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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted from 1/31/17 through 2/1/17. Three complaints investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 180 certified bed facility was 141 at the time of the survey. The survey sample consisted of 11 current Resident reviews (Residents #1 through #6, #12 through # 15 and #18) and seven closed record reviews (Resident #7 through #11 and #16 through #17).	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (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	F 157		2/21/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/16/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 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 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). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to notify the physician or responsible party (RP) that physician ordered medications were not available for administration for two of 18 residents in the survey sample, Resident #17 and Resident #16. 1. Facility staff failed to notify the physician and the RP that the physician ordered Abilify (1),	F 157	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center�s	

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Baclofen (2), Topamax (3), Vitamin D and Dicyclomine (4) were not available to be given to Resident #17.

2. The facility staff failed to notify the physician when anti-rejection medications were not available for Resident #16.

The findings include:

1. Resident #17 was admitted to the facility on 12/31/16 with diagnoses that included but were not limited to: fractured hip, osteoporosis, urinary retention, history of breast cancer, anemia, high blood pressure, depression and anxiety.

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 1/6/17, coded the resident as being able to understand others and being understood by others. Resident #17 was coded as having periods of inattention that fluctuated. Resident #17 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was independent after set up assistance was provided. In Section I - Active Diagnoses, the resident was not coded as having any infections. The pain assessment in Section J was not completed.

Review of Resident #17's care plan initiated on 1/6/17 documented, "Focus CARE NEEDS. Interventions Notify MD (medical doctor)/RP (responsible party) of significant changes in condition."

Review of the physician's orders dated 12/31/16 documented, "Abilify Tablet 15 MG (milligrams)

F 157

allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

F 157
1. Resident # 17 was discharged on 1/6/17. Resident #16 was discharged on 12/22/16. Pharmacy delivery times were increased from two to three times per day.
2. All residents are at risk. An audit of current resident MARs will be reviewed to identify any medications not administered as ordered due to unavailability. Those found out of compliance will be corrected accordingly.
3. RNs/LPNs will be in-serviced on the procedure to follow when medications are not available, including notification of the responsible party and physician.
RNs/LPNs will also be in-serviced on the use of the Stat box.
4. An audit of 10% of current residents and all new admissions MARs will be completed weekly x 4 weeks and monthly x 2 months to ensure the timely administration of medications ordered by the physician. Those found out of compliance will be corrected and forward to QA committee for further guidance as applicable.

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Give 1 tablet by mouth at bedtime; Baclofen Tablet 10 MG Give 1 tablet by mouth at bedtime; Topamax Tablet 25 MG Give 1 tablet by mouth at bedtime; Vitamin D Tablet Give 400 mg by mouth two times a day. Dicyclomine HCL Table 20 MG Give 0.5 tablet by mouth three times a day."

Review of the December 2016 medication administration record (MAR) documented:
"Abilify Tablet 15 MG (milligrams) Give 1 tablet by mouth at bedtime." On 12/31/16 at 9:00 p.m. there was a "9" and the nurse's initials documented. Review of the chart codes section of the MAR documented, "9=Other/See Progress Notes."
Baclofen Tablet 10 MG Give 1 tablet by mouth at bedtime." On 12/31/16 at 9:00 p.m. there was a "9" and the nurse's initials documented.
"Topamax Tablet 25 MG Give 1 tablet by mouth at bedtime." On 12/31/16 at 9:00 p.m. there was a "9" and the nurse's initials documented.
"Vitamin D Tablet Give 400 mg by mouth two times a day." On 12/31/16 at 4:00 p.m. there was a "9" and the nurse's initials documented.
"Dicyclomine HCL Table 20 MG Give 0.5 tablet by mouth three times a day." On 12/31/16 at 4:00 p.m. there was a "9" and the nurse's initials documented.

Review of the nurse's notes for 12/31/16 documented:
"18:19 (6:19 p.m.) Vitamin D Tablet....On order."
"20:50 (8:50 p.m.) Abilify Tablet 15 MG....Drug ordered."
"20:51 (8:51 p.m.) Baclofen Tablet 10 MG...Drug on order."
"20:51 Dicyclomine HCL Tablet 20 MG...Drug on order."
"20:52 (8:52 p.m.) Topamax Tablet 25 MG...Drug

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on order."

Further review of the nurse's notes did not evidence documentation that the physician or RP had been notified that the above medications were not given.

An interview was conducted on 2/1/17 at 5:20 p.m. with LPN (licensed practical nurse) #5, the nurse who cared for Resident #17 on 12/31/16. When asked about the process staff follows when a resident's medications are not available, LPN #5 stated, "If I can get some of the medications I would try to get them stat (Immediately), especially pain medications. We have a pharmacy right next to us (where medications can be obtained) and I would check the stat box (a box containing frequently used medications)." When asked about the process staff follows if the medications were not administered, LPN #5 stated, "I would contact the pharmacy to see if they were on route. I would contact my manager."

On 2/1/17 at 5:40 p.m. ASM (administrative staff member) #2, the director of nursing and ASM #4, the nurse consultant were made aware of the findings.

An interview was conducted on 2/1/17 at 5:50 p.m. with RN (registered nurse) #4. When asked about the process staff follows if they are unable to administer a resident's medications, RN #4 stated, "I notify my supervisor on call and I call the doctor who is on call." RN #4 stated that she would also notify the resident's RP. When asked if this was documented, RN #4 stated, "Yes in our communication notes."

An interview was conducted on 2/1/17 at 5:58

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p.m. with RN #6, the unit manager. When asked about the process staff follows if they are unable to administer a resident's medications, RN #6 stated that the RP and physician should be notified. When asked why they should be notified, RN #6 stated, "It's their right to know as far as the RP and as far as the physician, he could write for an alternative medication. If it affects their (the resident's) health condition the physician should know."

Review of the facility's policy titled, "Signification Change of Condition" documented, "POLICY: All staff members shall communicate any information about patient status change to appropriate license personnel immediately upon observation. PROCEDURE: 1. The patient's change of condition shall be reported immediately to a licensed nurse. 3. This assessment shall be reported to primary physician designated alternate. 4. Responsible party will also be notified of a change of condition. 6. Notification of physician, time, and date (moth, day and year) are to be documented in the Nurses Notes. 9. Notification of responsible party shall be documented in the Nurses Notes including time and name of person informed."

No further information was provided prior to exit.

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health

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care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.
(1) Abilify -- ABILIFY is indicated for the treatment of schizophrenia. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cbbd3dc0-6a39-48f7-91b9-a95c6c12ee0c
(2) Baclofen -- Baclofen is a centrally acting muscle relaxant commonly prescribed for spasticity in patients with multiple sclerosis. This information was obtained from:
https://livertox.nlm.nih.gov/Baclofen.htm
(3) Topamax -- Topiramate (Topamax) is licensed to be used, either in monotherapy or as adjunctive treatment, for generalized tonic clonic seizures or partial seizures with or without secondary generalization and for prevention of migraine. This information was obtained from:
https://www.ncbi.nlm.nih.gov/pubmed/18645165
(4) Dicyclomine -- Dicyclomine hydrochloride is indicated for the treatment of patients with functional bowel/irritable bowel syndrome. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=dac1bf89-575b-442e-99ff-6f94da4d872e
2. The facility staff failed to notify the physician when anti-rejection medications were not available for Resident #16.

Resident #16 was admitted to the facility on 12/1/16 and discharged on 12/22/16. His diagnoses included but were not limited to: old heart attack, acute respiratory failure, pneumonia, dysphagia (difficulty swallowing) (1), congestive heart failure, history of a heart transplant, diabetes, high blood pressure, severe sepsis

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F 157	Continued From page 7 (infection) (2), and depression. The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 12/15/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of his activities of daily living. In Section I - Active Diagnoses, the resident was coded as, "Heart Transplant Status." The physician order dated, 12/1/16, documented, "Sirolimus Solution (used to prevent the rejection of an organ transplant (1)) 1 MG/ML (milligram per milliliter); give 2 ml via J-tube (tube for feeding inserted in the small intestine (2)) one time a day every other day related to Heart Transplant Status." The MAR (medication administration record) for December 2016 documented, "Sirolimus Solution 1 MG/ML; give 2 ml via J-tube one time a day every other day related to Heart Transplant Status." The medication was not signed off as being administered on 12/2/16 and 12/3/16. A review of the nurse's notes for 12/2/16 did not reveal documentation regarding not administering the Sirolimus Solution. The nurse's note dated, 12/3/16 at 11:23 a.m. documented, "Orders - Administration Note - pharmacy contacted, med (medication) back ordered. MD/RP (medical doctor/responsible party) aware." There was no documentation evidencing the physician and RP were notified of the medication not being available for administration on 12/2/16.	F 157		

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F 157	Continued From page 8 An interview was conducted on 2/1/17 at 5:58 p.m. with RN #6, the unit manager. When asked about the process the staff follows if they are unable to administer a resident's medications, RN #6 stated, "The RP and physician should be notified." When asked why they should be notified, RN #6 stated, "It's their right to know as far as the RP and as far as the physician could write an alternative medication. If it affects their (the resident's) health condition the physician should know." No further information was provided prior to exit. (1) This information was obtained from the following website: <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012134/?report=details>. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader; Rothenberg and Chapman, page 311.	F 157		
F 281 SS=D	COMPLAINT DEFICIENCY SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of	F 281	F 281 1. Resident # 17 was discharged on	2/21/17

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F 281	Continued From page 9 a complaint investigation, it was determined that the facility staff failed to follow professional standards of practice for one of 18 residents in the survey sample, Resident #17. The facility staff failed to obtain an order for isolation for Resident #17. The findings include: Resident #17 was admitted to the facility on 12/31/16 with diagnoses that included but were not limited to: fractured hip, osteoporosis, urinary retention, history of breast cancer, anemia, high blood pressure, depression and anxiety. The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 1/6/17, coded the resident as being able to understand others and being understood by others. Resident #17 was coded as having periods of inattention that fluctuated. Resident #17 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was independent after set up assistance was provided. In Section I - Active Diagnoses, the resident was not coded as having any infections. The pain assessment in Section J was not completed. Review of the clinical record was conducted. The "Center Admission Alert" form dated, 12/29/16, documented, "Care Needs/Details" a check mark was documented next to, "Isolation - VRE (vancomycin resistant enterococci (1)) Location - urine." Another form in the packet documented, "Referral Process. Packet Preparation" documented, "Isolations? - VRE urine." Under	F 281	1/6/17. 2. All residents on actual and presumed isolation are at risk. An audit of current residents on actual and presumed isolation will be completed to ensure orders were obtained. Those found out of compliance will be corrected accordingly. 3. RNs/LPNs will be in-serviced on obtaining orders for residents requiring actual or presumed isolation. 4. An audit of current residents and new admissions with actual or presumed isolation will be completed weekly x 4 weeks and monthly x 2 months to ensure isolation orders were obtained. Those found out of compliance will be corrected and forwarded to the QA for further recommendation.	

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"NOTES" was documented, "ISOLATION."

Review of the hospital records failed to reveal any culture or laboratory test indicating the resident had VRE. The urinalysis done on 12/26/16 was clear, no indication of infection.

The physician orders dated 12/31/16 were reviewed. There was no documented order for isolation.

The comprehensive care plan dated, 1/1/17, did not reveal any documentation regarding isolation.

The MAR (medication administration record) and TAR (treatment administration record) did not reveal any documentation regarding isolation.

The admission assessment, dated 12/31/16, did not reveal any documentation regarding isolation.

The nurse's notes were reviewed. On 1/1/17 at 11:16 a.m. the nurse documented in part, "Patient also remains on isolation r/t (related to) peri - rectal VRE." The nurse's note dated, 1/2/17 at 1:15 p.m. documented in part, "Patient remains on isolation r/t VRE."

An interview was conducted with RN (registered nurse) #6 on 2/1/17 at 2:17 p.m. When asked how the staff finds out when a new admission is on isolation, RN #6 stated, "It comes in our admission packet from the admissions office and then it's confirmed during report from the hospital. Once the resident is here we review the discharge summary from the hospital." When asked if you need an order for isolation, RN #6 stated, "Yes, we get that when we get the orders authorized from the physician or nurse

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practitioner before they (residents) get here." When asked where it is documented that a resident is on isolation, RN #6 stated, "It's on the TAR." RN #6 was asked to review the physician orders for Resident #17. When asked if a she saw a documented physician order for isolation, RN #6 stated, "No, I don't."

An interview was conducted with RN #3, the nurse caring for Resident #17 on 12/31/16, on 2/1/17 at 3:30 p.m. When asked if she remembered the resident, she stated she did. When asked if the resident was on isolation, RN #3 stated, "I don't recall what she was on isolation for but I remember putting on a gown and gloves to enter her room." When asked if an order is needed for isolation, RN #3 stated, "Yes." When asked how staff finds out when a resident needs isolation, RN #3 stated, "Normally it comes with the discharge summary and we get it in report from the hospital." When asked if she remembers the day Resident #17 came to the facility, RN #3 stated, "I can't remember that day."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 2/1/17 at 3:42 p.m. When asked if the facility needs an order for isolation, ASM #2 stated, "Yes."

The facility policy, "Admitting Physician Orders" documented in part, "2. Upon receiving admission physician's orders from the physician, the nurse will record the order to include:...b. Admission orders should include:...9. Other orders as indicated by patient's condition with specific directions."

According to Potter and Perry's, Fundamentals of

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F 281	Continued From page 12 Nursing, 7th edition, page 268 documents the following statements: "Clarifying an order is competent nursing practice, and it protects the client and members of the health care team. When you carry out an incorrect or inappropriate intervention, it is as much your error as the person who wrote or transcribed the original order." The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also includes the following information: "As members of the health care team, nurses need to communicate information about clients accurately and in a timely, effective manner." The administrator, ASM #2, ASM #3, the incoming administrator, and ASM #4, the registered nurse consultant, were made aware of these findings on 2/1/17 at 3:45 p.m. COMPLAINT DEFICIENCY (1) This information was taken from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0063441/?term=VRE.	F 281		
F 309	PROVIDE CARE/SERVICES FOR HIGHEST	F 309		2/21/17

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F 309 SS=D	Continued From page 13 WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309		

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Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to maintain the highest level of wellbeing for one of 18 residents in the survey sample, Resident #17.

a. The facility staff failed to complete a pain assessment upon Resident #17's admission to the facility on 12/31/16.

b. The facility staff failed to obtain the physician ordered Augmentin (1) from the facility's stat (Immediate) box (box containing frequently used medications) for Resident #17 on 12/31/16.

The findings include:

a. Resident #17 was admitted to the facility on 12/31/16 with diagnoses that included but were not limited to: fractured hip, osteoporosis, urinary retention, history of breast cancer, anemia, high blood pressure, depression and anxiety.

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 1/6/17, coded the resident as being able to understand others and being understood by others. Resident #17 was coded as having periods of inattention that fluctuated. Resident #17 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was independent after set up assistance was provided. In Section I - Active Diagnoses, the resident was not coded as having any infections. The pain assessment in Section J was not completed.

F 309

F309

1. Resident # 17 was discharged on 1/6/17.
2. All residents are at risk. An audit of current residents will be conducted to verify that pain assessments were completed as required. An audit of current residents MARs will be completed to identify any medications not administered as ordered due to unavailability. Those found out of compliance will be corrected accordingly.
3. RNs/LPNs will be in-serviced on completing pain assessments and the procedure to follow when medications are not available including use of the Stat box.
4. An audit of 10% of current residents and all new admissions pain assessments and medications not administered as ordered due to unavailability will be completed weekly x 4 weeks and monthly x 2 months. Any anomaly will be rectified accordingly and forwarded to the QA committee for further recommendation as applicable.

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Review of the resident's care plan initiated on 1/1/17 did not evidence documentation related to pain.

Review of Resident #17's admission assessment dated 12/31/16 at 1:13 p.m. documented, "N. OTHER RELEVANT DX (diagnoses)/CONCERNS. 4. PAIN 4a. Resident has pain? a. Yes (was marked). 4b. Describe location and type of pain: there was no documentation. 4c. Numerical Rating Scale...there was no documentation."

Review of the nurse's notes dated 12/31/16 at 4:45 p.m. did not evidence documentation regarding the resident's pain.

A telephone interview was conducted on 2/1/17 at 5:15 p.m. with RN (registered nurse) #3, the nurse who admitted Resident #17. When asked how residents' were assessed for pain, RN #3 stated, "I give them the numbers zero to ten, ten being the highest and zero being the lowest (amount of pain)." When asked if that was documented, RN #3 stated that the pain assessment was documented in the nurse's notes." When asked if she recalled Resident #17, RN #3 stated, "Yes a little." When asked if she remembered if the resident had pain, RN #3 stated that she did remember the resident had pain because she had obtained a prescription from the doctor for pain medication and had taken it to the pharmacy next to the facility to have it filled so she could give it to the resident.

An interview was conducted on 2/1/17 at 5:20 p.m. with LPN (licensed practical nurse) #5, the nurse who cared for Resident #17 on 12/31/16. When asked how residents' were assessed for

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pain, LPN #5 stated, "I do a pain assessment every time I see a patient and I ask them when I do my med (medication) pass." When asked if the assessment was documented, LPN #5 stated that she would document it in her nurse's notes if the resident had pain.

On 2/1/17 at 5:40 p.m. ASM (administrative staff member) #2, the director of nursing and ASM #4, the nurse consultant were made aware of the findings.

An interview was conducted on 2/1/16 at 5:50 p.m. with RN #4. When asked the process staff followed to assess the residents' pain, RN #4 stated, "When they (the residents) walk in the door we do the first (pain) assessment within the first half hour. I try to do my pain assessment every two hours." When asked if the resident complaints of pain would be documented, RN #4 stated, "Absolutely. On our admission form there's an area for assessment of pain."

Review of the facility's policy titled, "Documentation Summary" documented, "POLICY: Licensed Nurses and CNAs will document all pertinent nursing assessments, care interventions, and follow up actions in the medical record. PROCEDURE: 3. Entries will be made as soon as possible after an event or observation is made."

No further information was provided prior to exit.

b. Review of the physician's orders dated 12/31/16 documented, "Augmentin Tablet 500-125 MG (milligrams)...Give 1 tablet by mouth two times a day..."

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F 309	Continued From page 17 Review of the December MAR (medication administration record) for 12/31/16 at 5:00 p.m. documented, "Augmentin Tablet 500-125 MG (milligrams)...Give 1 tablet by mouth two times a day..." There was a "9" and nurse's initials documented. Review of the MARs chart codes documented, "9=Other/See Progress Notes." Review of the nurse's notes for 12/3/16 at 6:20 p.m. documented, "Augmentin Tablet 500-125 MG...On order." Review of the resident's care plan initiated on 1/1/17 documented, "Focus The resident has a Urinary Tract Infection. Interventions Amoxicillin (sic, should be Augmentin) until (there was no further documentation)." An interview was conducted on 2/1/17 at 1:39 p.m. with LPN (licensed practical nurse) #6. When asked about the process staff follows when a medication is not available, LPN #6 stated, "To get an actual med (medication) we have a stat box on our unit. We can pull it from there or we have a (name of pharmacy) who can send us stat orders until our pharmacy can get them to us." A review of the facility's stat box contents documented, "Medication Amox/Clav 500-125mg. Sub (substitute) Augmentin. Qty (quantity) 3." A telephone interview was conducted on 2/1/17 at 3:25 p.m. with RN (registered nurse) #3, the nurse who admitted the resident. When asked about the process staff follows when a medication is not available for administration, RN #3 stated, "We go to the stat box." RN #3 further stated that if the medication was not available in the stat box then a physician's order would be obtained.	F 309		

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An interview was conducted on 2/1/17 at 5:20 p.m. with LPN #5, the nurse who cared for Resident #17 on 12/31/16. When asked about the process staff follows when a medication is not available for administration, LPN #5 stated, "If I can get some of the medications I would try to get them stat, especially pain medications and I check the stat box." When asked if she recalled Resident #17, LPN #5 stated, "Yes, vaguely." When asked about checking the stat box for the resident's Augmentin medication, LPN #5 did not recall if she had done that.

On 2/1/17 at 5:40 p.m. ASM (administrative staff member) #2, the director of nursing and ASM #4, the nurse consultant were made aware of the findings.

No further information was provided prior to exit.

COMPLAINT DEFICIENCY

(1) Augmentin -- an oral antibacterial combination consisting of the semisynthetic antibiotic amoxicillin and the ß-lactamase inhibitor, clavulanate potassium (the potassium salt of clavulanic acid). This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?id=44390

F 425 SS=D — PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH — F 425 — 2/21/17

CFR(s): 483.45(a)(b)(1)

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,

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dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to ensure physician ordered medications were available for administration for two of 18 residents in the survey sample, Resident #17 and Resident #16.

1. The facility staff failed to ensure the physician ordered Abilify (1), Baclofen (2), Topamax (3), Vitamin D, Dicyclomine (4) were available for administration to Resident #17 on 12/31/16.

2. The facility staff failed to ensure anti-rejection medications were available for administration to Resident #16.

The findings include:

1. Resident #17 was admitted to the facility on 12/31/16 with diagnoses that included but were not limited to: fractured hip, osteoporosis, urinary retention, history of breast cancer, anemia, high blood pressure, depression and anxiety.

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 1/6/17,

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1. Resident #17 was discharged on 1/6/17. Resident #16 was discharged on 12/22/16. Pharmacy delivery times were increased from two to three times per day.
2. All residents are at risk. An audit of current residents MARs will be completed to identify any medication not administered as ordered due to unavailability. Those found out of compliance will be corrected accordingly as appropriate.
3. RNs/LPNs will be in-serviced on the procedure to follow when medications are not available including notification of the responsible party and physician.
RNs/LPNs will be in-serviced on the use of the Stat box.
4. An audit of 10% of current residents and all new admissions MARs will be completed weekly x 4 weeks and monthly x 2 months to ensure medications are available and administered accordingly. Those found out of compliance will be corrected.

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coded the resident as being able to understand others and being understood by others. Resident #17 was coded as having periods of inattention that fluctuated. Resident #17 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was independent after set up assistance was provided. In Section I - Active Diagnoses, the resident was not coded as having any infections. The pain assessment in Section J was not completed.

Review of the physician's orders dated 12/31/16 documented, "Abilify Tablet 15 MG (milligrams) Give 1 tablet by mouth at bedtime; Baclofen Tablet 10 MG Give 1 tablet by mouth at bedtime; Topamax Tablet 25 MG Give 1 tablet by mouth at bedtime; Vitamin D Tablet Give 400 mg by mouth two times a day. Dicyclomine HCL Table 20 MG Give 0.5 tablet by mouth three times a day."

Review of the December 2016 medication administration record (MAR) documented: "Abilify Tablet 15 MG (milligrams) Give 1 tablet by mouth at bedtime." On 12/31/16 at 9:00 p.m. there was a "9" and the nurse's initials documented. Review of the chart codes section of the MAR documented, "9=Other/See Progress Notes."
Baclofen Tablet 10 MG Give 1 tablet by mouth at bedtime." On 12/31/16 at 9:00 p.m. there was a "9" and the nurse's initials documented.
"Topamax Tablet 25 MG Give 1 tablet by mouth at bedtime." On 12/31/16 at 9:00 p.m. there was a "9" and the nurse's initials documented.
"Vitamin D Tablet Give 400 mg by mouth two times a day." On 12/31/16 at 4:00 p.m. there was a "9" and the nurse's initials documented.
"Dicyclomine HCL Table 20 MG Give 0.5 tablet by

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mouth three times a day." On 12/31/16 at 4:00 p.m. there was a "9" and the nurse's initials documented.

Review of the nurse's notes for 12/31/16 documented:
"18:19 (6:19 p.m.) Vitamin D Tablet....On order."
"20:50 (8:50 p.m.) Abilify Tablet 15 MG....Drug ordered."
"20:51 (8:51 p.m.) Baclofen Tablet 10 MG...Drug on order."
"20:51 Dicyclomine HCL Tablet 20 MG...Drug on order."
"20:52 (8:52 p.m.) Topamax Tablet 25 MG...Drug on order."

An interview was conducted on 2/1/17 at 5:20 p.m. with LPN (licensed practical nurse) #5, the nurse who cared for Resident #17 on 12/31/16. When asked about the process staff follows when a resident medications are not available for administration, LPN #5 stated, "If I can get some of the medications I would try to get them stat (Immediate), especially pain medications. We have a pharmacy right next to us (where medications can be obtained) and I would check the stat box (a box containing frequently used medications)." When asked about the process staff follows if medications are not administered, LPN #5 stated, "I would contact the pharmacy to see if they were on route. I would contact my manager."

An interview was conducted on 2/1/17 at 5:30 p.m. with OSM (other staff member) #1, the pharmacist. When asked about the process they follow to get medications to the facility's residents, OSM #1 stated, "If the orders were put in between 2 to 3 (2:00 p.m. to 3:00 p.m.) the initial

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orders would go to a backup (pharmacy). This particular facility's meds (medications) do not get sent until after midnight."

On 2/1/17 at 5:40 p.m. ASM (administrative staff member) #2, the director of nursing and ASM #4, the nurse consultant were made aware of the findings.

An interview was conducted on 2/1/17 at 5:50 p.m. with RN (registered nurse) #4. When asked about the process staff follows if medications are not available for administration, RN #4 stated, "We have a back-up plan in place. We call the pharmacy and have them stat it out and we have another plan. We can call (name of pharmacy next to facility) which is right across the street and get it there and they have everything we need."

An interview was conducted on 2/1/17 at 5:58 p.m. with RN #6, the unit manager. When asked about the process staff follows if medications are not available for administration, RN #6 stated, "We utilize the stat box." When asked what staff did if the medication was not available in the stat box, RN #6 stated, "We call the pharmacy and request they send it." Resident #17's findings were reviewed with RN #6. When asked if staff had followed the facility's process RN #6 stated, "No."

No further information was provided prior to exit.

(1) Abilify -- ABILIFY is indicated for the treatment of schizophrenia. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cbbd3dc0-6a39-48f7-91b9-a95c6c12ee0c

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F 425	Continued From page 23 (2) Baclofen -- Baclofen is a centrally acting muscle relaxant commonly prescribed for spasticity in patients with multiple sclerosis. This information was obtained from: https://livertox.nlm.nih.gov/Baclofen.htm (3) Topamax -- Topiramate (Topamax) is licensed to be used, either in monotherapy or as adjunctive treatment, for generalized tonic clonic seizures or partial seizures with or without secondary generalization and for prevention of migraine. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/18645165 (4) Dicyclomine -- Dicyclomine hydrochloride is indicated for the treatment of patients with functional bowel/irritable bowel syndrome. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=dac1bf89-575b-442e-99ff-6f94da4d872e COMPLAINT DEFICIENCY 2. The facility staff failed to ensure anti-rejection medications were available for administration to	F 425		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Resident #16.

Resident #16 was admitted to the facility on 12/1/16 and discharged on 12/22/16. His diagnoses included but were not limited to: old heart attack, acute respiratory failure, pneumonia, dysphagia (difficulty swallowing) (1), congestive heart failure, history of a heart transplant, diabetes, high blood pressure, severe sepsis (infection) (2), and depression.

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 12/15/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of his activities of daily living. In Section I - Active Diagnoses, the resident was coded as, "Heart Transplant Status."

The physician order dated, 12/1/16, documented, "Sirolimus Solution (used to prevent the rejection of an organ transplant(1)) 1 MG/ML (milligram per milliliter); give 2 ml via J-tube (tube for feeding inserted in the small intestine) (2) one time a day every other day related to Heart Transplant Status."

The MAR (medication administration record) for December 2016 documented, "Sirolimus Solution 1 MG/ML; give 2 ml via J-tube one time a day every other day related to Heart Transplant Status." The medication was not signed off as being administered on 12/2/16 and 12/3/16.

A review of the nurse's notes for 12/2/16 did not reveal any documentation regarding not administering the Sirolimus Solution.

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The nurse's note dated, 12/3/16 at 11:23 a.m. documented, "Orders - Administration Note - pharmacy contacted, med (medication) back ordered. MD/RP (medical doctor/responsible party) aware."

An interview was conducted on 2/1/17 at 5:20 p.m. with LPN (licensed practical nurse) #5. When asked about the process staff follows when a resident's medications were not available, LPN #5 stated, "If I can get some of the medications I would try to get them stat, especially pain medications. We have a pharmacy right next to us (where medications can be obtained) and I would check the stat box (a box containing frequently used medications)." When asked about the process staff follows if the medications were not administered, LPN #5 stated, "I would contact the pharmacy to see if they were on route. I would contact my manager."

An interview was conducted on 2/1/17 at 5:30 p.m. with OSM (other staff member) #1, the pharmacist. When asked about the process they follow to get medications to the facility's residents, OSM #1 stated, "If the orders were put in between 2 to 3 (2:00 p.m. to 3:00 p.m.) the initial orders would go to a backup (pharmacy). This particular facility's meds (medications) do not get sent until after midnight."

An interview was conducted on 2/1/17 at 5:50 p.m. with RN (registered nurse) #4. When asked about the process staff follows if resident medications are not available, RN #4 stated, "We have a back-up plan in place. We call the pharmacy and have them stat it out and we have another plan. We can call (name of pharmacy

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F 425	Continued From page 26 next to facility) which is right across the street and get it there and they have everything we need." An interview was conducted on 2/1/17 at 5:58 p.m. with RN #6, the unit manager. When asked about the process staff follows if resident medications are not available, RN #6 stated, "We utilize the stat box." When asked what staff did if the medication was not available in the stat box, RN #6 stated, "We call the pharmacy and request they send it." No further information was provided prior to exit.	F 425		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 514		2/21/17

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F 514	Continued From page 27 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to maintain a complete and accurate medication record for one of 18 residents in the survey sample, Resident #17. a. Facility staff failed to document that Resident #17 received Oxycodone (1) on 12/31/16 at 4:45 p.m. b. The facility staff failed to document the reason and family notification of why Resident #17 was discontinued off isolation. The findings include: 1 a. Resident #17 was admitted to the facility on 12/31/16 with diagnoses that included but were not limited to: fractured hip, osteoporosis, urinary retention, history of breast cancer, anemia, high blood pressure, depression and anxiety. The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 1/6/17,	F 514	F 514 1. Resident # 17 was discharged on 1/6/17. 2. An audit of the MARs of current residents on narcotic pain medications will be completed to identify any missed documentation of administration. An audit of current residents discontinued from isolation, starting from 12/31/2016 to current date, will be completed to ascertain that there is a reason for the discontinuation of their isolations and that there is a documented family notification to the effect. Those found out of compliance will be corrected accordingly and as appropriate. 3. RNs/LPNs will be in-serviced on complete and accurate narcotic pain medication administration documentation. RNs/LPNs will be in-serviced on the protocol of the discontinuation of active isolation, including that of family notification to the effect. 4. An audit of 10% of current residents and all new admissions MARS will be	

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coded the resident as being able to understand others and being understood by others. Resident #17 was coded as having periods of inattention that fluctuated. Resident #17 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was independent after set up assistance was provided. In Section I - Active Diagnoses, the resident was not coded as having any infections. The pain assessment in Section J was not completed.

Review of the December 2016 physician's orders documented, "Oxycodone-Acetaminophen (Tylenol) Tablet 5-325 MG (milligrams) Give 1 tablet by mouth every 4 hours as needed for pain."

Review of the December 2016 MAR (medication administration record) documented, "Oxycodone-Acetaminophen (Tylenol) Tablet 5-325 MG (milligrams) Give 1 tablet by mouth every 4 hours as needed for pain." There was no documented evidence that the medication had been given.

A telephone interview was conducted on 2/1/17 at 5:15 p.m. with RN (registered nurse) #3, the nurse who admitted Resident #17. When asked how residents' were assessed for pain, RN #3 stated, "I give them the numbers zero to ten, ten being the highest and zero being the lowest (amount of pain)." When asked if that was documented, RN #3 stated that the pain assessment was documented in the nurse's notes." When asked if she recalled Resident #17, RN #3 stated, "Yes a little." When asked if she remembered if the resident had pain, RN #3 stated that she did remember the resident had

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completed weekly x 4 weeks and monthly x 2 months to ensure accurate documentation for the administration of narcotic pain medications. An audit of all discontinued isolations will be completed by the DON/SDC to ensure compliance with required protocols and family notification to the effect weekly x 4 weeks and monthly x 2 months. Any anomaly will be rectified accordingly and forwarded to the QA committee for further review and recommendation

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F 514	Continued From page 29 pain because she had obtained a prescription from the doctor for pain medication and had taken it to the pharmacy next to the facility to have it filled so she could give it to the resident. RN #3 stated she had given the resident the pain medication before she left the facility on 12/31/16. RN #3 was asked when the pain medication was given to Resident #17. RN #3 stated, "Well I usually leave around 3:30 (p.m.) to 4:30." When asked where that would be documented RN #3 stated it would be documented in the MAR and the nurse's notes. On 2/1/17 at 5:40 p.m. a request was made to ASM (administrative staff member) #2, the director of nursing for Resident #17's narcotic log. Review of Resident #17's narcotic log documented, "Percocet 5-325 mg 1 tab (tablet) q4 (every four hours) PRN (as needed). Date Month/Day/Year 12/31/16. Time 445 pm. Dose Given one." On 2/1/17 at 5:55 p.m. ASM #2 was made aware of the findings. An interview was conducted on 2/1/17 at 6:05 p.m. with OSM (other staff member) #7, the medical records manager. When asked if the narcotic log was part of the clinical record, OSM #7 stated, "It is not part of the clinical record." Review of the facility's policy titled, "Documentation Summary" documented, "POLICY: Licensed Nurses and CNAs will document all pertinent nursing assessments, care interventions, and follow up actions in the medical record. PROCEDURE: 3. Entries will be made as soon as possible after an event or observation is	F 514		

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made."

No further information was provided prior to exit.

(1) Oxycodone -- PERCOCET tablets should not be administered to patients with known hypersensitivity to oxycodone, acetaminophen, or any other component of this product.
(1) This information was obtained from the following website: <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012134/?report=details>.

(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader; Rothenberg and Chapman, page 311.
b. The facility staff failed to document the reason and family notification of why the Resident #17 was discontinued off isolation.

Review of the clinical record was conducted. The "Center Admission Alert" form dated, 12/29/16, documented, "Care Needs/Details" a check mark was documented next to, "Isolation - VRE (vancomycin resistant enterococci) (1) Location - urine." Another form in the packet documented, "Referral Process Packet Preparation" documented, "Isolations? - VRE urine." Under "NOTES" was documented, "ISOLATION."

Review of the hospital records failed to reveal any culture or laboratory test indicating the resident had VRE. The urinalysis done on 12/26/16 was clear, no indication of infection.

The physician orders dated 12/31/16 were reviewed. There was no documented order for isolation.

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The comprehensive care plan dated, 1/1/17, did not reveal any documentation regarding isolation.

The MAR (medication administration record) and TAR (treatment administration record) did not reveal any documentation regarding isolation.

The admission assessment, dated 12/31/16, did not reveal any documentation regarding isolation.

The nurse's notes were reviewed. On 1/1/17 at 11:16 a.m. the nurse documented in part, "Patient also remains on isolation r/t (related to) peri - rectal VRE." The nurse's note dated, 1/2/17 at 1:15 p.m. documented in part, "Patient remains on isolation r/t VRE."

An interview was conducted with RN (registered nurse) #6 on 2/1/17 at 2:17 p.m. When asked how the staff finds out when a new admission is on isolation, RN #6 stated, "It comes in our admission packet from the admissions office and they it's confirmed during report from the hospital. Once the resident is here we review the discharge summary from the hospital." When asked if you need an order for isolation, RN #6 stated, "Yes, we get that when we get the orders authorized from the physician or nurse practitioner before they get here." When asked where it is documented that a resident is on isolation, RN #6 stated, "It's on the TAR." RN #6 was asked to review the physician orders for Resident #17. When asked if a she saw a documented physician order for isolation, RN #6 stated, "No, I don't." When asked to explain why the isolation was discontinued, RN #6 stated, "I had called the hospital. I got all of her lab (laboratory) test results. On 12/26/16 a urinalysis and culture were obtained, both were negative for

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any infection. The hospital reported to me they had put her on isolation for a history of ESBL (extended-spectrum beta-lactamase (2)). They had not treated her for VRE or ESBL. So I spoke to the family, the patient, husband and son. They reported to me that the resident had had ESBL or VRE in 2011. I ran this by (name of nurse practitioner) and she agreed, that with the negative cultures and the resident not having any active infection on her recent stay at the hospital that it wasn't necessary to keep her on isolation." When asked if she documented all of the research, interview with the family and nurse practitioner, RN #6 stated, "No, I didn't." When asked if it was an important thing and should be documented in the clinical record, RN #6 stated, "Yes, it would."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 2/1/17 at 3:42 p.m. When asked if the research and discussion with the family and the nurse practitioner regarding the isolation precautions being removed for Resident #17, should have been documented in the clinical record, ASM #2 stated, "Yes, it should have been."

The facility policy, "Nursing Documentation" documented in part, "Policy: Licensed Nurses and CNAs (certified nursing assistants) will document all pertinent musing assessments, care interventions, and follow up actions in the medical record...12. Document all of the facts and pertinent information related to an event, course of treatment, patient condition, response to care, and deviations from the standard treatment along with the reason for the deviation....18. Every change in the patient's condition or significant

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F 514	Continued From page 33 patient care issues will be noted and charged until the condition is resolved or stabilized. Documentation that provides evidence of follow-through is critical. Use summary statements to describe changes of condition, stating objective facts." The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also includes the following information: "As members of the health care team, nurses need to communicate information about clients accurately and in a timely, effective manner." The ASM #1, the administrator, ASM #2, ASM #3, the incoming administrator, and ASM #4 the registered nurse consultant, were made aware of the above findings on 2/1/17 at 3:45 p.m. No further information was provided prior to exit. COMPLAINT DEFICIENCY (1) This information was taken from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0063441/?term=VRE (2) This information was taken from the following	F 514		

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F 514	Continued From page 34 website: https://www.ncbi.nlm.nih.gov/pubmed/11959586 COMPLAINT DEFICIENCY	F 514		