STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495184	A. BUILDING _____ B. WING _____	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN HALL AT WILLIAMSBURG LANDING	5500 WILLIAMSBURG LANDING DR WILLIAMSBURG, VA 23185

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 2-8-16 through 2-10-16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey.

The census in this 15 certified bed facility was 11 at the time of the survey. The survey sample consisted of 7 current Resident reviews (Residents #1 through #7) and 3 closed record reviews (Residents #8 through #10).

F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157	POC 2016

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a

F 157

1. Resident #5 received her routinely scheduled pain medication timely the morning after the fall with noted relief.
2. All residents in the facility have the potential to be affected by this deficient practice. The facility will review Incident Reports in addition to the 24 hour nursing report to identify any resident having a change in condition or incident where pain may be suspected or present and notification of the physician is required.

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles B Luckett | TITLE: Executive Vice-President | (X6) DATE: 3-4-16

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 /s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, the facility staff failed to notify the physician for one Resident (Resident # 5) in a survey sample of 10 residents. For Resident # 5, the facility staff failed to notify the physician of complaints of pain after a fall on 2/9/2016. Findings included: Resident # 5 was an 89 year old female admitted to the facility on 1/31/2016 with diagnoses of but not limited to: Fall, Fracture of Multiple Ribs on Right Side, and Constipation. Resident # 5 was recently admitted and her MDS (Minimum Data Set) assessment was not yet due. Her nursing admission assessment revealed she was alert and oriented times three (person, place and time), and able to make her needs known. Resident # 5 was documented as requiring assistance with her activities of daily living. Review of the Nurses Notes revealed a notation	F 157	3. A. The facility will review incident reports in addition to the 24 hour nursing report to identify any resident having a change in condition or incident where pain may be suspected or present and notification of the physician is required. B.The facility will develop a policy for Notification of Physician when a change in condition occurs. Subsequently, all licensed nursing staff will be inserviced on this policy. The facility will also review and revise the current Pain Assessment and Management Policy and revise to indicate how nursing staff are to respond to pain management issues and again provide mandatory inservicing on these policies. 4. Audit all resident records having an incident involving a complaint of pain will be audited for standard of care compliance with pain	

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F 157	Continued From page 2	F 157		

on 2/9/2016 at 8:00 AM "FOF early this AM, Resident trying to transfer without assistance" to commode, lost balance and fell. Resident complained of left rib pain and right rib symptoms.

On 2/9/2016 at approximately 10 AM, an interview was conducted with Registered Nurse (RN) A who stated she received report from the night shift nurse that the resident had fallen during the night. RN A reviewed the Nurses Notes and stated she was she thought abbreviation "FOF" documented in the note meant "Found on Floor". RN A stated a "Post Fall Assessment form was started after the fall. RN A presented the Post Fall Assessment form dated 2/9/2016 at 5 AM which documented "Resident continues to complain of pain from fall. States she has been hurting on left rib/opposite original fracture. No pain medication can be given at this time. When able to give, resident will receive. No skin issues at this time."

Review of the MAR (Medication Administration Record) on the back where PRN (as needed) medications were listed revealed documentation of administration of:

Aleve 220 milligrams every 12 hours as needed for pain was administered on 2/8/2016 at 8 AM. Tylenol 650 milligrams by mouth every 4 hours as needed for mild pain or temp greater than 101 last administered 2/4/2016 at 6 PM

Norco 5/325 milligrams at midnight on 2/9/2016 for pain with relief documented at 1:35 AM and Roboxicon administered at midnight on 2/9/2016

management and MD notification. The results of these audits will be reported to the DON with follow up at the Quality Assurance Committee.

5. Completion date: March 26, 2016

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F 157	Continued From page 3	F 157		

for back spasms with relief documented at 1:35 AM.

Review of the MAR revealed routine pain medications had been given as ordered on 2/9/2016:
Norco 5/325 milligrams one by mouth in the morning at 9 AM
Lidoderm 5 % patch (Lidocaine) apply one patch daily (on in the morning and off in the evening) for diagnosis of pain scheduled on at 9 AM and off at 9 PM was given at 9AM

The Director of Nursing came to the nurse ' s station and was asked about the nurse ' s note and any information about the fall. The DON read the nurse ' s note dated 2/9/2015 at 0800 and stated the note did not give specific information about the fall. The DON stated the initials "FOF" meant "found on floor" and that abbreviation is used routinely at that facility and in the medical field and "even in the legal arena." The DON stated there should be a Post Fall Assessment in the chart that would give more information. The Post Fall Assessment was located in the chart. The surveyor took the chart to the conference room to review.

An interview was conducted 2/9/2016 at approximately 10:10 AM in the conference room with the Director of Nursing who stated "an incident report is completed after a fall. If the fall was unwitnessed, neurochecks (neurological checks) would be done along with every shift charting via the nurses notes for 72 hours." The DON stated she had been informed about the fall during the morning report. The DON presented

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F 157	Continued From page 4	F 157		

the Incident Report, Post Fall Assessment form and Post Fall Assessment Q Shift x 48 hours form. The DON reviewed the chart, Nurses Notes, Incident Report and Post Fall Assessment with the surveyor.

The Incident Report documented the time of the incident as 2/9/2016 at 3:45 AM and that Resident # 5 was found on the floor near the commode in her room at the bedside. The note also stated the resident requested another pain pill but it was too early to be administered. Resident was assessed. Documentation showed "only complaint" was right and left ribs. "Ice applied upon arrival back to bed" after using bedside commode. Also stated the resident was assisted back to bed with use of walker for stability and one person assistance. "Call bell was placed within reach. Walker at bedside, resident encouraged to use call bell and not walk or transfer by herself." The Incident report documented the physician was notified via Centricity (a communication system used by the facility) on 2/9/2016 at 5 AM.

The documentation on the Post Fall Assessment Form on 2/9/2016 at 5 AM showed vital signs were taken with blood pressure of 190/80, pulse 102, respirations 20, oxygen saturation of 97 percent and pain was rated at an 8 of 10. Under additional comments was written: "Resident continues to complain of pain from fall. States she has been hurting on left rib/opposite original fracture. No pain medication can be given at this time. When able to give, resident will receive. No skin issues at this time." The DON stated "this resident is here for pain management! I am going to handle this." The DON left the conference

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F 157	Continued From page 5 room. Review of the clinical record revealed no documentation the physician was notified regarding the continued complaint of pain and the nurse's determination of no available pain medication due until 6 AM. Resident #5 did not receive the "as needed" medication, Norco, at 6 AM on 2/9/2016 when able to be given. The resident received her regularly scheduled medication of Norco at 9 AM on 2/9/2016. During the end of day debriefing on 2/9/2016 at 5 PM, the DON stated her expectation was that the nurse should have notified the doctor that the resident was complaining of pain after the fall and the pain medication (Norco) that was given at midnight, could have been given at 6 AM. The DON also stated that a chest x ray could have been obtained if the resident continued to complain of pain related to the fall. No further information was provided.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Resident interview, clinical record review, and facility documentation review, the facility staff failed to develop an initial care plan regarding bowel care for one resident, Resident #6, in a survey sample	F 281	POC 2016 F 281 1. Resident #5 was discharged with an appropriate treatment plan for pain management. Resident #6 was discharged with an appropriate treatment plan for the prevention of constipation.	

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of 10 residents. And the facility staff failed to follow the professional standards of nursing for medication administration for two Residents (Resident's #6, and #5) in a survey sample of 10 Residents.

1.a. The facility staff failed to develop an initial care plan regarding Bowel care for one resident, (Resident #6) in a survey sample of 10 residents. Resident #6 did not have a care plan to address bowel care after bowel surgery, which was the reason for admission to the facility for rehabilitation.

1.b. For Resident #6, the staff failed to transcribe a medication order on the MAR (medication administration record), failed to administer 3 medications that were ordered, and administered two medications that were discontinued by the doctor.

2. For Resident #5, the facility staff failed to clarify physician's order for pain medication Norco 5/325 milligrams written on 2/2/2016, failed to clarify orders for Trazadone and Lorazepam and failed to follow physicians order for Tramadol.

The findings included:

1.a. Resident #6 did not have a care plan to address bowel care after bowel surgery, which was the reason for admission to the facility for rehabilitation.

Resident #6, was initially admitted to the facility 2-4-16. Diagnoses included; left femoral hernia repair and resection of strangulated small bowel, hypothyroidism, cardiac disease,

2. All residents at Woodhaven Hall have the potential to be affected by the same deficient practice.
3. The facility will implement the following measures to ensure that the deficient practice does not recur:
   a. All licensed nursing staff will receive mandatory inservice training in Medication Management to include medication order transcription, medication reconciliation and medication documentation.
   b. Interim Care Plans will be reviewed by the MDS Coordinators after each admission to ensure the Care Plan addresses all risk factors relevant to the resident's reason for admission.
   c. The Interim Care Plan form will be modified to include risk factors for prevention of constipation.

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gastro-esophageal reflux disease (GERD), pain, allergic rhinitis, and constipation.

Resident #6's admission MDS (minimum data set) was not completed as the Resident had been admitted for only 5 days.

Review of the Certified Nursing Assistant (CNA) Activities of Daily Living sheets (ADL sheets) coded Resident #6 as needing limited to extensive assistance from staff for activities of daily living.

On 2-9-16 at 8:45 a.m. Resident #26 was interviewed during Medication administration, and was found to be talkative, appropriate, and oriented to person, place, time, and situation. The Resident complained of abdominal discomfort and constipation, stating she had not had a bowel movement in 3 days, and that the 2 she had experienced were very small and hard on Saturday (2-6-16).

The Resident's new abdominal surgical site was observed at the time of Medication administration and was red, swollen and angry completely around the site. To include above and below the incision by approximately 2-3 inches. The site was closed and had no drainage at this time.

RN (Registered Nurse) A was observed during medication pass observation to have 5 tablets total in the pill administration cup, and this was verified with her. RN A and the surveyor entered Resident #6's room, and RN A assisted the resident with taking medications which Resident #6 swallowed, and used 2 sprays of the nasal spray in each nare.

d. All physician orders will be reviewed for accurate transcription initially by 2 nurses and followed by a chart review on each subsequent shift. (covers new admissions)
e. A Medication Reconciliation process will occur daily to guarantee all medications ordered have been received by facility and pharmacy follow up occurs timely if necessary.
f. Nursing staff will be required to access the medication stat box for any medication due that has not yet been received from the pharmacy. If not available in the stat box, the ordering physician will be notified for instructions.
g. Develop a Bowel Management Policy and inservice all licensed nursing staff on same.
h. Nursing staff will complete a Medication Error Report for instances where medication management or administration is compromised.

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F 281	Continued From page 8 After medication pass observation, Resident #6's medication orders were reviewed and reconciled. The physicians orders revealed that "All of her supplements" were discontinued on 2-8-16 by the physician. These supplements had the reason for administration listed as "therapeutic", as no active need or diagnosis was given for the administration of these mineral supplements, to include Magnesium Citrate, and Preservision multi-vitamin. These medications had not been discontinued on the MAR, and so were administered. The Docusate had never been administered, and had never been placed on the MAR. On 2-9-16, Resident #6's care plan was reviewed. The Resident care plan must be developed to provided necessary care and services to meet the identified needs of a resident. and the findings were as follows: Resident #6 was admitted post-operatively after abdominal surgery to remove a portion of the small bowel, and reconnect the ends where the portion was removed. This information received on admission to skilled nursing indicates staff knowledge of a potential for bowel obstruction, infection, pain, and separation of the surgical re-attachment areas of the bowel. The care plan addressed general pain, and infection only. No bowel plan or interventions were care planned for this individual. RN A was made aware of the medication errors, and stated she would look into it. RN A stated the reason that Resident #6's supplements (therapeutic medications) had been discontinued was because the Resident had refused to take them due to stomach discomfort, and only wanted the necessary medications, so the doctor	F 281	i. Nursing staff will print a daily report of bowel activity from CareTracker. Nursing staff will review this report and treat all residents having no BM activity per policy. 4. The facility will complete an audit of all current residents to ensure all physician orders are transcribed properly on the MAR. Results of this audit will be forwarded to the Director of Nursing and reviewed through the Quality Assurance Committee. Errors identified will be immediately corrected. **Nursing administration staff will review the Bowel Activity Report on a regular basis to ensure all residents are managed properly. Results of this monitoring will be reported to the DON with follow up as necessary. Results of this monitoring will be reported through the Quality Assurance Committee.	

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F 281	Continued From page 9 had discontinued them. All nursing notes were reviewed in the clinical record, and document the following; On 2-4-16, The Resident complained of a dull ache and abdominal gas pain, on the admission assessment. On 2-6-16 the Resident complained of nausea and vomiting. On 2-7-16 the Resident complained of nausea, and was medicated for the complaint. On 2-8-16 the Resident complained of nausea, and an antibiotic medication was ordered for abdominal infection. On 2-9-16 the Resident complained of constipation, bowel sounds were assessed by nursing and found to be hypoactive in all 4 quadrants, nursing staff then encouraged a diet of bland solid foods to increase bowel movement. At no time were bowel softening, or bowel movement encouraging medications, offered or administered. These medications were ordered and available. On 2-10-16 a second copy of the MAR was obtained at 1:00 p.m. and revealed that the Miralax had been administered in the morning, however, the docusate still had not been placed on the MAR for administration, nor had it been discontinued. The docusate was for bowel care, and was available in the facility stat box. On 2-10-16, The facility document "Bladder and Bowel report" was reviewed. The document was completed by Certified Nursing Assistants (CNA's) daily, and revealed that Resident #6 was continent of bowel and had not had a bowel movement since Saturday 2-6-16.	F 281	** Nursing staff will audit all new admission records timely to ensure all physician orders are transcribed properly and medications are administered as ordered. Regular audits of existing resident records will be completed by nursing staff for the same standard of care. Results of this auditing will be reported to the DON and discussed at the Quality Assurance meeting. 5. Completion date: March 26, 2016	

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On 2-10-16 Resident #6 was again interviewed at 1:00 p.m., and stated that she still had not had a bowel movement, and it was now 4 days since the last one, which was hard and small. The Bowel and bladder report document had a box area denoted as "H0600 Bowel Patterns", which asked the question; "Constipation Present?". This area had not been filled out by staff, and had a dash in the space.

The DON (Director of Nursing) was requested to provide a copy of the facility bowel regimen policy for constipation, and she stated that they did not have one. No care plan interventions were instituted for Resident #6, after bowel surgery, and the Resident became constipated.

An interview was conducted with the Director of Nursing, (DON), the administrator, and nurse supervisor at the end of day debrief on 2-9-16 at 5:00 p.m., and on 2-10-16 at 3:00 p.m.. All in attendance were made aware of the findings. The DON stated that the follow up on the admission orders, and new orders had not been completed by staff. No further information was provided by the facility.

1b. For Resident #6, the staff failed to transcribe a medication order on the MAR (medication administration record), failed to administer 3 medications that were ordered, and administered two medications that were discontinued by the doctor.

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For Resident #6, the staff failed to transcribe a medication order on the MAR (medication administration record) for (Docusate), failed to administer 3 medications (Docusate, Lovenox, and Miralax) that were ordered, and administered two medications (Magnesium Citrate tablet, and Preservision multivitamin) that were discontinued by the doctor.

Resident #6's admission MDS (minimum data set) was not completed as the Resident had been admitted for only 6 days.

Review of the Certified Nursing Assistant (CNA) Activities of Daily Living sheets (ADL sheets) documented Resident #6 as needing limited to extensive assistance from staff for activities of daily living.

On 2-9-16 at 8:45 a.m. Resident #26 was interviewed during Medication administration, and was found to be talkative, appropriate, and oriented to person, place, time, and situation.

The Resident complained of abdominal discomfort and constipation, stating she had not had a bowel movement in 3 days, and that the 2 she had experienced were very small and hard on Saturday 2-6-16. The Resident's new abdominal surgical site was observed and was red, swollen and angry completely around the site. To include above and below the incision by approximately 2-3 inches. The site was closed and had no drainage at this time.

Resident #6 was also observed on 2-9-16 at 8:45 a.m. during the medication pour and pass

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observation receiving medications. Registered Nurse (RN) A, reviewed the MAR for Resident #6. RN A removed the 30 day, multiple dose blister packages, containing medications from the medication cart drawer and pushed the following 5 oral medications into the medication cup, and one nasal spray;

1. Align probiotic one tablet. To be given at 9:00 a.m.
2. Enteric coated Aspirin 81 mg (milligram) one tablet. To be given at 9:00 a.m.
3. Hyoscyamine sulfate 0.375 mg one tablet. To be given at 9:00 a.m.
4. Magnesium Citrate 200 mg one tablet. Discontinued 2-8-16.
5. Preservision H Reds one capsule. Discontinued 2-8-16.
6. Fluticasone 50 mcg (micrograms) nasal spray. To be given at 9:00 a.m.

RN A was observed to have 5 tablets total in the pill administration cup, and this was verified with her. RN A and the surveyor entered Resident #6's room, and RN A assisted the resident with taking medications which Resident #6 swallowed, and used 2 sprays of the nasal spray in each nare.

After medication pass observation, Resident #6's medication orders and MAR's were reviewed and reconciled. The following problems with regard to medication administration were found;

Miralax 1 scoop daily by mouth as needed for constipation, and Lovenox 40 mg (milligrams) subcutaneously by injection every day until fully ambulatory to prevent blood clots to be given at 9:00 p.m., were ordered on 2-8-16. Both drugs

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were ordered by the physician, and faxed to the pharmacy at the same time, on 2-8-16 at (3:55 p.m.).

The Lovenox was noted to be in the facility stat box, however, was never administered during survey, on 2-8-16, and 2-9-16. The Miralax was administered the morning of 2-10-16, after the facility was aware of the medication errors that were found by surveyors, and was noted to be in the facility bulk dose medications in the medication room on 2-9-16.

The Docusate sodium 100 mg one capsule BID (twice per day) as needed for bowel movement softening to prevent constipation which was ordered on admission 2-4-16, was never transcribed onto the MAR (medication administration record), and never administered.

Both the Magnesium Citrate, and Preservision multivitamin were administered on 2-9-16, during medication administration observations, and had both been discontinued on 2-8-16.

Further review of the physician orders revealed that "All of her supplements", as written by the doctor, were discontinued on 2-8-16. These supplements had the reason for administration listed as "therapeutic", as no active need or diagnosis was given for the administration of these mineral supplements, to include Magnesium Citrate, and Preservision multi-vitamin. These medications were not discontinued on the MAR, and so they were administered.

No where in the clinical record was there evidence documented that the physician was

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notified, or aware, that the Docusate, Miralax, and Lovenox had not been administered as ordered, however, RN A stated that the doctor was in the facility almost daily, and was aware.

On 2-9-16, Resident #6's care plan was reviewed. The Resident care plan must be developed to provided necessary care and services to meet the identified needs of a resident. and the findings are as follows; Resident #6 was admitted post-operatively after abdominal surgery to remove a portion of her small bowel, and reconnect the ends where the portion was removed. This information received on admission to skilled nursing indicated staff knowledge of a potential for bowel obstruction, infection, pain, and separation of the surgical re-attachment ends of the bowel. The care plan addresses general pain, and infection only. No bowel plan or interventions were care planned for this individual.

RN A was made aware of the medication errors, and stated she would look into it. RN A stated the reason that Resident #6's supplements (therapeutic medications) had been discontinued was because the Resident had refused to take them due to stomach discomfort, and only wanted the necessary medications, so the doctor had discontinued them.

All nursing notes were reviewed in the clinical record, and document the following:

On 2-4-16, The Resident complained of a dull ache and abdominal gas pain, on the admission assessment.
On 2-6-16 the Resident complained of nausea and vomiting.

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On 2-7-16 the Resident complained of nausea, and was medicated for the complaint.
On 2-8-16 the Resident complained of nausea, and an antibiotic medication was ordered for abdominal infection.
On 2-9-16 the Resident complained of constipation, bowel sounds were assessed by nursing and found to be hypoactive in all 4 quadrants, nursing staff then encouraged a diet of bland solid foods to increase bowel movement. At no time were bowel softening, or bowel movement encouraging medications, offered or administered. These medications were ordered and available.

On 2-10-16 a second copy of the MAR was obtained at 1:00 p.m. and revealed that the Miralax had been administered in the morning, however, not on 2-8-16, or 2-9-16, and the docusate still had not been placed on the MAR for administration, nor had it been discontinued. The Lovenox injection which was ordered at 3:55 p.m. on 2-8-16, was to be administered at 9:00 p.m., and had not been given on 2-8-16 nor 2-9-16, and was available in the facility stat box for administration.

On 2-10-16, The facility document "Bladder and Bowel report" was reviewed. The document was completed by Certified Nursing Assistants (CNA's) daily, and revealed that Resident #6 was continent of bowel and had not had a bowel movement since Saturday 2-6-16.

On 2-10-16 Resident #6 was again interviewed at 1:00 p.m., and stated that she still had not had a bowel movement, and it was now 4 days since the last one, which was hard and small. The Bowel and bladder report document had a boxed

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area denoted as "H0600 Bowel Patterns", which asked the question; "Constipation Present?". This area had not been filled out by staff, and had a dash in the space.

Review of the facility's policy for Medication Administration revealed: medications are administered as prescribed in accordance with the written orders of attending physicians.
A copy of the stat box contents was requested, and received, and revealed that the Docusate, and Lovenox were available in the stat box at all times, and miralax was also in the facility bulk dose medications.
When the Director of Nursing (DON) was asked what specific source of text was used to model their medication administration and nursing practice by, she stated " We use Potter and Perry."

Guidance was provided for appropriate documentation of physician's orders in 'Fundamentals of Nursing 7th Edition, Potter-Perry, page (p) 699, The physician, nurse practitioner, or physician's assistant prescribes medications by writing a medication order on a form in the client's medical record. Sometimes a prescriber orders a medication by talking directly to the nurse or by telephone...When a verbal or telephone order is received, the nurse who took the order writes the complete order or enters it into a computer and then reads it back and receives confirmation from the prescribe to confirm accuracy. "

Same source, page. 707, "A medication order is required for every medication you administer to a client...Regardless of how you receive an order, compare the prescriber's written orders with the

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medication administration record (MAR) when the medication is initially ordered. Once you determine that information on the client's MAR is accurate, use the MAR to prepare and administer medications."

Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 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."

An interview was conducted with the Director of Nursing, (DON), the administrator, and nurse supervisor at the end of day debrief on 2-9-16 at 5:00 p.m., and on 2-10-16 at 3:00 p.m. All in attendance were made aware of the findings. The DON stated that the medications were in the facility in the stat box, and follow up on the admission orders, and new orders had not been completed by staff. No further information was provided by the facility.

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2. For Resident # 5, the facility staff failed to clarify physician's order for pain medication Norco 5/325 milligrams written on 2/2/2016, failed to clarify orders for Trazadone and Lorazepam and failed to follow physician's order for Tramadol.

Resident # 5 was an 89 year old female admitted to the facility on 1/31/2016 with diagnoses of but not limited to: Fall, Fracture of Multiple Ribs on Right Side, and Constipation.

Resident # 5 was recently admitted and her MDS (Minimum Data Set) assessment was not yet due. Her nursing admission assessment revealed she was alert and oriented times three (person, place and time), and able to make her needs known. Resident # 5 was documented as requiring assistance with her activities of daily living.

Review of the clinical record on 2/9/2016 revealed an order handwritten on the Medication Administration Record to start on 2/2/2016 for Norco 5/325 milligrams one by mouth in AM (morning) daily and scheduled to be administered at 9 AM. A line was drawn through the date spaces until 2/8/2016 when initials were evident for 2/8/2016 and 2/9/2016 at 9 AM. Further review of the MAR showed on page 2 of 5 handwritten in the sixth space was Norco 5/325 milligrams by mouth every 6 hours as needed for pain. There was documentation of Norco being given several times "as needed" starting 2/3/2016.

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On 2/9/2016 at approximately 9:45 AM, RN A was asked for a complete copy of the MAR for review. On page 3 of 5, in the fourth slot was a handwritten order for Norco 5/325 milligrams one by mouth in AM (morning) daily. The order date was listed as 2/2/2016 and frequency at 9 AM. The medication had been administered daily 2/3/16-2/7/16 and then a line was drawn through the medication with a notation "moved to routine page, 2/7/16.

Review of the Physicians Orders since admission on 1/31/2016 revealed no order for Norco 5/325 milligrams. The Director of Nursing (DON) came to the nurses station at approximately . When asked about the order for the medication Norco, the DON looked at the chart and MAR and stated she would check. The DON and RN B looked at the chart and MAR. The DON stated that she wondered if the physician had placed the order in Centricity (a communication system used by the facility). RN B and RN C stated they would check.

On 2/9/2016 at 5 PM, an interview was conducted with the DON who stated "probably what happened was that the medication was generated through Centricity. The DON stated physician did the order in Centricity on 2/2/2016 at 3:48 PM and Pharmacy delivered the medication on 2/2/2016. The DON also stated "the nurses generated the medication on the MAR from the label." The surveyor asked for a copy of the order. The DON and RN C presented an order from Centricity printed on 2/9/2016 which stated Hydrocodone-Acetaminophen 5-325 milligram tabs (Hydrocodone-Acetaminophen) one by mouth in am, then every 6 hours as needed # 40 tablets with no refills entered by the physician on 2/2/2016 and electronically signed by the

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physician on 2/2/2016 at 3:48 PM. The DON stated the doctor "put the order in Centricity but the nurses did not print it out." The DON was asked to read the order and give her interpretation. The DON stated the order meant to "give the medication one time and then every 6 hours as needed." Then the DON stated she wanted to read the order again. The DON, RN B and RN C read the order. The DON and RN C stated the nurses read the order as one by mouth in the morning daily and then every 6 hours as needed. The DON stated the nurses did not transcribe the medication properly on the MAR because the routine medication that was listed on page 3 of 5 of the MAR was listed actually on the Treatment Administration Record (TAR). The Surveyors noted that on the top of the page is the name Mediation Administration Record. The DON stated "that page really is the TAR where the staff document pain assessments, weights and other treatments." The DON then stated she was going to make it clear to the staff that the form was really the TAR. The DON also stated she would discuss with the staff and doctors about physicians orders being written in Centricity.

On 2/9/2016 at 6 PM, RN B presented a copy of a physicians order written by the Medical Director on 2/9/2016 as a Clarification which was difficult to read. The DON stated the Medical Director wanted the Norco given every morning and then every 6 hours as needed until the Duragesic arrived. Then start Norco 5/325 by mouth every 6 hours as needed for pain.

Review of the MAR on 2/10/2016 revealed under the medication Norco 5/325 milligrams one by mouth in the morning daily, the words "until

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Duragesic Patch arrives" had been added to the bottom of the block. A line had been drawn through the medication and the words "DC' d 2/9/16" (discontinued 2/9/2016).

On 2/10/2016 at approximately 2 PM, the surveyor showed the most recent changes on the MAR to the DON who stated the nurse should have drawn a line through the medication that was written on 2/2/2016 and should have rewritten the order below after clarification. The DON stated that she was going to talk with the nurses about documenting on the MAR and handling physicians orders.

The Director of Nursing Stated Potter Perry was the professional standard used by the facility.

Guidance for nursing practice for the administration of medications was 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."

Also, guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 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:

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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 Physician's Order Form revealed a verbal order from the nurse practitioner written 2/8/2016 at 12 noon as clarification orders:
Tramadol 50 milligrams by mouth one tablet every 6 hours as needed for pain
Trazadone 50 milligrams one and a half tablets by mouth every night at bedtime for insomnia
Lorazepam 0.5 milligrams one tablet by mouth every 6 hours as needed for anxiety
Lorazepam 0.5 milligrams two tablets by mouth at bedtime as needed for anxiety/insomnia
Gabapentin 100 milligrams by mouth every night at bedtime for neuropathy
Melatonin 5 milligrams one tablet by mouth every night at bedtime for insomnia
Naproxen 220 milligrams one tablet by mouth every 12 hours as needed for pain
The orders were noted and faxed on 2/8/2016 at 12 noon

Review of the MAR on 2/9/ 16 and 2/10/16 revealed no noted changes to the MAR related to the clarification orders written on 2/8/2016. The medication Tramadol was not written on the MAR and Lorazepam 0.5 milligrams two tablets by mouth at bedtime as needed for anxiety/insomnia was not documented on the MAR but was still written as a routine medication at 9 PM daily.

Review of the MAR revealed on page 2 of 5 a typed order in the third slot for medications ordered on 1/31/2016 was:

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Tramadol HCL 50 milligrams tablet one tablet by mouth every 6 hours as needed (waiting for Hardcopy)-Do not send
There was documentation of administration 3 times: 2/1/2016 at 0745 (7:45 AM) and 2045 (8:45 PM) and 2/2/2016 at 2 PM
A line was drawn across the Medication order on the MAR and written to discontinue 2/2/2016.

Thorough review of the Physicians orders revealed no physicians order written on 2/2/2016 or any other date to discontinue the Tramadol noted in the clinical record.
The MAR did not have the medication Tramadol written on the MAR available for administration after 2/2/2016. Also, there was no documentation in the Nurses notes about changes in medication.
Lorazepam 0.5 milligrams 2 tablets by mouth at bedtime listed on page 2 of 5 with order date 1/31/16 to be administered at 2100 (9 PM). The MAR revealed this medication had been administered every day at 9 PM from 2/1/16-2/8/2016.
The medication Lorazepam 0.5 milligrams one tablet by mouth every 6 hours as needed was typed on the MAR on page 1 of 5 with order date 1/31/16. There was no documentation that the as needed dose was administered during the month of February.

The DON submitted Copies of all of the Physicians orders, Nurses Notes and MARs were requested and submitted by the DON. Eleven pages of Physicians Orders stapled together were received.

Review of the "Medication Reconciliation Form" dated 1/31/16 revealed a list of medications and dosages which included but not limited to:

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1. Trazodone 50 milligrams by mouth every night at bedtime
2. Lorazepam 0.5 milligrams by mouth "Q 6 hrs x 2 Q HS" (every 6 hours times 2 every night at bedtime) for anxiety/insomnia
3. Tramadol 50 milligrams by mouth every 6 hours as needed for back pain
The form was signed by a nurse on 1/31/16 and reviewed by another nurse on 2/2/16 at 1:30 AM

Review of the Admission Order Sheet dated 1/31/16 revealed medications listed under Routine Meds:
Tramadol 50 milligrams one tablet by mouth every 6 hrs as needed, Trazadone 50 milligrams 1.5 tablets at bedtime; Lorazepam 0.5 milligrams 1 tablet by mouth every 6 hours as needed and 2 tablets by mouth at bedtime, Gabapentin 100 milligrams 1 tablet by mouth at bedtime, Melatonin 5 milligrams 1 tablet by mouth at bedtime, Naproxen 220 milligrams 1 tablet as needed for pain every 12 hours. Then the words "DO NOT SEND" were written beneath the listing of routine medications. The form was signed by a nurse and written as a verbal order-on call physician. Documentation showed the order was faxed to the pharmacy on 1/31/16 at 3:30 PM. The form was reviewed by the night shift nurse on 2/2/16 at 1 AM.

Review of the Chart Summary Form on Page 2 and printed on February 2, 2016 revealed medications listed:
Trazadone 50 milligrams one and a half tablets at bedtime (The Medication Reconciliation form showed Trazadone 50 milligrams by mouth every night at bedtime) Listed on MAR on page 1 of 5 as Trazadone 150 milligrams 0.5 tab (75 milligrams) by night at bedtime at 9 PM

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Another medication listed was: Lorazepam 0.5 milligrams tablets 1/2 by mouth and 1 by mouth at bedtime as needed. (This order was unclear as it was written as to the exact meaning of the amounts of "1/2" and "1". It was documented on the MAR on page 1 of 5 typed as Lorazepam 0.5 milligrams 2 tablets by mouth at bedtime and administered each night routinely administered at 9 PM with an order date of 1/31/16 . And on page 2 of 5 was typed as Lorazepam 0.5 milligrams one tablet by mouth every 6 hours as needed with none administered during the month of February 2016, the order date was documented as 1/31/16. The clarification order written on 2/8/2016 showed Lorazepam 0.5 milligrams one tablet by mouth every 6 hours as needed for anxiety, and Lorazepam 0.5 milligrams two tablets by mouth at bedtime as needed for anxiety/insomnia. There were no changes noted on the MAR regarding Lorazepam after the clarification order written on 2/8/2016.

The DON was informed during an interview on 2/10/2016 at approximately 2:15 PM of Physicians orders that were not clarified, medications were not administered as ordered, and medications were not documented on the MAR and not made available for administration for the resident.

No further information was provided.

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,

F 309

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F 309

1. Resident #6 received medications to manage both constipation and blood clot management as ordered. Resident #5 received her Duragesic patches regularly as ordered once received from the pharmacy.

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F 309	Continued From page 26 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, Resident interview, facility documentation review, and clinical record review the facility staff failed to ensure the highest practicable well being for 2 Residents, (Resident's #6, and #5) in a survey sample of 10 residents. 1. Resident #6 was not adequately treated for constipation, and was not provided blood clot prevention medication ordered after surgery. 2. For Resident # 5, the facility staff failed to administer the pain medication Duragesic as ordered by the physician on 2/8/2016 and failed to treat pain after a fall on 2/9/2016 at 3:45 AM. The resident complained of pain and did not receive any pain medication until her routine scheduled pain medication administration at 9:00 AM. The findings included; 1. Resident #6 was not adequately treated for constipation, and not provided blood clot prevention medication, ordered after surgery. Resident #6, was initially admitted to the facility 2-4-16. Diagnoses included; left femoral hernia repair and resection of strangulated small bowel, hypothyroidism, cardiac disease, gastro-esophageal reflux disease (GERD), pain, allergic rhinitis, and constipation.	F 309	2. All residents have the potential to be affected by the same practice. 3. All physician orders will be reviewed for accurate transcription initially by 2 nurses and followed by a chart review on each subsequent shift. The nursing staff will be required to access the medication stat box for all new medication orders to ensure meds are started timely and there is no delay in treating a resident's condition. Lastly, the nursing staff will be required to notify the physician whenever there is an anticipated or actual delay in administering ordered medication to receive alternate orders or to place the current prescribed treatment on hold until received. The nursing staff will be required to document in the nursing notes evidence of this physician notification and the outcome. Licensed nursing staff will be inserviced on Professional Standards of Practice.	

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F 309	Continued From page 27	F 309	4. Nursing staff will complete a review on all new admission orders along with a review of all other orders daily. Results of this review process will be communicated to the DON with corrections addressed immediately. Results of this auditing will be monitored and reported through the Quality Assurance Committee. 5. Completion date: March 26, 2016	

Resident #6's admission MDS (minimum data set) was not completed as the Resident had been admitted for only 6 days.

Review of the Certified Nursing Assistant (CNA) Activities of Daily Living sheets (ADL sheets) coded Resident #6 as needing limited to extensive assistance from staff for activities of daily living.

On 2-9-16 at 8:45 a.m. Resident #26 was interviewed during Medication administration, and was found to be talkative, appropriate, and oriented to person, place, time, and situation.

The Resident complained of abdominal discomfort and constipation, stating she had not had a bowel movement in 3 days, and that the 2 she had experienced were very small and hard on Saturday 2-6-16. The Resident's new abdominal surgical site was observed and was red, swollen and angry completely around the site. To include above and below the incision by approximately 2-3 inches. The site was closed and had no drainage at this time.

Resident #6 was also observed on 2-9-16 at 8:45 a.m. during the medication pour and pass observation receiving medications. Registered Nurse (RN) A, reviewed the MAR for Resident #6. RN A removed the 30 day, multiple dose blister packages, containing medications from the medication cart drawer and pushed the following 5 oral medications into the medication cup, and one nasal spray;

1 .Align probiotic one tablet. To be given at 9:00 a.m.

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2. Enteric coated Aspirin 81 mg (milligram) one tablet. To be given at 9:00 a.m.
3. Hyoscyamine sulfate 0.375 mg one tablet. To be given at 9:00 a.m.
4. Magnesium Citrate 200 mg one tablet. Discontinued 2-8-16.
5. Preservision H Reds one capsule. Discontinued 2-8-16.
6. Fluticasone 50 mcg (micrograms) nasal spray. To be given at 9:00 a.m.

RN A was observed to have 5 tablets total in the pill administration cup, and this was verified with her. RN A and the surveyor entered Resident #6's room, and RN A assisted the resident with taking medications which Resident #6 swallowed, and used 2 sprays of the nasal spray in each nare.

After medication pass observation, Resident #6's medication orders and MAR's were reviewed and reconciled. The following problems with regard to prevention of blood clots, and constipation were found;

The physicians orders revealed that on 2-8-16 the doctor ordered Doxycycline to be given at 9:00 a.m., and 5:00 p.m.. Doxycycline is an antibiotic medication, which was ordered to be administered for the assessed abdominal surgical infection. This medication was found to be in the facility stat box, and administered on 2-8-16 at 5:00 p.m., and on 2-9-16 at 9:00 a.m., and 5:00 p.m..

Miralax 1 scoop daily by mouth as needed for constipation, and Lovenox 40 mg (milligrams) subcutaneously by injection every day until fully ambulatory to prevent blood clots to be given at

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9:00 p.m., were also ordered on 2-8-16, with the Doxycycline antibiotic for infection. All three drugs were ordered by the physician, and faxed to the pharmacy at the same time, on 2-8-16 at (3:55 p.m.).

The Lovenox was also noted to be in the facility stat box, however, was never administered during survey, on 2-8-16, and 2-9-16. The Miralax was finally administered the morning of 2-10-16, after the facility was aware of the medication errors that were found by surveyors, and was noted to be in the facility bulk dose medications in the medication room.

The Docusate sodium 100 mg one capsule BID (twice per day) as needed for bowel movement softening to prevent constipation which was ordered on admission 2-4-16, was never transcribed onto the MAR (medication administration record), and never administered.

Further review of the physician orders revealed that "All of her supplements", as written by the doctor, were discontinued on 2-8-16. These supplements had the reason for administration listed as "therapeutic", as no active need or diagnosis was given for the administration of these mineral supplements, to include Magnesium Citrate, and Preservision multi-vitamin. These medications were not discontinued on the MAR, and so they were administered.

No where in the clinical record was there evidence documented that the physician was notified, or aware, that the Docusate, Miralax, and Lovenox had not been administered as ordered, however, RN A stated that the doctor was in the

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facility almost daily, and was aware.

On 2-9-16, Resident #6's care plan was reviewed. The Resident care plan must be developed to provided necessary care and services to meet the identified needs of a resident. and the findings are as follows; Resident #6 was admitted post-operatively after abdominal surgery to remove a portion of her small bowel, and reconnect the ends where the portion was removed. This information received on admission to skilled nursing indicates staff knowledge of a potential for bowel obstruction, infection, pain, and separation of the surgical re-attachment ends of the bowel. The care plan addresses general pain, and infection only. No bowel plan or interventions were care planned for this individual.

RN A was made aware of the medication errors, and stated she would look into it. RN A stated the reason that Resident #6's supplements (therapeutic medications) had been discontinued was because the Resident had refused to take them due to stomach discomfort, and only wanted the necessary medications, so the doctor had discontinued them.

All nursing notes were reviewed in the clinical record, and document the following;

On 2-4-16, The Resident complained of a dull ache and abdominal gas pain, on the admission assessment.
On 2-6-16 the Resident complained of nausea and vomiting.
On 2-7-16 the Resident complained of nausea, and was medicated for the complaint.
On 2-8-16 the Resident complained of nausea,

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and an antibiotic medication was ordered for abdominal infection.
On 2-9-16 the Resident complained of constipation, bowel sounds were assessed by nursing and found to be hypoactive in all 4 quadrants, nursing staff then encouraged a diet of bland solid foods to increase bowel movement. At no time were bowel softening, or bowel movement encouraging medications, offered or administered. These medications were ordered and available.

On 2-10-16 a second copy of the MAR was obtained at 1:00 p.m. and revealed that the Miralax had been administered in the morning, however, not on 2-8-16, or 2-9-16, and the docusate still had not been placed on the MAR for administration, nor had it been discontinued. The Lovenox injection which was ordered at 3:55 p.m. on 2-8-16, was to be administered at 9:00 p.m., and had not been given on 2-8-16, nor 2-9-16, and was available in the facility stat box for administration.

On 2-10-16, The facility document "Bladder and Bowel report" was reviewed. The document was completed by Certified Nursing Assistants (CNA's) daily, and revealed that Resident #6 was continent of bowel and had not had a bowel movement since Saturday
2-6-16.

On 2-10-16 Resident #6 was again interviewed at 1:00 p.m., and stated that she still had not had a bowel movement, and it was now 4 days since the last one, which was hard and small. The Bowel and bladder report document had a boxed area denoted as "H0600 Bowel Patterns", which asked the question; "Constipation Present?".

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This area had not been filled out by staff, and had a dash in the space.

Review of the facility's policy for Medication Administration revealed: medications are administered as prescribed in accordance with the written orders of attending physicians.
A copy of the stat box contents was requested, and received, and revealed that the Docusate, and Lovenox were available in the stat box at all times, and miralax was also in the facility bulk dose medications.
When the Director of Nursing (DON) was asked what specific source of text is used to model their medication administration and nursing practice by, she stated " We use Potter and Perry."
Guidance was provided for appropriate documentation of physician's orders in 'Fundamentals of Nursing 7th Edition, Potter-Perry, page (p) 699, The physician, nurse practitioner, or physician's assistant prescribes medications by writing a medication order on a form in the client's medical record. Sometimes a prescriber orders a medication by talking directly to the nurse or by telephone...When a verbal or telephone order is received, the nurse who took the order writes the complete order or enters it into a computer and then reads it back and receives confirmation from the prescribe to confirm accuracy."

Same source, p. 707, "A medication order is required for every medication you administer to a client...Regardless of how you receive an order, compare the prescriber's written orders with the medication administration record (MAR) when the medication is initially ordered. Once you determine that information on the client's MAR is accurate, use the MAR to prepare and administer

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medications."

An interview was conducted with the Director of Nursing, (DON), the administrator, and nurse supervisor at the end of day debrief on 2-9-16 at 5:00 p.m., and on 2-10-16 at 3:00 p.m.. All in attendance were made aware of the findings. The DON stated that the medications were in the facility in the stat box, and follow up on the admission orders, and new orders had not been completed by staff. No further information was provided by the facility.

2. For Resident # 5, the facility staff failed to administer the pain medication Duragesic as ordered by the physician on 2/8/2016 and failed to treat pain after a fall on 2/9/2016 at 3:45 AM. The resident complained of pain and did not receive any pain medication until her routine scheduled pain medication administration at 9:00 AM.

Resident # 5 was an 89 year old female admitted to the facility on 1/31/2016 with diagnoses of but not limited to: Fall, Fracture of Multiple Ribs on Right Side, and Constipation.

Resident # 5 was recently admitted and her MDS (Minimum Data Set) assessment was not yet due. Her nursing admission assessment revealed she was alert and oriented times three (person, place and time), and able to make her needs known. Resident # 5 was documented as requiring assistance with her activities of daily living. She was documented as alert and oriented X3 according to the nursing notes and the incident report.

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The Interim Plan of Care, dated on admission 1/31/2016, revealed a problem including " Potential for Pain " listed with three interventions: Administer pain medication as ordered, assist resident with positioning for comfort and ask resident frequently if pain medication or other treatment is being effective; if continued pain is present, notify the physician.

The interim care plan (after the fall) dated 2/9/16 read that the resident requires assistance with ADLs, ½ bed rails and supervision for mobility aid. The Admission Nursing Assessment dated 1/31/2016, showed admitting diagnosis back pain, resident used assistive device of wheelchair " just while back pain " , comments " usually walks a lot independently " ,
Fall assessment score was documented as a 12. Total score of 10 or above represents HIGH RISK. Fall risk coded gait /balance abnormal, 1-2 falls in the past 3 months.

Review of the Nurses Notes revealed a notation on 2/9/2016 at 8:00 AM "FOF early this AM, Resident trying to transfer without assistance" to commode, lost balance and fell. Resident complained of left rib pain and right rib symptoms.

On 2/9/2016 at approximately 10 AM, an interview was conducted with Registered Nurse (RN) A who stated she received report from the night shift nurse that the resident had fallen during the night. RN A reviewed the Nurses

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Notes and stated she was she thought abbreviation "FOF" documented in the note meant "Found on Floor". RN A stated a "Post Fall Assessment form was started after the fall. RN A presented the Post Fall Assessment form dated 2/9/2016 at 5 AM which documented "Resident continues to complain of pain from fall. States she has been hurting on left rib/opposite original fracture. No pain medication can be given at this time. When able to give, resident will receive. No skin issues at this time."

Review of the MAR (Medication Administration Record) on the back where PRN (as needed) medications were listed revealed documentation of administration of:
Norco 5/325 milligrams at midnight on 2/9/2016 for pain with relief documented at 1:35 AM and Roboxicon administered at midnight on 2/9/2016 for back spasms with relief documented at 1:35 AM.
Aleve 220 milligrams every 12 hours as needed for pain was administered on 2/8/2016 at 8 AM.
Tylenol 650 milligrams by mouth every 4 hours as needed for mild pain or temp greater than 101 last administered 2/4/2016 at 6 PM

Review of the MAR revealed routine pain medications had been given as ordered on 2/9/2016:
Norco 5/325 milligrams one by mouth in the morning at 9 AM
Lidoderm 5 % patch (Lidocaine) apply one patch daily (on in the morning and off in the evening) for diagnosis of pain scheduled on at 9 AM and off at 9 PM was given at 9AM

The Director of Nursing (DON) came to the nurse ' s station and was asked about the nurse '

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s note and any information about the fall. The DON read the nurse ' s note dated 2/9/2015 at 0800 and stated the note did not give specific information about the fall. The DON stated the initials "FOF" meant "found on floor" and that abbreviation is used routinely at that facility and in the medical field and "even in the legal arena." The DON stated there should be a Post Fall Assessment in the chart that would give more information. The Post Fall Assessment was located in the chart and reviewed.

An interview was conducted 2/9/2016 at approximately 10:10 AM in the conference room with the Director of Nursing (DON) who stated "an incident report is completed after a fall. If the fall was unwitnessed, neurochecks (neurological checks) would be done along with every shift charting via the nurses notes for 72 hours." The DON stated she had been informed about the fall during the morning report. The DON presented the Incident Report, Post Fall Assessment form and Post Fall Assessment Q Shift x 48 hours form. The DON reviewed the chart, Nurses Notes, Incident Report and Post Fall Assessment with the surveyor.

The Incident Report documented the time of the incident as 2/9/2016 at 3:45 AM and that Resident # 5 was found on the floor near the commode in her room at the bedside. The note also stated the resident requested another pain pill but it was too early to be administered. Resident was assessed. Documentation showed "only complaint" was right and left ribs. "Ice applied upon arrival back to bed" after using bedside commode. Also stated the resident was assisted back to bed with use of walker for stability and one person assistance." Call bell

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was placed within reach. Walker at bedside, resident encouraged to use call bell and not walk or transfer by herself." The Incident report documented the physician was notified via Centricity (a communication system used by the facility) on 2/9/2016 at 5 AM.

The documentation on the Post Fall Assessment Form on 2/9/2016 at 5 AM showed vital signs were taken with blood pressure of 190/80, pulse 102, respirations 20, oxygen saturation of 97 percent and pain was rated at an 8 of 10 (a 10 indicates the most amount of pain). Under additional comments was written: "Resident continues to complain of pain from fall. States she has been hurting on left rib/opposite original fracture. No pain medication can be given at this time. When able to give, resident will receive. No skin issues at this time." The DON stated "this resident is here for pain management! I am going to handle this." The DON left the conference room.

Review of the Physicians Order Form revealed an order written by the physician on 2/8/2016 for Duragesic 12 micrograms every 72 hours to skin diagnosis pain, and Senna S one by mouth twice a day for diagnosis constipation. The order was noted and faxed by a nurse on 2/8/2016 at 4 PM. The Medication Duragesic was not documented on the MAR.

Copies of all of the Physicians orders, Nurses Notes and MARs were requested and submitted by the DON along with a copy of the Hydrocodone-Acetaminophen 5-325 milligrams order written in " Centricity " electronically signed by the Medical Director on 2/2/2016 at 3:48 PM.

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Review of the "Medication Reconciliation Form" revealed list of medications and dosages which included pain medications but not limited to:
Tramadol 50 milligrams by mouth every 6 hours as needed for back pain
Gabapentin 100 milligrams by mouth every night at bedtime for generalized pain and insomnia
Naproxen 220 milligrams by mouth every 12 hours as needed for pain/generalized/back
The form was signed by a nurse 1/31/16 and reviewed by another nurse on 2/2/16 at 1:30 AM

Review of the Admission Order Sheet dated 1/31/16 revealed a list of medications including but not limited to pain medications listed under Routine Meds:
Tramadol 50 milligrams one tablet by mouth every 6 hrs as needed, Gabapentin 100 milligrams 1 tablet by mouth at bedtime, Naproxen 220 milligrams 1 tablet as needed for pain every 12 hours. The form was signed by a nurse and written as a verbal order-on call physician. Documentation showed the order was faxed to the pharmacy on 1/31/16 at 3:30 PM. The form was reviewed by the night shift nurse on 2/2/16 at 1 AM.

Review of the Physician's Order Form revealed a verbal order from the nurse practitioner written 2/8/2016 at 12 noon as clarification orders:
Tramadol 50 milligrams by mouth one tablet every 6 hours as needed for pain
Trazadone 50 milligrams one a half tablets by mouth every night at bedtime for insomnia
Lorazepam 0.5 milligrams one tablet by mouth every 6 hours as needed for anxiety
Lorazepam 0.5 milligrams two tablets by mouth at bedtime as needed for anxiety/insomnia

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Gabapentin 100 milligrams by mouth every night at bedtime for neuropathy
Melatonin 5 milligrams one tablet by mouth every night at bedtime for insomnia
Naproxen 220 milligrams one tablet by mouth every 12 hours as needed for pain
The orders were noted and faxed on 2/8/2016 at 12 noon

Tramadol 50 milligrams should have been available for administration for pain after the fall on 2/9/2016 as per the documented clarification order written on 2/8/2016 for Tramadol 50 milligrams by mouth one tablet every 6 hours as needed for pain. Tramadol was not listed on the MAR.

Review of the clinical record revealed several medications were available for administration to the Resident # 5 after her fall on 2/9/2016 when she complained of pain at 5 AM and was told it was too early to receive a pain medication. Aleve, Tylenol, Tramadol and Norco were all available for administration as ordered by the physician. There was no documentation that Resident # 5 was offered the other pain medications available ordered " as needed " by the physician. There was no documentation that Norco was offered when able to be administered at 6 AM.

Duragesic 12 micrograms had been ordered on 2/8/2016 as a routine medication and was not listed on the MAR and not yet administered on 2/9/2016.

An interview was conducted with Resident # 5 on 2/9/2016 at 11:40 AM after she attended the

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group interview at 11:00AM. Resident # 5 stated she fell early that morning and was having pain in her left rib area but " felt better now " after she was given pain medication that morning. Resident # 5 was sitting in a wheelchair during the interviews and was wheeled into the meeting area by a staff member. Resident # 5 stated it was hard to move the wheelchair without help because her ribs were hurting. After the interviews, a staff member provided assistance to Resident # 5 to return to her room.

Review of the MAR revealed documentation of Norco 5/325 given at routine time of 9 AM on 2/9/2016.

During the end of day debriefing on 2/9/2016 at 5 PM, the Director of Nursing (DON) stated her expectation was that the nurse should have notified the doctor that the resident was complaining of pain after the fall and the pain medication (Norco) that was given at midnight was not due again until 6 AM. The DON also stated that a chest x ray could have been obtained if the resident continued to complain of pain related to the fall. The DON also stated she was going to talk with the nurse about the window of time for giving pain medications. DON stated "she could have given the pain medication Norco at 5 AM when the resident complained of pain because it was within the right time frame. She should have given pain medicine since the resident was complaining of pain." The DON then stated she would talk with the nurse about the expectation regarding documentation in the Nurses Notes at the time of a fall and about use of approved standard abbreviations for documentation. The DON stated the nurse involved was "a good nurse and had all the

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information but not in the right places." The DON again stated the nurse should have administered pain medication after the fall since the resident complained of pain. The DON also stated she was going to re-educate the nurses on completing orders

The DON stated the Pharmacy delivers medications several times a day and Resident # 5 should have been started on Duragesic on 2/8/2016 as ordered by the physician. The DON also stated that on 2/9/2016, RN A had the doctor write a hard prescription for Duragesic to make sure the Pharmacy would send the medication.

On 2/10/2016, review of the MAR reviewed Duragesic had been administered at 7 PM on 2/9/2016.

During an interview on 2/10/2016 at 11 AM, the DON stated the Pharmacy told her they did "receive the faxed copy of the order for Duragesic but it was not placed in the usual area in the Pharmacy, so it was not filled." The DON stated the Duragesic was filled on 2/9/2016 and administered to Resident # 5 that evening.

No other information was provided.

Duragesic 12 micrograms every 72 hours to skin diagnosis pain;
Duragesic (also known as Fentanyl) " is a pain medication used to treat persistent, moderate to severe, long term pain in people already taking other narcotic painkillers. " www.pdrhealth.com <http://www.pdrhealth.com>
" Fentanyl belongs to a class of drugs known as narcotic (opiate) analgesics. " www.webmd.com

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Norco 5/325 milligrams one by mouth in the morning, then every 6 hours as needed for pain
Norco is a combination medication used to relieve moderate to severe pain. " It contains a narcotic pain reliever (Hydrocodone) and a non narcotic pain reliever (Acetaminophen) "
www.webmd.com <http://www.webmd.com>

Tramadol 50 milligrams by mouth one tablet every 6 hours as needed for pain.
Tramadol is " a man-made synthetic analgesic (pain reliever) " www.webmd.com
<http://www.webmd.com>

Gabapentin 100 milligrams by mouth every night at bedtime for neuropathy
Gabapentin is used to treat seizures and " also used to relieve nerve pain. " www.webmd.com
<http://www.webmd.com>

Naproxen 220 milligrams one tablet by mouth every 12 hours as needed for pain.
Naproxen is a nonsteroidal anti-inflammatory drug (NSAID) used to relieve pain.
www.webmd.com <http://www.webmd.com>

Tylenol 650 milligrams by mouth as needed for mild pain or temperature greater than 101
Tylenol is a drug used to treat mild to moderate pain. www.webmd.com <http://www.webmd.com>

Robaxin 500 milligrams by mouth every 6 hours as needed for back spasms
Robaxin is a muscle relaxant used to treat muscle spasms and pain

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329	POC 2016	

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, Resident interview, clinical record review, and facility documentation review, the facility staff failed to ensure one Resident (Residents #6) was free from unnecessary medications, in a survey sample of 10 residents.

For Resident #6, the facility staff administered

F 329

1. Resident #6 was discharged on an appropriate bowel management program.
2. All residents within the facility are at risk to be affected by the same practice.
3. All physician orders will be reviewed for accurate transcription initially by 2 nurses and followed by a chart review on each subsequent shift. The focus here will be to ensure medications are categorized correctly and all have an appropriate indication for use. Nursing staff when verifying orders will obtain the appropriate indication for use from the physician.

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Magnesium Citrate which had been discontinued by the doctor.

The findings included:

Resident #6, was initially admitted to the facility 2-4-16. Diagnoses included; left femoral hernia repair and resection of strangulated small bowel, hypothyroidism, cardiac disease, gastro-esophageal reflux disease (GERD), pain, allergic rhinitis, and constipation.

Resident #6's admission MDS (minimum data set) was not completed as the Resident had been admitted for only 5 days.

Review of the Certified Nursing Assistant (CNA) Activities of Daily Living sheets (ADL sheets) coded Resident #6 as needing limited to extensive assistance from staff for activities of daily living.

On 2-9-16 at 8:45 a.m. Resident #26 was interviewed during Medication administration, and was found to be talkative, appropriate, and oriented to person, place, time, and situation. The Resident complained of abdominal discomfort and constipation, stating she had not had a bowel movement in 3 days, and that the 2 she had experienced were very small and hard on Saturday (2-6-16).

The Resident's new abdominal surgical site was observed during medication administration, and was noted to be red, swollen and angry completely around the site. To include above and below the incision by approximately 2-3 inches. The site was closed and had no drainage at this time.

4. The facility staff will complete an audit of current residents to ensure physician orders are transcribed correctly on the MAR. Nursing staff will continue to audit records of all admissions and all orders ongoing until such a time when 100% compliance is achieved. At that time, random orders will be reviewed along with all new admissions. Results of this audit will be reported to the DON with corrections addressed immediately. Results of this monitoring will be reported and reviewed through the Quality Assurance Committee.
5. Completion date: March 26, 2016

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Resident #6 was also observed on 2-9-16 at 8:45 a.m. during the medication pour and pass observation receiving medications. Registered Nurse (RN) A, reviewed the MAR (medication administration record) for Resident #6. RN A removed the 30 day, multiple dose blister packages, containing medications from the medication cart drawer and pushed the following 5 oral medications into the medication cup, and one nasal spray;

1 .Align probiotic one tablet. To be given at 9:00 a.m.
2. Enteric coated Aspirin 81 mg (milligram) one tablet. To be given at 9:00 a.m.
3. Hyoscyamine sulfate 0.375 mg one tablet. To be given at 9:00 a.m.
4. Magnesium Citrate 200 mg one tablet. Discontinued 2-8-16.
5. Preservision H Reds one capsule. Discontinued 2-8-16.
6. Fluticasone 50 mcg (micrograms) nasal spray. To be given at 9:00 a.m.

RN A was observed to have 5 tablets total in the pill administration cup, and this was verified with her. RN A and the surveyor entered Resident #6's room, and RN A assisted the resident with taking medications which Resident #6 swallowed, and used 2 sprays of the nasal spray in each nare.

After medication pass observation, Resident #6's medication orders were reviewed and reconciled. The physicians orders revealed that "All of her supplements" were discontinued on 2-8-16 by the physician. These supplements had the reason for administration listed as "therapeutic", as no

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active need or diagnosis was given for the administration of these mineral supplements, to include Magnesium Citrate and Preservision H Reds one capsule. These medications had not been discontinued on the MAR, and so were administered.

Also immediately following medication administration observation, RN A went to the medication room, and obtained the antibiotic Doxycycline from the stat box and administered it to Resident #6, as ordered.

On 2-9-16, Resident #6's care plan was reviewed. The Resident care plan must be developed to provided necessary care and services to meet the identified needs of a resident. and the findings are as follows; Resident #6 was admitted post-operatively after abdominal surgery to remove a portion of the small bowel, and reconnect the ends where the portion was removed. This information received on admission to skilled nursing indicates staff knowledge of a potential for bowel obstruction, infection, pain, and separation of the surgical re-attachment areas of the bowel. The care plan addresses general pain, and infection.

RN A was made aware of the medication errors, and stated she would look into it. RN A stated the reason that Resident #6's supplements (therapeutic medications) had been discontinued was because the Resident had refused to take them due to stomach discomfort, and only wanted the necessary medications, so the doctor had discontinued them.

All nursing notes were reviewed in the clinical record, and document the following;

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On 2-4-16, The Resident complained of a dull ache and abdominal gas pain, on the admission assessment.
On 2-6-16 the Resident complained of nausea and vomiting.
On 2-7-16 the Resident complained of nausea, and was medicated for the complaint.
On 2-8-16 the Resident complained of nausea, and an antibiotic medication was ordered for abdominal infection.
On 2-9-16 the Resident complained of constipation, bowel sounds were assessed by nursing and found to be hypoactive in all 4 quadrants, nursing staff then encouraged a diet of bland solid foods to increase bowel movement. At no time were bowel softening, or bowel movement encouraging medications, offered or administered. These medications were ordered and available.

On 2-10-16 a second copy of the MAR was obtained at 1:00 p.m. and revealed that the Miralax had been administered in the morning, however, the docusate still had not been placed on the MAR for administration, nor had it been discontinued. The Lovenox injection which was ordered at 3:55 p.m. on 2-8-16, was to be administered at 9:00 p.m., and had not been given on 2-8-16, nor 2-9-16, and was available in the facility stat box for administration.

Review of the facility's policy for Medication Administration revealed: medications are administered as prescribed in accordance with the written orders of attending physicians.

An interview was conducted with the Director of Nursing, (DON), the administrator, and nurse

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F 329	Continued From page 48 supervisor at the end of day debrief on 2-9-16 at 5:00 p.m., and on 2-10-16 at 3:00 p.m.. All in attendance were made aware of the findings. The DON stated that the follow up on the admission orders, and new orders had not been completed by staff. No further information was provided by the facility.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Resident interview, clinical record review, and facility documentation review, the facility staff failed to ensure one Resident's medications, (Residents #6) were administered with an error rate of less than 5%. The facility's medication error rate was 12% with 3 errors out of 25 opportunities, in a survey sample of 10 residents. On 2-9-16 during Medication pour and pass observations, for Resident #6, the facility staff failed to administer physician ordered Lovenox, and Docusate, and administered Magnesium Citrate, which had been discontinued by the doctor. The findings included: Resident #6, was initially admitted to the facility 2-4-16. Diagnoses included; left femoral hernia repair and resection of strangulated small bowel,	F 332	POC 2016 F 332 1. The facility notified the attending physician regarding the medication errors. The resident was discharged prior to receipt of report. 2. All residents have the potential to be affected by this deficient practice.	

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hypothyroidism, cardiac disease, gastro-esophageal reflux disease (GERD), pain, allergic rhinitis, and constipation.

Resident #6's admission MDS (minimum data set) was not completed as the Resident had been admitted for only 5 days.

Review of the Certified Nursing Assistant (CNA) Activities of Daily Living sheets (ADL sheets) coded Resident #6 as needing limited to extensive assistance from staff for activities of daily living.

On 2-9-16 at 8:45 a.m. Resident #26 was interviewed during Medication administration, and was found to be talkative, appropriate, and oriented to person, place, time, and situation. The Resident complained of abdominal discomfort and constipation, stating she had not had a bowel movement in 3 days, and that the 2 she had experienced were very small and hard on Saturday 2-6-16. The Resident's new abdominal surgical site was observed and was red, swollen and angry completely around the site. To include above and below the incision by approximately 2-3 inches. The site was closed and had no drainage at this time.

Resident #6 was also observed on 2-9-16 at 8:45 a.m. during the medication pour and pass observation receiving medications. Registered Nurse (RN) A, reviewed the MAR (medication administration record) for Resident #6. RN A removed the 30 day, multiple dose blister packages, containing medications from the medication cart drawer and pushed the following 5 oral medications into the medication cup, and one nasal spray;

3. All licensed nursing staff will be educated to follow the expectation that when orders are noted, this will require them to be transcribed to the MAR. Staff will monitor all new physician orders for accurate transcription to the MAR on a regular basis. Nursing staff will be required to inform administration when there is a question regarding a transcription issue. Nursing staff will be required to notify the physician and document the same in the nurse's notes when a medication issue is identified.
4. Audits of current records and all new admission records will be completed on a regular basis. Results of this auditing will be reported to the DON will any issues addressed immediately. Results of this monitoring will be reported through the Quality Assurance Committee.
5. Completion date: March 26, 2016

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1 .Align probiotic one tablet. To be given at 9:00 a.m.
2. Enteric coated Aspirin 81 mg (milligram) one tablet. To be given at 9:00 a.m.
3. Hyoscyamine sulfate 0.375 mg one tablet. To be given at 9:00 a.m.
4. Magnesium Citrate 200 mg one tablet. Discontinued 2-8-16.
5. Preservision H Reds one capsule. Discontinued 2-8-16.
6. Fluticasone 50 mcg (micrograms) nasal spray. To be given at 9:00 a.m.

RN A was observed to have 5 tablets total in the pill administration cup, and this was verified with her. RN A and the surveyor entered Resident #6's room, and RN A assisted the resident with taking medications which Resident #6 swallowed, and used 2 sprays of the nasal spray in each nare.

Also immediately following medication administration observation, RN A went to the medication room, and obtained the antibiotic Doxycycline from the stat box and administered it to Resident #6, as ordered.

After medication pass observation, Resident #6's medication orders were reviewed and reconciled. The physicians orders revealed that "All of her supplements" were discontinued on 2-8-16 by the physician. These supplements had the reason for administration listed as "therapeutic", as no active need or diagnosis was given for the administration of these mineral supplements, to include Magnesium Citrate, and Preservision multi-vitamin. These medications were not discontinued on the MAR, and so they were

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administered.

It was also documented in the physician orders that an order for "Docusate sodium 100 mg one capsule BID (twice per day) as needed for constipation", was written on the admission orders on 2-4-16, and had never been administered, and had never been transcribed onto the MAR (medication administration record) for administration. Two other orders were found in the physician orders, issued and written on 2-8-16, for; "Lovenox 40 mg sub-cutaneous injection daily" to prevent blood clots after surgery, and "Miralax 1 scoop by mouth daily as needed for constipation." Neither medication was administered on 2-8-16, or 2-9-16. Both of these medications and the Docusate were available for administration in the facility in the stat box, and or, in bulk house supply in the medication room.

No where in the clinical record was there evidence documented that the physician was notified, or aware, that the Docusate, Miralax, and Lovenox had not been administered as ordered, however, RN A stated that the doctor was in the facility almost daily, and was aware.

On 2-9-16, Resident #6's care plan was reviewed. The Resident care plan must be developed to provided necessary care and services to meet the identified needs of a resident. and the findings are as follows; Resident #6 was admitted post-operatively after abdominal surgery to remove a portion of the small bowel, and reconnect the ends where the portion was removed. This information received on admission to skilled nursing indicates staff knowledge of a potential for bowel obstruction, infection, pain, and separation of the surgical

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re-attachment areas of the bowel. The care plan addresses general pain, and infection only. No bowel plan or interventions were care planned for this individual.

RN A was made aware of the medication errors, and stated she would look into it. RN A stated the reason that Resident #6's supplements (therapeutic medications) had been discontinued was because the Resident had refused to take them due to stomach discomfort, and only wanted the necessary medications, so the doctor had discontinued them.

All nursing notes were reviewed in the clinical record, and document the following;

On 2-4-16, The Resident complained of a dull ache and abdominal gas pain, on the admission assessment.
On 2-6-16 the Resident complained of nausea and vomiting.
On 2-7-16 the Resident complained of nausea, and was medicated for the complaint.
On 2-8-16 the Resident complained of nausea, and an antibiotic medication was ordered for abdominal infection.
On 2-9-16 the Resident complained of constipation, bowel sounds were assessed by nursing and found to be hypoactive in all 4 quadrants, nursing staff then encouraged a diet of bland solid foods to increase bowel movement. At no time were bowel softening, or bowel movement encouraging medications, offered or administered. These medications were ordered and available.

On 2-10-16 a second copy of the MAR was obtained at 1:00 p.m. and revealed that the

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Miralax had been administered in the morning, after the facility staff were made aware of the medication errors by surveyors, however, not on 2-8-16, or 2-9-16. The docusate still had not been placed on the MAR for administration on 2-10-16, nor had it been discontinued. The Lovenox injection which was ordered at 3:55 p.m. on 2-8-16, was to be administered at 9:00 p.m., and had not been given on 2-8-16, nor 2-9-16, and was available in the facility stat box for administration.

On 2-10-16, The facility document "Bladder and Bowel report" was reviewed. The document was completed by Certified Nursing Assistants (CNA's) daily, and revealed that Resident #6 was continent of bowel and did not have a bowel movement since Saturday 2-6-16.

On 2-10-16 Resident #6 was again interviewed at 1:00 p.m. on 2-10-16, and stated that she still had not had a bowel movement, in 4 days. The Bowel and Bladder report document had a boxed area denoted as "H0600 Bowel Patterns", which asked the question "Constipation Present?". This area had not been filled out by staff, and had a dash in the space.

Review of the facility's policy for Medication Administration revealed: medications are administered as prescribed in accordance with the written orders of attending physicians.
A copy of the stat box contents was requested, and received, and revealed that the Docusate, and Lovenox were available in the stat box at all times, and miralax was also in the facility bulk dose medications.
When the Director of Nursing (DON) was asked what specific source of text is used to model their

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F 332	Continued From page 54 medication administration and nursing practice by, she stated " We use Potter and Perry." Guidance was provided for appropriate documentation of physician's orders in 'Fundamentals of Nursing 7th Edition, Potter-Perry, page (p) 699, The physician, nurse practitioner, or physician's assistant prescribes medications by writing a medication order on a form in the client's medical record. Sometimes a prescriber orders a medication by talking directly to the nurse or by telephone...When a verbal or telephone order is received, the nurse who took the order writes the complete order or enters it into a computer and then reads it back and receives confirmation from the prescribe to confirm accuracy." Same source, p. 707, "A medication order is required for every medication you administer to a client...Regardless of how you receive an order, compare the prescriber's written orders with the medication administration record (MAR) when the medication is initially ordered. Once you determine that information on the client's MAR is accurate, use the MAR to prepare and administer medications." An interview was conducted with the Director of Nursing, (DON), the administrator, and nurse supervisor at the end of day debrief on 2-9-16 at 5:00 p.m., and on 2-10-16 at 3:00 p.m.. All in attendance were made aware of the findings. The DON stated that the medications were in the facility in the stat box, and follow up on the admission orders, and new orders had not been completed by staff. No further information was provided by the facility.	F 332		
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=E	Continued From page 55 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to serve food in a sanitary manner. The facility staff failed to effectively wear a hair restraint while plating and serving food. The Findings included: On 2/9/16 at approximately 8:10 A.M. an observation was conducted of the 1st Floor Skilled Unit Dining Room. There were 3 employees working in the kitchen/dining room. Upon entering the dining room area, the surveyor asked Employee C where hair restraints were located. Employee C reached to the top of her head and stated "I have my hairnet on" and reached to the top of her head and touched the hairnet. The hairnet was not covering her bangs. The surveyor asked Employee C for a hairnet for the surveyor. All three employees stated there were no more hair nets in the dining room and informed the surveyor that more hair nets were available in the main kitchen. Employee C	F 371	POC 2016 F 371 1. The culinary department employee was inserviced on proper placement of hairnet. 2. All residents are at risk to be affected by this deficient practice. 3. Culinary staff will be inserviced on hairnet placement to prevent opportunity for contamination during meal service and tray plating. Culinary staff will sign indicating their hairnet is in place. Culinary supervisors will monitor for signatures to ensure all staff have hairnet in place as indicated. Supervisory documentation will be maintained in the manager's office for compliance beginning March 1, 2016.	

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F 371	Continued From page 56 offered to go to the main kitchen to obtain a hairnet for the surveyor. The Surveyor went to the main kitchen and obtained a hairnet. The surveyor returned to the kitchen/dining room on the skilled unit at approximately 8:12 AM. One Dietary employee wearing a chef's hat and was plating food. Another employee wearing a hairnet that completely covered her hair was standing in front of a pot preparing poached eggs. (Employee C) was working in the kitchen area while food was being plated, then began serving residents . The Dietary employee's (Employee C) hairnet was not on properly. Her bangs were exposed. She had approximately 3" of hair hanging down from the front of her head. Employee C was observed for 15 minutes while she assisted with plating food and serving residents. The hairnet was worn with the bangs exposed the entire time observed. Employee C stated her official title was Dining Room Server. When asked about her hairnet, she reached to the top of her head past her bangs and stated "I have my hairnet on." When asked if the hairnet was being worn properly, Employee C then agreed that all of her hair was not properly restrained by the hairnet. She then pulled the hairnet down over her bangs and stated "I thought it was on right but I guess it slipped back." When asked about the importance of effectively wearing a hairnet, she stated, "It's important so that hair won't get into the food. I thought it was on right but it must have slipped back." On 2/9/16 at 3:00 P.M. the Director of Dining Services (Employee D) was informed of the findings of hairnet not being worn properly by	F 371	4. Culinary manager will monitor the staff documentation and supervisory oversight documentation for compliance with the use of hairnets beginning March 1, 2016. Reports of this observation will be reported through the Quality Assurance Committee. 5. Completion date: March 26, 2016	

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F 371	Continued From page 57 Employee C. The Director of Dining Services (Employee D) said the hairnet worn by Employee C should have covered all of the hair and that the bangs should have been tucked in the hair net while serving in the Skilled Dining Room. The Director of Dining Services (Employee D) stated "it is an ongoing process to educate staff on the importance of proper use of hair restraints." During the end of day debriefing on 2/9/2016 at approximately 5 PM, the Director of Nursing (DON-Admin A), and the Administrator in Training (Admin B) were notified of the findings. No further information was presented.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	POC 2016 F 425 1. Duragesic patches were delivered for resident #5 as ordered. 2. All residents are at risk to be affected by this deficient practice.	

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure Physician ordered medications were available for administration for one resident (Residents # 5) in a survey sample of 10 residents.

For Resident # 5, the facility staff failed to have physician ordered Duragesic patch available for administration on 2/8/2016.

Findings included:

For Resident # 5, the facility staff failed to have physician ordered Duragesic patch available for administration on 2/8/2016.

Resident # 5 was an 89 year old female admitted to the facility on 1/31/2016 with diagnoses of but not limited to: Fall, Fracture of Multiple Ribs on Right Side, and Constipation.

Resident # 5 was recently admitted and her MDS (Minimum Data Set) assessment was not yet due at the time of survey. Her nursing admission assessment revealed she was alert and oriented times three (person, place and time), and able to make her needs known. Resident # 5 was documented as requiring assistance with her activities of daily living and with ambulation and always continent of bowel and bladder.

A review of the clinical record was conducted on 2/9/2016 at 10 AM.

3. A. All hard copy prescriptions that are sent to the pharmacy will be reviewed to ensure all orders has been entered into the computer and the medication/items have been dispensed.
   B. Pharmacy staff will ensure that all residents receive their medications in a timely manner by conducting an order review 2 times daily.
   C. Pharmacy staff will notify the facility to request a valid controlled substance prescription if none received with the medication order.
4. Pharmacy staff will review all orders 2 times daily for accuracy and to ensure the facility receives all ordered medications.
5. Completion date: March 26, 2016

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Review of the Physicians Order Form revealed an order written by the physician on 2/8/2016 for Duragesic 12 micrograms every 72 hours to skin for diagnosis of pain, and Senna S one by mouth twice a day for diagnosis of constipation. Documentation showed the order was noted and faxed by a nurse on 2/8/2016 at 4 PM. The Medication Duragesic was not documented on the MAR (Medication Administration Record).

An interview was conducted with RN A who stated she asked the physician "to write a hard script for Duragesic" because she noticed the medication was not listed on the MAR and not delivered by the pharmacy and was unavailable when she "did med (medication) pass this morning." RN A showed a copy of the prescription written by the doctor on 2/9/2016 for Duragesic 12 micrograms # 5, Apply every 72 hours with no refills. RN A stated she was going to fax the prescription and send to the Pharmacy as soon as she finished documenting on another resident.

Further review of the clinical record showed a copy of the hard script for Duragesic was faxed and noted by RN A on 2/9/2016 at 3:45 PM. Review of the MAR showed the medication Duragesic was written on the MAR.

During the end of day debriefing on 2/9/2016 at 5 PM, the Director of Nursing was informed of the failure of the staff to administer Duragesic on 2/8/2016 when ordered by the physician. The DON stated the Pharmacy delivers medications several times a day and Resident # 5 should have been started on Duragesic on 2/8/2016 as ordered by the physician. The DON also stated that RN A had the doctor write a hard prescription for Duragesic to make sure the Pharmacy would

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send the medication. The DON stated the expectation was that the nurse who transcribed the order should have written the medication on the MAR after notifying the Pharmacy of the new order, Pharmacy should have delivered the medication that day and the nurse should have administered it as soon as it arrived that same day. The DON stated she was "going to add Duragesic to the STAT box (an emergency supply of medications) to be available in the facility at all times, then the nurses could give the medication as soon as an order was received." The DON also stated she was going to re-educate the nurses on completing orders for medications.

Review of the MAR on 2/10/2016 showed documentation of administration of the medication Duragesic on 2/9/2016 at 7 PM.

During an interview on 2/10/2016 at 11 AM, the DON stated she "did confirm with the Pharmacy that they did receive the faxed copy of the order for Duragesic but it was not placed in the usual area in the Pharmacy, so it was not filled." The DON stated the Duragesic was filled on 2/9/2016 and administered to Resident # 5 that evening. The DON again stated she was going to add the medication Duragesic to the STAT box so the medication would be available in the facility at all times.

A valid physicians order was evident for the medication that was unavailable.

No further information was provided.