



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR  
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3232 Elder Street  
P.O. Box 83720  
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June 29, 2017

Steve Gannon, Administrator  
Quinn Meadows Rehabilitation & Care Center  
1033 West Quinn Road  
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Gannon:

On **June 15, 2017**, a survey was conducted at Quinn Meadows Rehabilitation & Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 10, 2017**. Failure to submit an acceptable PoC by **July 10, 2017**, may result in the imposition of penalties by **August 3, 2017**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 20, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 13, 2017**. A change in the seriousness of the deficiencies on **July 30, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **September 13, 2017** includes the following:

Denial of payment for new admissions effective **September 13, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 12, 2017**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 13, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **July 10, 2017**. If your request for informal dispute resolution is received after **July 10, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a smaller "Scott" following it.

David Scott, R.N., Supervisor  
Long Term Care

DS/lj  
Enclosures

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

PRINTED: 07/17/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>QUINN MEADOWS REHABILITATION &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>		
(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 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification survey conducted at the facility from 6/12/17 to 6/15/17.  The surveyors conducting the survey were:  Edith Cecil, RN, Team Coordinator Keitha Bevins RN  Survey Abbreviations:  DVT = deep vein thrombosis IV = intravenous MAR = Medication Administration Record MDS = Minimum Data Set POST = Physician Orders for Scope of Treatment	F 000			
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES  483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).  (i) These requirements include provisions to	F 155		7/17/17	

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

TITLE

(X6) DATE

Electronically Signed

07/05/2017

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 155	<p>Continued From page 1</p> <p>inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by:</p>	F 155			

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F 155	<p>Continued From page 2</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure physician orders reflected resuscitation code status revisions. This was true for 1 of 7 (#2) residents reviewed for physician orders and had the potential for harm if residents' code status was not honored during life-threatening emergencies. Findings include:</p> <p>Resident #2 was admitted to the facility on 5/22/09 with diagnoses which included chronic lower extremity venous insufficiency, hypokalemia (low potassium level in the blood), and obesity.</p> <p>Resident #2's most recent quarterly Minimum Data Set (MDS) assessment, dated 4/27/17, documented moderate cognitive impairment.</p> <p>Resident #2's June 2017 Physician Orders documented a "Do Not Resuscitate" (DNR) status, provision of comfort measures, no feeding tubes, and no interavenous fluids (IV) directives, dated 11/5/10.</p> <p>An undated facility form in the front of Resident #2's clinical chart communicated to staff that Resident #2 was a "FULL" code with direction for aggressive life-saving measures, feeding tube, and IV fluids.</p> <p>The Idaho Physician Orders for Scope of Treatment (POST) documented Resident #2's resuscitative status as "Full Code," aggressive life-saving interventions, feeding tube, IV fluids, antibiotics, and blood products. This form was signed by Resident #2 and a physician, and dated 5/5/17.</p>	F 155	<p>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority.</p> <p>Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</p> <p>F- 155 SS= D</p> <p>§ 483.10 (c) (6) (8) (g) (12), 483.24 (a) (3) Right to Refuse; Formulate Advance Directives</p> <p>The facility does ensure that physician orders reflect resuscitation code status revision.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>As reflected on the Statement of deficiencies-form CMS-2567, on 06/15/2017 during survey, Resident #2 revised POST resuscitation code status was entered by the Medical Record Director in the physician orders, to reflect</p>		

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F 155	Continued From page 3  A Care Plan Conference Summary form, dated 4/27/17, documented the POST for Resident #2 was reviewed and Resident #2 wanted to change his/her status to Full Code with aggressive life-saving interventions, IV fluids, and feeding tube.  On 6/15/17 at 12:10 pm, the Medical Records Director stated POST status was entered into the resident's clinical record as soon as the resident-signed document was received by Medical Records. The Medical Records Director stated, "I didn't change this one, I just recently did it."	F 155	the revised POST i.e. Full Code, Aggressive Interventions, feeding tube, IV fluids, antibiotics, and blood products.  Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:  This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.  However, all current Resident(s) who have decided to make a revision on the Idaho Physician Orders for Scope of Treatment (POST), may have the potential to be affected by this deficiency, hence to address Resident(s) that may have the potential to be affected by this deficiency;  · By 7/10/2017 the Administrator or Administrator Designee and a License Nurse, will do a one time review on all current Residents' to ensure that the Idaho Physician Orders for Scope of Treatment (POST) and the physician order(s) resuscitation code status match.  Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:		

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F 155	Continued From page 4	F 155	<p>To ensure that the deficient practice does not recur,</p> <p>By 7/10/2017, the Administrator or Administrator Designee, will provide a 1:1 In-service Education to the Medical Record Director regarding F 155, on the importance of timely entering of the physician orders for any revision that a Resident(s) made in their Idaho Physician Orders for Scope of Treatment (POST) to ensure that the physician order(s) reflect the resuscitation code status revisions.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or Administrator Designee will do a random unannounced review of at least 3 Residents Physician order(s) on Residents' that made a revision on their Idaho Physician Orders for Scope of Treatment (POST), to ensure that physician order(s) reflect the resuscitation code status revisions.</p> <p>Monitoring will start on 7/14/2017. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or Administrator Designee will present to the quarterly QA&amp;A Committee meeting the findings and/or corrective actions taken.</p>		

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F 155	Continued From page 5	F 155			
F 281 SS=D	<p>483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>(b)(3) Comprehensive Care Plans</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure conflicting medication orders were clarified with physicians. This was true for 1 of 7 (#7) residents reviewed for physician orders and had the potential for harm if medications were not administered correctly. Findings include:</p> <p>Resident #7 was admitted to the facility on 8/27/09 with diagnoses including unspecified dementia without behavioral disturbance, generalized muscle weakness, right and left-hand contractures and chronic pruritis (severe itching of the skin).</p> <p>Resident #7's Quarterly Minimum Data Set (MDS) assessment, dated 4/19/17, documented moderate cognitive impairment; dependent on staff for bed mobility, transfers, eating, toilet use, personal hygiene, and bathing; and impaired range of motion of one upper extremity.</p>	F 281	<p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p> <p>F- 281 SS=D §483.21 (b) (3) (i) Services Provided Meet Professional Standards</p> <p>The facility does ensure that conflicting medication orders are clarified with physicians.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>On 06/13/2017, upon identification during the survey, a copy of Resident # 7 hydrocodone 04/24/2017 written script (that was not provided to the facility License Nurse by the Hospice Nurse who received the order from the Hospice physician), was requested by the facility License Nurse from the Hospice Physician. The copy of the script was matched with Resident #7 medication</p>	7/17/17	

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F 281	<p>Continued From page 6</p> <p>A History and Physical (H&amp;P) evaluation, dated 8/28/16, documented Resident #7 received 1/2 tablet of hydrocodone (pain medication) 5-325 milligrams [mg] three times a day. The H&amp;P did not document whether the medication was to be given before- or with meals.</p> <p>Resident #7's handwritten Physician Prescription, dated 2/17/16, documented, "Hydrocodone 5-325 mg 1/2 tab by mouth with meals TID (three times daily) for chronic pain." A handwritten Physician Prescription, dated 4/24/17, documented an order for "Hydrocodone 5-325 mg 1/2 tab by mouth before meals for chronic pain."</p> <p>Recapitulated physician orders from February 2017 through June 2017 documented Resident #7 was to receive hydrocodone 5/325 mg 1/2 tab by mouth with meals three times a day.</p> <p>The pharmacy's Medication Regimen Review of Resident #7's medications, dated 5/25/17, did not include recommendations or identify irregularities with physician orders.</p> <p>The Medication Administration Record (MAR) for February 2017 through June 2017 documented Resident #7 received hydrocodone 5-325 mg 1/2 tab with meals daily through 6/13/17. This was not consistent with the 4/24/17 physician order for administration prior to meals. Resident #7 received the Hydrocodone for 51 days with meals after the order change.</p> <p>The facility's "Physician Orders" policy, dated June 2004, documented, "... physician orders must be given and managed in accordance with applicable laws and regulations ..."</p>	F 281	<p>supply and the Medication Administration Record(MAR) was updated on 06/13/2017 to ensure that script, medication supply, and the medication administration record matched.</p> <p>LN # 1 who administered the hydrocodone after Resident #7 ate breakfast, is no longer an employee of the facility.</p> <p>By 7/10/2017, a 1:1 In-service education by the Facility Administrator or Administrator Designee regarding F 281 on the importance of providing the facility Nurse a copy of the physician's order script in the event that there is a change in a physician's order instruction regarding when to administer a hydrocodone pain medication (i.e. with meals vs. before meals), was provided to the Hospice Nurse who did not supply the facility license nurse a copy of the hydrocodone 04/24/2017 written script she received from the Hospice physician with the reflected change.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, all current Hospice Resident(s)</p>		

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F 281	Continued From page 7  The facility's "Administering Oral Medications" policy and procedure, dated September 2003, directed staff to "... double check the MAR against physician orders before administering medications and administer PC (after meals) and AC (before meals) medications as ordered ..."  On 6/13/17 at 4:35 pm, LN # 1 stated she typically administered the hydrocodone closer to meal times, however on that day she administered it after Resident #7 ate breakfast. She noted she was not aware of the order change to administer the medication before meals.	F 281	who are on hydrocodone pain medication may have the potential to be affected by this deficiency, hence to address Resident(s) that may have the potential to be affected by this deficiency;  By 7/10/2017, the Administrator or Administrator Designee and a License Nurse, will do a one time review of all Hospice Resident(s) hydrocodone pain medication orders, to ensure that the Hospice Physician order(s) for hydrocodone pain medication, the Medication Administration Record (MAR), Hospice physician's script, and Medication Supplies provided by Hospice match.  Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:  To ensure that the deficient practice does not recur, By 7/10/2017, the Facility Administrator or Administrator Designee will provide 1:1 In-service education to Hospice Agency Director of Nursing regarding F 281 on the importance of providing the facility Nurse a copy of the physician's order script in the event that there is a change in a physician's order instruction regarding when to administer a hydrocodone pain medication (i.e. with meals vs. before meals).		

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F 281	Continued From page 8	F 281	<p>By 7/10/2017, the Administrator or Administrator Designee and a Licensed Nurse Designee, will provide All Licensed Nurses an In-service education regarding F-281 , with emphasis on the importance of double checking the MAR against the medication supply instruction(s), hence when there is a conflicting medication order(s) instruction, to make sure that the MAR is double checked against the physician order(s) to ensure that conflicting medication order(s)instructions are clarified with the physician before administering medication(s) and administer PC (after meals) and AC (before meals) as ordered.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or Administrator Designee will do a random unannounced review of at least 3 Hospice Residents on hydrocodone pain medication, to ensure that the Hospice Physician order(s) on hydrocodone pain medication, the Medication Administration Record (MAR), Hospice physician's script, and Medication Supplies provided by Hospice match.</p> <p>Monitoring will start on 7/14/2017. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p>		

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

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F 281	Continued From page 9	F 281	The Administrator or Administrator Designee will present to the quarterly QA&A Committee meeting the findings and/or corrective actions taken.		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  (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	F 514	Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	7/17/17	

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F 514	<p>Continued From page 10 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure physician orders were transcribed into the correct resident's clinical record. This was true for 1 of 7 (#2) residents reviewed for complete and accurate clinical records and had the potential for harm if physician orders were implemented with the wrong resident. Findings include:</p> <p>Resident #2 was admitted to the facility on 5/22/09 with diagnoses which included chronic lower extremity venous insufficiency, hypokalemia (low potassium level in the blood), and obesity.</p> <p>Resident #2's most recent quarterly Minimum Data Set (MDS) assessment, dated 4/27/17, documented moderate cognitive impairment.</p> <p>Resident #2's June 2017 Physician Orders directed staff to administer Coumadin, 3 mg, prophylactically (to prevent) for deep vein thrombosis (DVT) daily, initiated 5/31/17.</p> <p>The June 2017 Medication Administration Record [MAR] documented staff were to administer Coumadin (blood thinning medication), 3 mg daily for DVT, dated 5/31/17. Staff initials, logged on 6/1/17 at 5:00 pm, were circled, indicating the</p>	F 514	<p>F- 514 SS= D § 483.70 (i) (1) (5) Res Records-Complete/Accurate/Accessible</p> <p>The facility does ensure that Coumadin physician orders are transcribed into the correct resident's clinical record.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>By 7/10/2017, the Medical Record Director who transcribed the Coumadin on resident #2's clinical record will be provided a 1:1 in-service education by the facility Administrator with regards to F 514 with emphasis on the importance of entering Coumadin physician's order for the correct resident.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of</p>		

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F 514	<p>Continued From page 11</p> <p>medication was not administered. No other initials were noted on the MAR.</p> <p>On 6/14/17 at 2:30 pm, the facility's Corporate Clinical RN (CCRN) and RN #1 stated Resident #2 did not have an order for Coumadin and never received the medication. RN #1 stated she clarified the order with Resident #2's physician. RN #1 stated the Coumadin was ordered for another resident in the facility and was "accidentally" entered into Resident #2's clinical record.</p> <p>On 6/15/17 at 12:20 pm, the Medical Records Director stated Resident #2 did not have an order for Coumadin and noted, "I had a bunch of orders to put in, I guess I just put it in the wrong one (resident's clinical record)."</p>	F 514	<p>deficiencies-form CMS-2567.</p> <p>However, all current Resident(s) may have the potential to be affected by this deficiency, hence to address Resident(s) that may have the potential to be affected by this deficiency the Administrator or Administrator Designee and a License Nurse, by 7/10/2017, will do a one time review of all current Coumadin order(s) to ensure that Coumadin order(s) are transcribed into the correct resident(s) clinical records.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>To ensure that the deficient practice does not recur, By 7/10/2017, the Administrator or Administrator Designee will formulate a "Coumadin Transcription Check Log," for the Medical Record Director to utilized to ensure that Coumadin order(s) are transcribed into the correct resident(s) clinical record.</p> <p>By 7/10/2017, the Administrator or Administrator Designee will In-service the Medical Record Director regarding F 514, on how to utilize and the importance of utilizing the formulated "Coumadin Transcription Check Log," to ensure that Coumadin order(s) are transcribed into the correct resident(s) clinical record.</p>		

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F 514	Continued From page 12	F 514	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or Administrator Designee will do a random unannounced review of at least 3 new Coumadin order(s) by comparing the "Coumadin Transcription Check Log," with the physician order Medication Administration Record (MAR) to ensure that Coumadin order(s) are transcribed into the correct resident(s) clinical record.</p> <p>Monitoring will start on 7/14/2017. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or Administrator Designee will present to the quarterly QA&amp;A Committee meeting the findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>	