes dated 9/22/17 at 4:46 p.m. documented in part, "Resident has a port to the left upper chest, dressing intact."

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A 100% audit will be completed monthly by the QA Nurse for a period of three months for patients receiving dialysis care and services to validate physician orders and documentation of care provided.

Any areas of non-compliance will be immediately corrected and responsible staff will be counseled. The results of all audits will be forwarded to the QAPI committee for review and/or recommendations.

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The nurse's note dated, 9/23/17 at 1:45 p.m. documented in part, "Perm-a- cath (catheter) intact Lt (left) side of chest for dialysis on M-W-F (Monday - Wednesday - Friday)."

A Perm - a - cath or port is a venous catheter is a tube inserted into a vein in the neck, chest, or leg near the groin, usually only for short-term hemodialysis. The tube splits in two after the tube exits the body. The two tubes have caps designed to connect to the line that carries blood to the dialyzer and the line that carries blood from the dialyzer back to the body. A person must close the clamps on each line when connecting and disconnecting the catheter from the tubes. (3)

The nurse's note dated, 9/24/17 at 1:34 p.m. documented in part, "Perm-a-cath remains in place to Lt (left) chest, goes to dialysis on M-W-F."

The nurse's note dated, 9/24/17 at 10:42 p.m. documented in part, "Perm-a-cath remains in place to Lt chest, goes to dialysis on M-W-F."

On 9/25/17 at 12:17 p.m. the nurse documented in part, "Perm-a-cath remains in place to Lt chest, goes to dialysis on M-W-F."

The nurse's note dated 9/25/17 at 7:39 p.m. documented in part, "Cath intact no indication of infection at insertion site."

On 9/26/17 at 3:13 a.m. the nurse documented in part, "dialysis M-W-F... left side chest port."

The nurse's note dated 9/27/17 at 7:10 p.m.

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documented in part, "port intact to chest, no redness or swelling at insertion site."

Review of the nurse's notes from 9/28/17 through 10/4/17 did not reveal any documentation related to the resident's Perm-a-cath.

An interview was conducted with LPN (licensed practical nurse) #3, the nurse caring for the resident, on 10/4/17 at 3:30 p.m. When asked what type of dialysis access Resident #17 had, LPN #3 stated, "He has a Perm-a-cath in his chest." When asked if there is any special care needs for a resident on dialysis, LPN #3 stated, "Yes, we have to check his dressing every shift and look for signs of bleeding or infection." When asked if that is documented anywhere, LPN #3 stated, "There is usually a place on the TAR to check it off or you document it in the nurse's notes." The TAR for October was reviewed with LPN #3. When asked if she saw the documentation on the TAR, LPN #3 stated, "No, Ma'am."

An interview was conducted with LPN #4, the nurse manager, on 10/4/17 at 4:00 p.m. When asked what special care needs a nurse checks for a resident on dialysis, LPN #4 stated, "We have to make sure there is transportation to dialysis. We have to know the time and place of dialysis. We should know about the type of access; what kind, where." When asked if that is documented anywhere, LPN #4 stated, "Ideally yes." When asked where that is documented and how often, LPN #4 stated, "The nurse should be checking the access every shift and documenting it on the TAR or nurse's notes." The TAR and nurse's notes were reviewed with LPN #4. LPN #4 stated, "It's not there."

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The facility policy, "End-Stage Renal Disease, Care of a Resident with," documented in part, "1. Staff caring for residents with ESRD (end stage renal disease), including residents receiving dialysis care outside the facility shall be trained in the care and special needs of these residents. 2. Education and training of staff included, specifically.... g. The care of grafts and fistulas...5. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care."

"After completion of hemodialysis, monitor the vascular access site for bleeding. If bleeding is excessive, maintain pressure on the sited and notify the doctor."(4)

The administrator (administrative staff member - ASM) #1, ASM #2, the director of nursing, ASM #5, the assistant administrator of clinical services and ASM #6, the medical director, were made aware of the above findings on 10/4/17 at 4:13 p.m.

No further information was obtained prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman; page 164.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman; page 501.
(3) This information was obtained from the following website: https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis/vascular-access.

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F 309	Continued From page 13 (4) Medical Surgical Nursing Made Incredibly Easy, Lippincott Williams & Wilkins copyright 2004 page 565 Dialysis Monitoring and Aftercare:	F 309		
F 507 SS=D	LAB REPORTS IN RECORD - LAB NAME/ADDRESS CFR(s): 483.50(a)(2)(iv) (a) Laboratory Services (2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a laboratory test result was filed on the clinical record for one of 28 residents in the survey sample, Resident #5. The facility staff failed to have a results of a hemoglobin A1C on the clinical record for Resident #5. The findings include: Resident #5 was admitted to the facility on 5/3/16 with a readmission of 10/17/16 with diagnoses that included, but was not limited to: stroke, diabetes, urinary tract infection, and repeated falls. The most recent MDS (minimum data set), a significant change assessment, with an assessment reference date of 8/31/17, coded the resident as having short and long term memory	F 507	1. Corrective Action: On 10/5/17, the HgbA1C lab result was filed in the clinical record for Resident #5. 2. Other Residents Who Had The Potential To Be Affected: Patients who had orders for lab test had the potential to be affected. 3. Systemic Changes: On 10/12/17, a 100% audit of physician ordered labs for the last 90 days was completed by the QA Nurse to ensure such were filed in the resident's clinical record was completed. On 10/6/17, nursing and medical record staff were re-educated by the QA Nurse regarding the importance of filing labs in	10/23/17

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difficulties. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

The physician order dated, 828/17 documented, "Hemoglobin A1C* to be drawn on 8/29/17."

*The A1C test is a blood test that provides information about a person's average levels of blood glucose, also called blood sugar, over the past 3 months. The A1C test is sometimes called the hemoglobin A1c, HbA1c, or glycohemoglobin test. (1)

Review of the clinical record failed to reveal Resident #5's 8/29/17, Hemoglobin A1C laboratory test results.

The nurse's note dated, 8/29/17 at 5:38 p.m. documented, "Hemoglobin A1C Lab (laboratory) results obtained, NP (nurse practitioner) notified, no new orders."

The comprehensive care plan dated, 6/23/17, documented, "Focus: Endocrine system related to hypothyroidism, DM (diabetes mellitus)." The "Interventions" documented in part, "Obtain labs as ordered, notify physician of results."

An interview was conducted with LPN (licensed practical nurse) #4, the unit manager, on 10/4/17 at 11:16 a.m. LPN #4 was shown Resident #5's physician order for the Hemoglobin A1C, and was asked to see if she could locate it in the clinical record. LPN #4 stated, "I don't see it." When asked the process for laboratory test results, LPN #4 stated, "The doctor orders the lab test. It is entered in the treatment book. It is drawn." The TAR (treatment administration record) for August

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the resident's clinical record.

4. Monitoring:

A 100% lab audit will completed monthly by the QA Nurses for a period of three months to validate timely filing of lab results.

Any areas of non-compliance will be immediately corrected and responsible staff will be counseled. The results of all audits will be forwarded to the QAPI committee for review and/or recommendations.

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was reviewed with LPN #4. There was no documentation of the order for the Hemoglobin A1C on the TAR. When asked who handles the results when they come back, LPN #4 stated, "The unit manager or the supervisors get the results and I follow up on the next day."

On 10/4/17 at 12:02 p.m. LPN #4 returned to this surveyor and presented the results of the Hemoglobin A1C laboratory tests on 8/29/17. When asked where she obtained them, LPN #4 stated, "I got it from the lab."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 10/4/17 at 2:35 p.m. When asked the process to ensure the laboratory results are on the clinical record, ASM #2 stated, "The nurse managers or QA (quality assurance) nurses have a log that they keep a list of all labs ordered by the physician. They date the log when the results are received. Then the nurse manager or nurse who receives the labs, notifies the doctor and RP (responsible party) and takes any new orders."

The administrator, ASM #2, ASM #5, the assistant administrative of clinical services and ASM #6, the medical director, were made aware of the above findings on 10/4/17 at 4:13 p.m. At this time ASM #5 informed this surveyor the facility had no policy on laboratory testing.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://www.niddk.nih.gov/health-information/diabetes/overview/tests-diagnosis/a1c-test

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F 514	Continued From page 16	F 514		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE CFR(s): 483.70(i)(1)(5) (i) Medical records. (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 (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 514		10/23/17

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Based on staff interview and clinical record review, it was determined that facility staff failed to maintain a complete and accurate clinical record for two of 28 residents in the survey sample, Resident #2 and Resident #12.

1. A skin note belonging to another resident was filed in Resident #2's clinical record.

2. The facility staff filed documents belonging to another resident on Resident #12's clinical record.

The findings include:

1. Resident #2 was admitted to the facility on 4/28/17 with diagnoses that included but were not limited to: muscle weakness, heart failure, severe protein malnutrition, high blood pressure, pressure ulcer of the sacral region, anemia and anxiety disorder. Resident #2's most recent MDS (minimum data set assessment) was a significant change assessment with an ARD (assessment reference date) of 7/20/17. Resident #2 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #2 was coded as requiring extensive assistance of one-person physical assist with dressing, transfers, toileting, personal hygiene, and bathing.

Review of Resident #2's clinical record revealed a skin care note dated 6/8/17 that belonged to a different resident. The note documented in part, the following: "Note Text: Wound Care Specialist Evaluation. Patient Name: (Name of other patient): Age: 98. Gender: female..."

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1. Corrective Action:

On 10/5/17, the skin note for another resident was struck out of the electronic clinical record for Resident #2.

On 10/5/17, the POS was removed from Resident #12's clinical record.

2. Other Patients Who Had the Potential To Be Affected:

Patients who had skin notes or a POS had the potential to be affected.

3. Systemic Changes:

On 10/10/17, a 100% audit of the POS (Physician Order Summary) and skin notes was completed with no discrepancies notes.

Beginning 10/5/17, the wound nurse was re-educated regarding the importance of documenting in the appropriate electronic clinical record.

Beginning 10/5/17, nursing and medical record staff were re-educated regarding the importance of filing documentation in the appropriate clinical record.

4. Monitoring:

A 100% audit of the skin notes and the POS will be completed by the QA Nurse for a period of three months to validate presence of correct documentation in the appropriate electronic clinical record.

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On 10/4/17 at 2:34 p.m., an interview was conducted with RN (registered nurse) #1, the wound care and QA (quality assurance) nurse. RN #1 stated that she was responsible for transferring notes from the wound care physician into the electronic record. RN #1 stated that she had noticed the wrong note was in Resident #2's chart when this writer asked for a copy of the 6/8/17 note. RN #1 stated that she had crossed out the note and documented that it was in the "wrong chart." RN #1 stated that the note for the other resident should not have been in Resident #2's chart.

On 10/4/17 at 4:15 p.m., ASM (administrative staff member) #2, the administrator, ASM #4, the interim DON (Director of Nursing), ASM #5, the administrative clinical director and ASM #6 the medical director were all made aware of the above concerns. The facility did not have a policy on maintaining the clinical record.

Potter-Perry contains a quotation on page 477 regarding documentation as follows: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice."

2. The facility staff filed documents belonging to another resident on Resident #12's clinical record.

Resident #12 was admitted to the facility on

Any areas of non-compliance will be immediately corrected and responsible staff will be counseled. The results of all audits will be forwarded to the QAPI committee for review and/or recommendations.

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8/28/15 and readmitted on 12/31/15 with the diagnoses of but not limited to: dementia, dysphagia, diverticulitis, overactive bladder, high blood pressure and osteoporosis.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 9/15/17. Resident #12 was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for transfers, ambulation, hygiene and bathing; supervision for eating; and was frequently incontinent of bowel and bladder.

A review of the clinical record revealed a monthly POS (Physician's Order Sheet) for the month of October 2017, signed by the physician on 10/3/17, which was not Resident #12's POS.

On 10/4/17 at 3:14 p.m., an interview was conducted with LPN #6. She stated that the POS should not have been in Resident #12's chart. When asked who does the filing, LPN #6 stated the unit secretary. The unit secretary was standing nearby, and was then asked about filing the POS on Resident #12's chart. The unit secretary stated it was an honest mistake.

On 10/4/17 at approximately 2:00 p.m., the Administrator was made aware of the findings. A policy for maintaining medical records was requested. On 10/4/17 at 4:07 p.m., the Administrator stated there wasn't a policy.

No further information was provided by the end of the survey.