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	495318	A. BUILDING _____ B. WING _____	C 01/04/2018

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BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 1/3/18 through 1/4/18. Two complaints were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 86 at the time of the survey. The survey sample consisted of one current resident review (Resident 3) and two closed record reviews (Residents 1 and 2).	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		2/4/18

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

Electronically Signed | 01/26/2018

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to immediately notify the physician of a medication error involving Dilantin for one of three residents in the survey sample (Resident #1). Dosage of the anti-seizure medication Dilantin (Phenytoin) was increased in response to a miscommunicated lab test result. A dosage error with the ordered Dilantin increase discovered on 11/26/17 was not reported to the physician. The	F 580	Resident #1 is no longer a resident of this facility. An audit was completed by the Administrative Nurses (DON, ADON, SDC, QI nurse and/or MDS Nurse) of all resident orders received within the last 30 days for accuracy (orders vs. MAR) and to ensure ordered labs were obtained as ordered. Results of the audit were communicated to the physician. Physician was notified of any errors and orders were	

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F 580	Continued From page 2 continued Dilantin administration caused the resident's Dilantin level to exceed therapeutic levels resulting in hospitalization for treatment of Dilantin toxicity and multiple falls with injury associated with the toxic Dilantin levels (harm). The resident experienced a laceration to his left eyebrow region, ligament injury to the left pinky finger, a laceration to the right middle finger, several bruises/abrasions to his knees and swelling of his face due to repeated falls associated with toxic effects from the high Dilantin levels. The findings include: Resident #1 was admitted to the facility on 11/22/11 and was discharged to the hospital on 11/28/17. Diagnoses for Resident #1 included seizure disorder, intellectual disability, heart failure, functional quadriplegia, cognitive communication deficit, dementia, diabetes and psychosis. The minimum data set (MDS) dated 10/12/17 assessed Resident #1 with moderately impaired cognitive skills. This MDS assessed Resident #1 as always continent of bowel/bladder and to require supervision with set up help only for transfers, dressing and toileting. Resident #1's clinical record documented a physician's order dated 3/3/17 for Dilantin chew 100 mg (milligrams) to be given twice per day and an order dated 3/3/17 for Dilantin chew 50 mg to be given at 2:00 p.m. each day for treatment/prevention of seizures. The record documented a physician's order dated 11/15/17 for a Dilantin level to be obtained on 11/16/17. A lab report dated 11/18/17 documented the resident's Dilantin (free) level on 11/16/17 was	F 580	carried out as received. All Licensed Nurses (RN's and LPN's) were re-educated by Administrative Nurses (DON, ADON, SDC, QI nurse and/or MDS Nurse) on process of transcription of orders and medication error process using Receipt of Physician's orders and Notification of Physician for change in resident's condition and medication error policies. Administrative Nurses (DON, ADON, SDC, QI Nurse and/or MDS Nurse) will review during morning clinical meeting all new orders (medication and labs) and will initial the order slip, to ensure they are transcribed, carried out accurately, labs obtained as ordered and results accurately reported to the physician. To maintain continued compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	

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high at 2.5 mg/L (milligrams per liter) as compared to the reference range of 1.0 to 2.0 mg/L. A nurse documented notification to the physician of the lab results. A telephone order was documented on 11/18/17 increasing Resident #1's Dilantin dosage to 200 mg twice per day and 100 mg at be given at 2:00 p.m. each day in response to the lab test. This order also included instructions to repeat the resident's Dilantin level on 11/24/17.

A nursing note dated 11/18/17 documented, "[Physician] informed of resident Dilantin level 2.5, order given to give Dilantin 200 mg by mouth every morning and every evening and to give 100 mg by mouth at 2 pm daily. Dilantin level to be checked next week, placed in lab book to check 11/24/17."

There was no documentation of any verification or questioning of the physician order obtained on 11/18/17 to increase Resident #1's Dilantin when the lab report stated the resident's Dilantin level was already high.

The order for the increased Dilantin was inaccurately entered on the resident's November 2017 medication administration record (MAR). The order for Dilantin 200 mg twice per day was not added to the MAR until 11/26/17. Resident #1 continued to be administered Dilantin 100 mg twice per day from 11/18/17 through 11/25/17. The resident's 2:00 p.m. dose of Dilantin was increased from 50 mg to 100 mg starting on 11/18/17 as ordered. The twice per day 100 mg doses of Dilantin were stopped on 11/25/17 and starting on 11/26/17 the resident was administered Dilantin 200 mg twice per day. The resident's total daily dose of Dilantin progressed

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as follows: prior to 11/18/17 received 250 mg per day; 11/18/17 through 11/25/17 was given 300 mg per day; 11/26/17 until discharge on 11/28/17 was given 500 mg per day.

There was no notification to the physician concerning Resident #1's Dilantin not administered as ordered when discovered on 11/26/17. The correction was made on the MAR without notification to the physician and the resident was administered a total of 500 mg of Dilantin daily starting on 11/26/17.

The clinical record documented no repeat Dilantin level on 11/24/17 as ordered by the physician. There was no recognition or mention of the missed lab in the clinical record until after the resident's discharge to the hospital on 11/28/17.

The clinical record documented increased falls for Resident #1 in November 2017 as the Dilantin doses increased. The resident had experienced only one prior fall (on 9/9/17) from January through October of 2017. The resident experienced six falls in November 2017 prior to being sent to the emergency room on 11/28/17 following the third fall that day (11/28/17) resulting in a laceration above his left eye. Nursing notes documented the following falls with injuries for Resident #1 during November 2017.

11/7/17 at 6:21 p.m. - "Heard a loud noise, went to check to see, found resident in floor, on knees with bedside table overturned with resident over it...Resident has minor scratch on bridge of nose with minor bleeding from left nostril...Applied Band-Aid to bridge of nose..."

11/23/17 at 7:11 p.m. - "this nurse called to room

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by cna [certified nurses' aide] feeding residents roommate found him [Resident #1] lying on floor beside his bed with his legs over the trash can assessed no injury...assisted back to bed socks removed and skid socks applied."(sic)

11/26/17 at 1:15 p.m. - "heard noise in room....upon entering the room, observed resident lying on the right side at the foot of the bed, in front of w/c [wheelchair]. when asked resident denied falling. laceration noted to right middle finger, cleaned and dressed. no other injuries noted at this time...bruise noted to left hand. able to move wrist and all digits. some edema noted to left hand..."

11/28/17 at 1:42 p.m. - "Was called to residents room and was advised that resident was in floor in the bathroom...resident was sitting in floor in the bathroom with wheelchair sitting at bathroom door. Resident stated that he was attempting to go to the bathroom and got too fast...Resident stated that he was not hurt...No complaint of pain or discomfort..." (sic)

11/28/17 at 4:18 p.m. - "Heard loud noise...resident was sitting in the floor on roommates side of the room. Resident stated that the chair turned around on him and he fell into the floor..." (sic)

11/28/17 at 9:15 p.m. - "Resident found on the floor by CNA, call writer to room. Resident observed on the floor with call bell in hand bleeding from what appears to be left eye. Blood also noted to the back of head. facial swelling noted...resident responsive at time of fall and still responsive when sent to er [emergency room]...Sent to Er for eval [evaluation] per MD

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[physician] order. Resident's third fall of the day..."

Resident #1 was seen by the physician on 11/27/17 for evaluation of the laceration to the right middle finger that occurred on 11/26/17. The physician's note made no mention of the resident's Dilantin dosage. This progress note dated 11/27/17 documented, "I was called over the weekend that [Resident #1] had some falls... He had several additional falls and it was the nurse's opinion that he was putting himself on the floor, not actually falling... Medication administration record is reviewed in chart... Speech is quite garbled. He is generally up in a wheelchair, but has had more falls recently..." The physician's note made no mention of the resident's Dilantin levels, inaccurate Dilantin administration documented on the MAR or the missed Dilantin level lab due on 11/24/17.

The facility's investigation of the Dilantin error was not conducted until after the resident's discharge. The investigation included documentation dated 11/29/17 stating, "On 11/18/17 orders transcribed to MAR incomplete + lab work illegible on labbook no requisition filled out resulted in residents increased impairment + freq [frequent] falls resulted in resident being admitted to hospital." (sic)

A physician's progress note for Resident #1 dated 11/30/17 documented, "I received a call from [director of nursing], informing me that several weeks ago I was called about a lab result. I was told the patient's Dilantin Level was very low and I asked if the patient was actually receiving and taking his prescribed dose of 100 mg bid [twice per day]. She said he was taking it regularly. I

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ordered a significant increase in dose and a follow-up Dilantin level, but the order was not taken off and the lab was not done until the patient went to the hospital ER [emergency room]..."

Resident #1's emergency room report dated 11/28/17 documented the resident was diagnosed upon arrival with Dilantin toxicity due to an abnormally high Dilantin level. The ER report lab report dated 11/28/17 documented Resident #1's Dilantin level as a "critical value" measuring 40.6 ug/mL (micrograms per milliliter) with a reference range of 10.0 to 20.0 ug/mL. The resident was diagnosed with multiple bruises and abrasions in addition to a laceration above his left eye and a laceration to the right middle finger. The ER history and physical report dated 11/28/17 documented, "Pt [patient] arrives to the ED [emergency department] with multiple injuries. Pt has bandaged laceration to the right middle finger. Bruising to the left hand. abrasion under the chin and both knees. Abrasion to the back of the left ear as well as left eye. EMS [emergency medical services] states that nurse states the pts speech is normally slurred however it has worsened tonight...Lab called to report abnormal Dilanton [Dilantin] of 40.6..." The report documented the laceration above the resident's left eye as superficial and measured 1.5 centimeters in length. The note documented the resident had "... a deep abrasion on the right middle finger that appears to be old... also has contusion/hematoma of the entire left hand...is able to make a fist with the right hand and the middle finger flexes against resistance, but there is a deep laceration at the PIP [proximal interphalangeal] joint which extends into the joint capsule and the finger can be hyperextended at

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the PIP joint. The wound will be cleaned, finger splinted and antibiotics given..."

The resident was admitted to the hospital with treatment that included intravenous fluids, antibiotics and withholding all seizure medications along with daily monitoring of Dilantin levels. The laceration above the resident's left eye was cleansed and closed with skin glue. An orthopedic consultation report dated 11/30/17 documented, "evidently was admitted with superficial injuries after reported multiple falls... With these falls, apparently, had some other injuries contusion to his face with a 2 cm laceration to the left lateral eyebrow area that was managed in the emergency room. He also apparently had both knees with abrasions, but function intact...attention to the right hand x-rays demonstrated no acute fracture of the middle finger...The wound was not repaired. It was a traverse laceration approximately of 2 cm across the volar [palm] aspect of the proximal interphalangeal joint... Since the wound is at least a good 48 hours post injury, this will heal secondarily requiring no sutures..."

A physician consultation report dated 12/3/17 documented, "...He [Resident #1] was admitted with falls and several orthopedic injuries. This appears to have been secondary to Dilantin toxicity..." The resident remained hospitalized from 11/28/17 until 12/8/17. The hospital discharge summary dated 12/8/17 listed the resident's primary diagnosis as acute Dilantin toxicity. This summary report documented, "...He [Resident #1] presented to the hospital with reported multiple falls at the local nursing home resulting in multiple abrasions and bruises as well as a 1.5 cm simple laceration to the left lateral

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eye brow region...His Dilantin level was checked and it was found to be significantly elevated at 32 [on 11/29/17] (reference range is 10 - 20)... He was admitted with Dilantin toxicity. His gait instability was likely related to this. Dilantin was discontinued and levels were checked until it trended back close to normal..."

Further review of Resident #1's clinical record revealed no physician's order at the facility for a "free" Dilantin level.

Resident #1's plan of care (revised 7/26/17) documented prior to November the resident required minimal assistance with activities of daily living. This care plan stated the resident had potential for injury due to history of seizures. Interventions for seizure prevention included, "Administer medications as ordered by the physician...Monitor for adverse side effects of medication, i.e., headache, drowsiness, insomnia, anxiety depression, psychosis, blurred vision, diplopia [double vision], dizziness, numbness, ataxia [poor muscle coordination], tremor, nausea, vomiting, diarrhea, gingival hyperplasia, and rash and notify physician for evaluation and intervention...Obtain and monitor serum anticonvulsant medication levels as ordered and notify physician of results..."

The nurse that communicated the resident's Dilantin lab test to the physician on 11/18/17 and inaccurately entered the Dilantin order on the MAR was not available for interview as she no longer worked at the facility.

On 1/3/18 at 2:00 p.m. the licensed practical nurse (LPN #1) that worked on Resident #1's living unit was interviewed. LPN #1 stated

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Resident #1 routinely propelled himself around the facility and was "alert and active." LPN #1 stated prior to November 2017 the resident had no history of frequent falls and the resident was able to make his needs known.

On 1/3/18 at 2:15 p.m. the resident's physician was interviewed about the diagnosed Dilantin toxicity and associated injuries related to increased falls. The physician stated he was called by the nurse working on 11/18/17 and advised that the resident's Dilantin level was 2.5. The physician stated he had ordered a regular Dilantin level and not a "free" Dilantin level. The physician stated the normal range for regular Dilantin was 10 to 20 so he understood the resident's Dilantin level was low. The physician stated he asked the nurse if the resident had been taking his current dose of Dilantin as ordered and the nurse advised that the resident was routinely taking medications as ordered. The physician stated the nurse never told him that the lab result of 2.5 was a "free" Dilantin level so he thought the result was a regular Dilantin level. The physician stated the normal ranges were very different for a "free" Dilantin (1.0 to 2.0) as compared to a regular Dilantin level (10.0 to 20.0). The physician stated he understood the Dilantin level of 2.5 to be very low so he ordered an increase in the Dilantin. The physicians stated, "I doubled what he [Resident #1] was on which was already high." The physician stated there was a miscommunication about the lab result that resulted in the toxicity. When asked if the resident's increased falls in November 2017 were related to the Dilantin toxicity, the physician stated, "That's certainly possible." The physician stated Dilantin toxicity could cause loss of balance and visual changes. The physician

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stated Resident #1 may have not been able to report or verbalize any visual changes associated with the excess Dilantin levels. The physician also stated he had ordered a follow up Dilantin level (due on 11/24/17) and that lab was never done. The physician stated he was not aware of the Dilantin toxicity until the emergency room findings on 11/28/17 were reported to the facility on 11/30/17.

On 1/3/18 at 2:40 p.m. the administrator and director of nursing (DON) were interviewed about the Dilantin error with Resident #1. The administrator stated she was made aware of the Dilantin toxicity when adult protective services came to the facility on 11/30/17 and advised them of the emergency room findings of 11/28/17. The administrator stated the resident did not have a history of frequent falls and the pattern of falls in November 2017 was not typical for Resident #1. The administrator stated when the physician gave the order for the Dilantin level it was entered into the lab system as a "free" Dilantin level instead of a total Dilantin. The administrator stated this nurse also transcribed the Dilantin order of 11/18/17 inaccurately onto the resident's medication administration record. The administrator stated there was miscommunication of the lab result on 11/18/17 with the physician thinking the 2.5 level reported was a total Dilantin level instead of a "free" Dilantin level. The DON stated on 11/26/17 a nurse performing a monthly review of the MAR and physician orders found the Dilantin error listed inaccurately on Resident #1's MAR. The DON stated when this discrepancy was found on 11/26/17 the MAR was corrected and the resident started getting a total of 500 mg of Dilantin per day as originally ordered by the physician on 11/18/17. When asked if the

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BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

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F 580	Continued From page 12	F 580		

physician was notified when this error was found on 11/26/17 so that Dilantin levels could have been re-checked, the DON had no response. Concerning the repeat Dilantin level ordered and scheduled to be done on 11/24/17, the DON stated this lab test was not done. The DON stated it was listed on the lab sheet but the lab employee stated the entry was "illegible" so they did not draw blood or complete the test.

On 1/4/18 at 10:45 a.m. the DON displayed the options in their lab entry system for Dilantin levels. The DON stated there were three options in the computer system for Dilantin. The options included a Dilantin level, Dilantin Free + total and Dilantin Free. The DON stated if a regular Dilantin level was ordered the nurses should have selected option 1 "Dilantin level" and not "Dilantin Free." The DON stated, "There is a big difference in the results."

The facility's undated policy titled Medication Administration stated, "...The attending physician shall be notified immediately of all significant medication errors...No medication shall be administered unless the nurse is familiar with the pharmacology of the drug, its potential toxic effects and contraindications...Any deviation from the following principles shall be considered a medication error...To the right resident...Administration of the right medication...In the right dose...by the right route...By the right method...At the right time..."

The Nursing 2017 Drug Handbook on pages 1171 through 1173 describes Dilantin (Phenytoin) as an anticonvulsant used to prevent and treat seizures. This reference lists adverse effects of Dilantin to include decreased coordination and muscle

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F 580	Continued From page 13 control, mental confusion, slurred speech, dizziness, headache, blurred vision, nausea, vomiting and insomnia. This reference lists nursing considerations for Dilantin administration to include, "Monitor drug level. Therapeutic level of total phenytoin is 10 to 20 mcg/mL [micrograms per milliliter]. The therapeutic range of free phenytoin is 1 to 2 mcg/mL...Alert: Doubling the dose doesn't double the level but may cause toxicity. Consult pharmacist for specific dosing recommendations..." (1) These findings were reviewed with the administrator and DON on 1/4/18 at 10:30 a.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 580		
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	F 657		2/4/18

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F 657	Continued From page 14 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 staff interview, clinical record review and complaint investigation, the facility staff failed to review and revise the comprehensive care plan for one of three residents in the survey sample. Resident #1's plan of care was not reviewed and/or revised with interventions for fall/injury prevention after an increased frequency of falls in November 2017. The findings include: Resident #1 was admitted to the facility on 11/22/11 and was discharged to the hospital on 11/28/17. Diagnoses for Resident #1 included seizure disorder, intellectual disability, heart failure, functional quadriplegia, cognitive communication deficit, dementia, diabetes and psychosis. The minimum data set (MDS) dated 10/12/17 assessed Resident #1 with moderately impaired cognitive skills. This MDS assessed Resident #1 as always continent of bowel/bladder and to require supervision with set up help only for transfers, dressing and toileting. Resident #1's clinical record documented increased falls for Resident #1 in November 2017. The resident had experienced only one	F 657	Resident #1 is no longer a resident of this facility. An audit was completed by the Administrative Nurses (DON, ADON, SDC, QI Nurse and/or MDS Nurse) of all current residents that have had falls during past 30 days to ensure interventions were implemented and are in place; as well as the careplan was reviewed and/or revised for the resident. All Licensed Nurses (RN's and LPN's) were re-educated by Administrative Nurses (DON, ADON, SDC, QI nurse and/or MDS Nurse) on policy of reporting and Investigation of Resident Events and Incidents to include notification of change, intervention implementation and care plan revision The Administrative Clinical Team (to include but not limited to DON, ADON, SDC, QI Nurse and MDS Nurse) will review all falls during morning clinical meeting that occurred since previous meeting using the Incident/Accident Reports Review form to ensure	

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F 657	Continued From page 15 prior fall (on 9/9/17) from January through October of 2017. The resident experienced six falls in November 2017 prior to being sent to the emergency room on 11/28/17 following the third fall that day resulting in a laceration above his left eye. Nursing notes documented the following falls with injuries for Resident #1 during 2017. 9/9/17 - "...heard a bump, entered room observed resident lying face down on floor by his bed. Resident bleeding from head area. Further assessment revealed deep gash from chin, cut on bridge of nose and cut to L [left] eyelid. Cleansed and bandage applied. Transport call for transfer to ER..." 11/7/17 at 6:21 p.m. - "Heard a loud noise, went to check to see, found resident in floor, on knees with bedside table overturned with resident over it...Resident has minor scratch on bridge of nose with minor bleeding from left nostril...Applied Band-Aid to bridge of nose..." 11/23/17 at 7:11 p.m. - "this nurse called to room by cna [certified nurses' aide] feeding residents roommate found him [Resident #1] lying on floor beside his bed with his legs over the trash can assessed no injury...assisted back to bed socks removed and skid socks applied." 11/26/17 at 1:15 p.m. - "heard noise in room....upon entering the room, observed resident lying on the right side at the foot of the bed, in front of w/c [wheelchair]. when asked resident denied falling. laceration noted to right middle finger, cleaned and dressed. no other injuries noted at this time...bruise noted to left hand. able to move wrist and all digits. some edema noted to left hand..."	F 657	interventions were implemented, MD was notified and careplan was reviewed and/or revised for fall/injury prevention. To maintain continued compliance the Quality Improvement (QI) Nurse will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	

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11/28/17 at 1:42 p.m. - "Was called to residents room and was advised that resident was in floor in the bathroom...resident was sitting in floor in the bathroom with wheelchair sitting at bathroom door. Resident stated that he was attempting to go to the bathroom and got too fast...Resident stated that he was not hurt...No complaint of pain or discomfort..." (sic)

11/28/17 at 4:18 p.m. - "Heard loud noise...resident was sitting in the floor on roommates side of the room. Resident stated that the chair turned around on him and he fell into the floor..." (sic)

11/28/17 at 9:15 p.m. - "Resident found on the floor by CNA, call writer to room. Resident observed on the floor with call bell in hand bleeding from what appears to be left eye. Blood also noted to the back of head. facial swelling noted...resident responsive at time of fall and still responsive when sent to er [emergency room]...Sent to Er for eval [evaluation] per MD [physician] order. Resident's third fall of the day..."

Resident #1's plan of care (revised 7/26/17) listed the resident was at risk of falls due to a fall history, unsteady gait, unsteady balance and throwing self in floor for attention seeking. There were no revisions and/or updates to the resident's plan of care following any of the falls in 2017. The care plan made no mention of the resident's actual falls in 2017 or the increased frequency of falls starting in November 2017. Care plan interventions for fall/injury prevention included, analyze previous falls for trends, anti-tippers on wheelchair, non-slip socks, wing mattress, auto

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F 657	Continued From page 17 brakes on wheelchair, low bed, rest periods, rehab if needed, clutter free environment, call bell within reach and non-skid strips in floor by bed. The most recent revision to the fall prevention interventions was dated 9/14/15. On 1/3/18 at 2:40 p.m. the director of nursing (DON) was interviewed about any care plan updates concerning Resident #1's falls during 2017. The DON stated she thought they added non-skid footwear and checking Dilantin levels as interventions. When asked why the care plan had not been revised with interventions for fall/injury prevention, the DON had no response. On 1/4/18 at 10:05 a.m. the administrator was interviewed about Resident #1's care plan. The administrator stated the care plan should be reviewed and updated after any accident. These findings were reviewed with the administrator and director of nursing on 1/4/18 at 10:30 a.m.	F 657		
F 658 SS=G	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 staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to follow professional standards of care for one of three residents in the survey sample (Resident #1).	F 658	Resident #1 is no longer a resident of this facility. The DON and/or ADON will conduct an audit of all labs for the past 30 days to	2/4/18

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F 658	Continued From page 18 A) An abnormal Dilantin level lab result was inaccurately communicated to the physician. Resident #1's daily dosage of the anti-seizure medication Dilantin (Phenytoin) was increased when his levels were already high in response to the miscommunicated lab test result. The increased dosage caused the resident's Dilantin level to exceed therapeutic levels resulting in hospitalization for treatment of Dilantin toxicity and multiple falls with injury associated with the toxic Dilantin levels (harm). The resident experienced a laceration to his left eyebrow region, ligament injury to the left pinky finger, a laceration to the right middle finger, several bruises/abrasions to his knees and swelling of his face due to repeated falls associated with toxic effects from the high Dilantin levels. There was no evidence of any questioning or verification of the order that increased the resident's Dilantin when a lab result indicated Dilantin levels were already high. In addition, the resident's Dilantin order was inaccurately transcribed onto the medication administration record (MAR) resulting in Dilantin administered for eight days not according to the order. B) Nurses also failed to document and communicate a thorough assessment of Resident #1's laceration to his right middle finger at the time of injury on 11/26/17. The laceration was later assessed by the emergency room on 11/28/17 as deep, extending to the joint capsule and as beyond the time frame for sutures. The findings include:	F 658	ensure labs were obtained as ordered and the physician was notified of the results and orders received were relevant related to the lab results. A skin check will be conducted on all residents by the Treatment nurse and/or Administrative Nurses (DON, ADON, SDC, QI nurse and/or MDS Nurse and the physician will be notified of any new areas noted. All orders will be carried out as received. All Licensed Nurses (RN's and LPN's) were re-educated by Administrative Nurses (DON, ADON, SDC, QI nurse and/or MDS Nurse) on accurate notification to MD of lab results and process for MD notification and on completing weekly skin checks and documenting findings. As well as conducting skin checks after an incident and documenting any skin areas descriptively and notifying the doctor of the skin areas. Administrative Nurses (DON, ADON, SDC, QI Nurse and/or MDS Nurse) will review during morning clinical meeting all new orders (medication and labs) and will initial the order slip, to ensure they are transcribed, carried out accurately and labs obtained as ordered. The Administrative Nurses (DON, ADON, SDC, QI Nurse, Treatment Nurse and/or MDS Nurse) will review during morning clinical meeting utilizing the Clinical Meeting form to ensure all skin areas are documented thoroughly. To maintain continued compliance the	

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F 658	Continued From page 19 Resident #1 was admitted to the facility on 11/22/11 and was discharged to the hospital on 11/28/17. Diagnoses for Resident #1 included seizure disorder, intellectual disability, heart failure, functional quadriplegia, cognitive communication deficit, dementia, diabetes and psychosis. The minimum data set (MDS) dated 10/12/17 assessed Resident #1 with moderately impaired cognitive skills. This MDS assessed Resident #1 as always continent of bowel/bladder and to require supervision with set up help only for transfers, dressing and toileting. A) Resident #1's daily dosage of the anti-seizure medication Dilantin (Phenytoin) was increased when his levels were already high in response to a miscommunicated lab test result. The increased dosage caused the resident's Dilantin level to exceed therapeutic levels resulting in hospitalization for treatment of Dilantin toxicity and multiple falls with injury associated with the toxic Dilantin levels (harm). The resident experienced a laceration to his left eyebrow region, ligament injury to the left pinky finger, a laceration to the right middle finger, several bruises/abrasions to his knees and swelling of his face due to repeated falls associated with toxic effects from the high Dilantin levels. There was no evidence of any questioning or verification of the order that increased the resident's Dilantin when the lab result indicated Dilantin levels were already high. In addition, the resident's Dilantin order was inaccurately transcribed onto the medication administration record (MAR) resulting in Dilantin administered for eight days not according to the order.	F 658	ADON and/or Treatment Nurse will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	

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Resident #1's clinical record documented a physician's order dated 3/3/17 for Dilantin chew 100 mg (milligrams) to be given twice per day and an order dated 3/3/17 for Dilantin chew 50 mg to be given at 2:00 p.m. each day for treatment/prevention of seizures. The record documented a physician's order dated 11/15/17 for a Dilantin level to be obtained on 11/16/17.

A lab report dated 11/18/17 documented the resident's Dilantin (free) level on 11/16/17 was high at 2.5 mg/L (milligrams per liter) as compared to the reference range of 1.0 to 2.0 mg/L. A nurse documented notification to the physician of the lab results. A telephone order was documented on 11/18/17 increasing Resident #1's Dilantin dosage to 200 mg twice per day and 100 mg at be given at 2:00 p.m. each day in response to the lab test. This order also included instructions to repeat the resident's Dilantin level on 11/24/17.

A nursing note dated 11/18/17 documented, "[Physician] informed of resident Dilantin level 2.5, order given to give Dilantin 200 mg by mouth every morning and every evening and to give 100 mg by mouth at 2 pm daily. Dilantin level to be checked next week, placed in lab book to check 11/24/17."

The order for the increased Dilantin doses was inaccurately entered on the resident's November 2017 medication administration record (MAR). The order for Dilantin 200 mg twice per day was not added to the MAR until 11/26/17. Resident #1 continued to be administered Dilantin 100 mg twice per day from 11/18/17 through 11/25/17. The resident's 2:00 p.m. dose of Dilantin was increased from 50 mg to 100 mg starting on

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11/18/17 as ordered. The twice per day 100 mg doses of Dilantin were stopped on 11/25/17 and starting on 11/26/17 the resident was administered Dilantin 200 mg twice per day. The resident's total daily dose of Dilantin progressed as follows: prior to 11/18/17 received 250 mg per day; 11/18/17 through 11/25/17 was given 300 mg per day; 11/26/17 until discharge on 11/28/17 was given 500 mg per day.

The clinical record documented no repeat Dilantin level on 11/24/17 as ordered by the physician.

The clinical record documented increased falls for Resident #1 in November 2017 as the Dilantin doses increased. The resident had only one prior fall (on 9/9/17) from January through October of 2017. The resident experienced six falls in November 2017 prior to being sent to the emergency room on 11/28/17 following the third fall that day (11/28/17) resulting in a laceration above his left eye. Nursing notes documented the following falls with injuries for Resident #1 during November 2017.

11/7/17 at 6:21 p.m. - "Heard a loud noise, went to check to see, found resident in floor, on knees with bedside table overturned with resident over it...Resident has minor scratch on bridge of nose with minor bleeding from left nostril...Applied Band-Aid to bridge of nose..."

11/23/17 at 7:11 p.m. - "this nurse called to room by cna [certified nurses' aide] feeding residents roommate found him [Resident #1] lying on floor beside his bed with his legs over the trash can assessed no injury...assisted back to bed socks removed and skid socks applied."

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11/26/17 at 1:15 p.m. - "heard noise in room....upon entering the room, observed resident lying on the right side at the foot of the bed, in front of w/c [wheelchair]. when asked resident denied falling. laceration noted to right middle finger, cleaned and dressed. no other injuries noted at this time...bruise noted to left hand. able to move wrist and all digits. some edema noted to left hand..."

11/28/17 at 1:42 p.m. - "Was called to residents room and was advised that resident was in floor in the bathroom...resident was sitting in floor in the bathroom with wheelchair sitting at bathroom door. Resident stated that he was attempting to go to the bathroom and got too fast...Resident stated that he was not hurt...No complaint of pain or discomfort..." (sic)

11/28/17 at 4:18 p.m. - "Heard loud noise...resident was sitting in the floor on roommates side of the room. Resident stated that the chair turned around on him and he fell into the floor..." (sic)

11/28/17 at 9:15 p.m. - "Resident found on the floor by CNA, call writer to room. Resident observed on the floor with call bell in hand bleeding from what appears to be left eye. Blood also noted to the back of head. facial swelling noted...resident responsive at time of fall and still responsive when sent to er [emergency room]...Sent to Er for eval [evaluation] per MD [physician] order. Resident's third fall of the day..."

Resident #1 was seen by the physician on 11/27/17 for evaluation of the laceration to the right middle finger that occurred on 11/26/17 and

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the physician's note made no mention of the resident's Dilantin dosage. This progress note dated 11/27/17 documented, "I was called over the weekend that [Resident #1] had some falls... He had several additional falls and it was the nurse's opinion that he was putting himself on the floor, not actually falling...Medication administration record is reviewed in chart...Speech is quite garbled. He is generally up in a wheelchair, but has had more falls recently..." The physician's note made no mention of the resident's Dilantin levels, inaccurate Dilantin entry on the MAR or the missed Dilantin level lab due on 11/24/17.

The facility's investigation of the Dilantin error was not conducted until after the resident's discharge. The investigation included documentation dated 11/29/17 stating, "On 11/18/17 orders transcribed to MAR incomplete + lab work illegible on labbook no requisition filled out resulted in residents increased impairment + freq [frequent] falls resulted in resident being admitted to hospital." (sic)

A physician's progress note for Resident #1 dated 11/30/17 documented, "I received a call from [director of nursing], informing me that several weeks ago I was called about a lab result. I was told the patient's Dilantin Level was very low and I asked if the patient was actually receiving and taking his prescribed dose of 100 mg bid [twice per day]. She said he was taking it regularly. I ordered a significant increase in dose and a follow-up Dilantin level, but the order was not taken off and the lab was not done until the patient went to the hospital ER [emergency room]..."

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BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

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Resident #1's emergency room report dated 11/28/17 documented the resident was diagnosed upon arrival with Dilantin toxicity due to an abnormally high Dilantin level. The ER report lab report dated 11/28/17 documented Resident #1's Dilantin level as a "critical value" measuring 40.6 ug/mL (micrograms per milliliter) with a reference range of 10.0 to 20.0 ug/mL. The resident was diagnosed with multiple bruises and abrasions in addition to a laceration above his left eye and a laceration to the right middle finger. The ER history and physical report dated 11/28/17 documented, "Pt [patient] arrives to the ED [emergency department] with multiple injuries. Pt has bandaged laceration to the right middle finger. Bruising to the left hand. abrasion under the chin and both knees. Abrasion to the back of the left ear as well as left eye. EMS [emergency medical services] states that nurse states the pts speech is normally slurred however it has worsened tonight...Lab called to report abnormal Dilanton [Dilantin] of 40.6..." The report documented the laceration above the resident's left eye as superficial and measured 1.5 centimeters in length. The note documented the resident had "... a deep abrasion on the right middle finger that appears to be old... also has contusion/hematoma of the entire left hand...is able to make a fist with the right hand and the middle finger flexes against resistance, but there is a deep laceration at the PIP [proximal interphalangeal] joint which extends into the joint capsule and the finger can be hyperextended at the PIP joint. The wound will be cleaned, finger splinted and antibiotics given..."

The resident was admitted to the hospital with treatment that included intravenous fluids, antibiotics, withholding all seizure medications

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along with daily monitoring of Dilantin levels. The laceration above the resident's left eye was cleansed and closed with skin glue. An orthopedic consultation report dated 11/30/17 documented, "evidently was admitted with superficial injuries after reported multiple falls... With these falls, apparently, had some other injuries contusion to his face with a 2 cm laceration to the left lateral eyebrow area that was managed in the emergency room. He also apparently had both knees with abrasions, but function intact...attention to the right hand x-rays demonstrated no acute fracture of the middle finger...The wound was not repaired. It was a traverse laceration approximately of 2 cm across the volar [palm] aspect of the proximal interphalangeal joint... Since the wound is at least a good 48 hours post injury, this will heal secondarily requiring no sutures..."

A physician consultation report dated 12/3/17 documented, "...He [Resident #1] was admitted with falls and several orthopedic injuries. This appears to have been secondary to Dilantin toxicity..." The resident remained hospitalized from 11/28/17 until 12/8/17. The hospital discharge summary dated 12/8/17 listed the resident's primary diagnosis as acute Dilantin toxicity. This summary report documented, "...He [Resident #1] presented to the hospital with reported multiple falls at the local nursing home resulting in multiple abrasions and bruises as well as a 1.5 cm simple laceration to the left lateral eye brow region... His Dilantin level was checked and it was found to be significantly elevated at 32 [on 11/29/17] (reference range is 10 - 20)... He was admitted with Dilantin toxicity. His gait instability was likely related to this. Dilantin was discontinued and levels were checked until it

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trended back close to normal..."

Further review of Resident #1's clinical record revealed no physician's order at the facility for a "free" Dilantin level.

Resident #1's plan of care (revised 7/26/17) documented prior to November the resident required minimal assistance with activities of daily living. This care plan stated the resident had potential for injury due to history of seizures. Interventions for seizure prevention included, "Administer medications as ordered by the physician...Monitor for adverse side effects of medication, i.e., headache, drowsiness, insomnia, anxiety depression, psychosis, blurred vision, diplopia [double vision], dizziness, numbness, ataxia [poor muscle coordination], tremor, nausea, vomiting, diarrhea, gingival hyperplasia, and rash and notify physician for evaluation and intervention...Obtain and monitor serum anticonvulsant medication levels as ordered and notify physician of results..."

The nurse that communicated the resident's Dilantin lab test to the physician on 11/18/17 and inaccurately entered the Dilantin order on the MAR was not available for interview as she no longer worked at the facility.

On 1/3/18 at 2:00 p.m. the licensed practical nurse (LPN #1) that worked on Resident #1's living unit was interviewed. LPN #1 stated Resident #1 routinely propelled himself around the facility and was "alert and active." LPN #1 stated prior to November 2017 the resident had no history of frequent falls and the resident was able to make his needs known.

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On 1/3/18 at 2:15 p.m. the resident's physician was interviewed about the diagnosed Dilantin toxicity and associated injuries related to increased falls. The physician stated he was called by the nurse working on 11/18/17 and advised that the resident's Dilantin level was 2.5. The physician stated he had ordered a regular Dilantin level and not a "free" Dilantin level. The physician stated the normal range for regular Dilantin was 10 to 20 so he understood the resident's Dilantin level was low. The physician stated he asked the nurse if the resident had been taking his current dose of Dilantin as ordered and the nurse advised that the resident was routinely taking medications as ordered. The physician stated the nurse never told him that the lab result of 2.5 was a "free" Dilantin level so he thought the result was a regular Dilantin level. The physician stated the normal ranges were very different for a "free" Dilantin (1.0 to 2.0) as compared to a regular Dilantin level (10.0 to 20.0). The physician stated he understood the Dilantin level of 2.5 to be very low so he ordered an increase in the Dilantin. The physicians stated, "I doubled what he [Resident #1] was on which was already high." The physician stated there was a miscommunication about the lab result that resulted in the toxicity. When asked if the resident's increased falls in November 2017 were related to the Dilantin toxicity, the physician stated, "That's certainly possible." The physician stated Dilantin toxicity could cause loss of balance and visual changes. The physician stated Resident #1 may have not been able to report or verbalize any visual changes associated with the excess Dilantin levels. The physician also stated he had ordered a follow up Dilantin level (due on 11/24/17) and that lab was never done. The physicians stated he was not aware of

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the Dilantin toxicity until the emergency room findings on 11/28/17 were reported to the facility on 11/30/17.

On 1/3/18 at 2:40 p.m. the administrator and director of nursing (DON) were interviewed about the Dilantin error with Resident #1. The administrator stated she was made aware of the Dilantin toxicity when adult protective services came to the facility on 11/30/17 and advised them of the emergency room findings of 11/28/17. The administrator stated the resident did not have a history of frequent falls and the pattern of falls in November 2017 was not typical for Resident #1. The administrator stated when the physician gave the order for the Dilantin level it was entered into the lab system as a "free" Dilantin level instead of a total Dilantin. The administrator stated this nurse also transcribed the Dilantin order of 11/18/17 inaccurately onto the resident's medication administration record. The administrator stated there was miscommunication of the lab result on 11/18/17 with the physician thinking the 2.5 level reported was a total Dilantin level instead of a "free" Dilantin level. The DON stated on 11/26/17 a nurse performing a monthly review of the MAR and physician orders found the Dilantin error listed inaccurately on Resident #1's MAR. The DON stated when this discrepancy was found on 11/26/17 the MAR was corrected and the resident started getting a total of 500 mg of Dilantin per day as originally ordered by the physician on 11/18/17. When asked if the physician was notified when this error was found on 11/26/17 so that Dilantin levels could have been re-checked, the DON had no response. Concerning the repeat Dilantin level ordered and scheduled to be done on 11/24/17, the DON stated this lab test was not done. The DON

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stated it was listed on the lab sheet but the lab employees stated the entry was "illegible" so they did not draw blood or complete the test.

On 1/4/18 at 10:45 a.m. the DON displayed the options in their lab entry system for Dilantin levels. The DON stated there were three options in the computer system for Dilantin. The options included a Dilantin level, Dilantin Free + total and Dilantin Free. The DON stated if a regular Dilantin level was ordered the nurses should have selected option 1 "Dilantin level" and not "Dilantin Free." The DON stated, "There is a big difference in the results."

The facility's undated policy titled Medication Administration stated, "...The attending physician shall be notified immediately of all significant medication errors...No medication shall be administered unless the nurse is familiar with the pharmacology of the drug, its potential toxic effects and contraindications...Any deviation from the following principles shall be considered a medication error...To the right resident...Administration of the right medication...In the right dose...by the right route...By the right method...At the right time..."

The Nursing 2017 Drug Handbook on pages 1171 through 1173 described Dilantin (Phenytoin) as an anticonvulsant used to prevent and treat seizures. This reference lists adverse effects of Dilantin to include decreased coordination and muscle control, mental confusion, slurred speech, dizziness, headache, blurred vision, nausea, vomiting and insomnia. This reference lists nursing considerations for Dilantin administration to include, "Monitor drug level. Therapeutic level of total phenytoin is 10 to 20 mcg/mL

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[micrograms per milliliter]. The therapeutic range of free phenytoin is 1 to 2 mcg/mL...Alert: Doubling the dose doesn't double the level but may cause toxicity. Consult pharmacist for specific dosing recommendations..." (1)

B) Nurses failed to document and communicate a thorough assessment of Resident #1's laceration to his right middle finger at the time of injury. The laceration was assessed by the physician on 11/27/17 as not suitable for sutures because of swelling and risk of infection due to length of time since the actual injury. The laceration was assessed at the emergency room on 11/28/17 as deep, extending to the joint capsule and as beyond the time frame for sutures.

Resident #1's clinical record documented a nursing note dated 11/26/17 at 1:15 p.m. stating, "heard noise in room....upon entering the room, observed resident lying on the right side at the foot of the bed, in front of w/c [wheelchair]. when asked resident denied falling. laceration noted to right middle finger, cleaned and dressed. no other injuries noted at this time...bruise noted to left hand. able to move wrist and all digits. some edema noted to left hand..." The note stated the physician and responsible party were notified.

There was no documented assessment of the finger laceration in Resident #1's clinical record other than "laceration noted to right middle finger." The nursing notes and fall incident report dated 11/26/17 documented no description indicating the exact location, length, depth or appearance of the laceration. The fall incident report dated 11/26/17 documented only, "laceration noted on right middle finger..." A skin

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condition flowsheet dated 11/27/17 documented, "resident has a laceration noted to the right third finger." This assessment sheet documented no exact location, length, depth, appearance or description of the cut.

A physician's progress note dated 11/27/17 documented the resident had a laceration to the palm surface of the right middle finger that had been previously dressed by nursing. This note stated, "There is a laceration transversely across the palmar surface of the proximal phalanx. There is no active bleeding or drainage. The margins are separated a few mm [millimeters] due to the swelling, but no surrounding redness or sign of infection... As swelling developed the margins have separated, but were not seen under the dressing. It does not appear to be infected yet, but likely will be infected and beyond the time frame for suturing..."

The resident was sent to the emergency room (ER) on 11/28/17 following multiple falls. The ER report dated 111/28/17 documented, "...has a deep abrasion on the right middle finger that appears to be old... is able to make a fist with the right hand and the middle finger flexes against resistance, but there is a deep laceration at the PIP [proximal interphalangeal] joint which extends into the joint capsule and the finger can be hyperextended at the PIP joint. The wound will be cleaned, finger splinted and antibiotics given..." An orthopedic report dated 11/30/17 documented, "...a transverse laceration approximately of 2 cm [centimeters] across the volar [palm] aspect of the proximal interphalangeal joint...Since the wound is at least a good 48 hours post injury, this will heal secondarily requiring no sutures..."

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On 1/3/18 at 2:15 p.m. the resident's physician was interviewed about Resident #1's right middle finger laceration. The physician stated a nurse called him and advised him the resident cut his finger during a fall on 11/26/17. The physician stated he was not made aware of the degree or depth of the laceration. The physician stated when he evaluated the laceration the next day on 11/27/17 the edges of the wound were separated and swelling was present. The physician stated since the laceration was a day old it was too late to put in sutures due to a risk for infection.

On 1/3/18 at 2:40 p.m. the director of nursing (DON) was interviewed about a documented, thorough assessment of Resident #1's finger laceration. The DON reviewed the nursing note and wound treatment record and stated there was no documentation describing the laceration other than it was on the right middle finger. The DON stated a thorough description of the laceration should have been included in the clinical record, on the wound flow sheet and communicated to the physician at the time of the injury. The DON stated the depth, length and extent of Resident #1's right middle finger laceration was not known by what was documented in the notes.

The nurse caring for Resident #1 on 11/26/17 at the time of the injury was not available for interview as she no longer worked at the facility.

The Lippincott Manual of Nursing Practice 10th edition states on pages 16 and 17 concerning standards of care, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care

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F 658	Continued From page 33 provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events...Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered, and follow physician's orders that should have been question or not followed, such as orders containing medication dosage errors." (2) These findings were reviewed with the administrator and DON on 1/4/18 at 10:30 a.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017. (2) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		2/4/18

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F 689	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to implement interventions for fall/injury prevention for one of three residents in the survey sample. Resident #1 had no interventions implemented to ensure safety and promote fall/injury prevention after multiple falls in the facility. The findings include: Resident #1 was admitted to the facility on 11/22/11 and was discharged to the hospital on 11/28/17. Diagnoses for Resident #1 included seizure disorder, intellectual disability, heart failure, functional quadriplegia, cognitive communication deficit, dementia, diabetes and psychosis. The minimum data set (MDS) dated 10/12/17 assessed Resident #1 with moderately impaired cognitive skills. This MDS assessed Resident #1 as always continent of bowel/bladder and to require supervision with set up help only for transfers, dressing and toileting. Resident #1's clinical record documented increased falls starting in November 2017. The resident had only one prior fall (on 9/9/17) from January through October of 2017. The resident experienced six falls in November 2017 prior to being sent to the emergency room on 11/28/17 following the third fall that day (11/28/17) resulting in a laceration above his left eye. Nursing notes documented the following falls with injuries for Resident #1 during 2017. 9/9/17 - "...heard a bump, entered room observed resident lying face down on floor by his bed.	F 689	Resident #1 is no longer a resident of this facility. An audit was completed by the Administrative Nurses (DON, ADON, SDC, QI Nurse and/or MDS Nurse) of all current residents that have had falls during past 30 days to ensure interventions were implemented and are in place; as well as the careplan was reviewed and/or revised for the resident. All Licensed Nurses (RN's and LPN's) were re-educated by Administrative Nurses (DON, ADON, SDC, QI nurse and/or MDS Nurse) on policy of reporting and Investigation of Resident Events and Incidents to include notification of change, intervention implementation and care plan revision The Administrative Clinical Team (to include but not limited to DON, ADON, SDC, QI Nurse and MDS Nurse) will review all falls during morning clinical meeting that occurred since previous meeting using the Incident/Accident Reports Review form to ensure interventions were implemented, MD was notified and careplan was reviewed and/or revised for fall/injury prevention. To maintain continued compliance the Quality Improvement (QI) Nurse will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and	

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F 689	Continued From page 35 Resident bleeding from head area. Further assessment revealed deep gash from chin, cut on bridge of nose and cut to L [left] eyelid. Cleansed and bandage applied. Transport call for transfer to ER..." 11/7/17 at 6:21 p.m. - "Heard a loud noise, went to check to see, found resident in floor, on knees with bedside table overturned with resident over it...Resident has minor scratch on bridge of nose with minor bleeding from left nostril...Applied Band-Aid to bridge of nose..." 11/23/17 at 7:11 p.m. - "this nurse called to room by cna [certified nurses' aide] feeding residents roommate found him [Resident #1] lying on floor beside his bed with his legs over the trash can assessed no injury...assisted back to bed socks removed and skid socks applied." 11/26/17 at 1:15 p.m. - "heard noise in room....upon entering the room, observed resident lying on the right side at the foot of the bed, in front of w/c [wheelchair]. when asked resident denied falling. laceration noted to right middle finger, cleaned and dressed. no other injuries noted at this time...bruise noted to left hand. able to move wrist and all digits. some edema noted to left hand..." 11/28/17 at 1:42 p.m. - "Was called to residents room and was advised that resident was in floor in the bathroom...resident was sitting in floor in the bathroom with wheelchair sitting at bathroom door. Resident stated that he was attempting to go to the bathroom and got too fast...Resident stated that he was not hurt...No complaint of pain or discomfort..." (sic)	F 689	corrective action taken.	

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11/28/17 at 4:18 p.m. - "Heard loud noise...resident was sitting in the floor on roommates side of the room. Resident stated that the chair turned around on him and he fell into the floor..." (sic)

11/28/17 at 9:15 p.m. - "Resident found on the floor by CNA, call writer to room. Resident observed on the floor with call bell in hand bleeding from what appears to be left eye. Blood also noted to the back of head. facial swelling noted...resident responsive at time of fall and still responsive when sent to er [emergency room]...Sent to Er for eval [evaluation] per MD [physician] order. Resident's third fall of the day..."

Resident #1's plan of care (revised 7/26/17) listed the resident was at risk of falls due to a fall history, unsteady gait, unsteady balance and throwing self in floor for attention seeking. There were no revisions and/or updates to the resident's plan of care following any of the falls in 2017. The care plan made no mention of the resident's actual falls in 2017 or the increased frequency of falls starting in November 2017. Care plan interventions for fall/injury prevention included, analyze previous falls for trends, anti-tipper on wheelchair, non-slip socks, wing mattress, auto brake system on wheelchair, low bed, rest periods, rehab if needed, clutter free environment, call bell within reach and non-skid strips in floor by bed. The most recent revision to the fall prevention interventions was dated 9/14/15.

Fall/incident reports for each of the above falls were reviewed. The fall report dated 11/7/17 documented a safety discussion with the resident

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about going to bed when tired and stated, "will also discuss ordering a new Dilantin level..." The report dated 11/23/17 stated socks were removed and non-skid socks applied. The resident's care plan prior to the fall listed the resident was supposed to have on non-skid socks. The report dated 11/26/17 documented a urinalysis was done due to increased confusion. The fall reports dated 11/28/17 at 1:22 p.m. and 11/28/17 at 4:02 p.m. documented the resident was re-educated about using the locks on the wheelchair. The resident's care plan prior to the fall documented the resident was supposed to have a wheelchair with an "auto" brake system. There was no mention about the care plan interventions found not in use at the time of the falls (non-skid socks, wheelchair with auto lock brakes) and there were no other interventions listed or implemented following the resident's falls.

On 1/3/18 at 2:40 p.m. the director of nursing (DON) was interviewed about any interventions implemented to promote safety for Resident #1 after the actual falls. The DON stated she thought they added non-skid footwear and checked the resident's Dilantin level as interventions. When asked about any increased supervision or other interventions to prevent Resident #1 from falls/injury the DON had no response.

On 1/4/18 at 10:05 a.m. the administrator was interviewed about Resident #1's falls and lack of interventions. The administrator stated the care plan should be reviewed and updated after any accident.

These findings were reviewed with the administrator and director of nursing on 1/4/18 at

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F 689	Continued From page 38 10:30 a.m.	F 689		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to ensure one of three residents in the survey sample was free from a significant medication error (Resident #1). Resident #1's daily dosage of the anti-seizure medication Dilantin (Phenytoin) was increased when his Dilantin levels were already high in response to a miscommunicated lab test result. The increased dosage caused the resident's Dilantin level to exceed therapeutic levels resulting in hospitalization for treatment of Dilantin toxicity and multiple falls with injury associated with the toxic Dilantin levels (harm). The resident experienced a laceration to his left eyebrow region, ligament injury to the left pinky finger, a laceration to the right middle finger, several bruises/abrasions to his knees and swelling of his face due to repeated falls associated with toxic effects from the high Dilantin levels. The findings include: Resident #1 was admitted to the facility on 11/22/11 and was discharged to the hospital on 11/28/17. Diagnoses for Resident #1 included seizure disorder, intellectual disability, heart	F 760	Resident #1 is no longer a resident of this facility. An audit was completed by the Administrative Nurses (DON, ADON, SDC, QI nurse and/or MDS Nurse) of all resident orders received within the last 30 days for accuracy (orders vs. MAR) and to ensure ordered labs were obtained as ordered. Results of the audit were communicated to the physician. Physician was notified of any errors and orders were carried out as received. All Licensed Nurses (RN□s and LPN□s) were re-educated by Administrative Nurses (DON, ADON, SDC, QI nurse and/or MDS Nurse) on process of transcription of orders and medication error process using Receipt of Physician's orders and Notification of Physician for change in resident's condition and medication error policies. Administrative Nurses (DON, ADON, SDC, QI Nurse and/or MDS Nurse) will review during morning clinical meeting all new orders (medication and labs) and will initial the order slip, to ensure they are	2/4/18

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F 760	Continued From page 39 failure, functional quadriplegia, cognitive communication deficit, dementia, diabetes and psychosis. The minimum data set (MDS) dated 10/12/17 assessed Resident #1 with moderately impaired cognitive skills. This MDS assessed Resident #1 as always continent of bowel/bladder and to require supervision with set up help only for transfers, dressing and toileting. Resident #1's clinical record documented a physician's order dated 3/3/17 for Dilantin chew 100 mg (milligrams) to be given twice per day and an order dated 3/3/17 for Dilantin chew 50 mg to be given at 2:00 p.m. each day for treatment/prevention of seizures. The record documented a physician's order dated 11/15/17 for a Dilantin level to be obtained on 11/16/17. A lab report dated 11/18/17 documented the resident's Dilantin (free) level on 11/16/17 was high at 2.5 mg/L (milligrams per liter) as compared to the reference range of 1.0 to 2.0 mg/L. A nurse documented notification to the physician of the lab results. A telephone order was documented on 11/18/17 increasing Resident #1's Dilantin dosage to 200 mg twice per day and 100 mg at be given at 2:00 p.m. each day in response to the lab test. This order also included instructions to repeat the resident's Dilantin level on 11/24/17. A nursing note dated 11/18/17 documented, "[Physician] informed of resident Dilantin level 2.5, order given to give Dilantin 200 mg by mouth every morning and every evening and to give 100 mg by mouth at 2 pm daily. Dilantin level to be checked next week, placed in lab book to check 11/24/17."	F 760	transcribed, carried out accurately, labs obtained as ordered and results accurately reported to the physician. To maintain continued compliance the DON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	

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The order for the increased Dilantin doses was inaccurately entered on the resident's November 2017 medication administration record (MAR). The order for Dilantin 200 mg twice per day was not added to the MAR until 11/26/17. Resident #1 continued to be administered Dilantin 100 mg twice per day from 11/18/17 through 11/25/17. The resident's 2:00 p.m. dose of Dilantin was increased from 50 mg to 100 mg starting on 11/18/17 as ordered. The twice per day 100 mg doses of Dilantin were stopped on 11/25/17 and starting on 11/26/17 the resident was administered Dilantin 200 mg twice per day. The resident's total daily dose of Dilantin progressed as follows: prior to 11/18/17 received 250 mg per day; 11/18/17 through 11/25/17 was given 300 mg per day; 11/26/17 until discharge on 11/28/17 was given 500 mg per day.

The clinical record documented no repeat Dilantin level on 11/24/17 as ordered by the physician.

The clinical record documented increased falls for Resident #1 in November 2017 as the Dilantin doses increased. The resident had only one prior fall (on 9/9/17) from January through October of 2017. The resident experienced six falls in November 2017 prior to being sent to the emergency room on 11/28/17 following the third fall that day resulting in a laceration above his left eye. Nursing notes documented the following falls with injuries for Resident #1 during November 2017.

11/7/17 at 6:21 p.m. - "Heard a loud noise, went to check to see, found resident in floor, on knees with bedside table overturned with resident over it...Resident has minor scratch on bridge of nose with minor bleeding from left nostril...Applied

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Band-Aid to bridge of nose..."

11/23/17 at 7:11 p.m. - "this nurse called to room by cna [certified nurses' aide] feeding residents roommate found him [Resident #1] lying on floor beside his bed with his legs over the trash can assessed no injury...assisted back to bed socks removed and skid socks applied."

11/26/17 at 1:15 p.m. - "heard noise in room....upon entering the room, observed resident lying on the right side at the foot of the bed, in front of w/c [wheelchair]. when asked resident denied falling. laceration noted to right middle finger, cleaned and dressed. no other injuries noted at this time...bruise noted to left hand. able to move wrist and all digits. some edema noted to left hand..."

11/28/17 at 1:42 p.m. - "Was called to residents room and was advised that resident was in floor in the bathroom...resident was sitting in floor in the bathroom with wheelchair sitting at bathroom door. Resident stated that he was attempting to go to the bathroom and got too fast...Resident stated that he was not hurt...No complaint of pain or discomfort..." (sic)

11/28/17 at 4:18 p.m. - "Heard loud noise...resident was sitting in the floor on roommates side of the room. Resident stated that the chair turned around on him and he fell into the floor..." (sic)

11/28/17 at 9:15 p.m. - "Resident found on the floor by CNA, call writer to room. Resident observed on the floor with call bell in hand bleeding from what appears to be left eye. Blood also noted to the back of head. facial swelling

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noted...resident responsive at time of fall and still responsive when sent to er [emergency room]...Sent to Er for eval [evaluation] per MD [physician] order. Resident's third fall of the day..."

Resident #1 was seen by the physician on 11/27/17 for evaluation of the laceration to the right middle finger that occurred on 11/26/17 and the physician's note made no mention of the resident's Dilantin dosage. This progress note dated 11/27/17 documented, "I was called over the weekend that [Resident #1] had some falls... He had several additional falls and it was the nurse's opinion that he was putting himself on the floor, not actually falling...Medication administration record is reviewed in chart...Speech is quite garbled. He is generally up in a wheelchair, but has had more falls recently..." The physician's note made no mention of the resident's Dilantin levels, inaccurate Dilantin entry on the MAR or the missed Dilantin level lab due on 11/24/17.

The facility's investigation of the Dilantin error was not conducted until after the resident's discharge. The investigation included documentation dated 11/29/17 stating, "On 11/18/17 orders transcribed to MAR incomplete + lab work illegible on labbook no requisition filled out resulted in residents increased impairment + freq [frequent] falls resulted in resident being admitted to hospital." (sic)

A physician's progress note for Resident #1 dated 11/30/17 documented, "I received a call from [director of nursing], informing me that several weeks ago I was called about a lab result. I was told the patient's Dilantin Level was very low and I

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asked if the patient was actually receiving and taking his prescribed dose of 100 mg bid [twice per day]. She said he was taking it regularly. I ordered a significant increase in dose and a follow-up Dilantin level, but the order was not taken off and the lab was not done until the patient went to the hospital ER [emergency room]..."

Resident #1's emergency room report dated 11/28/17 documented the resident was diagnosed upon arrival with Dilantin toxicity due to an abnormally high Dilantin level. The ER report lab report dated 11/28/17 documented Resident #1's Dilantin level as a "critical value" measuring 40.6 ug/mL (micrograms per milliliter) with a reference range of 10.0 to 20.0 ug/mL. The resident was diagnosed with multiple bruises and abrasions in addition to a laceration above his left eye and a laceration to the right middle finger. The ER history and physical report dated 11/28/17 documented, "Pt [patient] arrives to the ED [emergency department] with multiple injuries. Pt has bandaged laceration to the right middle finger. Bruising to the left hand. abrasion under the chin and both knees. Abrasion to the back of the left ear as well as left eye. EMS [emergency medical services] states that nurse states the pts speech is normally slurred however it has worsened tonight...Lab called to report abnormal Dilanton [Dilantin] of 40.6..." The report documented the laceration above the resident's left eye as superficial and measured 1.5 centimeters in length. The note documented the resident had "... a deep abrasion on the right middle finger that appears to be old... also has contusion/hematoma of the entire left hand...is able to make a fist with the right hand and the middle finger flexes against resistance, but there

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is a deep laceration at the PIP [proximal interphalangeal] joint which extends into the joint capsule and the finger can be hyperextended at the PIP joint. The wound will be cleaned, finger splinted and antibiotics given..."

The resident was admitted to the hospital with treatment that included intravenous fluids, antibiotics, withholding all seizure medications along with daily monitoring of Dilantin levels. The laceration above the resident's left eye was cleansed and closed with skin glue. An orthopedic consultation report dated 11/30/17 documented, "evidently was admitted with superficial injuries after reported multiple falls... With these falls, apparently, had some other injuries contusion to his face with a 2 cm laceration to the left lateral eyebrow area that was managed in the emergency room. He also apparently had both knees with abrasions, but function intact...attention to the right hand x-rays demonstrated no acute fracture of the middle finger...The wound was not repaired. It was a traverse laceration approximately of 2 cm across the volar [palm] aspect of the proximal interphalangeal joint... Since the wound is at least a good 48 hours post injury, this will heal secondarily requiring no sutures..."

A physician consultation report dated 12/3/17 documented, "...He [Resident #1] was admitted with falls and several orthopedic injuries. This appears to have been secondary to Dilantin toxicity..." The resident remained hospitalized from 11/28/17 until 12/8/17. The hospital discharge summary dated 12/8/17 listed the resident's primary diagnosis as acute Dilantin toxicity. This summary report documented, "...He [Resident #1] presented to the hospital with

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reported multiple falls at the local nursing home resulting in multiple abrasions and bruises as well as a 1.5 cm simple laceration to the left lateral eye brow region...His Dilantin level was checked and it was found to be significantly elevated at 32 [on 11/29/17] (reference range is 10 - 20)... He was admitted with Dilantin toxicity. His gait instability was likely related to this. Dilantin was discontinued and levels were checked until it trended back close to normal..."

Further review of Resident #1's clinical record reveal no physician's order for a "free" Dilantin level.

Resident #1's plan of care (revised 7/26/17) documented prior to November the resident required minimal assistance with activities of daily living. This care plan stated the resident had potential for injury due to history of seizures. Interventions for seizure prevention included, "Administer medications as ordered by the physician...Monitor for adverse side effects of medication, i.e., headache, drowsiness, insomnia, anxiety depression, psychosis, blurred vision, diplopia [double vision], dizziness, numbness, ataxia [poor muscle coordination], tremor, nausea, vomiting, diarrhea, gingival hyperplasia, and rash and notify physician for evaluation and intervention...Obtain and monitor serum anticonvulsant medication levels as ordered and notify physician of results..."

The nurse that communicated the resident's Dilantin lab test to the physician on 11/18/17 and inaccurately entered the Dilantin order on the MAR was not available for interview as she no longer worked at the facility.

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On 1/3/18 at 2:00 p.m. the licensed practical nurse (LPN #1) that worked on Resident #1's living unit was interviewed. LPN #1 stated Resident #1 routinely propelled himself around the facility and was "alert and active." LPN #1 stated prior to November 2017 the resident had no history of frequent falls and the resident was able to make his needs known.

On 1/3/18 at 2:15 p.m. the resident's physician was interviewed about the diagnosed Dilantin toxicity and associated injuries related to increased falls. The physician stated he was called by the nurse working on 11/18/17 and advised that the resident's Dilantin level was 2.5. The physician stated he had ordered a regular Dilantin level and not a "free" Dilantin level. The physician stated the normal range for regular Dilantin was 10 to 20 so he understood the resident's Dilantin level was low. The physician stated he asked the nurse if the resident had been taking his current dose of Dilantin as ordered and the nurse advised that the resident was routinely taking medications as ordered. The physician stated the nurse never told him that the lab result of 2.5 was a "free" Dilantin level so he thought the result was a regular Dilantin level. The physician stated the normal ranges were very different for a "free" Dilantin (1.0 to 2.0) as compared to a regular Dilantin level (10.0 to 20.0). The physician stated he understood the Dilantin level of 2.5 to be very low so he ordered an increase in the Dilantin. The physicians stated, "I doubled what he [Resident #1] was on which was already high." The physician stated there was a miscommunication about the lab result that resulted in the toxicity. When asked if the resident's increased falls in November 2017 were related to the Dilantin toxicity, the physician

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stated, "That's certainly possible." The physician stated Dilantin toxicity could cause loss of balance and visual changes. The physician stated Resident #1 may have not been able to report or verbalize any visual changes associated with the excess Dilantin levels. The physician also stated he had ordered a follow up Dilantin level (due on 11/24/17) and that lab was never done. The physicians stated he was not aware of the Dilantin toxicity until the emergency room findings on 11/28/17 were reported to the facility on 11/30/17.

On 1/3/18 at 2:40 p.m. the administrator and director of nursing (DON) were interviewed about the Dilantin error with Resident #1. The administrator stated she was made aware of the Dilantin toxicity when adult protective services came to the facility on 11/30/17 and advised them of the emergency room findings of 11/28/17. The administrator stated the resident did not have a history of frequent falls and the pattern of falls in November 2017 was not typical for Resident #1. The administrator stated when the physician gave the order for the Dilantin level it was entered into the lab system as a "free" Dilantin level instead of a total Dilantin. The administrator stated this nurse also transcribed the Dilantin order of 11/18/17 wrong onto the resident's medication administration record. The administrator stated there was miscommunication of the lab result on 11/18/17 with the physician thinking the 2.5 level reported was a total Dilantin level instead of a "free" Dilantin level. The DON stated on 11/26/17 a nurse performing a monthly review of the MAR and physician orders found the Dilantin error listed inaccurately on Resident #1's MAR. The DON stated when this discrepancy was found on 11/26/17 the MAR was corrected and the resident

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started getting a total of 500 mg of Dilantin per day as originally ordered by the physician on 11/18/17. When asked if the physician was notified when this error was found on 11/26/17 so that Dilantin levels could have been re-checked, the DON had no response. Concerning the repeat Dilantin level ordered and scheduled to be done on 11/24/17, the DON stated this lab test was not done. The DON stated it was listed on the lab sheet but the lab employees stated the entry was "illegible" so they did not draw blood or complete the test.

On 1/4/18 at 10:45 a.m. the DON displayed the options in their lab entry system for Dilantin levels. The DON stated there were three options in the computer system for Dilantin. The options included a Dilantin level, Dilantin Free + total and Dilantin Free. The DON stated if a regular Dilantin level was ordered the nurses should have selected option 1 "Dilantin level" and not "Dilantin Free." The DON stated, "There is a big difference in the results."

The facility's undated policy titled Medication Administration stated, "...The attending physician shall be notified immediately of all significant medication errors...No medication shall be administered unless the nurse is familiar with the pharmacology of the drug, its potential toxic effects and contraindications...Any deviation from the following principles shall be considered a medication error...To the right resident...Administration of the right medication...In the right dose...by the right route...By the right method...At the right time..."

The Nursing 2017 Drug Handbook on pages 1171 through 1173 described Dilantin (Phenytoin) as

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F 760	Continued From page 49 an anticonvulsant used to prevent and treat seizures. This reference lists adverse effects of Dilantin to include decreased coordination and muscle control, mental confusion, slurred speech, dizziness, headache, blurred vision, nausea, vomiting and insomnia. This reference lists nursing considerations for Dilantin administration to include, "Monitor drug level. Therapeutic level of total phenytoin is 10 to 20 mcg/mL [micrograms per milliliter]. The therapeutic range of free phenytoin is 1 to 2 mcg/mL...Alert: Doubling the dose doesn't double the level but may cause toxicity. Consult pharmacist for specific dosing recommendations..." (1) These findings were reviewed with the administrator and DON on 1/4/18 at 10:30 a.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 760		
F 770 SS=G	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to obtain	F 770	Resident #1 is no longer a resident of this facility.	2/4/18

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F 770	Continued From page 50 laboratory tests as ordered by the physician for one of three residents in the survey sample (Resident #1). Resident #1 had a free Dilantin level performed when the physician ordered a total Dilantin level. Resident #1's daily dosage of the anti-seizure medication Dilantin (Phenytoin) was increased when his Dilantin levels were already high after the free Dilantin level was miscommunicated to the physician as a total Dilantin level. A follow up Dilantin level ordered by the physician was not obtained. The increased dosage caused the resident's Dilantin level to exceed therapeutic levels resulting in hospitalization for treatment of Dilantin toxicity and multiple falls with injury associated with the toxic Dilantin levels (harm). The resident experienced a laceration to his left eyebrow region, ligament injury to the left pinky finger, a laceration to the right middle finger, several bruises/abrasions to his knees and swelling of his face due to repeated falls associated with toxic effects from the high Dilantin levels. The findings include: Resident #1 was admitted to the facility on 11/22/11 and was discharged to the hospital on 11/28/17. Diagnoses for Resident #1 included seizure disorder, intellectual disability, heart failure, functional quadriplegia, cognitive communication deficit, dementia, diabetes and psychosis. The minimum data set (MDS) dated 10/12/17 assessed Resident #1 with moderately impaired cognitive skills. This MDS assessed Resident #1 as always continent of bowel/bladder and to require supervision with set up help only for transfers, dressing and toileting.	F 770	The DON and/or ADON will conduct an audit of all labs for the past 30 days to ensure labs were obtained as ordered and the physician was notified of the results and orders received were relevant related to the lab results. All Licensed Nurses (RN's and LPN's) were re-educated by Administrative Nurses (DON, ADON, SDC, QI nurse and/or MDS Nurse) on accurate notification to MD of lab results and process for MD notification Administrative Nurses (DON, ADON, SDC, QI Nurse and/or MDS Nurse) will review during morning clinical meeting all new orders (medication and labs) and will initial the order slip, to ensure they are transcribed, carried out accurately and labs obtained as ordered. To maintain continued compliance the ADON will share the results of the audits with the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and corrective action taken.	

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Resident #1's clinical record documented a physician's order dated 3/3/17 for Dilantin chew 100 mg (milligrams) to be given twice per day and an order dated 3/3/17 for Dilantin chew 50 mg to be given at 2:00 p.m. each day for treatment/prevention of seizures. The record documented a physician's order dated 11/15/17 for a Dilantin level to be obtained on 11/16/17.

A lab report dated 11/18/17 documented the resident's Dilantin (free) level on 11/16/17 was high at 2.5 mg/L (milligrams per liter) as compared to the reference range of 1.0 to 2.0 mg/L. A nurse documented notification to the physician of the lab results. A telephone order was documented on 11/18/17 increasing Resident #1's Dilantin dosage to 200 mg twice per day and 100 mg at be given at 2:00 p.m. each day in response to the lab test. This order also included instructions to repeat the resident's Dilantin level on 11/24/17.

A nursing note dated 11/18/17 documented, "[Physician] informed of resident Dilantin level 2.5, order given to give Dilantin 200 mg by mouth every morning and every evening and to give 100 mg by mouth at 2 pm daily. Dilantin level to be checked next week, placed in lab book to check 11/24/17."

The order for the increased Dilantin doses was inaccurately entered on the resident's November 2017 medication administration record (MAR). The order for Dilantin 200 mg twice per day was not added to the MAR until 11/26/17. Resident #1 continued to be administered Dilantin 100 mg twice per day from 11/18/17 through 11/25/17. The resident's 2:00 p.m. dose of Dilantin was

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increased from 50 mg to 100 mg starting on 11/18/17 as ordered. The twice per day 100 mg doses of Dilantin were stopped on 11/25/17 and starting on 11/26/17 the resident was administered Dilantin 200 mg twice per day. The resident's total daily dose of Dilantin progressed as follows: prior to 11/18/17 received 250 mg per day; 11/18/17 through 11/25/17 was given 300 mg per day; 11/26/17 until discharge on 11/28/17 was given 500 mg per day.

The clinical record documented no repeat Dilantin level on 11/24/17 as ordered by the physician.

The clinical record documented increased falls for Resident #1 in November 2017 as the Dilantin doses increased. The resident had experienced only one prior fall (on 9/9/17) from January through October of 2017. The resident experienced six falls in November 2017 prior to being sent to the emergency room on 11/28/17 following the third fall that day (11/28/17) resulting in a laceration above his left eye. Nursing notes documented the following falls with injuries for Resident #1 during November 2017.

11/7/17 at 6:21 p.m. - "Heard a loud noise, went to check to see, found resident in floor, on knees with bedside table overturned with resident over it...Resident has minor scratch on bridge of nose with minor bleeding from left nostril...Applied Band-Aid to bridge of nose..."

11/23/17 at 7:11 p.m. - "this nurse called to room by cna [certified nurses' aide] feeding residents roommate found him [Resident #1] lying on floor beside his bed with his legs over the trash can assessed no injury...assisted back to bed socks removed and skid socks applied." (sic)

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11/26/17 at 1:15 p.m. - "heard noise in room....upon entering the room, observed resident lying on the right side at the foot of the bed, in front of w/c [wheelchair]. when asked resident denied falling. laceration noted to right middle finger, cleaned and dressed. no other injuries noted at this time...bruise noted to left hand. able to move wrist and all digits. some edema noted to left hand..."

11/28/17 at 1:42 p.m. - "Was called to residents room and was advised that resident was in floor in the bathroom...resident was sitting in floor in the bathroom with wheelchair sitting at bathroom door. Resident stated that he was attempting to go to the bathroom and got too fast...Resident stated that he was not hurt...No complaint of pain or discomfort..." (sic)

11/28/17 at 4:18 p.m. - "Heard loud noise...resident was sitting in the floor on roommates side of the room. Resident stated that the chair turned around on him and he fell into the floor..." (sic)

11/28/17 at 9:15 p.m. - "Resident found on the floor by CNA, call writer to room. Resident observed on the floor with call bell in hand bleeding from what appears to be left eye. Blood also noted to the back of head. facial swelling noted...resident responsive at time of fall and still responsive when sent to er [emergency room]...Sent to Er for eval [evaluation] per MD [physician] order. Resident's third fall of the day..."

Resident #1 was seen by the physician on 11/27/17 for evaluation of the laceration to the

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right middle finger that occurred on 11/26/17 and the physician note made no mention of the resident's Dilantin dosage. This progress note dated 11/27/17 documented, "I was called over the weekend that [Resident #1] had some falls... He had several additional falls and it was the nurse's opinion that he was putting himself on the floor, not actually falling...Medication administration record is reviewed in chart...Speech is quite garbled. He is generally up in a wheelchair, but has had more falls recently..." The physician's note made no mention of the resident's Dilantin levels, inaccurate Dilantin entry on the MAR or the missed Dilantin level lab due on 11/24/17.

The facility's investigation of the Dilantin error was not conducted until after the resident's discharge. The investigation included documentation dated 11/29/17 stating, "On 11/18/17 orders transcribed to MAR incomplete + lab work illegible on labbook no requisition filled out resulted in residents increased impairment + freq [frequent] falls resulted in resident being admitted to hospital." (sic)

A physician's progress note for Resident #1 dated 11/30/17 documented, "I received a call from [director of nursing], informing me that several weeks ago I was called about a lab result. I was told the patient's Dilantin Level was very low and I asked if the patient was actually receiving and taking his prescribed dose of 100 mg bid [twice per day]. She said he was taking it regularly. I ordered a significant increase in dose and a follow-up Dilantin level, but the order was not taken off and the lab was not done until the patient went to the hospital ER [emergency room]..."

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Resident #1's emergency room report dated 11/28/17 documented the resident was diagnosed upon arrival with Dilantin toxicity due to an abnormally high Dilantin level. The ER report lab report dated 11/28/17 documented Resident #1's Dilantin level as a "critical value" measuring 40.6 ug/mL (micrograms per milliliter) with a reference range of 10.0 to 20.0 ug/mL. The resident was diagnosed with multiple bruises and abrasions in addition to a laceration above his left eye and a laceration to the right middle finger. The ER history and physical report dated 11/28/17 documented, "Pt [patient] arrives to the ED [emergency department] with multiple injuries. Pt has bandaged laceration to the right middle finger. Bruising to the left hand. abrasion under the chin and both knees. Abrasion to the back of the left ear as well as left eye. EMS [emergency medical services] states that nurse states the pts speech is normally slurred however it has worsened tonight...Lab called to report abnormal Dilanton [Dilantin] of 40.6..." The report documented the laceration above the resident's left eye as superficial and measured 1.5 centimeters in length. The note documented the resident had "... a deep abrasion on the right middle finger that appears to be old... also has contusion/hematoma of the entire left hand...is able to make a fist with the right hand and the middle finger flexes against resistance, but there is a deep laceration at the PIP [proximal interphalangeal] joint which extends into the joint capsule and the finger can be hyperextended at the PIP joint. The wound will be cleaned, finger splinted and antibiotics given..."

The resident was admitted to the hospital with treatment that included intravenous fluids,

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antibiotics, withholding all seizure medications along with daily monitoring of Dilantin levels. The laceration above the resident's left eye was cleansed and closed with skin glue. An orthopedic consultation report dated 11/30/17 documented, "evidently was admitted with superficial injuries after reported multiple falls... With these falls, apparently, had some other injuries contusion to his face with a 2 cm laceration to the left lateral eyebrow area that was managed in the emergency room. He also apparently had both knees with abrasions, but function intact...attention to the right hand x-rays demonstrated no acute fracture of the middle finger...The wound was not repaired. It was a traverse laceration approximately of 2 cm across the volar [palm] aspect of the proximal interphalangeal joint... Since the wound is at least a good 48 hours post injury, this will heal secondarily requiring no sutures..."

A physician consultation report dated 12/3/17 documented, "...He [Resident #1] was admitted with falls and several orthopedic injuries. This appears to have been secondary to Dilantin toxicity..." The resident remained hospitalized from 11/28/17 until 12/8/17. The hospital discharge summary dated 12/8/17 listed the resident's primary diagnosis as acute Dilantin toxicity. This summary report documented, "...He [Resident #1] presented to the hospital with reported multiple falls at the local nursing home resulting in multiple abrasions and bruises as well as a 1.5 cm simple laceration to the left lateral eye brow region...His Dilantin level was checked and it was found to be significantly elevated at 32 [on 11/29/17] (reference range is 10 - 20)... He was admitted with Dilantin toxicity. His gait instability was likely related to this. Dilantin was

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discontinued and levels were checked until it trended back close to normal..."

Further review of Resident #1's clinical record revealed no physician's order for a "free" Dilantin level.

Resident #1's plan of care (revised 7/26/17) documented prior to November the resident required minimal assistance with activities of daily living. This care plan stated the resident had potential for injury due to history of seizures. Interventions for seizure prevention included, "Administer medications as ordered by the physician...Monitor for adverse side effects of medication, i.e., headache, drowsiness, insomnia, anxiety depression, psychosis, blurred vision, diplopia [double vision], dizziness, numbness, ataxia [poor muscle coordination], tremor, nausea, vomiting, diarrhea, gingival hyperplasia, and rash and notify physician for evaluation and intervention...Obtain and monitor serum anticonvulsant medication levels as ordered and notify physician of results..."

The nurse that communicated the resident's Dilantin lab test on 11/18/17 to the physician and inaccurately entered the Dilantin order on the MAR was not available for interview as she no longer worked at the facility.

On 1/3/18 at 2:00 p.m. the licensed practical nurse (LPN #1) that worked on Resident #1's living unit was interviewed. LPN #1 stated Resident #1 routinely propelled himself around the facility and was "alert and active." LPN #1 stated prior to November 2017 the resident had no history of frequent falls and the resident was able to make his needs known.

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On 1/3/18 at 2:15 p.m. the resident's physician was interviewed about the diagnosed Dilantin toxicity and associated injuries related to increased falls. The physician stated he was called by the nurse working on 11/18/17 and advised that the resident's Dilantin level was 2.5. The physician stated he had ordered a regular Dilantin level and not a "free" Dilantin level. The physician stated the normal range for regular Dilantin was 10 to 20 so he understood the resident's Dilantin level was low. The physician stated he asked the nurse if the resident had been taking his current dose of Dilantin as ordered and the nurse advised that the resident was routinely taking medications as ordered. The physician stated the nurse never told him that the lab result of 2.5 was a "free" Dilantin level so he thought the result was a regular Dilantin level. The physician stated the normal ranges were very different for a "free" Dilantin (1.0 to 2.0) as compared to a regular Dilantin level (10.0 to 20.0). The physician stated he understood the Dilantin level of 2.5 to be very low so he ordered an increase in the Dilantin. The physicians stated, "I doubled what he [Resident #1] was on which was already high." The physician stated there was a miscommunication about the lab result that resulted in the toxicity. When asked if the resident's increased falls in November 2017 were related to the Dilantin toxicity, the physician stated, "That's certainly possible." The physician stated Dilantin toxicity could cause loss of balance and visual changes. The physician stated Resident #1 may have not been able to report or verbalize any visual changes associated with the excess Dilantin levels. The physician also stated he had ordered a follow up Dilantin level (due on 11/24/17) and that lab was never

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done. The physicians stated he was not aware of the Dilantin toxicity until the emergency room findings on 11/28/17 were reported to the facility on 11/30/17.

On 1/3/18 at 2:40 p.m. the administrator and director of nursing (DON) were interviewed about the Dilantin error with Resident #1. The administrator stated she was made aware of the Dilantin toxicity when adult protective services came to the facility on 11/30/17 and advised them of the emergency room findings of 11/28/17. The administrator stated the resident did not have a history of frequent falls and the pattern of falls in November 2017 was not typical for Resident #1. The administrator stated when the physician gave the order for the Dilantin level it was entered into the lab system as a "free" Dilantin level instead of a total Dilantin. The administrator stated this nurse also transcribed the Dilantin order of 11/18/17 wrong onto the resident's medication administration record. The administrator stated there was miscommunication of the lab result on 11/18/17 with the physician thinking the 2.5 level reported was a total Dilantin level instead of a "free" Dilantin level. The DON stated on 11/26/17 a nurse performing a monthly review of the MAR and physician orders found the Dilantin error listed inaccurately on Resident #1's MAR. The DON stated when this discrepancy was found on 11/26/17 the MAR was corrected and the resident started getting a total of 500 mg of Dilantin per day as originally ordered by the physician on 11/18/17. When asked if the physician was notified when this error was found on 11/26/17 so that Dilantin levels could have been re-checked, the DON had no response. Concerning the repeat Dilantin level ordered and scheduled to be done on 11/24/17, the DON stated this lab test

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

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was not done. The DON stated it was listed on the lab sheet but the lab employees stated the entry was "illegible" so they did not draw blood or complete the test.

On 1/4/18 at 10:45 a.m. the DON displayed the options in their lab entry system for Dilantin levels. The DON stated there were three options in the computer system for Dilantin. The options included a Dilantin level, Dilantin Free + total and Dilantin Free. The DON stated if a regular Dilantin level was ordered the nurses should have selected option 1 "Dilantin level" and not "Dilantin Free." The DON stated, "There is a big difference in the results."

The facility's undated policy titled Medication Administration stated, "...The attending physician shall be notified immediately of all significant medication errors...No medication shall be administered unless the nurse is familiar with the pharmacology of the drug, its potential toxic effects and contraindications...Any deviation from the following principles shall be considered a medication error...To the right resident...Administration of the right medication...In the right dose...by the right route...By the right method...At the right time..."

The Nursing 2017 Drug Handbook on pages 1171 through 1173 described Dilantin (Phenytoin) as an anticonvulsant used to prevent and treat seizures. This reference lists adverse effects of Dilantin to include decreased coordination and muscle control, mental confusion, slurred speech, dizziness, headache, blurred vision, nausea, vomiting and insomnia. This reference lists nursing considerations for Dilantin administration to include, "Monitor drug level. Therapeutic level

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F 770	Continued From page 61 of total phenytoin is 10 to 20 mcg/mL [micrograms per milliliter]. The therapeutic range of free phenytoin is 1 to 2 mcg/mL...Alert: Doubling the dose doesn't double the level but may cause toxicity. Consult pharmacist for specific dosing recommendations..." (1) These findings were reviewed with the administrator and DON on 1/4/18 at 10:30 a.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 770		