STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495266	A. BUILDING _____ B. WING _____	C 03/05/2018

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HANOVER HEALTH AND REHABILITATION CENTER	8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2-27-18 through 3-5-18. The facility was in substantial compliance with 42 CFR Part 483.73, (emergency preparedness) Requirement for Long-Term Care Facilities. Three complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2-27-18 through 3/2 and 3-5-18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 120 certified bed facility was 95 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #15, 81, 246, 26, 250, 40, 11, 74, 4, 83, 31, 94, 6, 87, 79, 62, 39, 12,18, and #66) and four closed record reviews (Residents #245, #95, #295, and #345).	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, group interview and in the course of a	F 558	The statements included are not an admission and do not constitute	4/6/18

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

Electronically Signed | 03/26/2018

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F 558	Continued From page 1 complaint investigation, the facility staff failed to provide hydration according to residents' preferences for two residents (Residents # 87 and 94) in a survey sample of 24 residents. 1. For Resident # 87, the facility staff failed to provide ice water per her request. 2. For Resident # 94, the facility staff failed to provide ice water per her request. Findings included: 1. For Resident # 87, the facility staff failed to provide ice water per her request. Resident # 87 was admitted to the facility on 2/9/2018 with diagnoses of but not limited to: Cerebral Infarction, hemiplegia and hemiparesis affecting left dominant side, generalized muscle weakness, Type 1 Diabetes Mellitus, Bipolar Disorder, Hypothyroidism, Hypertension, Major Depressive Disorder Recurrent, Anxiety Disorder, and Dementia without behavioral disturbance. The only Minimum Data Set (MDS) was an admission 14 day assessment with an Assessment Reference Date (ARD) of 2/16/18. The MDS coded Resident # 87 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required one person assistance with activities of daily living; always continent of bowel and bladder. During the group interview on 2/28/18 at 10:30 AM, a group interview was conducted with 7 residents. Six of the 7 residents reported extremely long wait times for the call lights to be answered. Four of the 7 residents stated they	F 558	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 centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F 558 Reasonable Accommodations Needs / Preferences 1. Patient # 87 was discharged from the facility. Patient # 94 was offered fluids at each shift, meals, med pass and as requested. 2. All patients are at risk for the deficient practice. 3. Measures put in place to prevent re-occurrences: " SDC or Designee will educate all staff related to need for fresh ice water to be placed at bedside every shift and as needed. " DON and Unit Manager will audit 30% unit residents weekly for 4 weeks. On-going monitoring will be maintained by QA & A and through monthly resident council. 4. The facility will monitor performance 5 times weekly with Department Managers. Performance will be reviewed through quarterly QA & A meeting.	

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F 558	Continued From page 2	F 558		

frequently did not get fresh ice water in their water pitchers.

Review of the clinical record was conducted on 2/28/2018 at 9 AM and 3/1/2018 at 11 AM.

On 2/28/18 at 4:00 PM, observed Resident # 87 sitting in her room. Resident # 87 stated she had water in her pitcher but no ice. Observed the water pitcher felt cool to touch and did not have condensation on the outside.

On 3/1/2018 at 9:00 AM, Resident # 87 stated she had to put her pants back on to get her own water one night. Resident # 87 stated she had waited so long for staff to bring her ice water that she just decided to go to the nurses station to get it for herself. Resident # 87 stated it was very frustrating to have to ask for ice water repeatedly. Observed the water pitcher was half full with no ice.

On 3/2/2018 at 1:00 PM, Resident # 87 stated she had to ask for water again on the night shift and still did not have ice in her water pitcher. Observed the water pitcher felt cool but not cold to touch, there was no condensation on the outside of the pitcher. Resident # 87 stated she had not received ice in the pitcher "in a while."

During the end of day debriefing on 3/2/2018 at 3:10 PM, the facility Administrator and Corporate Nurse Consultant (Admin B) were informed of the findings. Admin B stated residents should get ice water in their pitchers as they prefer.

On 3/5/2018 at 2:45 PM, observed nursing staff , CNA (Certified Nursing Assistant) A bringing a cup of ice to Resident # 87's room.

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Resident # 87 stated she had asked another staff member for ice and CNA A brought in one cupful of ice. Resident # 87 shook her head and stated "I like ice water. Why can't they just fill the pitcher with ice water?" Resident # 87 stated she had told the facility staff several times that she "wanted ice water and they always bring in a cup of ice." She stated she does not like lukewarm or cool water. Resident # 87 stated she often did not get fresh water especially on the night shift. Surveyor touched the water pitcher, it was room temperature, had 3/4 of the pitcher full of water but no ice inside.

Review of the care plan revealed no documentation of Resident # 87's preference for a pitcher full of ice water.

On 3/5/2018 at 3:00 PM, CNA A was interviewed and stated she was told by another staff member that Resident # 87 wanted some ice so she brought a cup of ice to the room. CNA A stated Resident # 87 thanked her but stated she wanted more than a cup of ice. CNA A stated she was going to fill the water pitcher with ice.

No further information was provided.

2. For Resident # 94, the facility staff failed to provide ice water per her request.

Resident # 94 was admitted to the facility on 2/9/2018 with diagnoses of but not limited to: Fracture of Right Femur, Cardiac Pacemaker, Hypertension, Peptic ulcer, Urinary Tract Infection, Acute Post Hemorrhagic Anemia, Diabetes, chronic Kidney Disease, Atrial Fibrillation, and Obstructive Sleep Apnea.

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F 558	Continued From page 4	F 558		

The only Minimum Data Set (MDS) was an admission 5 day assessment with an Assessment Reference Date (ARD) of 2/16/18. The MDS coded Resident # 94 with a BIMS (Brief Interview for Mental Status) of 14/15 indicating no cognitive impairment; the resident required extensive assistance of one person with activities of daily living except required extensive assistance of two staff persons for transfers and required supervision and set up only for eating; frequently incontinent of bowel and occasionally incontinent of bladder.

During the group interview on 2/28/18 at 10:30 AM, a group interview was conducted with 7 residents. Six of the 7 residents reported extremely long wait times for the call lights to be answered. Resident # 94 stated it was a frequent problem that call bells were not answered timely. Resident # 94 stated she often had to wait for her water pitcher to be filled with ice water. Resident # 94 stated sometimes the only reason she the call bell was for ice water and she couldn't get that.

On 2/28/2018 at 1:50 PM, an interview was conducted with Resident # 94 who stated there were many times that she had to wait a long time for her call bell to be answered. Resident # 94 stated one time she rang the call bell for water and it took over an hour for staff to bring her water. Resident # 94 stated she often "had to wait a long time just to get water." Resident # 94 stated she liked ice in her water. Resident # 94 stated she had told the staff many times that she liked ice in her water.

On 3/1/2018 at 9:30 AM, observed water pitcher sitting on over-bed table had half pitcher of water

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F 558	Continued From page 5 but no ice. On 3/1/2018 at 11:00 AM, an interview was conducted with CNA A who stated the CNAs do the best they can. CNA A stated the facility was often working short especially on the weekends and it took a longer time for call bells to be answered. CNA A stated they deliver water regularly each shift and try to handle the requests for water and ice as soon as possible. On 3/2/2018 at 10:30M, observed half a pitcher of water. No ice was noted inside the pitcher. Resident # 94 stated she did not get ice water yet. On 3/2/2018 at 2:30 PM, observed Resident # 94 sitting in wheelchair in the hallway near the Activities Room. Resident # 94 stated staff had given her a cup of ice earlier before lunch. During the end of day debriefing on 3/2/2018 at 3:10 PM, the facility Administrator and Corporate Nurse Consultant (Admin B) were informed of the findings. Admin B stated residents should get ice water in their pitchers as they prefer. No further information was provided.	F 558		
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--	F 657		4/6/18

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F 657	Continued From page 6 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for 1 (Resident #295) of 24 residents in the survey sample to revise the comprehensive care plan. Resident #295's skin care plan was not revised when there was a change in condition or interventions added. The findings included: Resident #295 was admitted to the facility on 6/19/17 with the diagnoses of, but not limited to, sepsis, cellulitis of right lower leg, urinary tract infection, malnutrition, chronic kidney disease stage 3, and history of bladder cancer and urostomy (a stoma created through the	F 657	F 657 Care Plan Timing and Revision 1. Patient # 295 was discharged from the facility. 2. All residents with skin impairments are at risk for deficient practice. 3. Measures taken to prevent re-occurrences: " DON / Designee in-service nursing on Care Plan revision for change in skin condition. " 100% audit of patients with skin impairment and validate Care Plan accuracy. " Monitor 30% patients weekly for 3 weeks for accuracy of Care Plan.	

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F 657	Continued From page 7 abdominal wall to remove urine from the body; the urine usually drains into a collection bag). Resident #295 was discharged to the hospital on 7/16/17, therefore a closed record review was conducted. On 3/2/18 Resident #295's clinical record was reviewed, the review revealed: The most recent full MDS (Minimum Data Set) was an admission assessment with an Assessment Reference Date (AR) of 6/26/17. The MDS coded Resident #295 with no cognitive impairment; required extensive assistance from staff for bed mobility, transfers, dressing, and bathing; limited assistance from staff for toilet use and personal hygiene; supervision for locomotion on and off the unit; and was independent with eating. Resident #295 was coded as being at risk for pressure ulcers and had pressure reducing devices to chair and bed; height was coded as 65 inches and weight of 149 pounds; frequently incontinent of bowel and urinary continence not rated due to urinary ostomy. The Admission Assessment/Screening form dated 6/19/17 included a skin assessment which had documented the following skin problems: Left trochanter and left thigh bruising, scattered bruising bilateral upper extremities, bruise to left inner thigh and hip, red patches noted to groin with yellow cream, excoriation to buttocks and bilateral lower extremity red blanching dry flaky skin to feet. Resident #295's initial care plan was created on 6/20/17 and included a focus area of "Potential for skin impairment." The Goal was listed as "Resident will have no evidence of skin impairment through next review" with a created	F 657	4. Performance will be reviewed through QA & A weekly.	

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on date of 6/20/17, revision on 7/7/17 and target date of 9/20/17. The interventions included: "Keep skin clean and dry; Lotion to dry skin; Moisture barrier cream as needed for protection of skin; and Weekly Skin Assessment." Although there was a "Revision on" date of 7/7/17, there were no changes made to the skin care plan.

The resident had decreased appetite, diarrhea, weight loss, and was diagnosed with C. difficile on 7/11/17. Evaluations and interventions were put in place for the weight loss. Review of the "Weekly Skin Assessment" dated 7/4/17 included "Sacrum...Redness" and on 7/11/17 the assessment had documented a Stage II pressure ulcer on the coccyx 1cm x 0.5 cm x 0.1 cm (1 centimeter long, 0.5 cm wide and 0.1 cm deep) with additional notes that read: "redness to the buttocks and redness to the heals (sic)." On 7/14/17, the physician ordered the treatment "mepilex (an absorbent foam dressing) to coccyx every 3 days and as needed for wound care" and "skin prep wipes...Apply to bilateral heels topically every shift for skin care." The National Pressure Ulcer Advisory Panel (NPUAP) describes a Stage II pressure ulcer (injury) as: Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.

The care plan was not updated to reflect the actual skin impairments or treatments.

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F 657	Continued From page 9 On 3/5/18 at 3:20 p.m. an interview was conducted with Corporate Nurse (Admin-B) and when the failure to revise the care plan was discussed, Admin-B stated "I don't know why the care plan wasn't updated, it should've been." No further information was provided by the facility staff.	F 657		
F 658 SS=E	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 observation, staff interview, resident interview, clinical record review, facility documentation review and in the course of a complaint investigation, the facility staff failed to provide care and services based on professional standards for 7 residents (Residents # 87, # 12, # 94, # 39, #345, # 74, and # 245) in a survey sample of 24 residents. 1. For Resident # 87, the facility staff failed to administer medications timely as ordered by the physician and failed to discontinue a duplicate order for Alprazolam. 2. For Resident # 12, the facility staff failed to administer medications timely as ordered by the physician. 3. For Resident # 94, the facility staff failed to administer medications timely as ordered by the physician.	F 658	F 658 Services Provided Meet Professional Standards 1. All patients affected by the deficient practice were immediately addressed by reporting to the Physician prior to the end of the survey. 2. All patients are at risk for deficient practice. 3. Measures taken to prevent re-occurrences: " DON / Designee will in-service all Licensed Nurses on medication administration. " Unit Manager / Designee will audit 30% on patients with medication administration records weekly for 3 weeks for timeliness. 4. Performance will be reviewed	4/6/18

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F 658	Continued From page 10 4. For Resident # 39, the facility staff failed to administer medications timely as ordered by the physician. 5. For Resident # 345, the facility staff failed to administer medications timely as ordered by the physician. 6. For Resident #74 the facility staff documented eight hours of enteral tube feeding as infused on the MAR (medication administration record) before it actually did infuse. 7. For Resident #245 the facility staff failed to administer medications timely as ordered by a physician. Findings included: 1. For Resident # 87, the facility staff failed to (a) administer medications as ordered by the physician and (b) failed to discontinue a duplicate order for Alprazolam. Resident # 87 was admitted to the facility on 2/9/2018 with diagnoses of but not limited to: Cerebral Infarction, hemiplegia and hemiparesis affecting left dominant side, generalized muscle weakness, Type 1 Diabetes Mellitus, Bipolar Disorder, Hypothyroidism, Hypertension, Major Depressive Disorder Recurrent, Anxiety Disorder, and Dementia without behavioral disturbance. The only Minimum Data Set (MDS) was an admission 14 day assessment with an Assessment Reference Date (ARD) of 2/16/18.	F 658	quarterly through QA & A meeting.	

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F 658	Continued From page 11	F 658		

The MDS coded Resident # 87 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required one person assistance with activities of daily living; always continent of bowel and bladder.

During the initial tour of the facility on 2/27/2018 at 8 PM, Resident # 87 was observed lying in bed. Resident # 87 stated she hated that she had to wait so long for her pain medications at night. Resident # 87 stated she asked for her pain medication during the night shift "for the past 4 nights and had to wait hours for the medication and the medicine doesn't really help."

Review of the clinical record was conducted on 2/28/2018 and 3/1/2018.

Review of the Progress Notes revealed documentation of complaints of pain twice on 2/27/2018.

2/27/18 at 09:41 AM of "no complaints of pain or discomforts at this time. Resident voiced complaints of pain and received medications as ordered non pharmacological ineffective."

2/27/18 at 11:53 PM .." PRN (as needed) pain medications given x 1 (one time) will continue to monitor."

Further review of the Progress Notes revealed documentation of "skilled notes" from 2/16/2018 -2/28/2018. The Nursing Progress Notes revealed documentation of administration of pain medication three times during 2/16/18-2/28/2018. Two times were documented on 2/27/2018 , once in the note at 9:41 AM and again at 11:53 PM. The only other documentation in the progress

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notes about pain was written on 2/19/2108 at 10:22 PM.

Review of the MAR (Medication Administration Record) revealed documentation of Tramadol 50 milligrams being administered on 2/27/2018 at 1:40 AM and no further documentation of an as needed pain medication being administered on 2/27/2018.

Further review of the MAR revealed documentation of administration of PRN Tramadol 7 times from 2/16- 2/28/18. The dates and times on the MAR were:
2/16/18-1711 (5:11 PM) Pain Level 4-Effective
2/19/18-1921 (7:21 PM) Pain Level 3-Effective
2/22/18-0329 (3:29 AM) Pain Level 4-Effective
2/24/18-0411 (4:11 AM) Pain Level 4-Effective
2/26/18-0543 (5:43 AM) Pain Level 7-Effective
2/27/18-0140 (1:40 AM) Pain Level 3-Effective
2/28/18-1537 (3:37 PM) Pain Level 6-Effective

The documentation in the Progress Notes did not match the documentation on the MAR.

Review of the Physicians Orders revealed an order written 2/9/2018 for Tramadol 50 milligrams by mouth every 6 hours as needed for pain.

On 3/5/2018 at 11:00 AM during rounds, Resident # 87 told the surveyor that she had not had any of her morning medications. Resident # 87 stated she also had asked for pain medications but had not yet received it. The surveyor observed several staff members in the hallway and at the nurses station.

On 3/5/2018 at 11:15 AM, the Director of Nursing (DON) was asked where the medication nurse for

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Resident # 87 was located. The DON stated she did not know where the nurse was located but she would check it out. The DON stated the nurse was at lunch. When asked if morning medications had been administered, the DON stated she was unsure. The DON also stated she did not have a key to open the medication cart when the surveyor asked to see the medication card for Resident # 87.

On 3/5/2017 at 11:20 AM, the DON was observed talking with another nurse, Licensed Practical Nurse (LPN) B. Resident # 87 was sitting in her wheelchair next to the medication cart.

On 3/5/18 at 11:23 AM, observed LPN B at the medication cart pouring medications. LPN stated she was going to give Resident # 87 her morning medications. LPN B stated another nurse, Registered Nurse (RN) B, was assigned to administer medications to Resident # 87 but RN B was running behind. Review of the MAR revealed the morning medications had not been administered yet. There were no initials in the slots for the morning medications at 9:00 AM 11:26 AM, observed LPN B administer medications to Resident # 87. LPN B stated she also gave Resident # 87 a pain pill (Tramadol) along with the regularly scheduled medications.

On 3/5/18 at 11:25 AM, an interview was conducted with RN B who stated she was from an agency and was assigned to work with Resident # 87. RN B admitted that she had not administered morning medications to Resident # 87 and several other residents who had medications due at 9:00 AM. RN B stated she had not been able to access the computer system until 9 AM and had to resolve an issue with another resident

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before passing the medications. RN B stated she had informed the facility staff, Unit Manager (RN C) and the DON. RN B stated she had not been given any help despite notifying the facility staff that she was behind in administering the morning medications. RN B stated she still had several other residents to give the morning medications. RN B stated then it would "be time to give the 1:00 medications." RN B stated the expectation was that medications should be given within one hour before and one hour after the time scheduled. RN B stated she needed help due to several things that had happened that morning and caused her to be called away from her medication pour and pass duties.

On 3/5/18 at 11:40 AM, the Corporate Nurse Consultant (Admin B) was informed that morning medications had not been administered to several residents on the West Wing including Resident # 87. Admin B stated the facility staff had not informed her that medications had not been administered or that there was an issue. Admin B stated she would investigate the issue. The surveyor requested a copy of the MAR.

On 3/5/18 at 11:55 AM, review of the MAR revealed check marks and initials for the morning medications indicating the medications had been administered at 9:00. The surveyor asked Admin B why the documentation appeared to indicate the medications were administered timely. Admin B stated the computer system depicted the documentation in that manner but a report could be printed that would document the actual time of administration of medications. Review of the report revealed the actual time of administration of medications to be 11:23 AM and documented at 11:27 AM.

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Glimeperide 4 milligrams by mouth in the morning related to Type 1 Diabetes Due at 9:00 AM
Lasix 20 milligrams give one tablet by mouth in the morning for CHF (Congestive Heart Failure) Due at 9:00 AM
Lisinopril 20 milligrams give one tablet by mouth one time a day for Hypertension Due at 9:00 AM
Plavix 75 milligrams give 75 milligrams by mouth one time a day for unspecified sequelae of unspecified cerbrovascular disease Due at 9:00 AM
Protonix 20 milligrams give one tablet by mouth for Gastroesophageal Reflux Disease Due at 9:00 AM
Venlafaxine Extended Release 24 hour 150 milligrams give 150 milligrams by mouth one time a day for depression Due at 9:00 AM
Vitamin D 3 5000 Unit Give 5000 unit by mouth one time a day for unspecified sequelae of unspecified cerbrovascular disease Due at 9:00 AM
Gabapentin 600 milligrams give 2 tablets by mouth three times a day for Hereditary and Idiopathic Neuropathy Due at 9:00 AM.

Review of the facility medication times schedule policy revealed morning medication times as 9:00 AM. The expectation is that medications should be administered within one hour before or after the scheduled time.

The facility policy "General Dose Preparation and Medication Administration stated:
4.1.1 Verify each a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in Appendix 17: Facility Medication

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Administration Times Schedule.
4.1.2 Confirm that the MAR reflects the most recent medication order.....

4.1.5 If necessary, obtain vital signs.
5.4 Administer medications within timeframe specified by Facility policy
6.1 Document necessary medication administration/treatment information (e.g. (example) when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms."

On 3/5/18 at 1:35 PM, an interview was conducted with Resident # 87 who stated she was feeling better after getting her medications along with a pain pill at 11:26. Resident # 87 stated she still had not received her medications that were due at 1:00 PM.

Admin B cited Lippincott as its Nursing professional guidance used by the facility. "Fundamentals of Nursing, by Lippincott", stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."

Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

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Additional Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com)
Rights of Medication Administration
1. Right patient
" Check the name on the order and the patient.
" Use 2 identifiers.
" Ask patient to identify himself/herself.
" When available, use technology (for example, bar-code system).
2. Right medication
" Check the medication label.
" Check the order.
3. Right dose
" Check the order.
" Confirm appropriateness of the dose using a current drug reference.
" If necessary, calculate the dose and have another nurse calculate the dose as well.
4. Right route
" Again, check the order and appropriateness of the route ordered.
" Confirm that the patient can take or receive the medication by the ordered route.
5. Right time
" Check the frequency of the ordered medication.
" Double-check that you are giving the ordered dose at the correct time.
" Confirm when the last dose was given.
6. Right documentation
" Document administration AFTER giving the ordered medication.
" Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.
7. Right reason
" Confirm the rationale for the ordered

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medication. What is the patient's history? Why is he/she taking this medication?
" Revisit the reasons for long-term medication use.
8. Right response
" Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant?
" Be sure to document your monitoring of the patient and any other nursing interventions that are applicable.
Reference: Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania.
www.nursingcenter.com Accessed online 3/8/2018.

On 3/5/18 at 5 PM, the facility administrator and corporate nurse (Admin B) were informed of the failure of the staff to administer medications as ordered by the physician and failure to discontinue a duplicate order for Alprazalam after clarification of the initial order.

No further information was provided.

(b) Further review of the Physicians Orders and March MAR on page 7 of 9 revealed documentation of an order written on 2/9/18 for Alprazalam 0.5 milligrams give one tablet by mouth as needed for anxiety.

Another order written on 2/22/2018 at 8:34 AM for Xanax 0.5 milligrams (Alprazalam) give one tablet by mouth every 12 hours as needed for anxiety.

During the end of day debriefing, the facility

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administrator and Corporate Nurse Consultant (Admin B) were informed of the findings. The administrator stated the nurses clarified the order on 2/22/18. The Corporate nurse (Admin B) stated the nurses should have discontinued the initial Alprazalam order dated 2/9/18 after clarification.

No further information was provided.

2. For Resident # 12, the facility staff failed to administer medications timely as ordered by the physician.

Resident # 12 was admitted to the facility on 12/7/2017 with diagnoses of but not limited to: Gastroesophageal Reflux Disease, Gastrointestinal Hemorrhage, Ulcer of Esophagus, Acute Post Hemorrhagic Anemia, Multiple Sclerosis, Congestive Heart Failure and Hypertension.

The most recent Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 12/15/17. The MDS coded Resident # 12 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required limited to extensive assistance of one staff person with activities of daily living except only required supervision and set up for eating; Resident # 12 was coded as always continent of bowel and frequently incontinent of bladder.

Review of the February MAR revealed Metoprolol 25 milligrams give 12.5 milligrams by mouth twice a day. Spaces for blood pressure and pulse were

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available above the slot for the initials for the nurse administering the medications.
On 2/10/18 at 9 AM, no documentation of blood pressure, pulse and medication not documented as given.
On 2/9/2018 at 9 AM, there were X's documented in the slots for blood pressure and pulse.
There were no blood pressures or pulses documented from 2/13/2018 at 5 PM throughout the rest of the month.

On 3/1/2018 at 4 PM, an interview with the Administrator and Corporate nurse (Admin B) was conducted. Admin B stated the nurses should take blood pressures and pulses if parameters are written in the orders. The Administrator stated blood pressures and pulses do not have to be taken on everyone who is taking blood pressure medications. Admin B stated the Pharmacy automatically puts a place to document blood pressures and pulses for some blood pressure medications. Admin B stated it is by default. Admin B also stated the nurses should follow physicians orders and take vital signs if the listed on the MAR. Admin B reviewed the MAR for Resident # 12 and stated the nurses should have taken the blood pressure and pulse prior to administering Metoprolol as listed on the MAR and should have clarified with the physician if there was a question about the need to take vital signs prior to administration of the medication.

No further information was provided.

3. For Resident # 94, the facility staff failed to administer medications timely as ordered by the physician.

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Resident # 94 was admitted to the facility on 2/9/2018 with diagnoses of but not limited to: Fracture of Right Femur, Cardiac Pacemaker, Hypertension, Peptic ulcer, Urinary Tract Infection, Acute Post Hemorrhagic Anemia, Diabetes, chronic Kidney Disease, Atrial Fibrillation, and Obstructive Sleep Apnea.

The only Minimum Data Set (MDS) was an admission 5 day assessment with an Assessment Reference Date (ARD) of 2/16/18. The MDS coded Resident # 94 with a BIMS (Brief Interview for Mental Status) of 14/15 indicating no cognitive impairment; the resident required extensive assistance of one person with activities of daily living except required extensive assistance of two staff persons for transfers and required supervision and set up only for eating; frequently incontinent of bowel and occasionally incontinent of bladder.

On 3/5/2018 at 11:35 AM, Resident # 94 was observed being transported to the front lobby via wheelchair. Resident # 94 stated she was going to a doctor's appointment.

On 3/5/18 at 11:40 AM, the corporate nurse (Admin B) was informed that morning medications had not been administered to several residents on the West Wing including Resident # 94. Admin B stated the facility staff had not informed her that medications had not been administered or that there was an issue. Admin B stated she would investigate the issue.

On 3/5/2018 at 1:35 PM, observed Resident # 94 was in her room, curtain was pulled and facility staff member was behind the curtain providing

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care.
On 3/5/2018 at 1:40 PM, an interview was conducted with Resident # 94 who stated she had returned to the facility at approximately 1:00 PM. Resident # 94 stated she did not receive any of her morning medications prior to leaving for her doctor's appointment. Resident # 94 stated she had not received her diabetic medicine early that morning either.

Aspirin 325 milligrams give one tablet by mouth one time a day for Prophylaxis. Due at 9:00 AM
Bumex 2 milligrams give one tablet by mouth one time a day for fluid retention. Due at 9:00 AM
CoQ10 100 milligrams give 2 capsules by mouth every Monday, Wednesday, and Friday for supplement. Due at 9:00 AM
Diltiazem 120 milligrams give one tablet by mouth for Hypertension. Due at 9:00 AM
Linagliptin 5 milligrams give one tablet by mouth one time a day for Diabetes Mellitus. Due at 7:30 AM
Multivital tablet(Multiple Vitamins-Minerals) give one tablet by mouth one time a day for supplement. Due at 9:00 AM
Pro-StatSugar Free Liquid give 30 milliliters by mouth one time a day for supplement. Due at 9:00 AM
Bumex 2 milligrams give one tablet by mouth two times a day for fluid retention. Due at 9:00 AM
Cipro 250 milligrams give 250 milligrams by mouth two times a day for UTI (Urinary Tract Infection) Due at 9:00 AM
Coreg 3.125 milligrams give one tablet by mouth two times a day for Hypertension. Due at 9:00 AM
Ferrous Sulfate 325 milligrams give one tablet by mouth two time a day for supplement. Due at 9:00 AM

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Protonix delayed release 40 milligrams give one tablet by mouth two times a day for Gastroesophageal Reflux Disease Due at 9:00 AM
Saccharomyces boulardil Capsule 250 milligrams give one capsule by mouth two times a day for Probiotic Due at 9:00 AM.

The surveyor requested a copy of the MAR. Review of the MAR revealed documentation that 9:00 AM medications were administered. There was no documentation that the medications were administered late.

On 3/5/18 at 5: 00 PM. an interview was conducted with Admin B who stated the morning medications were not given at 7:30 and 9:00 AM as scheduled but were given upon Resident # 94's return from her medical appointment after 1 PM. Admin B stated the facility could generate a pharmacy system report to determine the actual time medications were administered. Admin B stated anyone looking at the MAR would have thought the medications were administered on time as scheduled. Admin B also stated any nurse giving the next dose of medication would not automatically know the previous medications were administered late.

No further information was provided.

4. For Resident # 39, the facility staff failed to administer medications timely as ordered by the physician.

Resident # 39 was admitted to the facility on 1/17/2018 with diagnoses of but not limited to:

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Displaced fracture of right tibia, fracture of upper and lower right fibula, muscle weakness, Cervicalgia, Hypertension, Hypothyroidism, Allergic Rhinitis and Asthma.

The only Minimum Data Set (MDS) was an admission 5 day assessment with an Assessment Reference Date (ARD) of 2/16/18. The MDS coded Resident # 87 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required extensive assistance of one person with activities of daily living except ; always continent of bowel and bladder.

Review of the clinical record was conducted on 2/28/2018 and 3/1/2018.

Review of the February 2018 Medication Administration Record (MAR) revealed Amlodipine 5 milligrams one tablet by mouth was not documented as administered on 2/10/2018 at 9 AM.

Review of the Nurses Progress notes revealed no documentation of a reason for the omission of the administration of the medication.

An interview was conducted with the Corporate Nurse Consultant (Admin B) who stated medications should be administered as ordered by the physician. Admin B also stated she could not find any documentation of the reason for the omission.

Review of the facility policy "General Dose Preparation and Medication Administration revealed statements:
4.1.1 Verify each a medication is administered

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that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in Appendix 17: Facility Medication Administration Times Schedule.
4.1.2 Confirm that the MAR reflects the most recent medication order.....

4.1.5 If necessary, obtain vital signs.
5.4 Administer medications within timeframe specified by Facility policy
6.1 Document necessary medication administration/treatment information (e.g. (example) when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms."
The Corporate Consultant cited Lippincott as the Nursing professional guidance used by the facility.

Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

Valid physicians orders were evident.

During the end of day debriefing on 3/5/18, the facility Administrator and Admin B were informed of the findings. No further information was provided.

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5. For Resident # 345, the facility staff failed to administer medications timely as ordered by the physician.

Resident # 345 was a 56 year old female who was admitted to the facility on 3/15/2017 with diagnoses of but not limited to: Sepsis, Bacteremia, Cirrhosis of liver, Wedge Compression Fracture of T11-T12 Vertebra, Psoriasis, Anemia, Collapsed Vertebra Thoracic Region, Acute Osteomyelitis. Methicillin Sensitive Staphylococcus Aureus.

Resident # 345's MDS (minimum data set) was an admission 5 day assessment with an Assessment Reference Date (ARD) of 2/20/15. The MDS coded Resident # 345 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required extensive assistance of one to two staff persons with activities of daily living except required total assistance of two staff persons for bathing; always continent of bowel and bladder.

On 3/5/2018, review of the closed clinical record was conducted. The record revealed that Resident #345 was admitted to the facility on 3/15/2017 at 2:25 p.m. and discharged from the facility on 4/13/2017 with home health.

Review of the admission skilled note dated 3/15/2017 at 4:56 PM stated Resident # 345 was admitted to the facility for strengthening and Intravenous Antibiotic Therapy for Sepsis related

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to Methicillin Sensitive Staphylococcus Aureus, Bacteremia/manubriosternal joint infection. Resident # 345 had a PICC (Parenterally Inserted Central Catheter) in her upper right arm. Documentation stated Resident # 345 was alert and oriented times 3 (person, place and time).

Review of the March 2017 Medication Administration Record (MAR) revealed documentation of the administration times for Cefazolin in Sodium Chloride Solution 2-0.9 grams per 50 milliliters use 2 grams intravenously every 8 hours for MSSA (Methicillin Sensitive Staphylococcus Aureus). The medication was scheduled each day at 8 AM, 4 PM and 12 AM (midnight). There were numerous dates where the medications were administered late.

3/16/17 due at 4 PM, administered at 6:32 PM
3/17/17 due at 4 PM, administered at 5:51 PM
3/18/17 due at 8 AM, administered at 9:56 AM
3/18/17 due at 4 PM, administered at 7:26 PM
3/19/17 due at 12 AM, administered at 2:01 AM
3/19/17 due at 8 AM, administered at 9:09 AM
3/20/17 due at 12 AM, administered at 1:13 AM
3/21/17 due at 12 AM, administered at 1:33 AM
3/21/17 due at 8 AM, administered at 9:21 AM
3/22/17 due at 8 AM, administered at 9:49 AM
3/22/17 due at 4 PM, administered at 6:25 PM
3/23/17 due at 8 AM, administered at 9:31 AM
3/24/17 due at 8 AM, administered at 10:12 AM
3/24/17 due at 4 PM, administered at 5:27 PM
3/25/17 due at 8 AM, administered at 9:25 AM
3/26/17 due at 8 AM, administered at 9:24 AM
3/27/17 due at 8 AM, administered at 12:19 PM
3/27/17 due at 4 PM, administered at 5:21 PM
3/23/17 due at 8 AM, administered at 9:31 AM

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3/29/17 due at 8 AM, administered at 11:44 AM
3/23/17 due at 8 AM, administered at 9:31 AM
3/31/17 due at 8 AM, administered at 10:39 AM

The order was for the antibiotic to be given every 8 hours. On the dates the medications were given outside the window of acceptable range The administration of the medications outside of the every 8 hour range resulted in instances when the medication was administered with as few as 5 hours and as long as 11 hours and a half hours from the previous dose. Below are some examples of instances when untimely administration of medication resulted in shortened (less than 6 hours) and extended (greater than 10 hours) time frames between doses:

5 hours 58 min between 3/16/17 at 18:32 and 3/16/17 at 11:30 PM
11 hours 33 min between 3/27/17 at 12:47 AM and 3/27/17 at 12:19 PM
5 hours 2 min between 3/27/17 at 12:19 PM and 3/27/17 at 5:21 PM
4 hours 55 min between 3/29/17 at 11:44 AM and 3/29/17 at 4:39 PM

Review of the April 2017 Medication Administration Record (MAR) revealed documentation of the administration times for Cefazolin in Sodium Chloride Solution 2-0.9 grams per 50 milliliters use 2 grams intravenously every 8 hours for MSSA (Methicillin Sensitive Staphylococcus Aureus). The medication was scheduled each day at 8 AM, 4 PM and 12 AM (midnight). There were numerous dates where the medications were administered late.

4/3/17 due at 12 AM, administered at 1:33 AM

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4/3/17 due at 8 AM, administered at 9:29 AM
4/4/17 due at 8 AM, administered at 9:42 AM
4/3/17 due at 8 AM, administered at 9:29 AM
4/5/17 due at 4 PM, administered at 7:17 PM
4/5/17 due at 8 AM, administered at 9:14 AM
4/6/17 due at 4 PM, administered at 5:47 PM
4/7/17 due at 8 AM, administered at 9:17 AM
4/8/17 due at 8 AM, administered at 9:09 AM
4/8/17 due at 4 PM, administered at 5:04 PM

Review of the facility medication times schedule policy revealed every 8 hours medication times as 8:00 AM, 4:00 PM and 12 Midnight. The expectation is that medications should be administered within one hour before or after the scheduled time.

The facility policy "General Dose Preparation and Medication Administration stated:
4.1.1 Verify each a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in Appendix 17: Facility Medication Administration Times Schedule.
4.1.2 Confirm that the MAR reflects the most recent medication order.....

4.1.5 If necessary, obtain vital signs.
5.4 Administer medications within timeframe specified by Facility policy
6.1 Document necessary medication administration/treatment information (e.g. (example) when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms."

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Admin B cited Lippincott as its Nursing professional guidance used by the facility. Admin B stated the expectation is that medications should be administered within one hour before or after the scheduled time.

"Fundamentals of Nursing, by Lippincott", was stated as the facility nursing practice reference. That reference provides guidance for nursing standards. The reference stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."

The Corporate Consultant (Admin B) cited Lippincott as the Nursing professional guidance used by the facility.

Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

On 3/5/18 at 5 PM, the facility administrator and corporate nurse (Admin B) were informed of the failure of the staff to administer medications as ordered by the physician.

No further information was provided.

COMPLAINT DEFICIENCY

6. For Resident #74 the facility staff documented

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eight hours of enteral tube feeding as infused on the MAR
(medication administration record) before it actually did infuse.

Resident #74 was admitted to the facility on 1-26-18. Diagnoses included; tonsil cancer, stroke, respiratory failure, dysphagia, aphasia, aspiration pneumonia, diabetes, gastrostomy tube for feeding, congestive heart failure, and heart disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-26-18 was an admission assessment, and coded the resident's BIMS (brief interview of mental status) score as a "5" out of a possible 15, or severe cognitive impairment. The MDS coded the resident as requiring extensive assistance to total dependence of one to two staff members for ADL's (activities of daily living) such as bed mobility and hygiene.

Observation of the Resident was conducted at 10:00 a.m., on 3-1-18, and revealed the Resident lying in bed with a feeding pump infusing Glucerna 1.5 cal tube feeding at 50 milliliters (ml) per hour.

Review of the MAR (medication administration record) on 3-1-18 documented that on 3-1-18 at 10:00 a.m., the Resident had already received 500 ml (milliliters) of Glucerna 1.5 cal tube feeding.

Review of the current physician's orders revealed an order for Glucerna 1.5 cal tube feeding, infusing at 50 ml per hour, hold feeding 1 to 2 hours per day as needed.

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The day shift on 3-1-18 started at 7:00 a.m., and the feeding had only been infusing for 3 hours at the time of observation, so by physician's order only 150 ml should have infused.

The MAR had spaces to sign the amount of feeding that had infused for each of the 3 eight hour shifts (day/evening/night). The MAR required the amount infused would be documented at the end of each eight hour shift to reveal the correct total amount infused for that shift. This revealed that the MAR was not being documented with the correct amount infused, as 50 to 100 ml of feeding could be withheld each day, and necessary calories that were received by the Resident could not be properly calculated by the Registered Dietician if incorrect data was provided on the MAR document.

Review of the Resident's care plan stated infuse tube feeding per doctor's order.

Review of the facility's policy and procedure for Medication Administration directed that documentation of medications and treatments are only completed after the medication or treatment is completed. The DON (director of nursing) stated that the facility used "Lippincott" as their reference for professional standards

Guidance is given to nursing by "Lippincott", "After administering a medication, or treatment, record it immediately on the appropriate record form. Never chart a medication before administering it. Recording immediately after administration prevents errors. The recording of a medication includes the name of the medication, dose, route, and exact time of administration."

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On 3-2-18 at 4:00 p.m., the Corporate RN (registered nurse) stated, The expectation is that the nurse "should document the feeding after it is completed."

On 3-2-18 at 4:00 p.m., at the end of day debriefing, the Administrator and Corporate RN were notified of above findings.

7. For Resident #245 the facility staff failed to administer medications as ordered by a physician.

Resident #245 was admitted to the facility on 11-28-17. Diagnoses included; small bowel obstruction, hypertension, dementia with behaviors, depression, stroke, congestive obstructive pulmonary disease, high cholesterol, and chronic kidney disease.

The most recent MDS (minimum data set) for Resident #245, had an ARD (Assessment reference date) of 12-15-17, and was a full admission assessment. The MDS coded the Resident with a BIMS (brief interview of mental status) score as "unable to complete" due to severe cognitive impairment. The MDS coded the resident as requiring limited to extensive assistance of one to two staff members for ADL's (activities of daily living) such as bed mobility and transferring, and no falls while in the facility.

Review of the MARs (medication administration records) for November and December 2017, revealed the following omissions, not signed and not documented as given, and no nursing note to explain the omission:

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November 2017
11-30-17 - Amlodipine besylate tablet 10 mg (milligrams) give one per day at 9:00 a.m.
11-30-17 - Aspirin tablet 325 mg give once per day at 9:00 a.m.
11-30-17 - Cholecalciferol tablet 1000 units give once per day at 9:00 a.m.
11-30-17 - Multivitamin one tablet give once per day at 9:00 a.m.
11-30-17 - Sertraline hydrochloride tablet 50 mg give once per day at 9:00 a.m.
11-30-17 - Tiotropium Bromide-Clodaterol aerosol 2.5-2.5 mcg (micrograms) inhaled once per day at 9:00 a.m.
11-30-17 - Memantine hydochloride tablet 5 mg give twice per day at 9:00 a.m., and 9:00 p.m., both were omitted.
11-30-17 - Metoprolol tablet 25 mg twice per day at 9:00 a.m., and 9:00 p.m., the 9:00 a.m, dose was omitted.
11-29-17 - Oxygen at 2 liters per minute via nasal cannula every shift, omitted on day shift.
11-30-17 - Oxygen at 2 liters per minute via nasal cannula every shift, omitted on day evening.

December 2017
12-9-17 - Aricept 5 mg once per day at 9:00 p.m.
12-9-17 - Atorvastatin calcium 25 mg once per day at 9:00 p.m.
12-9-17 - Memantine hydochloride tablet 5 mg give twice per day at 9:00 a.m., and 9:00 p.m., the 9:00 p.m. dose was omitted.
12-9-17 - Metoprolol tablet 25 mg twice per day at 9:00 a.m., and 9:00 p.m., the 9:00 p.m., dose was omitted.

Oxygen at 2 liters per minute via nasal cannula

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every shift, was omitted multiple times in December, and are as follows;
12-3-17 day, 12-5-17 evening, 12-6-17 evening, 12-7-17 day, 12-8-17 day, and 12-9-17 evening.

Current physician orders were reviewed, and revealed current orders for all of the above omissions.

Resident #245's careplan was reviewed and stated to administer medications and treatments as ordered.

Review of the facility's policy and procedure for Medication Administration directed that medications and treatments were to be administered as per the physician's order. The DON (director of nursing) stated that the facility used "Lippincott" as their reference for professional standards

Guidance is given to nursing by "Lippincott", "After administering a medication, or treatment, record it immediately on the appropriate record form. Never chart a medication before administering it. Recording immediately after administration prevents errors. The recording of a medication includes the name of the medication, dose, route, and exact time of administration."

On 3-2-18 at 4:00 p.m., the Corporate RN (registered nurse) stated, The expectation is that the nurse "should document the administration of medications after completed."

On 3-2-18 at 4:00 p.m., at the end of day debriefing, the Administrator and Corporate RN were notified of above findings.

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F 684 SS=E	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to ensure the highest practicable well being for 4 residents (Resident #15, 26, 40 and #87) in a survey sample of 24 residents. 1. Resident #15 had a significant weight gain (8 pounds in one day); daily weights were discontinued by the diet technician. 2. Resident #26 had a significant weight gain; the weight was not rechecked. 3. Resident #40 had weight fluctuations; the resident was not weighed consistently (standing and sitting). 4. For Resident # 87, the facility staff failed to provide pain medications timely. The findings included: 1. Resident #15 was admitted to the facility on 12/12/17. Diagnoses included high blood pressure, diabetes and congestive heart failure.	F 684	F 684 Quality of Care 1. Residents affected by the deficient practice weights reviewed by Physician and responsible parties made aware of any discrepancies. Resident # 87 pain medications were administered and Physician was made aware during survey. No untoward effects. 2. All residents are at risk. 3. Measures taken: " DON / Designee will in-service all Licensed Nurses on appropriate process for weights. " DON / Designee will in-service all Licensed Nurses on pain medication administration. " A 30% audit of patients weights weekly for 3 weeks for changes. " A 30% audit of patients receiving pain meds weekly for 3 weeks for accuracy. 4. Performance will be reviewed quarterly through QA & A meeting.	4/6/18

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Resident #15's most recent Minimum Data Set assessment was an admission 5 day assessment with an assessment reference date of 12/19/17. Resident #15 was coded with a Brief Interview of Mental status score of "10" out of a possible 15 indicating mild cognitive impairment. The resident required limited assistance with activities of daily living such as eating and mobility.

On 2/28/18 at approximately 9:30 AM, Resident #15 was observed in her room in the wheel chair. She was clean and well groomed. No edema evident.

Review of the clinical record, including the weight tracking revealed the following weights:
12/13/17: 178 #
12/16/17: 187.2 #

On 12/18/17, the physician progress notes read: "Weight has also gone up 10 #" Assessment: Congestive Heart Failure. Start on Bumex (diuretic)...monitor weights daily."

Daily weights continued through February, 2018.

2/21/18: 189.6# (standing)
2/22/18: 198 # (standing)
2/23/18: 190.6# (standing)
2/24/18: 189.5 (standing)
2/25/18: 198.6# (standing)
2/28/18: 192.6 (standing)

Dietary notes dated 2/23/18 read: "5%, 7.5%, 10% weight gain. Reasons why weight change may have occurred: Weight stable x 2 months, fluctuates related to daily weights. No changes to intake. Suggest discontinue daily weights, go to

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weekly weights." This was written by the dietetic technician. There was no nursing documentation of the resident's lung sounds or assessment for edema. There were no physician progress notes.

Review of the care plan dated 2/27/18 revealed: "Monitor/document/report prn (as needed) any signs/symptoms of complications from weight gain, i.e., ineffective breathing patterns, altered breathing patterns, altered cardiac output." There was nothing in the care plan regarding weights, actions for increased weight.

On 3/2/18 at approximately 10:00 AM, the Administrator stated, "The CNA's (certified nursing assistants) obtain the weights." She added that the weights were obtained by different CNA's.

On 3/2/18 at approximately 1:30 PM, the Corporate Registered Dietician stated, "They should get a reweight the next day ideally." When asked if the 9.1# weight gain in one day was concerning (2/24/18 to 2/25/18), the dietician stated, "Yes."

2. Resident #26 had a significant weight gain; the weight was not rechecked.

Resident #26 was admitted to the facility on 5/18/17. Diagnoses included dementia with behavior disturbance and depression.

Resident #26's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/7/18. Resident #26 was coded with a Brief Interview of Mental status score of "5" out of a possible 15 indicating

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severe cognitive impairment. The resident required limited to extensive assistance with activities of daily living such as eating and mobility.

02/28/18 02:47 PM Resident #26 is up in her wheel chair, with legs elevated on the bed. Water is in reach. Has a chair alarm attached, functional.

Review of Resident #26's weight tracking revealed:

10/9/17: 96.6 #
11/1/17: 102 # (wheel chair)
11/12/17: 86.9 #
11/20/17: 86.3

The 11/13/17 weight committee meeting notes read as followed: "Suspect that weight of 102# is incorrect, reweight pending."

Review of the weight monitoring policy read: "The nursing staff will obtain reweights within 24 hours when a weight variance of 5 # from last weight and/or when a significant weight change is identified."

3. Resident #40 had weight fluctuations; the resident was not weighed consistently (standing and sitting).

Resident #40 was admitted to the facility on 10/16/17 and was readmitted on 1/5/18. Diagnoses included fracture of left femur and congestive heart failure.

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Resident #40's most recent Minimum Data Set assessment was a significant change in status 5 day assessment with an assessment reference date of 1/12/18. Resident #40 was coded with a Brief Interview of Mental status score of "15" out of a possible 15 indicating no cognitive impairment. The resident required extensive assistance with activities of daily living such as eating and mobility.

Review of the resident's weight tracking revealed:

1/1/18: 117.1 #
1/5/18: 124.6 #
1/15/18: 122.7#
1/24/18: 121.4 # (wheelchair)
2/5/18: 109.3 #
2/6/18: 112.5 #
2/8/18: 116.1 #

On 2/9/18, the weight committee meeting notes documented the following: 5, 7.5 and 10 % weight loss. No recent reasons why weight change may have occurred: weight appears to be fluctuating, resident weighed in wheelchair and standing...weight trending downward... Weight changes may be contributed to wheelchair and standing weight."

On 2/28/18 at the end of the day exit, the Administrator and Corporate Nurse Consultant were notified of above findings.

4. For Resident # 87, the facility staff failed to provide pain medicine timely.

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Resident # 87 was admitted to the facility on 2/9/2018 with diagnoses of but not limited to: Cerebral Infarction, hemiplegia and hemiparesis affecting left dominant side, generalized muscle weakness, Type 1 Diabetes Mellitus, Bipolar Disorder, Hypothyroidism, Hypertension, Major Depressive Disorder Recurrent, Anxiety Disorder, and Dementia without behavioral disturbance.

The only Minimum Data Set (MDS) was an admission 14 day assessment with an Assessment Reference Date (ARD) of 2/16/18. The MDS coded Resident # 87 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required one person assistance with activities of daily living; always continent of bowel and bladder.

During the initial tour of the facility on 2/27/2018 at 8 PM, Resident # 87 was observed lying in bed. Resident # 87 stated she hated that she had to wait so long for her pain medications at night. Resident # 87 stated she asked for her pain medication during the night shift "for the past 4 nights and had to wait hours for the medication and the medicine doesn't really help."

On 2/28/2018 at 10:30 AM, Resident # 87 participated in the Resident Council Group Interview along with 6 other residents. Resident # 87 again stated that she had to wait too long for pain medication and that the pain medication did not really work. Resident # 87 stated the facility was often late administering medications.

Review of the clinical record was conducted on 2/28/2018 and 3/1/2018.

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Review of the Physicians Orders revealed an order written 2/9/2018 for Tramadol 50 milligrams by mouth every 6 hours as needed for pain.

Review of the Progress Notes revealed documentation of complaints of pain twice on 2/27/2018.

2/27/18 at 09:41 AM of "no complaints of pain or discomforts at this time. Resident voiced complaints of pain and received medications as ordered non pharmacological ineffective."

2/27/18 at 11:53 PM .." PRN (as needed) pain medications given x 1 (one time) will continue to monitor."
There was no documentation in the Progress Notes of complaints of pain on the 4 days prior to 2/27/18.

Further review of the Progress Notes revealed documentation of "skilled notes" from 2/16/2018 -2/28/2018. The Nursing Progress Notes revealed documentation of administration of pain medication three times during 2/16/18-2/28/2018. Two times were documented on 2/27/2018 , once in the note at 9:41 AM and again at 11:53 PM. The only other documentation in the progress notes about pain was written on 2/19/2108 at 10:22 PM.

Review of the MAR (Medication Administration Record) revealed documentation of Tramadol 50 milligrams being administered on 2/27/2018 at 1:40 AM and no further documentation of an as needed pain medication being administered on 2/27/2018.

Further review of the MAR revealed

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documentation of administration of PRN Tramadol 7 times from 2/16- 2/28/18. The dates and times on the MAR were:
2/16/18-1711 (5:11 PM) Pain Level 4-Effective
2/19/18-1921 (7:21 PM) Pain Level 3-Effective
2/22/18-0329 (3:29 AM) Pain Level 4-Effective
2/24/18-0411 (4:11 AM) Pain Level 4-Effective
2/26/18-0543 (5:43 AM) Pain Level 7-Effective
2/27/18-0140 (1:40 AM) Pain Level 3-Effective
2/28/18-1537 (3:37 PM) Pain Level 6-Effective

The documentation in the Progress Notes did not match the documentation on the MAR.

Review of the care plan revealed a focus of Pain with interventions to "Medicate as ordered and notify MD (medical doctor) for pain not relieved with medication or with new complaints of pain."

Thorough review of the nurses notes revealed no documentation of notification of the doctor of pain not relieved by the as needed medication Tramadol.

On 3/5/2018 at 11:00 AM during rounds, Resident # 87 told the surveyor that she had not had any of her morning medications. Resident # 87 stated she also had asked for pain medications but had not yet received it. Resident # 87 stated she asked for the pain medication at 10:40 AM because her "neuropathy" was giving her "fits this morning." Resident # 87 stated she could not finish her therapy because of the pain.

On 3/5/2017 at 11:02 AM, the surveyor observed several staff members in the hallway and at the nurses station.

On 3/5/2018 at 11:15 AM, the Director of Nursing

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(DON) was asked where the medication nurse for Resident # 87 was located. The DON stated she did not know where the nurse was located but she would check it out. The DON stated the nurse was at lunch. When asked if morning medications had been administered, the DON stated she was unsure. The DON also stated she did not have a key to open the medication cart when the surveyor asked to see the medication card for Resident # 87.

On 3/5/2017 at 11:20 AM, the DON was observed talking with another nurse, Licensed Practical Nurse (LPN) B. Resident # 87 was sitting in her wheelchair next to the medication cart.

On 3/5/18 at 11:23 AM, observed LPN B at the medication cart pouring medications. LPN B stated she was going to give Resident # 87 her morning medications. LPN B stated another nurse, Registered Nurse (RN) B, was assigned to administer medications to Resident # 87 but RN B was running behind. Review of the MAR revealed the morning medications had not been administered yet. There were no initials in the slots for the morning medications at 9:00 AM
On 3/5/18 at 11:26 AM, observed LPN B administer medications to Resident # 87. LPN B stated she also gave Resident # 87 a pain pill (Tramadol) along with the regularly scheduled medications. LPN B stated residents should get pain medications when requested.

On 3/5/18 at 11:25 AM, an interview was conducted with RN B who stated she was from an agency and was assigned to work with Resident # 87. RN B admitted that she had not administered morning medications to Resident # 87 and several other residents who had medications due

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at 9:00 AM. RN B stated she had not been able to access the computer system until 9 AM and had to resolve an issue with another resident before passing the medications. RN B stated she then had to wait for the facility to print MARs. RN B stated she had informed the facility staff, Unit Manager (RN C) and the DON. RN B stated she had not been given any help despite notifying the facility staff that she was behind in administering the morning medications. RN B stated she still had several other residents to give the morning medications. RN B stated then it would "be time to give the 1:00 medications." RN B stated the expectation was that medications should be given within one hour before and one hour after the time scheduled. RN B stated she needed help due to several things that had happened that morning and caused her to be called away from her medication pour and pass duties. RN B stated she was trying to get to that room to pass medications and would have given the pain medication at that time.

On 3/5/18 at 11:40 AM, the Corporate Nurse Consultant (Admin B) was informed that morning medications had not been administered to several residents on the West Wing including Resident # 87. Admin B stated the facility staff had not informed her that medications had not been administered or that there was an issue. Admin B stated she would investigate the issue. The surveyor requested a copy of the MAR.

On 3/5/2018 at 11:50 AM, interview conducted with Resident # 87 who stated her pain level was a 10. Resident # 87 also stated "they had to stop my exercises to tell them I was in pain." Resident # 87 stated she also asked for ice packs to help with the pain.

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F 684	Continued From page 46 On 3/5/18 at 11:55 AM, review of the MAR revealed check marks and initials for the morning medications indicating the medications had been administered at 9:00. The surveyor asked Admin B why the documentation appeared to indicate the medications were administered timely. Admin B stated the computer system depicted the documentation in that manner but a report could be printed that would document the actual time of administration of medications. Review of the report revealed the actual time of administration of medications to be 11:23 AM and documented at 11:27 AM. Glimeperide 4 milligrams by mouth in the morning related to Type 1 Diabetes Due at 9:00 AM Lasix 20 milligrams give one tablet by mouth in the morning for CHF (Congestive Heart Failure) Due at 9:00 AM Lisinopril 20 milligrams give one tablet by mouth one time a day for Hypertension Due at 9:00 AM Plavix 75 milligrams give 75 milligrams by mouth one time a day for unspecified sequelae of unspecified cerbrovascular disease Due at 9:00 AM Protonix 20 milligrams give one tablet by mouth for Gastroesophageal Reflux Disease Due at 9:00 AM Venlafaxine Extended Release 24 hour 150 milligrams give 150 milligrams by mouth one time a day for depression Due at 9:00 AM Vitamin D 3 5000 Unit Give 5000 unit by mouth one time a day for unspecified sequelae of unspecified cerbrovascular disease Due at 9:00 AM Gabapentin 600 milligrams give 2 tablets by mouth three times a day for Hereditary and Idiopathic Neuropathy Due at 9:00 AM.	F 684		

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Review of the facility medication times schedule policy revealed morning medication times as 9:00 AM. The expectation is that medications should be administered within one hour before or after the scheduled time.

The facility policy "General Dose Preparation and Medication Administration stated:
4.1.1 Verify each a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in Appendix 17: Facility Medication Administration Times Schedule.
4.1.2 Confirm that the MAR reflects the most recent medication order.....

4.1.5 If necessary, obtain vital signs.
5.4 Administer medications within timeframe specified by Facility policy
6.1 Document necessary medication administration/treatment information (e.g. (example) when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms."

On 3/5/18 at 1:35 PM, an interview was conducted with Resident # 87 who stated she was feeling better after getting her medications along with a pain pill at 11:26. Resident # 87 stated she still had not received her medications that were due at 1:00 PM.

On 3/5/2018 at 1:45 PM, an interview was conducted with the Physical Therapist (Employee F) who stated Resident # 87 had complained of

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pain after completing 75 minutes of therapy. Employee F stated she told the nursing staff at 10:45 AM that Resident # 87 requested pain medication after therapy.

Resident # 87 received the pain medication at 11:26 AM. Resident # 87 rated the pain at a 10/10.

Admin B cited Lippincott as its Nursing professional guidance used by the facility. "Fundamentals of Nursing, by Lippincott", was stated as the facility nursing practice reference. That reference provides guidance for nursing standards. The reference stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."

The Corporate Consultant cited Lippincott as the Nursing professional guidance used by the facility.

Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

Additional Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com)
Rights of Medication Administration
1. Right patient
" Check the name on the order and the patient.
" Use 2 identifiers.

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" Ask patient to identify himself/herself.
" When available, use technology (for example, bar-code system).
2. Right medication
" Check the medication label.
" Check the order.
3. Right dose
" Check the order.
" Confirm appropriateness of the dose using a current drug reference.
" If necessary, calculate the dose and have another nurse calculate the dose as well.
4. Right route
" Again, check the order and appropriateness of the route ordered.
" Confirm that the patient can take or receive the medication by the ordered route.
5. Right time
" Check the frequency of the ordered medication.
" Double-check that you are giving the ordered dose at the correct time.
" Confirm when the last dose was given.
6. Right documentation
" Document administration AFTER giving the ordered medication.
" Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.
7. Right reason
" Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication?
" Revisit the reasons for long-term medication use.
8. Right response
" Make sure that the drug led to the desired effect. If an antihypertensive was given, has

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F 684	Continued From page 50 his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? " Be sure to document your monitoring of the patient and any other nursing interventions that are applicable. Reference: Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. www.nursingcenter.com Accessed online 3/8/2018. Valid physicians orders were evident. During the end of day debriefing on 3/5/18, the facility Administrator and Admin B were informed of the findings that Resident # 87 received her as needed pain medication 40-45 minutes after requesting it. Admin B stated residents should receive pain medications as ordered by the physician and upon their request. No further information was provided.	F 684		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review and in the course of a complaint investigation, the facility staff failed to provide pain management for one resident (Resident # 87) in a survey sample	F 697	F 697 Pain Management 1. Resident # 87 medication was administered during survey and Physician	4/6/18

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F 697	Continued From page 51 of 24 residents. 1. For Resident # 87, the facility staff failed to provide pain medicine timely. Findings included: Resident # 87 was admitted to the facility on 2/9/2018 with diagnoses of but not limited to: Cerebral Infarction, hemiplegia and hemiparesis affecting left dominant side, generalized muscle weakness, Type 1 Diabetes Mellitus, Bipolar Disorder, Hypothyroidism, Hypertension, Major Depressive Disorder Recurrent, Anxiety Disorder, and Dementia without behavioral disturbance. The only Minimum Data Set (MDS) was an admission 14 day assessment with an Assessment Reference Date (ARD) of 2/16/18. The MDS coded Resident # 87 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required one person assistance with activities of daily living; always continent of bowel and bladder. During the initial tour of the facility on 2/27/2018 at 8 PM, Resident # 87 was observed lying in bed. Resident # 87 stated she hated that she had to wait so long for her pain medications at night. Resident # 87 stated she asked for her pain medication during the night shift "for the past 4 nights and had to wait hours for the medication and the medicine doesn't really help." On 2/28/2018 at 10:30 AM, Resident # 87 participated in the Resident Council Group Interview along with 6 other residents. Resident # 87 again stated that she had to wait too long for pain medication and that the pain medication did	F 697	was made aware of the discrepancy. 2. All patients receiving pain medications are at risk for the deficient practice. 3. DON or Designee will in-service Licensed Nurses on medication administration. " A 30% audit will be completed on residents medication administration record for timely administration weekly for 3 weeks. 4. Performance will be reviewed through quarterly QA & A meeting.	

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not really work. Resident # 87 stated the facility was often late administering medications.

Review of the clinical record was conducted on 2/28/2018 and 3/1/2018.

Review of the Physicians Orders revealed an order written 2/9/2018 for Tramadol 50 milligrams by mouth every 6 hours as needed for pain.

Review of the Progress Notes revealed documentation of complaints of pain twice on 2/27/2018.

2/27/18 at 09:41 AM of "no complaints of pain or discomforts at this time. Resident voiced complaints of pain and received medications as ordered non pharmacological ineffective."

2/27/18 at 11:53 PM .." PRN (as needed) pain medications given x 1 (one time) will continue to monitor."
There was no documentation in the Progress Notes of complaints of pain on the 4 days prior to 2/27/18.

Further review of the Progress Notes revealed documentation of "skilled notes" from 2/16/2018 -2/28/2018. The Nursing Progress Notes revealed documentation of administration of pain medication three times during 2/16/18-2/28/2018. Two times were documented on 2/27/2018 , once in the note at 9:41 AM and again at 11:53 PM. The only other documentation in the progress notes about pain was written on 2/19/2108 at 10:22 PM.

Review of the MAR (Medication Administration

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Record) revealed documentation of Tramadol 50 milligrams being administered on 2/27/2018 at 1:40 AM and no further documentation of an as needed pain medication being administered on 2/27/2018.

Further review of the MAR revealed documentation of administration of PRN Tramadol 7 times from 2/16- 2/28/18. The dates and times on the MAR were:
2/16/18-1711 (5:11 PM) Pain Level 4-Effective
2/19/18-1921 (7:21 PM) Pain Level 3-Effective
2/22/18-0329 (3:29 AM) Pain Level 4-Effective
2/24/18-0411 (4:11 AM) Pain Level 4-Effective
2/26/18-0543 (5:43 AM) Pain Level 7-Effective
2/27/18-0140 (1:40 AM) Pain Level 3-Effective
2/28/18-1537 (3:37 PM) Pain Level 6-Effective

The documentation in the Progress Notes did not match the documentation on the MAR.

Review of the care plan revealed a focus of Pain with interventions to "Medicate as ordered and notify MD (medical doctor) for pain not relieved with medication or with new complaints of pain."

Thorough review of the nurses notes revealed no documentation of notification of the doctor of pain not relieved by the as needed medication Tramadol .

On 3/5/2018 at 11:00 AM during rounds, Resident # 87 told the surveyor that she had not had any of her morning medications. Resident # 87 stated she also had asked for pain medications but had

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not yet received it. Resident # 87 stated she asked for the pain medication at 10:40 AM because her "neuropathy" was giving her "fits this morning." Resident # 87 stated she could not finish her therapy because of the pain.

On 3/5/2017 at 11:02 AM, the surveyor observed several staff members in the hallway and at the nurses station.

On 3/5/2018 at 11:15 AM, the Director of Nursing (DON) was asked where the medication nurse for Resident # 87 was located. The DON stated she did not know where the nurse was located but she would check it out. The DON stated the nurse was at lunch. When asked if morning medications had been administered, the DON stated she was unsure. The DON also stated she did not have a key to open the medication cart when the surveyor asked to see the medication card for Resident # 87.

On 3/5/2017 at 11:20 AM, the DON was observed talking with another nurse, Licensed Practical Nurse (LPN) B. Resident # 87 was sitting in her wheelchair next to the medication cart.

On 3/5/18 at 11:23 AM, observed LPN B at the medication cart pouring medications. LPN B stated she was going to give Resident # 87 her morning medications. LPN B stated another nurse, Registered Nurse (RN) B, was assigned to administer medications to Resident # 87 but RN B was running behind. Review of the MAR revealed the morning medications had not been administered yet. There were no initials in the slots for the morning medications at 9:00 AM
On 3/5/18 at 11:26 AM, observed LPN B administer medications to Resident # 87. LPN B

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stated she also gave Resident # 87 a pain pill (Tramadol) along with the regularly scheduled medications. LPN B stated residents should get pain medications when requested.

On 3/5/18 at 11:25 AM, an interview was conducted with RN B who stated she was from an agency and was assigned to work with Resident # 87. RN B admitted that she had not administered morning medications to Resident # 87 and several other residents who had medications due at 9:00 AM. RN B stated she had not been able to access the computer system until 9 AM and had to resolve an issue with another resident before passing the medications. RN B stated she then had to wait for the facility to print MARs. RN B stated she had informed the facility staff, Unit Manager (RN C) and the DON. RN B stated she had not been given any help despite notifying the facility staff that she was behind in administering the morning medications. RN B stated she still had several other residents to give the morning medications. RN B stated then it would "be time to give the 1:00 medications." RN B stated the expectation was that medications should be given within one hour before and one hour after the time scheduled. RN B stated she needed help due to several things that had happened that morning and caused her to be called away from her medication pour and pass duties. RN B stated she was trying to get to that room to pass medications and would have given the pain medication at that time.

On 3/5/18 at 11:40 AM, the Corporate Nurse Consultant (Admin B) was informed that morning medications had not been administered to several residents on the West Wing including Resident #

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87. Admin B stated the facility staff had not informed her that medications had not been administered or that there was an issue. Admin B stated she would investigate the issue. The surveyor requested a copy of the MAR.

On 3/5/2018 at 11:50 AM, interview conducted with Resident # 87 who stated her pain level was a 10. Resident # 87 also stated "they had to stop my exercises to tell them I was in pain." Resident # 87 stated she also asked for ice packs to help with the pain.

On 3/5/18 at 11:55 AM, review of the MAR revealed check marks and initials for the morning medications indicating the medications had been administered at 9:00. The surveyor asked Admin B why the documentation appeared to indicate the medications were administered timely. Admin B stated the computer system depicted the documentation in that manner but a report could be printed that would document the actual time of administration of medications. Review of the report revealed the actual time of administration of medications to be 11:23 AM and documented at 11:27 AM.

Glimeperide 4 milligrams by mouth in the morning related to Type 1 Diabetes Due at 9:00 AM
Lasix 20 milligrams give one tablet by mouth in the morning for CHF (Congestive Heart Failure) Due at 9:00 AM
Lisinopril 20 milligrams give one tablet by mouth one time a day for Hypertension Due at 9:00 AM
Plavix 75 milligrams give 75 milligrams by mouth one time a day for unspecified sequelae of unspecified cerbrovascular disease Due at 9:00 AM
Protonix 20 milligrams give one tablet by mouth

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for Gastroesophageal Reflux Disease Due at 9:00 AM
Venlafaxine Extended Release 24 hour 150 milligrams give 150 milligrams by mouth one time a day for depression Due at 9:00 AM
Vitamin D 3 5000 Unit Give 5000 unit by mouth one time a day for unspecified sequelae of unspecified cerbrovascular disease Due at 9:00 AM
Gabapentin 600 milligrams give 2 tablets by mouth three times a day for Hereditary and Idiopathic Neuropathy Due at 9:00 AM

Review of the facility medication times schedule policy revealed morning medication times as 9:00 AM. The expectation is that medications should be administered within one hour before or after the scheduled time.

The facility policy "General Dose Preparation and Medication Administration stated:
4.1.1 Verify each a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in Appendix 17: Facility Medication Administration Times Schedule.
4.1.2 Confirm that the MAR reflects the most recent medication order.....

4.1.5 If necessary, obtain vital signs.
5.4 Administer medications within timeframe specified by Facility policy
6.1 Document necessary medication administration/treatment information (e.g. (example) when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN

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medications, application sight) on appropriate forms."

On 3/5/18 at 1:35 PM, an interview was conducted with Resident # 87 who stated she was feeling better after getting her medications along with a pain pill at 11:26. Resident # 87 stated she still had not received her medications that were due at 1:00 PM.

On 3/5/2018 at 1:45 PM, an interview was conducted with the Physical Therapist (Employee F) who stated Resident # 87 had complained of pain after completing 75 minutes of therapy. Employee F stated she told the nursing staff at 10:45 AM that Resident # 87 requested pain medication after therapy.

Documentation on the Pharmacy report revealed Resident # 87 received the pain medication at 11:26 AM. Resident # 87 rated the pain at a 10/10.

Admin B cited Lippincott as its Nursing professional guidance used by the facility. "Fundamentals of Nursing, by Lippincott", was stated as the facility nursing practice reference. That reference provides guidance for nursing standards. The reference stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."

The Corporate Consultant cited Lippincott as the Nursing professional guidance used by the facility.

Guidance is given from Lippincott Solutions,

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"Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

Additional Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com)
Rights of Medication Administration
1. Right patient
" Check the name on the order and the patient.
" Use 2 identifiers.
" Ask patient to identify himself/herself.
" When available, use technology (for example, bar-code system).
2. Right medication
" Check the medication label.
" Check the order.
3. Right dose
" Check the order.
" Confirm appropriateness of the dose using a current drug reference.
" If necessary, calculate the dose and have another nurse calculate the dose as well.
4. Right route
" Again, check the order and appropriateness of the route ordered.
" Confirm that the patient can take or receive the medication by the ordered route.
5. Right time
" Check the frequency of the ordered medication.
" Double-check that you are giving the ordered dose at the correct time.
" Confirm when the last dose was given.
6. Right documentation

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F 697	Continued From page 60 " Document administration AFTER giving the ordered medication. " Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug. 7. Right reason " Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? " Revisit the reasons for long-term medication use. 8. Right response " Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? " Be sure to document your monitoring of the patient and any other nursing interventions that are applicable. Reference: Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. www.nursingcenter.com Accessed online 3/8/2018. Valid physicians orders were evident. During the end of day debriefing on 3/5/18, the facility Administrator and Admin B were informed of the findings that Resident # 87 received her as needed pain medication 40-45 minutes after requesting it. Admin B stated residents should receive pain medications as ordered by the physician and upon their request. No further information was provided.	F 697		

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F 757	Continued From page 61	F 757		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, facility documentation and clinical record review, the facility failed to ensure one resident (Resident #250) in a survey sample of 24 resident, was free from un-necessary medications. Resident #250 was prescribed Seroquel (antipsychotic) for anxiety. The findings included:	F 757	F 757 Drug Regimen is Free from Unnecessary Drugs 1. Resident # 250 has been discharged from facility. 2. All residents with orders for Seroquel are at risk for deficient practice. 3. DON / Designee will in-service Licensed Nurses on the appropriate diagnosis for Seroquel. " A 100% audit of residents on	4/6/18

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F 757	Continued From page 62 Resident #250 was admitted to the facility on 2/4/18 and was readmitted 2/21/18. Diagnoses included acute respiratory failure, pneumonia, myocardial infarction and congestive heart failure. Resident #250's most recent Minimum Data Set assessment was a 5 day assessment with an assessment reference date of 2/10/18. Resident #250 was coded with a Brief Interview of Mental status score of "13" out of a possible 15 indicating no cognitive impairment. The resident required extensive assistance with activities of daily living such as dressing and mobility. On 2/28/18 at approximately 4:15 PM, an interview was conducted with the resident. He was pleasant, answered questions appropriately and clearly. Review of the physician's note dated 2/26/18 revealed: "Alert and oriented X 3. Psychiatric: Normal mood and affect." There was no mention of the use of Seroquel, although Seroquel 25 mg (milligrams) at night was on the discharge list of medications. There was no diagnosis for this medication, however, the discharge diagnoses included "acute hypoxic respiratory failure along with respiratory distress, acute encephalopathy with hallucination/delirium." The diagnosis for use at the facility was "anxiety." There was no mention in the physician's notes regarding tapering of the Seroquel or referral to psychiatric services. Further review of the clinical record revealed on 3/4/18, the diagnosis for the Seroquel was changed to "Give 25 mg by mouth at hs (hour of sleep) related to unspecified dementia without behavioral disturbance." There was no	F 757	Seroquel will be reviewed weekly for 3 weeks for appropriate diagnosis. 4. Performance will be reviewed through quarterly QA & A meeting.	

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F 757	Continued From page 63 documentation of behavioral issues. According to Saunders Nursing Drug Handbook, 2011, pages 984-985, Seroquel is an "antipsychotic" with a black box warning which states, "Elderly with dementia related psychosis are at increased risk of death." Precautions included "Alzheimer's dementia, cardiovascular disease (congestive heart failure, history of myocardial infarction)." Appropriate uses include: Schizophrenia, acute manic episodes with bipolar disorder. The FDA (food and drug administration)sent out a Seroquel medication guide which stated, " risk of death in the elderly with dementia. Medicines like SEROQUEL can increase the risk of death in elderly people who have memory loss (dementia). SEROQUEL is not for treating psychosis in the elderly with dementia." On 3/5/18 at 11:45 AM, an interview with the Corporate Nurse Consultant was conducted. She stated she was not aware of these diagnoses for the Seroquel. On 3/5/18, at approximately 5:00 PM, the Administrator and Corporate Nurse Consultant were notified of above findings.	F 757		
F 760 SS=E	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:	F 760		4/6/18

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F 760	Continued From page 64 Based on observation, staff interview, resident interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure two residents (Resident # 94 and # 345) in a survey sample of 24 residents were free from a significant medication error. 1. For Resident # 94, the facility staff failed to administer medications timely as ordered by the physician. On 3/5/2018, scheduled morning medications were not administered until the afternoon (including but not limited to: oral diabetic medicine, antihypertensives, antibiotics). 2. For Resident # 345, the facility staff failed to administer Intravenous antibiotic medications timely as ordered by the physician. Findings included: Resident # 94 was admitted to the facility on 2/9/2018 with diagnoses of but not limited to: Fracture of Right Femur, Cardiac Pacemaker, Hypertension, Peptic ulcer, Urinary Tract Infection, Acute Post Hemorrhagic Anemia, Diabetes, chronic Kidney Disease, Atrial Fibrillation, and Obstructive Sleep Apnea. The only Minimum Data Set (MDS) was an admission 5 day assessment with an Assessment Reference Date (ARD) of 2/16/18. The MDS coded Resident # 94 with a BIMS (Brief Interview for Mental Status) of 14/15 indicating no cognitive impairment; the resident required extensive assistance of one person with activities of daily living except required extensive assistance of two staff persons for transfers and required supervision and set up only for eating; frequently	F 760	F 760 Residents are Free of Significant Med Errors 1. Resident # 94 medications were administered during the survey, the Physician was notified and no untoward effects. Resident # 345 was discharged from the facility. 2. All residents may be at risk for deficient practice. 3. DON / Designee will in-service all Licensed Nurses on proper medication administration. " A 30% audit weekly of residents medication administration record for timeliness for 3 weeks. 4. Performance will be monitored quarterly through QA & A meeting.	

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incontinent of bowel and occasionally incontinent of bladder.

On 3/5/2018 at 11:35 AM, Resident # 94 was observed being transported to the front lobby via wheelchair. Resident # 94 stated she was going to a doctor's appointment.

On 3/5/18 at 11:40 AM, the corporate nurse (Admin B) was informed that morning medications had not been administered to several residents on the West Wing including Resident # 94. Admin B stated the facility staff had not informed her that medications had not been administered or that there was an issue. Admin B stated she would investigate the issue.

On 3/5/2018 at 1:35 PM, observed Resident # 94 was in her room, curtain was pulled and facility staff member was behind the curtain providing care.
On 3/5/2018 at 1:40 PM, an interview was conducted with Resident # 94 who stated she had returned to the facility at approximately 1:00 PM. Resident # 94 stated she did not receive any of her morning medications prior to leaving for her doctor's appointment. Resident # 94 stated she had not received her diabetic medicine early that morning either.

Aspirin 325 milligrams give one tablet by mouth one time a day for Prophylaxis. Due at 9:00 AM
Bumex 2 milligrams give one tablet by mouth one time a day for fluid retention. Due at 9:00 AM
CoQ10 100 milligrams give 2 capsules by mouth every Monday, Wednesday, and Friday for supplement. Due at 9:00 AM
Diltiazem 120 milligrams give one tablet by mouth for Hypertension. Due at 9:00 AM

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Linagliptin 5 milligrams give one tablet by mouth one time a day for Diabetes Mellitus. Due at 7:30 AM
Multivital tablet(Multiple Vitamins-Minerals) give one tablet by mouth one time a day for supplement. Due at 9:00 AM
Pro-StatSugar Free Liquid give 30 milliliters by mouth one time a day for supplement. Due at 9:00 AM
Bumex 2 milligrams give one tablet by mouth two times a day for fluid retention. Due at 9:00 AM
Cipro 250 milligrams give 250 milligrams by mouth two times a day for UTI (Urinary Tract Infection) Due at 9:00 AM
Coreg 3.125 milligrams give one tablet by mouth two times a day for Hypertension. Due at 9:00 AM
Ferrous Sulfate 325 milligrams give one tablet by mouth two time a day for supplement. Due at 9:00 AM
Protonix delayed release 40 milligrams give one tablet by mouth two times a day for Gastroesophageal Reflux Disease Due at 9:00 AM
Saccharomyces boulardil Capsule 250 milligrams give one capsule by mouth two times a day for Probiotic Due at 9:00 AM

The surveyor requested a copy of the MAR. Review of the MAR revealed documentation that 9:00 AM medications were administered. There was no documentation that the medications were administered late.

On 3/5/18 at 5: 00 PM. an interview was conducted with Admin B who stated the morning medications were not given at 7:30 and 9:00 AM as scheduled but were given upon Resident # 94's return from her medical appointment after 1

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PM. Admin B stated the facility could generate a pharmacy system report to determine the actual time medications were administered. Admin B stated anyone looking at the MAR would have thought the medications were administered on time as scheduled. Admin B also stated any nurse giving the next dose of medication would not automatically know the previous medications were administered late. Admin B presented a copy of the Pharmacy report that showed documentation of the actual time of administration of each medication.

Admin B also presented 7 sheets of Physician's Progress Notes written by the Physician that stated "All the patients that did not receive their meds on time today. I was fully informed of all these patients. I have reviewed the information thoroughly and do not anticipate any harm to the patients. The note was photocopied and the names of seven residents were written on the bottom of each form.

No further information was provided.

2. For Resident # 345, the facility staff failed to administer Intravenous antibiotic medications as ordered by the physician.

Resident # 345 was a 56 year old female who was admitted to the facility on 3/15/2017 with diagnoses of but not limited to: Sepsis, Bacteremia, Cirrhosis of liver, Wedge Compression Fracture of T11-T12 Vertebra, Psoriasis, Anemia, Collapsed Vertebra Thoracic

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Region, Acute Osteomyelitis. Methicillin Sensitive Staphylococcus Aureus.

Resident # 345's MDS (minimum data set) was an admission 5 day assessment with an Assessment Reference Date (ARD) of 2/20/15. The MDS coded Resident # 345 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required extensive assistance of one to two staff persons with activities of daily living except required total assistance of two staff persons for bathing; always continent of bowel and bladder.

On 3/5/2018, review of the closed clinical record was conducted. The record revealed that Resident #345 was admitted to the facility on 3/15/2017 at 2:25 p.m. and discharged from the facility on 4/13/2017 with home health.

Review of the admission skilled note dated 3/15/2017 at 4:56 PM stated Resident # 345 was admitted to the facility for strengthening and Intravenous Antibiotic Therapy for Sepsis related to Methicillin Sensitive Staphylococcus Aureus, Bacteremia/manubriosternal joint infection. Resident # 345 had a PICC (Parenterally Inserted Central Catheter) in her upper right arm. Documentation stated Resident # 345 was alert and oriented times 3 (person, place and time).

Review of the March 2017 Medication Administration Record (MAR) revealed documentation of the administration times for Cefazolin in Sodium Chloride Solution 2-0.9 grams per 50 milliliters use 2 grams intravenously every 8 hours for MSSA (Methicillin Sensitive Staphylococcus Aureus). The medication was

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scheduled each day at 8 AM, 4 PM and 12 AM (midnight). There were numerous dates where the medications were administered late.

3/16/17 due at 4 PM, administered at 6:32 PM
3/17/17 due at 4 PM, administered at 5:51 PM
3/18/17 due at 8 AM, administered at 9:56 AM
3/18/17 due at 4 PM, administered at 7:26 PM
3/19/17 due at 12 AM, administered at 2:01 AM
3/19/17 due at 8 AM, administered at 9:09 AM
3/20/17 due at 12 AM, administered at 1:13 AM
3/21/17 due at 12 AM, administered at 1:33 AM
3/21/17 due at 8 AM, administered at 9:21 AM
3/22/17 due at 8 AM, administered at 9:49 AM
3/22/17 due at 4 PM, administered at 6:25 PM
3/23/17 due at 8 AM, administered at 9:31 AM
3/24/17 due at 8 AM, administered at 10:12 AM
3/24/17 due at 4 PM, administered at 5:27 PM
3/25/17 due at 8 AM, administered at 9:25 AM
3/26/17 due at 8 AM, administered at 9:24 AM
3/27/17 due at 8 AM, administered at 12:19 PM
3/27/17 due at 4 PM, administered at 5:21 PM
3/23/17 due at 8 AM, administered at 9:31 AM
3/29/17 due at 8 AM, administered at 11:44 AM
3/23/17 due at 8 AM, administered at 9:31 AM
3/31/17 due at 8 AM, administered at 10:39 AM

The order was for the antibiotic to be given every 8 hours. On the dates the medications were given outside the window of acceptable range The administration of the medications outside of the every 8 hour range resulted in instances when the medication was administered with as few as 5 hours and as long as 11 hours and a half hours from the previous dose. Below are some examples of instances when untimely administration of medication resulted in shortened (less than 6 hours) and extended

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(greater than 10 hours) time frames between doses:

5 hours 58 min between 3/16/17 at 18:32 and 3/16/17 at 11:30 PM
11 hours 33 min between 3/27/17 at 12:47 AM and 3/27/17 at 12:19 PM
5 hours 2 min between 3/27/17 at 12:19 PM and 3/27/17 at 5:21 PM
4 hours 55 min between 3/29/17 at 11:44 AM and 3/29/17 at 4:39 PM

Review of the April 2017 Medication Administration Record (MAR) revealed documentation of the administration times for Cefazolin in Sodium Chloride Solution 2-0.9 grams per 50 milliliters use 2 grams intravenously every 8 hours for MSSA (Methicillin Sensitive Staphylococcus Aureus). The medication was scheduled each day at 8 AM, 4 PM and 12 AM (midnight). There were numerous dates where the medications were administered late.

4/3/17 due at 12 AM, administered at 1:33 AM
4/3/17 due at 8 AM, administered at 9:29 AM
4/4/17 due at 8 AM, administered at 9:42 AM
4/3/17 due at 8 AM, administered at 9:29 AM
4/5/17 due at 4 PM, administered at 7:17 PM
4/5/17 due at 8 AM, administered at 9:14 AM
4/6/17 due at 4 PM, administered at 5:47 PM
4/7/17 due at 8 AM, administered at 9:17 AM
4/8/17 due at 8 AM, administered at 9:09 AM
4/8/17 due at 4 PM, administered at 5:04 PM

Review of the facility medication times schedule policy revealed every 8 hours medication times as 8:00 AM, 4:00 PM and 12 Midnight. The

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expectation is that medications should be administered within one hour before or after the scheduled time.

The facility policy "General Dose Preparation and Medication Administration stated:
4.1.1 Verify each a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in Appendix 17: Facility Medication Administration Times Schedule.
4.1.2 Confirm that the MAR reflects the most recent medication order.....

4.1.5 If necessary, obtain vital signs.
5.4 Administer medications within timeframe specified by Facility policy
6.1 Document necessary medication administration/treatment information (e.g. (example) when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms."

Admin B cited Lippincott as its Nursing professional guidance used by the facility. Admin B stated the expectation is that medications should be administered within one hour before or after the scheduled time.

"Fundamentals of Nursing, by Lippincott", was stated as the facility nursing practice reference. That reference provides guidance for nursing standards. The reference stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."

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The Corporate Consultant (Admin B) cited Lippincott as the Nursing professional guidance used by the facility.

Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

Additional Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com)
Rights of Medication Administration
1. Right patient
" Check the name on the order and the patient.
" Use 2 identifiers.
" Ask patient to identify himself/herself.
" When available, use technology (for example, bar-code system).
2. Right medication
" Check the medication label.
" Check the order.
3. Right dose
" Check the order.
" Confirm appropriateness of the dose using a current drug reference.
" If necessary, calculate the dose and have another nurse calculate the dose as well.
4. Right route
" Again, check the order and appropriateness of the route ordered.
" Confirm that the patient can take or receive the medication by the ordered route.

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F 760	Continued From page 73 5. Right time " Check the frequency of the ordered medication. " Double-check that you are giving the ordered dose at the correct time. " Confirm when the last dose was given. 6. Right documentation " Document administration AFTER giving the ordered medication. " Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug. 7. Right reason " Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? " Revisit the reasons for long-term medication use. 8. Right response " Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? " Be sure to document your monitoring of the patient and any other nursing interventions that are applicable. Reference: Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. www.nursingcenter.com Accessed online 3/8/2018. On 3/5/18 at 5 PM, the facility administrator and corporate nurse (Admin B) were informed of the failure of the staff to administer medications timely as ordered by the physician.	F 760		

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F 760	Continued From page 74 No further information was provided.	F 760		
F 761 SS=D	COMPLAINT DEFICIENCY Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		4/6/18

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F 761	Continued From page 75 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure expired intravenous (IV) supplies were not available for use in 1 of 2 medication rooms. The east medication room contained the following expired items: 2 IV bags of 0.9% sodium chloride, 21 heparin flushes, and 3 vials of 0.9% sodium chloride. The findings included: On 3/2/18 at approximately 8:40 a.m. an inspection of the east medication room was conducted with Registered Nurse-D (RN-D). The following expired items were found in the medication room readily accessible for use: Two 250 ml (milliliter) bags of 0.9% sodium chloride were observed with expiration dates of 1/2018 and 2/2018 respectively; Twenty-one 5 ml heparin flushes with expiration dates ranging from 2/2017-2/28/18; and Three 10 ml single use vials of 0.9% sodium chloride with expiration dates of 12/1/16. When asked who was responsible for ensure expired medications were removed from the room, RN-D stated the "Nurses should've caught the expired items." On 3/2/18 at approximately 9:10 a.m. the west medication room was inspected and no expired items were observed. On 3/2/18 at 9:20 a.m. when asked if there were any residents on IV therapy, RN-D stated there were none.	F 761	F 761 Label / Store Drugs and Biologicals 1. The expired drugs and biologicals found were immediately disposed of during survey process. 2. All drugs and biologicals are at risk for expiration. 3. Measures taken to prevent re-occurrences: " DON / Designee will in-service all Licensed Nurses on proper storage of drugs and biologicals. " Weekly rounds to audit med carts and medication rooms for proper storage of medications and biologicals for 3 weeks. 4. Performance will be reviewed in quarterly QA & A meeting.	

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F 761	Continued From page 76 On 3/5/18 at 5:40 p.m. the Administrator and Corporate Nurse were informed of the expired IV fluids in the east medication room. No further information was offered by the facility staff.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(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 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		4/6/18

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANOVER HEALTH AND REHABILITATION CENTER	8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111

(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 842	Continued From page 77 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to keep an accurate medical record for one resident (Resident # 87) in a survey sample of 24 residents.	F 842	F 842 Resident Records □ Identifiable Information 1. Resident # 87, the diagnosis was	

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F 842	Continued From page 78 For Resident # 87, the facility staff failed to ensure accurate documentation of diagnoses and blood pressures. Findings included: Resident # 87 was admitted to the facility on 2/9/2018 with diagnoses of but not limited to: Cerebral Infarction, hemiplegia and hemiparesis affecting left dominant side, generalized muscle weakness, Type 1 Diabetes Mellitus, Bipolar Disorder, Hypothyroidism, Hypertension, Major Depressive Disorder Recurrent, Anxiety Disorder, and Dementia without behavioral disturbance. The only Minimum Data Set (MDS) was an admission 14 day assessment with an Assessment Reference Date (ARD) of 2/16/18. The MDS coded Resident # 87 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required one person assistance with activities of daily living; always continent of bowel and bladder. Review of the clinical record was conducted on 2/28/2018 and 3/1/2018. Review of the Nurses Progress Notes revealed documentation of statement "skilled for CVA (Cerebrovascular Accident) and TIA (Transient Ischemic Attack) Left sided weakness" on 2/9/18, 2/10/18 and 2/11/18. Notes written 2/13/2018 -2/16/2018 documented Skilled Note: Skilled for Cerebrovascular Accident, Left Hemiparesis, Hypertension, Diabetes Mellitus and Bipolar.	F 842	immediately corrected. The BP was typed in error. 2. All residents requiring SNF documentation are at risk for deficient practice. 3. DON / Designee will in-service all Licensed Nurses on accurate skilled progress note documentation. " A 30% audit of skilled patients progress notes will be monitored for accurate diagnosis and typographic errors in Blood Pressures. Audit will be performed weekly for 3 weeks. 4. Performance will be monitored through Quarterly QA & A meeting.	

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F 842	Continued From page 79	F 842		

On 2/19/2018 at 10:22 PM, a skilled note stated "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma. Resident is alert and oriented x 3. Took all medication. C/O (complaint of pain), PRN (as needed) medication given and effective...."
On 2/20/2018 at 1:38 PM, Skin/Wound note stated "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma.
On 2/20/2018 at 9:39 PM, a skilled note stated "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma.
On 2/21/2018 at 11:21 PM, a skilled note stated "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma.
On 2/22/2018 at 5:38 PM, a skilled note stated "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma.
On 2/22/2018 at 7:53 PM, a skilled note stated "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma.
On 2/23/2018 at 10:53 PM, a skilled note stated "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma.
On 2/24/2018 at 12:28 PM, a skilled note stated "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma.
On 2/25/2018 at 12:16 PM, a skilled note stated "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma.
On 2/26/2018 at 10:37 AM, a skilled note stated "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma.
On 2/27/2018 at 9:41 AM, a skilled note stated "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma.
On 2/27/2018 at 11:53 PM, a skilled note stated "Skilled for left pubic fracture, fall dementia, HTN

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F 842	Continued From page 80	F 842		

(Hypertension), OA (Osteoarthritis), Glaucoma.

On On 2/28/2018 at 5:08 PM, a skilled note stated "Skilled therapy related to CVA (Cerebrovascular Accident), HTN (Hypertension), DM (Diabetes Mellitus) and bipolar.

On 3/1/2018 at 12:19 AM, a skilled note stated "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma.

From 2/19/2018-2/27/2018 and on 3/1/2018, facility staff documented "Skilled for left pubic fracture, fall dementia, HTN (Hypertension), OA (Osteoarthritis), Glaucoma."

On 2/28/2018, facility staff documented "Skilled therapy related to CVA (Cerebrovascular Accident), HTN (Hypertension), DM (Diabetes Mellitus) and bipolar.

Review of the MDS revealed no documentation of diagnoses of pubic fracture, glaucoma and osteoarthritis.

Review of the care plan and Physicians Progress Notes revealed no documentation of a left pubic fracture, Glaucoma or Osteoarthritis. The care plan listed diagnoses of Cerebral Infarction, hemiplegia and hemiparesis affecting left dominant side, generalized muscle weakness, Type 1 Diabetes Mellitus, Bipolar Disorder, Hypothyroidism, Hypertension, Major Depressive Disorder Recurrent, Anxiety Disorder, and Dementia without behavioral disturbance.

Review of the Physical Therapy Notes dated

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F 842	Continued From page 81	F 842		

2/12/2018 -2/22/2018 revealed no documentation of a left pubic fracture. The therapy notes stated diagnosis "Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and muscle weakness.

On 3/5/2018 at 1:35 PM, an interview was conducted with the Physical therapist (Employee F) about whether Resident # 87 was able to finish her exercises that day. Employee F stated Resident # 87 finished her exercise routine of 75 minutes to strengthen the muscles weakened by a stroke.

Other inaccurate information was noted in Resident # 87's record. There were inaccurate blood pressure readings.

Review of the March 2018 Medication Administration Record revealed blood pressures taken at 9 AM prior to scheduled administration of Lisinopril 20 milligrams give one tablet by mouth one time a day for hypertension. Review revealed 138/555 blood pressures of 138/555 documented on 3/4/2018 at 9 AM and again 3/5/18 at 9 AM. The diastolic blood pressure was listed as 555 on both dates. Systolic blood pressures are higher than diastolic blood pressures. A measurement of 555 is unattainable.

No further information was provided.