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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 2/28/17 through 3/2/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey.<br><br>The census in this 120 certified bed facility was 83 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents #1 through #14) and 4 closed record reviews (Residents #15 through #18). | F 000 | | |
| F 225 SS=D | INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br>CFR(s): 483.12(a)(3)(4)(c)(1)-(4)<br><br>483.12(a) The facility must-<br><br>(3) Not employ or otherwise engage individuals who-<br><br>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;<br><br>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or<br><br>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. | F 225 | | 4/10/17 |

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

Electronically Signed | 03/17/2017

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

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(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and

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| F 225 | Continued From page 2<br>if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to investigate timely and report an injury of unknown origin to the state agency (SA) for one Resident (Resident #15) in a survey sample of 18 Residents.<br><br>For Resident #15, the facility staff failed to investigate an injury of unknown origin (IUO) in a timely manner and failed to report a fractured arm that was identified as an IUO to the SA.<br><br>The findings included:<br><br>Resident #15, a female, was initially admitted to the facility 8/3/15 and readmitted after a hospitalization 3/16/16. Her diagnoses included hemiplegia, epileptic syndrome, dysphagia, cognitive communication deficit, gastrostomy, hypertension, hyperlipidemia, constipation, osteoporosis, cerebrovascular accident, and gastroesophageal reflux disease. Resident #15 was discharged from the facility to home on 9/2/15.<br><br>Resident #15's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/8/16 was coded as an annual assessment. Resident #15 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #15 was coded as requiring extensive to total assistance of one to two staff members to perform her activities of daily living. For | F 225 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.<br><br>F225<br>1- Resident #15 sustained a fracture on 6/10/16 and it was determined at that time by the physician that the fracture was related to the resident diagnosis of Osteopenia and Degenerative joint changes of the spine and scapula.<br>2- The DON or Designee will review shift report and Incident and Accident report of residents for any indication of injuries of unknown origin and ensure that these incidences are reported to the State Agency appropriately.<br>3- The DON or designee will educate all current licensed nursing staff on the procedure to follow in reporting injuries of unknown origin to the DON or designee so that the incident can be reviewed and reported to the State Agency as applicable. | |

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| F 225 | Continued From page 3 | F 225 | 4-The DON or designee will review shift report and Incident and Accident reports for residents on a weekly basis to ensure that any injuries of unknown origin are reported to the State Agency, as applicable. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation. | |

transferring and bed mobility, she was coded as requiring extensive assistance of two staff members for bed mobility and total assistance on two staff members for transferring. Resident #15 was assessed and coded as needing a mechanical lift to transfer in and out of bed. At the time of the injury, Resident #15's bed and transferring ability was coded the same as the 8/8/16 MDS.

During the course of a complaint investigation, Resident #15's clinical record was reviewed. Documentation within the clinical record revealed:

"6/10/16 Resident's daughter states that her mother is showing s/s (signs and symptoms) of pain. Assessment performed. Confirmation of pain to left shoulder noted AEB (as evidenced by) grimacing with palpation of shoulder, guarding of shoulder with right hand, and physical acknowledgment of pain by nodding head when asked."

Resident #15's physician was informed of the pain in her shoulder and ordered for x-rays to be obtained.

The x-ray was obtained at 7:15 p.m. and revealed "There is an acute displaced oblique fracture of the proximal left humeral diaphysis with 3 cm (centimeter) of overlapping fracture fragments and 1.5 cm of medial displacement of the distal fracture fragment. There is also a minimally displaced acute fracture of the acromion process of the scapula at the acromicoclavicular joint, but no evidence of acromicoclavicular separation. No evidence of dislocation or radiopaque foreign bodies. Demineralization consistent with osteoporosis. Moderate disease of the left

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acromicoclavicular and glenohumeral joints."

The physician was informed of the results and ordered for the shoulder to be stabilized. Resident #15 was treated with a sling, ice, bed rest with no transfers, and pain medication. Her physician was in to the facility and assessed her on 6/12/16 and continued the previous treatment plan. The physician's plan was for Resident #15 to be evaluated by an orthopedist on Monday 6/13/16. Resident #15's family were concerned an appointment would not be made until later in the week, therefore they wanted Resident #15 evaluated in the emergency room.

The physician was notified of the family's wishes and Resident #15 was evaluated in the ER. Upon returning to the facility, conservative treatment was continued until she was seen by the orthopedist who continued with symptomatic treatment. Resident #15 was treated with pain management, positioning, a sling to the arm, and ice.

Review of the investigation conducted by the facility revealed the previous DON (director of nursing) revealed on 6/6/16 a CNA (certified nursing assistant) notified the nurse that she heard a "creeking (sp)" noise when positioning Resident #15 in bed. The nurse assessed Resident #15, having difficulty performing ROM (range of motion) to Resident #15's left arm due to a long term contracture. At the time of the assessment, Resident #15 displayed no indications of pain, swelling or "deformity." The nurse indicated she assessed Resident #15 later in the shift for pain or discomfort with her left arm, with no indication Resident #15 was in distress. Review of the investigation revealed the nurse

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that assessed Resident #15 was not interviewed until 6/14/16 (4 days after the fracture was diagnosed) and the investigation was not completed until 6/21/16 (11 days after the injury was identified).

Review of the nursing notes from 6/6/16 though 6/10/16 revealed no indication Resident #15 displayed any indications of pain or distress with her left arm or shoulder. Additionally review of the nursing notes prior to 6/10/16 revealed no evidence or falls or any indication of anything that would cause a fracture. Documentation was evident that in December, 2015, Resident #15 was diagnosed as having spontaneous fracture of her ribs. The rib fracture led to a diagnoses of severe osteopenia.

A thorough review of the investigation revealed no evidence the SA was notified of an IUO for Resident #15's left shoulder fracture. The current DON was not at the facility at the time of the diagnosed fracture. The administrator stated she had reviewed the investigation conducted at the time of diagnoses and could find no evidence the SA was notified of the IUO. The administrator stated the fracture should have been reported to the SA as an IUO, 3/2/17 at 10:45 a.m.

Review of the facility's policy entitled "Abuse, Neglect, Misappropriation/Crime Initial Reporting Guidelines" included:

"1. Centers must report incidents or allegation of mistreatment, neglect, abuse (injuries of unknown origin), exploitation (misappropriation of patient property), or any crime against a patient or reasonably suspected by any Center staff or visitor.

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| F 225 | Continued From page 6<br><br>Center staff includes any employee, volunteer, or contractor of the Center such as Center Administrators, administrative staff, physicians, RNs (registered nurse), LPNs (licensed practical nurse) nurse aides, podiatrists, dentists, beauticians, housekeepers, dietary, laundry, maintenance staff and laboratory personnel.<br><br>2. Injuries of unknown origin (injuries not witnessed or patient can't state what happened) should be handled the same as an allegation of mistreatment, neglect or abuse and must be reported to the State Survey Agency."<br><br>The administrator, DON, and corporate consultant were informed of the failure of the staff to investigate timely and report an IUO (fractured left shoulder) to the SA for Resident #15, 3/2/17 at 1:46 p.m. | F 225 | | |
| F 281 SS=E | COMPLAINT DEFICIENCY<br>SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br>CFR(s): 483.21(b)(3)(i)<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, facility documentation review and clinical record review, the facility staff failed to | F 281 | F281<br>1- Resident #11 is receiving Xanax as ordered. The Lovenox order for resident | 4/10/17 |

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| F 281 | Continued From page 7<br>follow the professional standards of nursing regarding medications for 3 Residents (#11, #2 and #3) in a survey sample of 18 residents.<br><br>1. For Resident # 11, the facility staff failed to ensure that an antianxiety medication (Xanax) was given as prescribed.<br><br>2. For Resident #2, the facility staff failed to obtain clarification for an inaccurately written physician order. The route for administration of Lovenox (an anticoagulant that helps prevent the formation of blood clots) was written to be administered intramuscularly, instead of subcutaneously, per the physician's verbal order.<br><br>3. For Resident # 1, the facility staff failed to clarify a physician's order for the medication Florastor.<br><br>Findings included:<br><br>1. For Resident # 11, the facility staff failed to ensure that an antianxiety medication (Xanax) was given as prescribed.<br><br>Resident #11 was admitted to the facility on 2/27/17. Diagnoses included but were not limited to: Chronic respiratory failure, COPD (chronic obstructive pulmonary disease), anxiety, congestive heart failure and sleep apnea.<br><br>Resident #11's most recent MDS (minimum data set) had not yet been completed, but a nursing assessment dated 2/27/17 indicated the resident was alert and oriented times three (person, place and time).<br><br>On 2/28/17, Resident #11 was observed in the | F 281 | #2 was corrected on 12/29/16. The Florastor order for Resident #1 was corrected on 3/1/17.<br>2- The Unit Manager or designee will audit current residents with new medication orders to ensure that the medication is received from the pharmacy and administered timely. The UM or designee will audit new medication orders to ensure that they are transcribed correctly.<br>3- The DON or designee will educate all licensed nursing staff on notifying the pharmacy of new medication orders for timely delivery and administration of the new medication. The licensed nursing staff will also be educated on proper transcription of medication orders.<br>4- The Unit Manager or designee will review new medication orders on a weekly basis for residents to ensure that the medication is delivered and administered timely. The UM or designee will review new orders on a weekly basis to ensure that they are transcribed correctly as ordered by the physician. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation. | |

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bed, with oxygen in place at 6 liters per minute by a nasal cannula. LPN (licensed practical nurse) (D) had prepared the resident's medications, remarking that, "The Xanax is not here, I will call the pharmacy." LPN (D) did check the stat box for the Xanax, which did not contain the medication. Upon entering the room, Resident #11 stated, "I need my Xanax, I am anxious." LPN (D) stated that she would notify the pharmacy and obtain the medication and offered him Tylenol.

Review of the MAR (medication administration record) for February and March. Upon review, there was a physician's order dated 2/27/17 for Xanax 0.25 mg (milligrams) every 8 hours for anxiety ( to be given at 12:00 AM, 8:00 AM and 4:00 PM). The February MAR showed the Xanax had not been given on the 27th or the 28th. The first dose was given on 3/1/17 at 12:00 AM. There was a total of four times the medication was not given.

Potter and Perry, 7th edition, page 930, documents that antianxiety medications are used to treat dyspnea (difficulty breathing).

Review of the nurses notes contained the following information:

On 2/28/17 at 5:56 AM, the note read: "waiting for med to arrive from pharmacy."

On 2/28/17 at 7:41 AM, the note read: "awaiting pharmacy delivery."

On 2/28/17 at 4:15 PM, "med not in, calling for script (prescription- Xanax requires a "hard " or handwritten order).

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On 2/28/17 at 7:00 PM, "complained of anxiety, med on order, will be in tonite."

On 3/1/17 at 9:40 AM, an interview was conducted with LPN (E). She stated, "The hard script is sent from the hospital and we fax it to the pharmacy. We call them to stat it out, turnaround time is four hours."

On 3/2/17 at approximately 8:35 AM, the Administrator and DON (director of nursing) were notified of above findings.

2. For Resident #2, the facility staff failed to accurately transcribe the route for administration of Lovenox (an anticoagulant that helps prevent the formation of blood clots). Resident #2's Lovenox order was written to be administered intramuscularly (IM), instead of subcutaneously (SQ).

Resident #2 was admitted to the facility on 8/4/16. Diagnoses included heart failure, hypertension, arthritis, cerebrovascular disease, and schizophrenia.

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/3/17 was coded as a quarterly assessment. Resident #2 was coded a BIMS (brief interview of mental status) score of '15' out of 15, cognitively intact. She was also coded as needing extensive to total assistance of one to two staff members for activities of living, except eating. For eating, she was coded as requiring supervision.

Resident #2 was observed on 2/28/17 at 2:40 p.m. During this observation Resident #2 was in

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her bed with an air mattress in place and a worn black bible positioned across her chest. Resident #2 was very talkative and denied having any concerns. Resident #2 said, "Yes, I refuse just about everything they want me to do. God has healed me and takes care of me".

On 3/1/17 at 8:15 a.m., a review of Resident #2's clinical record was initiated.

Review of Resident #2's clinical record revealed a signed physician's order that read, "12/5/16, Lovenox Inject 70 mg/ml (milligram/milliliters) intramuscularly (IM) two times a day related to HEART FAILURE." The order was created by LPN (licensed practical nurse) C on 12/5/16 and electronically signed by the physician on 12/8/16.

Review of the December 2016 EMAR (electronic medication administration record) revealed a corresponding order which indicated between 12/5/16 through 12/29/16, Resident #2 had refused the Lovenox on all days except 12/17 and 12/18. On these dates and times, LPN G was the nurse that documented administration of Lovenox intramuscularly. Further review of the MAR revealed the location of the injection sites as follows:
"a. 12/17/16 9:48 Route intramuscularly; Location Abdomen LLQ (left lower quadrant).
b. 12.17/16 17:49 Route intramuscularly; Location Abdomen RLQ (right lower quadrant).
c. 12/18/16 9:01 Route intramuscularly; Location Abdomen LLQ.
d. 12/18/16 17:09 Route intramuscularly; Location Abdomen LLQ."

A pharmacy Consultation Report written during a monthly medication regimen review dated

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12/29/16 read, "During the review of [Resident's Name] medical record, the following omissions or errors were noted on the medication administration record / prescriber order sheets (POS): Enoxaparin (Lovenox) is ordered to be given IM -IT SHOULD NEVER BE GIVEN IM. Only Subcutaneous or IV (intravenous) is allowed. Please update and notify medical records. It was signed by the consultant pharmacist on 12/29/16. LPN A's, unit manager, signature was hand written on this form and dated 12/29/16. The interim director of nursing, RN (registered nurse) A, also signed the consultation report.

On 3/1/17 at 3:12 p.m., an interview was conducted with the DON (director of nursing) regarding the physician's order to administer Lovenox IM. The DON said she had spoken with the pharmacy and the DON wrote the following regarding her conversation, "Pharmacy process is to verify before sending. Per pharmacy this should have been caught before sent to us. Syringe does not allow to be given IM."

On 3/1/17 at 4:20 p.m., during an end of day meeting, the DON said there were 5 prefilled Lovenox syringes remaining in Resident #2's initially delivered box of 8 Lovenox syringes. The DON provided a copy of the box label , and the label on one of the prefilled individually wrapped Lovenox syringes. The label on the box read, "INJECT 70 MG (.7 ML) INTRAMUSCULARLY TWO TIMES A DAY." The needle attached to the syringe was thin and short, like a needle for administering subcutaneous insulin. The DON was confident that the administered Lovenox was not administered IM.

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On 3/2/17 at 9:00 a.m., a telephone interview was conducted with the Pharmacy Account Manager, Other A. During this interview, Other A said the pharmacist that received the physician order electronically should have noticed the route was not correct and the pharmacist should have notified the facility staff to get clarification prior to releasing the Lovenox to the facility. Other A said the Lovenox should not have been sent to the facility with the wrong route written on the directions. When asked about the risks of giving Lovenox IM instead of SQ, Other A said it would be best to talk with the clinical consultant pharmacist, Other B, regarding any clinical questions..

On 3/2/17 at 9:30 a.m., a follow-up interview was conducted with Resident #2. When asked about having received any injections, Resident #2 adamantly said, "No, I wouldn't let them stick me. The Lord is taking care of me."

On 3/2/17 at 9:40 a.m., a unit charge nurse, LPN H, was interviewed regarding Resident #2's order to administer the Lovenox intramuscularly. Between 12/5 through 12/29, LPN H documented 5 occasions in which Resident #2 refused Lovenox. LPN H stated, "She always refuses it. I just ask her which medications she wants take, she usually refuses all of them." When asked about the order written to administer intramuscularly, LPN H said she knew the Lovenox was to be administer subcutaneously and the prefilled syringe was also an indicator that it should be administered subcutaneously.

On 3/2/17 at 10:28 a.m., a telephone interview was conducted with Other B, the pharmacy consultant. Other B stated, "The in-house

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pharmacist would review and approve the physician order before sending the medication out to the facility." Other B said the pharmacist should have caught the error and notified the facility before sending the Lovenox. When asked about the risk to the resident if Lovenox was administered intramuscularly, Other B said, "If given in the muscle, this medication to reduce blood clots would be released much slower."

On 3/2/17 at 11:12 a.m., the DON cited Mosby's Potter and Perry, Fundamentals of Nursing, as a reference for facility's professional nursing standards.

On 3/2/17 at 2:05 p.m., a follow-up conversation with the DON regarding Resident #2's Lovenox order was conducted. The DON said the expectation was for the nurses to get clarification on the order.

On 3/2/17 at 2:35 p.m., an interview was conducted with LPN C, the nurse that created and electronically transmitted the physician order to the pharmacy. LPN C stated, "The doctor said subcutaneously, I accidentally click on intramuscularly. I knew it was to be given subcutaneously".

On 3/2/17 at 2:55 p.m., a request was made for the facility's policy/procedure for pharmacy services and responsibilities. The nurse consultant, Admin C, said, "We use the pharmacy's policy and follow the guidance provided in our quality assurance (QA) tool."

Guidance for nursing practice regarding physician's orders was included in, Mosby's 'Fundamentals of Nursing' 7th Edition, page 336,

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"The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients. Therefore you need to assess all orders, and if you find one to be erroneous or harmful, further clarification from the physician is necessary."

On 3/2/17 at 3:50 p.m., the administration was informed of the facility staff's failure to clarify an order to administer Resident #2's Lovenox IM. No additional information was provided.
3. For Resident # 1, the facility staff failed to clarify a physicians order for the medication Florastor (a probiotic).

"Probiotics are live microorganisms that may be able to help prevent and treat some illnesses. Promoting a healthy digestive tract and a healthy immune system are their most widely studied benefits at this time. These are also commonly known as friendly, good, or healthy bacteria.

Probiotics: Find Out About the Benefits and Side Effects - MedicineNet
www.medicinenet.com/probiotics/article.htm"

Resident #1 was a 71 year old female who was admitted to the facility on 7/12/2004. Resident #1's diagnoses included but were not limited to: Hypertension, Diabetes, Congestive Heart Failure, Gastroesophageal Reflux Disease, and History of Colon Cancer.

The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 12/9/2016. The MDS coded Resident #1 as having a Brief Interview of

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Mental Status score of 7, indicating severe cognitive impairment. Resident # 1 required total assistance of two staff persons for Activities of Daily Living except required extensive assistance of two staff persons for bed mobility and supervision with eating. Resident # 1 was coded as always incontinent of bowel and frequently incontinent of bladder.

Review of the clinical record was conducted on 3/1/2017 at 8:45 AM.
Review of the February 2017 Physicians orders revealed an order written on 7/11/2016 for Florastor 250 milligrams, Give 1 milligram by mouth two times a day.

Review of the February 2017 Medication Administration Record (MAR) revealed Florastor 250 milligrams, Give 1 milligram by mouth two times a day had been documented as administered every day.

On 3/1/2017 at 11:15 AM, an interview was conducted with Unit Manager, Licensed Practical Nurse A (LPN A) who stated the order and MAR should have stated Florastor 250 milligrams one capsule by mouth two times a day. LPN A stated the medication comes from the Pharmacy as Florastor 250 milligrams and nurses give one capsule twice a day.

LPN A reviewed the MAR on the medication cart with the surveyor and noted the directions were written as Florastor 250 milligrams give 1 milligram by mouth twice a day and immediately beneath that was an order to give Florastor 250 milligrams one capsule by mouth twice a day. LPN A stated the medication nurses were able to see both directions but she was sure the nurses

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gave 250 milligrams, not 1 milligram.

On 3/2/2017 at 9:15 AM, an interview via the telephone was conducted with the Pharmacy Representative (Other A) who stated the order should have one capsule not one milligram. Other A stated she would check her computer to see how the order was written originally but was sure it should have been one capsule.

On 3/12/2017 at 11:12 AM, the Director of Nursing stated Mosbys was the professional standard used by the facility. The Director of Nursing stated the nurses should have transcribed the order correctly and should have clarified the order as written on the MAR.

On 3/2/2017 at 12:10 PM, Other A called to talk with the surveyor. Other A stated she researched the computers in the Pharmacy and found that Resident # 1 had been on the medication for years and was for Florastor 250 milligrams one capsule twice a day, Other A stated the medication was reordered when Resident # 1 was readmitted on 7/11/2016 and the nurse keyed in one milligram when it was entered in the pharmacy computer. Other A stated the Pharmacist recognized the error and changed it to give one capsule twice a day. Other A also stated the facility staff should have discontinued the wrong order and should have keyed in the correct order. Other A stated the Pharmacy staff could only see the corrected order on their computer screen.

Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, page 705: Professional standards,

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| F 281 | Continued From page 17<br>such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:<br>1. The right medication<br>2. The right dose<br>3. The right client<br>4. The right route<br>5. The right time<br>6. The right documentation."<br><br>Review of the facility policy on General Dose Preparation and Medication Administration, Revision date 1/1/13 page 2 of 3 stated: "Prior to administration of medication, Facility staff should take all measures required...<br>Facility staff should:<br>4.1.1 Verify each time 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.<br>4.1.2 Confirm that the MAR reflects the most recent medication order."<br><br>During the end of day debriefing on 3/2/2017, the facility administrator, Director of Nursing and Corporate Nurse (Admin C) were informed of the findings. | F 281 | | |
| F 309 SS=E | PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>CFR(s): 483.24, 483.25(k)(l) | F 309 | | 4/10/17 |

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| F 309 | Continued From page 18<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.<br><br>483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:<br><br>(k) Pain Management.<br>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.<br><br>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review, and clinical record review, the facility staff | F 309 | F309<br>1- Resident #1 is currently receiving | |

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| F 309 | Continued From page 19<br>failed to implement Diabetic management per physicians orders for one resident (Resident # 1) in a survey sample of 18 residents.<br><br>For Resident # 1, the facility staff failed to ensure the administration of insulin according to the parameters per physician's orders. Insulin was administered 4 times outside of the parameters ordered by the physician.<br><br>Findings included:<br><br>Resident #1 was a 71 year old female who was admitted to the facility on 7/12/2004. Resident #1's diagnoses included but were not limited to: Hypertension, Diabetes, Congestive Heart Failure, Gastroesophageal Reflux Disease, and History of Colon Cancer.<br><br>The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 12/9/2016. The MDS coded Resident #1 as having a Brief Interview of Mental Status score of 7, indicating severe cognitive impairment. Resident # 1 required total assistance of two staff persons for Activities of Daily Living except required extensive assistance of two staff persons for bed mobility and supervision with eating. Resident # 1 was coded as always incontinent of bowel and frequently incontinent of bladder.<br><br>Review of the clinical record was conducted on 3/1/2017 at 8:45 AM.<br><br>Review of the February 2017 Physicians Orders revealed Novolog Pen Fill Insulin Inject 10 units subcutaneously every 2 hours. Check Blood Sugar. If Blood Sugar is greater than 400 give | F 309 | Insulin as ordered.<br>2- The Unit Manager or designee will audit current residents with Insulin orders to ensure that Insulin is administered according to the parameters per physician orders.<br>3- The DON or designee will educate all licensed nursing staff on correctly following physician- ordered Insulin parameters.<br>4- The Unit Manager or designee will review residents with Insulin orders on a weekly basis to ensure that the Inulin is administered according to the parameters per the physician orders. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations. | |

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Novolog 10 units. Hold if Blood Sugar is less than 400.

Review of the February 2017 Medication Administration Record revealed Novolog Pen Fill Insulin Inject 10 units subcutaneously every 2 hours. check Blood Sugar. If Blood Sugar is greater than 400 (milligrams/deciliter) give Novolog 10 units. Hold if Blood Sugar is less than 400.

Review of the February 2017 MAR (Medication Administration Record) revealed Novolog Insulin 10 units was administered four times outside of the parameters:
2/2/2017 at 4 PM, Blood Sugar 369
2/2/2017 at 6 PM, Blood Sugar 367
2/2/2017 at 8 PM, Blood Sugar 344
2/3/2017 at 4 PM, Blood Sugar 386

On 3/12/2017 at 11:12 AM, the Director of Nursing stated Mosbys was the professional standard used by the facility.

On 3/2/2017 at 11:20 AM, an interview was conducted with Licensed Practical Nurse A who stated Novalog Insulin should not have been given on those 4 occasions because the blood sugar was not greater than 400. LPN A stated the documentation showed insulin had been administered on those 4 occasions. LPN A stated nurses should follow physicians orders. LPN A stated the nurse who administered the Novalog insulin on those dates and times worked on the 3-11 shift. LPN A attempted to call the nurse to enable the surveyor to talk to her but the call went to voicemail.

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On 3/2/2017 at 1 PM, an interview was conducted with the Director of Nursing who stated the expectation was that nurses should follow physicians orders.

Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, page 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

1. The right medication
2. The right dose
3. The right client
4. The right route
5. The right time
6. The right documentation."

Review of the facility policy on General Dose Preparation and Medication Administration, Revision date 1/1/13 page 2 of 3 stated: "Prior to administration of medication, Facility staff should take all measures required...

Facility staff should:

4.1.1 Verify each time 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."

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| F 309 | Continued From page 22<br><br>On 3/2/2017 during the end of day debriefing, the facility administrator, Director of Nursing and corporate nurse (Admin C) were informed of the findings.<br><br>No further information was provided. | F 309 | | |
| F 329 SS=D | DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>CFR(s): 483.45(d)(e)(1)-(2)<br><br>483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>483.45(e) Psychotropic Drugs.<br>Based on a comprehensive assessment of a resident, the facility must ensure that-- | F 329 | | 4/10/17 |

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| F 329 | Continued From page 23<br>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure two Residents (Residents' #6 and #3) in a survey sample of 18 Residents were free from unnecessary medications.<br><br>1. For Resident #6, Carvedilol (an antihypertensive medication) was administered 2/25/17 at 5 p.m. without a blood pressure taken. The medication was ordered by the physician to not be administered if Resident #6's systolic blood pressure was less than 100 mmHg (millimeters of pressure); and<br><br>2. For Resident #3, the facility staff administered 50 mg (milligrams) Hydralazine (an anti-hypertension medication) for a blood pressure measurement of 106/62. According to the physician's order, Hydralazine was not to be given for a systolic blood pressure (systolic blood pressure) less than 110.<br><br>The findings included:<br><br>1. For Resident #6, Carvedilol (an | F 329 | F329<br>1- Resident #6 is receiving Carvedilol as ordered. Resident #3 is receiving Hydralazine as ordered.<br>2- The Unit Manager or Designee will audit the medication administration records for current residents receiving hypertension medications to ensure that they are administered and documented appropriately as ordered and the blood pressures are obtained and documented appropriately.<br>3- The DON or Designee will educate all licensed nursing staff on following physician ordered parameters with the administration of hypertension medication and documenting the administration or findings appropriately on the medication administration record.<br>4- The Unit Manager or designee will review the medication administration records for current residents receiving hypertension medications to ensure that they are administered and documented appropriately as ordered and that blood pressures are obtained and documented | |

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antihypertensive medication) was administered 2/25/17 at 5 p.m. without a blood pressure taken. The medication was ordered by the physician to not be administered if Resident #6's systolic blood pressure was less than 100 mmHg (millimeters of pressure).

Resident #6, a female, was admitted to the facility 7/5/12. Her diagnoses included congestive heart failure, atrial fibrillation, hypertension, hyperlipidemia, hypothyroidism, dysphagia, dementia, constipation, anemia, obsessive compulsive disorder, deep vein thrombosis, major depressive disorder, anxiety, pain, and insomnia.

Resident #6's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/13/16 was coded as a significant change assessment. Resident #6 was coded as having short and long term memory deficits and required moderate assistance with making daily life decisions. She was also coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating she was coded as needing stand by assistance.

Resident #6 was observed 3/1/17 at 7:42 a.m. She was out of bed and dressed, feeding herself breakfast. Resident #6 was alert and verbally responsive.

Review of Resident #6's clinical record revealed a signed physician's order that included:

"7/29/16 Carvedilol 3.125 mg (milligram) orally two times a day related to chronic systolic heart failure (428.22). Hold for SBP (systolic blood pressure-the amount of pressure the heart exerts

appropriately on a weekly basis. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations

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when it is pumping) <100."

An accompanying entry was noted on the eMAR (electronic medication administration record) with nurses' initials indicating the medication was administered. Blood pressure readings were evident for twice daily with the exception of 2/25/17 at 5 p.m. No blood pressure reading was evident, however documentation indicated Carvedilol 3.125 mg was administered at that time. A thorough review of the clinical record, including nursing notes, revealed no evidence Resident #6's blood pressure was obtained even though Carvedilol was administered.

When interviewed, 3/2/17 at 11:02 a.m., the DON (director of nursing) stated she had reviewed Resident #6's clinical record and could find no evidence a blood pressure was obtained prior to Carvedilol 3.125 mg being administered 2/25/17 at 5 p.m.

Review of the facility's policy entitled "General Dose Preparation and Medication Administration" included

"4. Prior to administration of medication Facility staff should take all measures required by Facility policy and Applicable Law, including but not limited to the following:

4.1.5 If necessary, obtain vial signs."

Guidance was provided at https://medlineplus.gov:

"Carvedilol comes as a tablet and an extended-release (long-acting) capsule to take by mouth. The tablet is usually taken twice a day

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with food. The extended-release capsule is usually taken once a day in the morning with food. Try to take carvedilol at around the same time(s) every day. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take carvedilol exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor."

Guidance for nursing practice for the administration of medications is included in, "Fundamentals of Nursing 7th Edition, p 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients."

Same source, page 709, "The nurse is also responsible for documenting any preassessment data required of certain drugs, such as a blood pressure measurement for antihypertensive medications, or laboratory values, as in the case of Dilantin before giving the drug."

And, page 710, "The ongoing physical or mental status of a client affects whether a medication is given or how is is administered. The nurse needs to assess a client carefully before giving any medication. For example, check the client's blood pressure before giving antihypertensive...Assessment findings also serve as a baseline in evaluating the effects of medication therapy."

The administrator, DON, and corporate consultant were advised of the failure of the staff to ensure Resident #6 was free from unnecessary medication, 3/2/17 at 11:05 a.m.

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Carvedilol was administered without a blood pressure being obtained. Documentation was evident that the medication had been held previously as Resident #6's systolic blood pressure had been less than 100 mmHg.

2. For Resident #3, the facility staff administered 50 mg (milligrams) Hydralazine (an anti-hypertension medication) for a blood pressure measurement of 106/62. According to the physician's order, Hydralazine was to be held if the systolic blood pressure (SBP) was less than 110. Systolic blood pressure is a measure of blood pressure while the heart is beating.

Resident #3 was initially admitted to the facility 3/16/11 and readmitted after a hospitalization on 12/21/16. Diagnoses included chronic kidney disease, hyperlipidemia, end stage renal disease, peripheral vascular disease, depression, gastroesophageal reflux disease, osteoarthritis and hypertension.

Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/17/16 was coded as a quarterly assessment. She was coded a BIMS (brief interview of mental status) score of '15' out of 15, cognitively intact. She was coded as needing extensive to total assistance of one to two staff members with her activities of daily living with the exception of eating. For eating Resident #3 was coded as needing set up assistance of one staff member.

On 2/28/17 at 4:30 p.m., Resident #3 was observed sitting up in bed. Resident #3 was alert, oriented and verbally responsive.

On 3/1/17 at 8:15 a.m., a review of Resident #3's

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clinical record was initiated.

Review of Resident #3's comprehensive care plan revealed a plan for hypertension with interventions to monitor vital signs and administer medications per the physician's orders.

Review of the clinical record revealed a physician order dated 2/21/16, "Hydralazine Tablet 50 MG (milligram), give 50 mg by mouth two times a day every Tue., Thu., Sat. related to ESSENTIAL HYPERTENSION **HOLD FOR SBP < (less than) 110." Review of the eMAR (electronic medication administration record) revealed on 1/21/17 at 9:00 a.m., the blood pressure measurement was 106/62 and there was a check mark and LPN (license practical nurse) I's initials indicating the medication was administered.

A thorough review of Resident #3's clinical record did not reveal any documentation or evidence that Hydralazine was held on 1/21/17 per physician orders.

On 3/1/17 at 4:30 p.m., during an end of day briefing, the DON (director of nursing) was informed of the Hydralazine that was administered on 1/21/17 when the SBP was less than 110. The DON said she would follow-up.

On 3/2/17 at 10:59 a.m., a follow-up interview was conducted with the DON at which time she said the nurse did administer the Hydralazine when it should have been held.

Review of the facility's policy entitled "General Dose Preparation and Medication Administration" included:

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| F 329 | Continued From page 29<br>"4.1 Facility staff should:<br>4.1.1 Verify each time 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 for in Appendix 17: Facility Medication Administration Times Schedule:"<br><br>On 3/2/17 at 3:45 p.m., the administrator, DON, and corporate consultant were informed of the failure of the staff to follow a physician order regarding administering Hydralazine 50 mg when Resident #3's SBP was below 110. No additional information was provided. | F 329 | | |
| F 406 SS=D | PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES<br>CFR(s): 483.65(a)(1)(2)<br><br>(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-<br><br>(1) Provide the required services; or<br><br>(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.<br>This REQUIREMENT is not met as evidenced by: | F 406 | | 4/10/17 |

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| F 406 | Continued From page 30<br>Based on staff interview, clinical record review, and observation, the facility staff failed to provide therapy after a significant decline in mobility was identified for one Resident (Resident #6) in a survey sample of 18 Residents.<br><br>Resident #6 experienced a significant decline in transferring and bed mobility, going from minimal to no assistance of staff to move in her bed and transfer from bed to chair, to requiring extensive assistance of one to two staff members. No assessment of the decline, nor referral for therapy was completed by the facility, even though the decline was identified.<br><br>The findings included:<br><br>Resident #6, a female, was admitted to the facility 7/5/12. Her diagnoses included congestive heart failure, atrial fibrillation, hypertension, hyperlipidemia, hypothyroidism, dysphagia, dementia, constipation, anemia, obsessive compulsive disorder, deep vein thrombosis, major depressive disorder, anxiety, pain, and insomnia.<br><br>Resident #6's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/13/16 was coded as a significant change assessment. Resident #6 was coded as having short and long term memory deficits and required moderate assistance with making daily life decisions. She was also coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating she was coded as needing stand by assistance.<br><br>Review of the previous MDS assessment, a quarterly with an ARD of 9/22/16, revealed | F 406 | F406<br>1- Resident #6 is receiving Restorative nursing for mobility and transfers.<br>2- The Rehabilitation Manager or Designee will audit current residents showing a decline in activities of daily living to determine if the resident could benefit from rehabilitative services.<br>3- The DON or Designee will educate the Interdisciplinary team on reviewing residents showing a decline in activities of daily living and determining if they could benefit from rehabilitative services.<br>4- The Rehabilitation Manager or designee will review current residents showing a decline in activities of daily living to determine if the resident could benefit from rehabilitative services The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations | |

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Resident #6 coded as requiring only supervision for bed mobility and minimal assistance of one staff member to transfer from her bed to her chair.

With the completion of the significant change assessment, the interdisciplinary team held a care plan meeting in December, 2016 with the staff uncertain of what day the meeting was held on. Other J, the head of therapy, presented some information of what was discussed in Resident #6's care plan meeting, 3/2/17 at 9:51 a.m. Other J stated the form indicated Resident #6 had experienced a decline in mobility and documentation on the paper indicated "Per CNA (certified nursing assistant) (arrow up-increased) support R/T (related to) safety concerns of staff."

Included on the paper was also, "0 (no) UTI (urinary tract infection), last fall 9/25/16, Ativan (an antianxiety medication), RNP (restorative nursing program) B & B (bowel and bladder). No information was identified during the provided documentation that the interdisciplinary team identified the significant decline in mobility for Resident #6. Other J stated the interdisciplinary team did not consider any therapy screening or referral. Other J was unable to state why the decline had not been identified nor that any interventions were developed for the decline during the care plan meeting.

RN (registered nurse) A, the MDS coordinator and at the time of Resident #6's noted decline DON (director of nursing), stated 3/2/17 at 8:35 a.m., "nothing was done" once Resident #6's decline was identified. RN A stated no referral for a therapy screen was completed nor was the decline addressed on Resident #6's care plan.

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| F 406 | Continued From page 32<br>RN A stated she did not know why the decline was not addressed nor any strategies developed to address the decline.<br><br>The administrator, DON, and corporate consultant were informed of the failure of the facility staff to assess or refer Resident #6 to therapy after a significant decline in mobility was identified, 3/2/17 at 11:05 a.m. | F 406 | | |
| F 425 SS=D | PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br>CFR(s): 483.45(a)(b)(1)<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to ensure medication was available for Resident #11 and failed to identify an inaccurate medication order for Resident #2, in a survey sample of 18 residents.<br><br>1. Resident #11's Xanax (an antianxiety medication) was not available from the pharmacy.<br><br>2. For Resident #2, the facility's pharmacist failed | F 425 | F425<br>1- Resident #11 has ordered medications available for administration. The route of administration for Lovenox was clarified for Resident #2 on 12/29/16.<br>2- The Unit Manager or designee will audit the medication administration records for current residents to ensure that they have medications available for administration. The Unit Manager or designee will audit current residents receiving Lovenox to | 4/10/17 |

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| F 425 | Continued From page 33<br>to identify an inaccurate physician order after reviewing the order and before sending the medication, Lovenox-an anticoagulant, to the facility for administration to the resident. The order was written to administer the Lovenox intramuscularly (IM), instead of subcutaneously. According to the Nursing Drug Reference, Lovenox is not to be given IM.<br><br>The findings included:<br>1. Resident #11's Xanax (an antianxiety medication) was not available from the pharmacy.<br><br>Resident #11 was admitted to the facility on 2/27/17. Diagnoses included but were not limited to: Chronic respiratory failure, COPD (chronic obstructive pulmonary disease), anxiety, congestive heart failure and sleep apnea.<br><br>Resident #11's most recent MDS (minimum data set) had not yet been completed, but a nursing assessment dated 2/27/17 indicated the resident was alert and oriented times three (person, place and time).<br><br>On 2/28/17, Resident #11 was observed in the bed, with oxygen in place at 6 liters per minute by a nasal cannula. LPN (licensed practical nurse) (D) had prepared the resident's medications, remarking that, "The Xanax is not here, I will call the pharmacy." LPN (D) did check the stat box for the Xanax, which did not contain the medication. Upon entering the room, Resident #11 stated, "I need my Xanax, I am anxious." LPN (D) stated that she would notify the pharmacy and obtain the medication and offered him Tylenol.<br><br>Review of the MAR (medication administration | F 425 | ensure the order is transcribed correctly.<br>3- The DON or Designee will educate all licensed nursing staff on the process of ordering and refilling medications from the pharmacy. The Licensed nursing staff will be educated on proper transcription of medication orders. The Pharmacy Director or designee will educate Pharmacy staff on the process involving receipt of electronic orders, identification of inaccuracies or clarification needed and notification identified issues to facility nurses for making needed modifications.<br>4- The Unit Manager or designee will review the medication administration records and shift reports for current residents on a weekly basis to ensure that medications are available for administration. The Unit Manager or designee will review new medication orders on a weekly basis to ensure that the orders are transcribed correctly. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations | |

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record) for February and March. Upon review, there was a physician's order dated 2/27/17 for Xanax 0.25 mg (milligrams) every 8 hours for anxiety ( to be given at 12:00 AM, 8:00 AM and 4:00 PM). The February MAR showed the Xanax had not been given on the 27th or the 28th. The first dose was given on 3/1/17 at 12:00 AM. There was a total of four times the medication was not given.

Potter and Perry, 7th edition, page 930, documents that antianxiety medications are used to treat dyspnea (difficulty breathing).

Review of the nurses notes contained the following information:

On 2/28/17 at 5:56 AM, the note read: "waiting for med to arrive from pharmacy."

On 2/28/17 at 7:41 AM, the note read: "awaiting pharmacy delivery."

On 2/28/17 at 4:15 PM, "med not in, calling for script (prescription- Xanax requires a "hard " or handwritten order).

On 2/28/17 at 7:00 PM, "complained of anxiety, med on order, will be in tonite."

On 3/1/17 at 9:40 AM, an interview was conducted with Licensed Practical Nurse (E). She stated, "The hard script is sent from the hospital and we fax it to the pharmacy. We call them to stat it out, turnaround time is four hours."

On 3/2/17 at approximately 8:35 AM, the Administrator and DON (director of nursing) were notified of above findings.

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2. For Resident #2, the facility's pharmacist failed to identify an inaccurate physician order after reviewing the order and before sending the medication, Lovenox-an anticoagulant, to the facility for administration to the resident. The order was written to administer the Lovenox intramuscularly (IM), instead of subcutaneously (SQ). According to the Nursing Drug Reference, Lovenox was not to be given IM.

Resident #2 was admitted to the facility on 8/4/16 Diagnoses included heart failure, hypertension, arthritis, cerebrovascular disease, and schizophrenia.

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/3/17 was coded as a quarterly assessment. Resident #2 was coded a BIMS (brief interview of mental status) score of '15' out of 15, cognitively intact. She was also coded as needing extensive to total assistance of one to two staff members for activities of living, except eating. For eating, she was coded as requiring supervision. Under Active Diagnoses, Resident #2 was coded for Hypertension.

On 3/1/17 at 8:15 a.m., a review of Resident #2's clinical record was initiated.

Review of Resident #2's clinical record revealed a signed physician's order that read, "12/5/16, Lovenox Inject 70 mg/ml (milligram/milliliters) INTRAMUSCULARLY two times a day related to HEART FAILURE." The order was created by LPN (licensed practical nurse) C, and electronically signed by the physician on 12/8/16.

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Review of the December 2016 MAR (medication administration record) revealed a corresponding order which indicated between 12/5/16 through 12/29/16, Resident #2 had refused the Lovenox on all days except 12/17 and 12/18. On these dates and times, LPN G was the nurse that documented the administration of the Lovenox intramuscularly. Further review of the MAR revealed the location of the injection sites as follows:
"a. 12/17/16 9:48 Route intramuscularly; Location Abdomen LLQ (left lower quadrant).
b. 12.17/16 17:49 Route intramuscularly; Location Abdomen RLQ (right lower quadrant).
c. 12/18/16 9:01 Route intramuscularly; Location Abdomen LLQ.
d. 12/18/16 17:09 Route intramuscularly; Location Abdomen LLQ."

A pharmacy Consultation Report written during a monthly medication regimen review dated 12/29/16 read, "During the review of [Resident's Name] medical record, the following omissions or errors were noted on the medication administration record /prescriber order sheets (POS): Enoxaparin (Lovenox) is ordered to be given IM -IT SHOULD NEVER BE GIVEN IM. Only Subcutaneous or IV (intravenous) is allowed. Please update and notify medical records. It was signed by the consultant pharmacist on 12/29/16. LPN C's, unit manager, signature was hand written on this form and dated 12/29/16. The acting director of nursing, RN A, had also signed the consultation report.

Review of Mosby's 2015 NURSING DRUG REFERENCE, located at the unit nursing station read on page 427, "Lovenox, Subcut route- Do not give IM..."

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On 3/1/17 at 3:12 p.m., an interview was conducted with the DON (director of nursing) regarding the physician order to administer Lovenox intramuscularly as well as LPN C documentation of having administered the Lovenox. The DON said she had spoken with the pharmacy consultant, Other A, and the DON wrote the following regarding their conversation, "Pharmacy process is to verify before sending. Per pharmacy this should have been caught before sent to us. Syringe does not allow to be given IM." The DON said LPN G was an agency nurse and unavailable for interview at this time.

On 3/1/17 at 4:20 p.m., during an end of day meeting, the DON said there were 5 Lovenox syringes remaining in Resident #2's initially delivered box of 8 Lovenox syringes. The DON provided a copy of the box label, and the prefilled individually wrapped Lovenox syringe. The label on the box of Lovenox syringes read, "INJECT 70 MG (.7 ML) INTRAMUSCULARLY TWO TIMES A DAY". The needle attached to the syringe was thin and short, like a needle for administering subcutaneous insulin. The DON was confident that the Lovenox was not administered intramuscularly.

On 3/2/17 at 9:00 a.m., a telephone interview was conducted with the Pharmacy Account Manager, Other A. During this interview, Other A said the pharmacist that received the physician order electronically should have noticed the route was not correct and the pharmacist should have notified the facility staff to get clarification. Other A said the Lovenox should not have been sent to the facility with the wrong route written on the directions. When asked about the risks of giving

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Lovenox IM instead of SQ, Other A said it would be best to talk with the clinical consultant pharmacist, Other B.

On 3/2/17 at 10:28 a.m., telephone interview was conducted with Other B, the pharmacy's clinical consultant. Other B stated, "The inhouse pharmacist would review and approve the physician order before sending the medication to the facility." Other B said the pharmacist should have caught the error and notified the facility before sending out the Lovenox. When asked about the risk to the resident if Lovenox was administered intramuscularly, other B said, "If given in the muscle, the Lovenox (medication to reduce blood clots) would be released much slower."

On 3/2/17 at 11:12 a.m., the DON cited Mosby's Potter and Perry, Fundamentals of Nursing as a reference for the facility's professional nursing standards.

On 3/2/17 at 2:35 p.m., an interview was conducted with LPN C, the nurse that created the physician order and transmitted the order to the pharmacist for review and approval. LPN C stated, "The doctor said subcutaneously, I accidentally clicked on intramuscularly. I knew it was to be given subcutaneously."

On 3/2/17 at 2:55 p.m., a request was made for a copy of the facility's policy/procedure for the pharmacy services and responsibility. The nurse consultant, Admin C, said, "We use the pharmacy's policy and follow the guidance provided in our quality assurance (QA) tool."

Guidance for the role of the pharmacist was

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| F 425 | Continued From page 39<br>included in "Mosby's Fundamentals of Nursing 7th Edition, page 703, " The pharmacist is responsible for filling prescriptions accurately and for being sure that prescriptions are valid. Dispensing the correct medication, in the proper dosage and amount, with an accurate label is the pharmacist's main task."<br><br>On 3/2/17 at 3:50 p.m., the administration was informed of the facility's consultant pharmacist's failure to review and correct an order to administer Resident #2's Lovenox IM. No additional information was provided. | F 425 | | |
| F 514 SS=E | RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>CFR(s): 483.70(i)(1)(5)<br><br>(i) Medical records.<br>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete;<br><br>(ii) Accurately documented;<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments; | F 514 | | 4/10/17 |

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| F 514 | Continued From page 40<br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review and clinical record review and in the course of an investigation of a complaint, the facility staff failed to ensure a complete and accurate record for seven residents (Residents #s 1, 2, 6, 7, 5, 13 and 8) in a survey sample of 18 residents.<br><br>1. For Resident # 1, the facility staff failed to document baths and showers.<br><br>2. For Resident #2, (A) The facility failed to accurately transcribe the route for administration of Lovenox (an anticoagulant that helps prevent the formation of blood clots) and (B) The facility's Pharmacy Consultant failed to accurately document in Monthly Pharmacy Review notes that there were irregularities and/or recommendations that were included in a Pharmacy Consultation Report.<br><br>3. For Resident #6, the consultant pharmacist failed to ensure the interdisciplinary note included irregularities noted during the monthly drug regimen review conducted on 11/29/16; | F 514 | F 514<br>1-Showers and baths for Resident #1 are being documented appropriately. The route of administration for Lovenox was clarified for Resident #2 on 12/29/16. The Pharmacist consultant corrected the pharmacy note to review the report for any noted pharmacy recommendations and/or irregularities for resident #6, #13, #7, #5.<br>2- The Unit Manager or designee will audit the documentation for current residents to ensure that baths and showers are accurately documented. The DON or designee will audit the medical record for current residents to ensure that the consultant pharmacist accurately documented the medication regimen review in the medical record.<br>3 □ The DON or designee will educate all CNA□s and Licensed nursing staff on proper documentation of baths and showers. The Pharmacy Clinical Manager or designee will educate the consultant pharmacists on appropriate technique for documentation of recommendations in the | |

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| F 514 | Continued From page 41<br><br>4. For Resident #7, the consultant pharmacist failed to ensure the interdisciplinary note included irregularities noted during the monthly drug regimen review conducted on 12/29/16;<br><br>5. For Resident #5, the pharmacist failed to ensure the pharmacy regimen review was accurate.<br><br>6. For Resident #13, the pharmacist failed to ensure the pharmacy regimen review was accurate.<br><br>7. For Resident #8, the pharmacist failed to ensure the pharmacy regimen review was accurate.<br><br>Findings included:<br><br>1. For Resident # 1, the facility staff failed to document baths and showers.<br><br>Resident #1 was a 71 year old female who was admitted to the facility on 7/12/2004. Resident #1's diagnoses included but were not limited to: Hypertension, Diabetes, Congestive Heart Failure, Gastroesophageal Reflux Disease, and History of Colon Cancer.<br><br>The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 12/9/2016. The MDS coded Resident #1 as having a Brief Interview of Mental Status score of 7, indicating severe cognitive impairment. Resident # 1 required total assistance of two staff persons for Activities of Daily Living except required extensive assistance of two staff persons for bed mobility and | F 514 | electronic records.<br>4 □ The Unit Manager or designee will audit the documentation for current residents to ensure that baths and showers are accurately documented on a weekly basis. The DON or designee will audit the medical record for current residents to ensure that the consultant pharmacist accurately documented the medication regimen review in the medical record on a monthly basis. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations. | |

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supervision with eating. Resident # 1 was coded as always incontinent of bowel and frequently incontinent of bladder.

Review of the CNA (Certified Nursing Assistant) documentation records revealed no documentation of a bath or shower on 7/1/2016 and 7/2/2016. On 7/3/2016, it was documented "(1,8,8)" which indicated that "activity did not occur." The numbers in the parentheses indicate task completed, bathing: self performance and bathing support provided in that order. Under the Legend Report for Bathing, "1" indicated No the task was not completed, Bathing: Self performance "8" meant the Activity itself did not occur. and Bathing: Support Provided "8" meant "ADL (Activity of Daily Living) activity itself did not occur."

On 3/2/2017 at 11:00 AM, an interview was conducted with Unit 2 Unit Manager LPN A (Licensed Practical Nurse A) who stated all of the residents receive some type of bathing activity every day. LPN A stated the residents receive showers at least twice a week on their scheduled days and bed baths on the other days. LPN A stated she was very familiar with Resident # 1 and knew that she was scheduled to receive showers on Tuesdays and Fridays. LPN A stated she was sure the nursing assistants provided some type of bath to residents every day because residents received bed baths on the days they were not scheduled for a shower. LPN A stated Resident # 1 did not usually refuse baths or showers so she was sure some type of bathing occurred daily. LPN A stated the usual process was that the CNAs were expected to notify the charge nurse if any assignments were not completed. The charge nurse would then be

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responsible for following up on the assignments, making sure the residents needs were met and would document on the clinical record. LPN A stated she did not know why there was no documentation of a bath or shower on 7/1/2016 or 7/2/2016 and why the bathing activity did not occur on 7/3/2016. LPN A stated that she as the Unit Manager and the charge nurses routinely make rounds and monitor care being given to residents. LPN A stated there had been no noted problems with baths not being given to Resident # 1.

LPN A presented a copy of the shower schedule and a copy of the Wing 2 Group Assignments dated 7/1/2016 on 7-3 shift.

Review of the facility Shower Schedule revealed that Resident # 1 was scheduled to have showers on Tuesdays and Fridays on Day Shift. 7/1/2016 was a Friday and was a day Resident # 1 was due to have a shower.

Review of the CNA Assignment sheet for 7/1/2016 revealed no documentation on the assignment sheet that indicated Resident # 1 did not receive a shower on that day. There was no documentation in the Interdisciplinary notes about the assigned shower not being given.

On 3/2/2017 at 11:14 AM, an interview was conducted with CNA (Certified Nursing Assistant) A who stated she worked with Resident # 1 sometimes. CNA A stated Resident # 1 usually washed her upper body and the CNA assigned would wash the lower body and genital area and go over the upper body to make sure it was clean and dry. CNA A stated the CNAs provide showers according to the shower schedule and would

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report to the charge nurse if a shower was not given as scheduled. CNA A stated the CNAs were responsible for documenting on the ADL form.

During the end of day debriefing on 3/2/2017, the facility administrator, Director of Nursing and Corporate Nurse (Admin C) were informed of the findings.

No further information was provided.

2. For Resident #2 :

A. The facility staff failed to accurately transcribe the route for administration of Lovenox (an anticoagulant that helps prevent the formation of blood clots); and
B. The facility's Pharmacy Consultant failed to accurately document in Monthly Pharmacy Review notes that there were irregularities and/or recommendations that were included in corresponding Pharmacy Consultation Reports.

Resident #2 was admitted to the facility on 8/4/16 Diagnoses included heart failure, hypertension, arthritis, cerebrovascular disease, and schizophrenia.

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/3/17 was coded as a quarterly assessment. Resident #2 was coded a BIMS (brief interview of mental status) score of '15' out of 15, cognitively intact. She was also coded as needing extensive to total assistance of one to two staff members for activities of living, except eating. For eating, she was coded as requiring supervision.

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On 3/1/17, at 8:15 a.m., a review of Resident #2's clinical record was initiated.

A. Review of Resident 2's clinical record revealed a signed physician's order that read, "12/5/16, Lovenox Inject 70 mg/ml (milligram/milliliters) INTRAMUSCULARLY two times a day related to HEART FAILURE." The order was created by LPN (licensed practical nurse) C.

Review of the December 2016 MAR (medication administration record) revealed a corresponding order which indicated between 12/5/16 through 12/29/16, Resident #2 had refused the Lovenox on all days except 12/17 and 12/18. On these dates and times, LPN G was the nurse that documented the administration of the Lovenox intramuscularly. Further review of the MAR revealed the location of the injection sites as follows:
"a. 12/17/16 9:48 Route intramuscularly; Location Abdomen LLQ (left lower quadrant).
b. 12.17/16 17:49 Route intramuscularly; Location Abdomen RLQ (right lower quadrant).
c. 12/18/16 9:01 Route intramuscularly; Location Abdomen LLQ.
d. 12/18/16 17:09 Route intramuscularly; Location Abdomen LLQ."

A pharmacy Consultation Report written during a monthly medication regimen review dated 12/29/16 read, "During the review of [Resident's Name} medical record, the following omissions or errors were noted on the medication administration record/prescriber order sheets (POS): Enoxaparin (Lovenox) is ordered to be given IM -IT SHOULD NEVER BE GIVEN IM. Only Subcutaneous or IV (intravenous) is

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allowed. Please update and notify medical records. It was signed by the consultant pharmacist on 12/29/16. LPN A's, unit manager, signature was hand written on this form and dated 12/29/16. The interim director of nursing, RN (registered nurse) A had also signed the consultation report.

A review of the facility's Mosby's, 2015 NURSE DRUG REFERENCE, located at the unit nursing station, on page 427 read, "Lovenox. Subcut route-Do not give IM".

On 3/1/17 at 3:12 p.m., an interview was conducted with the DON (director of nursing) regarding the physician order to administer Lovenox intramuscularly as well as LPN G's documentation of having administered the Lovenox on four occasions. The DON said she had spoken with the pharmacy and the DON wrote the following regarding their conversation, "Pharmacy process is to verify before sending. Per pharmacy this should have been caught before sent to us. Syringe does not allow to be given IM."

On 3/1/17 at 4:20 p.m., during an end of day meeting, the DON said there were 5 Lovenox syringes remaining in Resident #2's initially delivered box of 8 Lovenox syringes. The DON provided a copy of the box, and the prefilled individually wrapped Lovenox syringe. The label on the box read, "INJECT 70 MG (.7 ML) INTRAMUSCULARLY TWO TIMES A DAY". The needle attached to the syringe was thin and short, like a needle for administering subcutaneous insulin. The DON was confident that the administered Lovenox was not administered intramuscularly. The DON also said LPN G was

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an agency nurse and she was not available to be interviewed at this time.

On 3/2/17 at 9:00 a.m., a telephone interview was conducted with the Pharmacy Account Manager, Other A. During this interview, Other A said the in-house pharmacist that received the physician order electronically should have noticed the route was not correct and the pharmacist should have notified the facility staff to get clarification. Other A said the Lovenox should not have been sent to the facility with the wrong route written in the directions. When asked about the risks of giving Lovenox IM instead of SQ, Other A said it would be best to talk with the consultant pharmacist, Other B.

On 3/2/17 at 10:28 a telephone interview was conducted with Other B, the pharmacy consultant. Other B stated, "The in-house pharmacist would review and approve the physician order before sending the medication out to the facility." Other B said the in-house pharmacist should have caught the error and notified the facility before sending the Lovenox to the facility. When asked about the risk to the resident if Lovenox was administered intramuscularly. Other B said, "If given in the muscle, the Lovenox (a medication to reduce blood clots) would be released much slower."

On 3/2/17 at 11:12 a.m., the DON cited Mosby's Potter and Perry, Fundamentals of Nursing as a reference for facility's professional nursing standards.

On 3/2/17 at 2:05 p.m., a follow-up conversation with the DON regarding Resident #2's Lovenox

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order was discussed. The DON said the expectation was for the nurses to get clarification on the order.

On 3/2/17 at 2:35 p.m., an interview was conducted with LPN C, the nurse that created the order and electronically transmitted the physician order to the pharmacist. LPN C stated, "The doctor said subcutaneous, I accidentally clicked on intramuscularly. I knew it was to be given subcutaneously."

Guidance for nursing practice for following physician's orders was included in, "Mosby's Fundamentals of Nursing 7th Edition, p. 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients. Therefore you need to assess all orders, and if you find one to be erroneous or harmful, further clarification from the physician is necessary."

B. Further review of Resident #2's clinical record revealed two Pharmacy Notes that read:

a. "12/29/16 - Pharmacy Note: The resident was reviewed and based upon the information available at the time of the review, and assuming the accuracy of such information, it is my professional judgement that at such time, the resident's medication regimen contains no new irregularities (as defined in State Operations Manual Appendix (SOM) PP 483.60)."

b. " 1/27/17 -Pharmacy Note
[ ] See Report for any noted irregularities and/or recommendations
[ ] Additional comments:

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| F 514 | Continued From page 49<br><br>[x] Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgment at such time, the resident's medication regimen contained no new irregularities (as defined in SOM Appendix pp 483.60(c)). For purposes of the foregoing statement, the term "irregularities means an event or circumstance that is subsequently inconsistent with customary, accepted clinical approaches to providing pharmaceutical products and services, or that could reasonably be expected to impede or interfere with the achievement of intended or reasonably expected outcomes."<br><br>Review of the Consultation Reports, revealed the completion of reports during the mentioned pharmacy reviews:<br><br>a. 12/29/16 Consultation Report read, "During the review of [Resident's Name] medical record, the following omissions or errors were noted on the medication administration record/prescriber order sheets (POS): Enoxaparin (Lovenox) is ordered to be given IM -IT SHOULD NEVER BE GIVEN IM. Only Subcutaneous or IV (intravenous) is allowed. Please update and notify medical records."<br><br>b. 1/27/17 Consultation Report read, "[Resident's Name] receives a diuretic, HCTZ, and does not have a recent electrolyte evaluation on file. Please consider monitoring a basic metabolic panel (BMP) on the next convenient lab day and every six months thereafter." The physician accepted the recommendation and signed this report on 2/11/17. | F 514 | | |

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On 3/2/17 at 10:28 a.m., a telephone interview was conducted with Other B, the pharmacy clinical consultant. Other B was asked about the Pharmacy Notes that read, "no irregularities" when there were irregularities and recommendations identified in corresponding Pharmacy Consultation Reports. Other B stated, "We are in the process of standardizing our documentation. There should not be a note that reads "no irregularities" when the pharmacist finds irregularities or recommendations and prepares a Consultation Report."

On 3/2/17 at 3:50 p.m., the administration was informed of the facility staff's failure to clarify an order to administer Lovenox IM and the Pharmacy Notes that inaccurately included 'no irregularities' when irregularities and/or recommendations were present. No additional information was provided.

3. For Resident #6, the consultant pharmacist failed to ensure the interdisciplinary note included irregularities noted during the monthly drug regimen review conducted on 11/29/16.

Resident #6, a female, was admitted to the facility 7/5/12. Her diagnoses included congestive heart failure, atrial fibrillation, hypertension, hyperlipidemia, hypothyroidism, dysphagia, dementia, constipation, anemia, obsessive compulsive disorder, deep vein thrombosis, major depressive disorder, anxiety, pain, and insomnia.

Resident #6's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/13/16 was coded as a significant change assessment. Resident #6 was coded as having short and long term memory deficits and required

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moderate assistance with making daily life decisions. She was also coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating she was coded as needing stand by assistance.

Review of Resident #6's clinical record revealed the consultant pharmacist had completed Resident #6's monthly drug regimen review on 11/29/16. Included in the interdisciplinary note completed on the day of the review was:

"The resident was reviewed and based upon the information available at the time of the review, and assuming the accuracy of such information, it is my professional judgement that at such time, the resident's medication regimen contains no new irregularities (as defined in SOM (state operations manual) Appendix PP 483.60." The note was electronically signed by the consultant pharmacist.

Additionally, a "Consultation Report" was completed for the same day, 11/29/16, and signed by the same pharmacist. The "Consultation Report" was a form completed by the pharmacist, during the monthly drug regimen review, that communicated irregularities identified to the physician.

The "Consultation Report" completed on 11/29/16 included:

"Comment:
(Resident #6's name) receives Tylenol 1 gm (gram) TID (three times daily) routinely and may be appropriate for a analgesic dose reduction. (Also, I do not see pain scores documented since

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| F 514 | Continued From page 52<br>September-consider monitoring.)<br><br>RECOMMENDATION:<br>Please consider a reduction in routine analgesic therapy by changing the Tylenol to PRN (as needed).<br><br>Physician's Response:<br><br>(X) I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below."<br><br>The recommendation was signed by the physician declining any changes in Resident #6's pain control management.<br><br>The administrator, DON (director of nursing), and corporate consultant were informed of the failure of the pharmacist to document accurately the results of Resident #6's monthly drug regimen review within the interdisciplinary notes, 3/2/17 at 11:05 a.m.<br><br>4. For Resident #7, the consultant pharmacist failed to ensure the interdisciplinary note included irregularities noted during the monthly drug regimen review conducted on 12/29/16.<br><br>Resident #7, a female, was initially admitted to the facility 1/4/12 and readmitted after a hospitalization 11/29/16. Her diagnoses included gastrostomy, hypertension, clostridium difficile, dysphagia, hyperlipidemia, methicillin resistant staph aureus, major depressive disorder, gastroesophageal reflux disease, Vitamin D deficiency, dementia, lymphedema, cerebral infarction, type II diabetes mellitus, congestive heart failure, and unspecified kidney failure. | F 514 | | |

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Resident #7's most recent MDS with an ARD of 12/6/16 was coded as a quarterly assessment. Resident #7 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #7 was also coded as needing total assistance of one to two staff members to perform her activities of daily living.

Review of Resident #7's clinical record revealed the pharmacist conducted a monthly drug regimen review on 12/29/16. Included within the interdisciplinary notes was an entry:

"The resident was reviewed and based upon the information available at the time of the review, and assuming the accuracy of such information, it is my professional judgment that at such time, the resident's medication regimen contains no new irregularities (as defined in SOM Appendix PP 483.60)." The entry was signed by the pharmacist on 12/29/16.

A "Consultation Report" was completed by the same pharmacist, on the same day, and included:

"Comment:
(Resident #7's name) has an order for linezolid (Zyvox-an antibiotic) and a serotonergic medication, Mirtazapine.

Recommendation:
Alternative interventions should be considered, and the potential benefit of linezolid should be weighed against the risk for serotonin toxicity.
If linezolid must be given:
1. Immediately stop the Mirtazapine.

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2. Monitoring is required for emergent symptoms of central nervous system toxicity for 2 week (5 weeks for fluoxetime), or until 24 hours after the last dose of linezolid whichever comes first. Possible symptoms include mental changes (confusion, hyperactivity, memory problems), muscle twitching, excessive sweating, shivering or shaking, diarrhea, trouble with coordination, and/or fever.
3. Treatment with Mirtazapine may be resumed 24 hours after the last dose of linezolid. The dose may need to be restarted at the initially tolerated dose and retitrated to previous dosage level."

The physician signed the recommendation on 1/12/17. Documentation within Resident #7's clinical record revealed Mirtazapine was held from the time the Linezolid was initiated and the recommendation was created by the pharmacist.

The administrator, DON, and corporate consultant were informed of the failure of the pharmacist to ensure the monthly drug regimen review findings were accurate within the interdisciplinary notes, 3/2/17 at 11:05 a.m.

5. For Resident #5, the pharmacist failed to ensure the pharmacy regimen review was accurate.

Resident #5, a 95 year old, was admitted to the facility on 11/25/16. His diagnoses included dementia, reflux, hypertension, and anxiety.

The most recent Minimum Data Set assessment was an admission assessment with an assessment reference date of 12/7/16. He was coded with a Brief Interview of Mental Status

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score of 5 indicating severe cognitive impairment. He required extensive assistance with activities of daily living.

Resident #5's clinical record was reviewed. The monthly pharmacy drug regimen reviews were included in the "Progress Notes" section. Included in the progress notes was a "Pharmacy Note" dated 1/26/17. The note read "The resident's medical record including electronic documentation was reviewed on this date." In addition, there were three statements for the pharmacist to choose from:
1. "See report for any noted irregularities and/ or recommendations"
2. "Additional comments:"
3. "Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities (as defined in SOM (state operation manual) Appendix PP 483.60 (c))."

In this 1/26/17 pharmacy review, the pharmacist chose the 3rd statement, indicating there were no pharmacy recommendations.

A second note was documented in the progress notes dated 2/2/17 that read "Md (doctor) aware of pharmacy recommendation for BMP (basic metabolic panel) q (every) 6 months."

The pharmacy recommendation was located in the "documentation" section of the clinical record. It was signed by the physician and had been scanned into the clinical record. The pharmacy recommendation titled "Consultation Report" was dated 1/26/17 and electronically signed by the

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same pharmacist who wrote the note in the progress notes on 1/26/17. The Consultation Report read "Recommendation: Please consider checking BMP on the next convenient lab day and every six month thereafter."

At the end of day meeting on 3/2/17, it was reviewed with the Administrator, Director of Nursing and Corporate Nurse that although the pharmacist indicated in the progress notes that there was no irregularities identified during the monthly drug regimen review, a recommendation resulting from the monthly review was made to the physician. The regulation regarding the monthly drug regimen was reviewed at this time. No further information was provided.

6. For Resident #13, the pharmacist failed to ensure the pharmacy regimen review was accurate.

Resident #13, a 93 year old, was re-admitted to the facility on 11/3/16. Her diagnoses included spinal stenosis, dysphagia, hypertension, and hyperthyroidism.

The most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 12/4/16. She was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She required extensive assistance with activities of daily living.

Resident #13's clinical record was reviewed. The monthly pharmacy drug regimen reviews were included in the "Progress Notes" section. Included in the progress notes was a "Pharmacy Note" dated 1/27/17. The note read "The resident's medical record including electronic

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documentation was reviewed on this date." In addition, there were three statements for the pharmacist to choose from:
1. "See report for any noted irregularities and/ or recommendations"
2. "Additional comments:"
3. "Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities (as defined in SOM (state operation manual) Appendix PP 483.60 (c))."

In this 1/27/17 pharmacy review, the pharmacist chose the 3rd statement, indicating there were no pharmacy recommendations.

A second note was documented in the progress notes dated 2/1/17 that read "MD (doctor) declined recommendation from pharmacy to re-evaluate continued use of the NSAID (non-steroidal anti inflammatory drug), Nabumetone, and consider changing to a non-NSAID alternative such as acetaminophen ER (extended release) (Tylenol arthritis) 650 mg (milligram) three times daily if clinically appropriate. MD declined and stated will consider in a few months."

The pharmacy recommendation was located in the "documentation" section of the clinical record. It was signed by the physician and had been scanned into the clinical record. The pharmacy recommendation titled "Consultation Report" was dated 1/27/17 and electronically signed by the same pharmacist who wrote the note in the progress notes on 1/27/17. The Consultation Report read "Recommendation: Please

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re-evaluate continued use of the NSAID, nabumetone, and consider changing to a non_NSAID alternative such as acetaminophen ER (Tylenol Arthritis) 650 mg three times daily if clinically appropriate."

At the end of day meeting on 3/2/17, it was reviewed with the Administrator, Director of Nursing and Corporate Nurse that although the pharmacist indicated in the progress notes that there was no irregularities identified during the monthly drug regimen review, a recommendation resulting from the monthly review was made to the physician. The regulation regarding the monthly drug regimen was reviewed at this time. No further information was provided.

7. For Resident #8, the pharmacist failed to ensure the pharmacy regimen review was accurate.

Resident #8, an 89 year old, was admitted to the facility on 5/1/15. Her diagnoses included Alzheimer's disease, reflux, depression, pain, dementia and hypertension.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/23/17. She was coded with a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. She required extensive assistance with activities of daily living.

Resident #8's clinical record was reviewed. The monthly pharmacy drug regimen reviews were included in the "Progress Notes" section. Included in the progress notes was a "Pharmacy Note" dated 1/26/17. The note read "The

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resident's medical record including electronic documentation was reviewed on this date." In addition, there were three statements for the pharmacist to choose from:
1. "See report for any noted irregularities and/ or recommendations"
2. "Additional comments:"
3. "Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities (as defined in SOM (state operation manual) Appendix PP 483.60 (c))."

In this 1/26/17 pharmacy review, the pharmacist chose the 3rd statement, indicating there were no pharmacy recommendations.

A second note was documented in the progress notes dated 2/5/17 that read "MD (doctor) in facility, assessing resident from fall today, no new orders received, also viewed consultation report from pharmacy, and declined recommendations at this time, cause resident is stable and a difficult patient to treat."

The pharmacy recommendation was located in the "documentation" section of the clinical record. It was signed by the physician and had been scanned into the clinical record. The pharmacy recommendation titled "Consultation Report" was dated 1/26/17 and electronically signed by the same pharmacist who wrote the note in the progress notes on 1/26/17. The Consultation Report read, "(Resident name) takes haloperidol, lisinipril/HCTZ (hydrochlorothiazide), and donepezil. These medications are both associated with a risk of torsades de pointes or

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495185 | A. BUILDING _____ B. WING _____ | C 03/02/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WAVERLY HEALTH AND REHABILITATION CENTER | 456 E MAIN ST WAVERLY, VA 23890 |

| (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 514 | Continued From page 60<br>prolonged QT interval (measurement of heart activity). Recommendation: Please consider re-evaluating continued use of this combination."<br><br>At the end of day meeting on 3/2/17, it was reviewed with the Administrator, Director of Nursing and Corporate Nurse that although the pharmacist indicated in the progress notes that there was no irregularities identified during the monthly drug regimen review, a recommendation resulting from the monthly review was made to the physician. The regulation regarding the monthly drug regimen was reviewed at this time. No further information was provided.<br><br>COMPLAINT DEFICIENCY | F 514 | | |