| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495311 | A. BUILDING _____ B. WING _____ | 10/13/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OUR LADY OF HOPE HEALTH CENTER | 13700 NORTH GAYTON ROAD RICHMOND, VA 23233 |

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

An unannounced Medicare/Medicaid standard survey was conducted 10/12/16 through 10/13/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow.

The census in this 31 certified bed facility was 29 at the time of the survey. The survey sample consisted of 9 current resident reviews ( Resident #1 to #9) and two closed record reviews (Resident #10 to #11).

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

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 change in room or roommate assignment as

F 157

**Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**
The responsible party and physician were notified 11/2/16 of Resident # 4 not receiving the Clonidine Patch on 10/3/2016. The nurse who failed to notify the MD/RP received a corrective action.

11/26/16

**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**
The DON/designee will conduct an audit for all current residents to determine if MD/RP were notified of any missed doses of medication over the last 90 days. The facility will notify MD/RP if instances are noted. An audit will be conducted by the DON/Designee to ensure every physician ordered medication is available to each current resident.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jan Fretwell | Administrator | 11-4-16 |

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

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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, facility document review and clinical record review, it was determined that the facility staff failed to notify the responsible party and the physician when prescribed medication was not administered as ordered for one of 11 residents in the survey sample, Resident #4.

Facility staff failed to notify the responsible party and the physician that the physician ordered clonidine (1) patch was not available and not administered on 10/3/16.

The findings include:

Resident #4 was admitted to the facility on 4/18/13 with diagnoses that included but were not limited to: stroke, depression, high blood pressure and irregular heart beat.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 9/7/16 coded the resident as having a 12 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from

**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**
Licensed nurses will be educated regarding notification of MD/RP in the event a physician ordered medication has not been administered.
Licensed nurses will be educated on the procedure to reorder medications from pharmacy in a timely manner.

**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**
The DON/Designee will conduct audits 5 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then weekly of Facility Administration history reports to determine if medications have not been administered and if the MD/RP were notified. The DON/Designee will conduct weekly audits for 4 weeks, then audits every other week for 4 weeks, then monthly audits to ensure every physician ordered medication is available to each current resident. The DON/Designee will report findings to the QA Committee for the next 12 months.

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staff for all activities of daily living.

Review of Resident #4's care plan initiated on 3/13/15 and edited on 6/13/16 documented, "Problem. Resident is at risk for impaired cardiac status due to Hypertension (high blood pressure), CVA (cerebral vascular accident, stroke)... Approach. Administer meds (medications) as ordered."

Review of the physician's orders for October 2016 documented, "Clonidine patch weekly; 0.1 mg (milligram)/24 hr; amt (amount): 1....Once a day on Mon; 05:00 PM."

Review of the MAR (medication administration record) documented, "Clonidine patch weekly; 0.1 mg/24 hr (hour); Amount to Administer: 1." On 10/3/16 at 5:00 p.m. the MAR documented, "(Nurse's initials). Scheduled Date. 10/03/2016. Scheduled Time. 5:00 PM. Charted date -- Time 5:16 PM. Reasons/Comments. Not Administered: Drug/Item unavailable. Created by. (name of nurse)." Further review of the MAR evidenced documentation that Resident #4 received the clonidine patch on 10/10/16, the next scheduled dose.

Review of the nurse's notes for 10/3/16 did not evidence documentation that the physician or RP (responsible party) were notified that the clonidine patch was not administered as ordered.

Review of the resident's blood pressures from 10/3/16 to 10/10/16 documented that the blood pressures ranged from, "104/70 to 172/87 (2)."

Review of the physician's communication book for 10/3/16 and 10/4/16 did not evidence

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| F 157 | Continued From page 3 | F 157 | | |

documentation that the physician had been notified that the clonidine was not administered.

An interview was conducted on 10/13/16 at 10:25 a.m. with LPN (licensed practical nurse) #2, regarding the process staff follows if a medication is not available. LPN #2 stated, "If it's not in the cart, call the pharmacy, the MD (medical doctor) and RP if it's not in the stat (immediate) box." When asked how long it took the pharmacy to deliver a medication, LPN #2 stated, "It'll come that day." When asked what it meant when the nurse's initials were in parenthesis on the MAR, LPN #2 stated, "It means she didn't receive it." LPN #2 stated, "If we're unable to get the patch the doctor should have been notified." When asked what if any consequence may occur if the resident did not receive the clonidine, LPN #2 stated, "She could have a stroke." At this time, the stat box was checked with LPN #2 and clonidine patches were not available in the stat box.

An interview was conducted on 10/13/16 at 10:45 a.m. with RN (registered nurse) #1, the nursing supervisor, regarding the process staff follows if a medication is not available. RN #1 stated, "Check the stat box, if it's not in there call the MD, call the RP and let them know what is happening." When asked how long it would take for the pharmacy to send the medication, RN #1 stated, "Probably the next day, not later than the next day." When asked if it was acceptable for the clonidine to not be given for a week, RN #1 stated, "No, it's not acceptable."

A telephone interview was conducted on 10/13/16 at 3:50 p.m. with ASM (administrative staff member) #3, the physician. When asked when he

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expected to be notified if a medication was not given, ASM #3 stated, "I expect written or verbal notification." When asked if a clonidine patch was not administered for a week what he would expect, ASM #3 stated, "I would have expected to be notified."

On 10/13/16 at 4:10 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Medical Care Rights in Nursing Facility" documented, "POLICY: The Resident has the right to be fully informed in language that he or she can understand of his/her total health status, including but not limited to, his/her medical condition. PROCEDURE: 6. Except in a medical emergency or when a Resident has been declared incompetent, a Facility must consult with the Resident immediately and notify the Resident's physician and, if known, the Resident's legal representative or interested family member promptly or within 24 hours when there is: c. A need to alter treatment significantly..."

No further information was provided prior to exit.

(1) Clonidine -- Clonidine is used alone or with other medications to treat high blood pressure (hypertension). If it continues for a long time, the heart and arteries many not function properly. This can damage the blood vessels of the brain, heart, and kidneys, resulting in a stroke. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009680/?report=details

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| F 157 | Continued From page 5<br>(2) Blood pressure -- Normal blood pressure for adults is defined as a systolic pressure below 120 mmHg and a diastolic pressure below 80 mmHg. This information was obtained from: https://www.nhlbi.nih.gov/health/health-topics/topics/hbp/ | F 157 | | |
| F 167 SS=C | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE<br><br>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.<br><br>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview and facility document review, it was determined that the facility staff failed to ensure survey results were readily accessible.<br><br>The most recent survey results were located on the second shelf of a built in bookshelf on top of built in cabinets. The results were in a binder alongside multiple books and movies. Also, the results were not accessible for all wheelchair bound residents.<br><br>The findings include:<br><br>On 10/12/16 at 11:25 a.m., a sign that | F 167 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>The survey results binder was moved to the bookcase between the windows, which has a height that is accessible to residents in wheelchairs.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>This is the only location of a survey results binder for residents.<br><br>**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**<br>Residents were educated in the Resident Council meeting on 10/27/16 as to the new location of the survey results binder. The sign indicating the location of the results was modified to indicate the bookshelf between the windows. The Administrator will round weekly for 4 weeks to ensure the binder is in the correct location which is accessible. Following this, rounds will be conducted monthly for the next 5 months. | 11/26/16 |

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| F 167 | Continued From page 6 | F 167 | **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** Results of weekly and then monthly rounds will be reviewed at the QA meeting for the next 6 months. Additional monitoring will occur as needed. | |

documented, "survey results are located on the bookshelf in the day room" was observed on the wall outside the doors entering the nursing center unit. At this time, observation of the day room was conducted. One bookshelf was observed in the back of the room. Two built in bookshelves on top of built in cabinets were observed in the front of the room. The survey results were observed in a binder labeled "state survey results" on the second shelf on one of the built in bookshelves that was on top of a built in cabinet. Multiple books and movies were also present on the shelf. The survey results were difficult to find and were not readily accessible to residents who were wheelchair bound.

On 10/13/16 at 8:05 a.m., the survey results remained in the same location.

On 10/13/16 at 10:18 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked where the survey results were located. RN #1 stated the results were probably in the director of nursing's office. RN #1 was asked if a copy of the results were available for resident access. RN #1 stated she had seen a book/pamphlet that she thought was located at the nurse's station. RN #1 was asked if the results were accessible for all residents (including wheelchair bound residents) without having to ask for assistance. RN #1 stated she had seen a binder that documented, "survey." RN #1 stated someone had asked her what the binder was so she went through the binder with the person and she thought the binder was located in the day room. At this time, RN #1 was asked to accompany this surveyor to the day room and locate the survey results. RN #1 entered the room and searched the entire room. RN #1

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| F 167 | Continued From page 7<br>stated, "It was sitting on the table. They rearranged in here. I feel like I'm on a scavenger hunt." After several minutes (and after assisting a few residents in the room), RN #1 located the survey results on the second shelf of one of the built in bookshelves. RN #1 agreed the survey results were not easy to locate and were not accessible to all residents.<br><br>On 10/13/16 at 1:30 p.m., a group interview was conducted with four residents. None of the residents were aware of the location of the most recent survey results. The residents were made aware the results were located on the second shelf on a built in bookshelf on top of the built in cabinets in the day room. The residents were asked if that location made the results readily accessible to all residents. The residents stated not everyone would be able to reach the results.<br><br>On 10/13/16 at 2:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.<br><br>The facility policy titled, "Disclosure of Survey Results" documented in part, "All residents admitted to the facility will be fully informed of the results of the most recent HCFA Long Term Care Survey in a summary form that is easily understood by the public. Each deficiency will be summarized along with outcome(s) and action(s) taken..."<br><br>No further information was presented prior to exit. | F 167 | | |
| F 176 SS=D | 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE | F 176 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>A self-administration of medication | 11/26/16 |

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F 176 Continued From page 8

An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to assess a resident for self-administration of medications for one of 11 residents in the survey sample, Resident #1.

Resident #1 was observed self-administering eye drops and facility staff had not performed an assessment to determine Resident #1's capability and safety.

The findings include:

Resident #1 was admitted to the facility on 5/21/14 with diagnoses that included but were not limited to; chronic obstructive pulmonary disease, chronic pain, peripheral vascular disease, depression, osteoporosis (a condition where bones become brittle) and anxiety.

Resident #1's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 9/30/16, coded Resident #1 as scoring a 13, out of a possible score of 15, on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating that Resident #1 was unable to complete the interview. The staff assessment was completed and coded Resident #3 as being cognitively intact in her cognitive skills for daily

F 176 observation was completed 10/25/16 for Resident # 1.

**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**
The DON/Designee will conduct an audit of current residents' physicians' orders to ensure all residents with self-administer medication orders have a self-administration of medication observation completed to ensure their capability. Care plans will be updated as needed.

**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**
Licensed nurses will be educated regarding the completion of the self-administration of medication observation prior to the resident being given medication to keep at bedside as well as quarterly re-evaluations to insure residents are capable of doing so.

**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**
The DON/Designee will review new orders daily through the Facility Activity Report. New orders for self-administration of medication will result in the DON/Designee ensuring the self-administration of medication observation has been completed and care plan updated. The DON/Designee will add the self-administration of medication observation to the quarterly assessment schedule to ensure quarterly

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| F 176 | Continued From page 9 | F 176 | assessments have been completed. The DON/Designee will review observations following each due date to make sure they were completed. The DON/Designee will report findings to the QA committee for the next 12 months. | |

decision making.

During the facility tour conducted on 10/12/16 at approximately 11:15 a.m. Resident #1 was observed sitting in a wheelchair in her room. Resident #1 was holding a box in her hand which contained a pharmacy label. When asked what she was holding and Resident #1 stated that she had her eye drops and was going to put some in her eyes. Resident #1 was asked whether or not she always self-administered her eye drops, Resident #1 stated that she did.

A review of Resident #1's clinical record, revealed, in part, a "Physician Order Report" dated 7/30/2016 - 8/30/2016 and signed by the physician. The "Physician Order Report" had the following orders:
"8/1/16 - open ended. Artificial Tears (PF) (preservative free) (dextran 70-hypromellose) (OTC) (over the counter). dropperette; amt (amount): 1 (one) drop each eye twice daily as needed for dry eye. PT. (patient) MAY KEEP AT BEDSIDE AND SELF ADMINISTER AS NEEDED."
"8/1/2-16 - open ended. chlorhexidine gluconate mouthwash; 0.12% (percent); amt: 15 ml (milliliters); mucous membrane. Special Instructions: PT. MAY KEEP AT BEDSIDE AND SELF ADMINISTER. Twice a Day: 09:00 AM: 05:00 PM."

Further review of Resident #1's clinical record did not reveal any documentation regarding Resident #1 self-administering medications.

On 10/13/16 at 10:55 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2

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was asked what the process was when a resident wanted to self-administer medications. ASM #2 stated, "We do an assessment for ability to self-administer the medications. If a resident wants to keep a medication at the bedside, we complete the assessment to determine the resident's capability and cognitive ability along with safety and make sure we keep out of reach of other residents. The doctor writes an order that medications can be self-administered." When asked about Resident #1, ASM #2 stated, "Resident #1 has mouthwash and artificial tears at the bedside, she has had them since August 1st." ASM #2 was asked to provide the evidence that an assessment was done to assess Resident #1's capability and level of safety. ASM #2 looked through the computer and stated, "I don't see it. It wasn't done. Typically I follow up, one of the nurses, the unit manager or I complete it." At this time ASM #2 was asked to provide a policy regarding self-administration of medications.

On 10/13/16 at 1:30 p.m. a meeting was held with ASM #1, the administrator and ASM #2, the director of nursing. Both ASM #1 and ASM#2 were aware of the concern.

On 10/13/16 at 2:50 p.m. an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to about the process followed for a resident who wanted to keep medications by the bedside and self-administer. RN #2 stated, "We have a form in Matrix (the electronic clinical record), the MD (medical doctor) would write an order and then we would complete the self-administration assessment form." When asked about Resident #1, RN #2 stated that she did know that (name of Resident #1) had eye drops and mouthwash and that she

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| F 176 | Continued From page 11<br>was "quite capable" to administer them herself. RN #2 further stated, "She (Resident #1) always lets us know when she is using the mouthwash and eye drops."<br><br>A review of the facility policy titled, "Assisted Living Medication Self-Administration and Quarterly Review" revealed, in part, the following documentation: "Policy: The facility will ensure safe self-administration of medications to all residents who administers their own medications. Procedure: Self -Administration: 1. The ability to self-administer medications will be assessed by the resident's primary care physician prior to admission. 3. If primary care physician approves resident self-administration of medications, the DON (director of nursing) and/or designee will conduct an initial Assessment for Self-Administration of Medications upon admission."<br><br>No further information was provided prior to the end of the survey process. | F 176 | | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to provide care in a manner to promote dignity promote a resident's dignity for | F 241 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>A Foley catheter privacy bag for resident #3 was provided. The Licensed nurse and CNA assigned to Resident # 3 received counseling 11/2/16.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>The DON/Designee will conduct an audit of current residents with Foley Catheter orders and visually assess the residents' | 11/26/16 |

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| F 241 | Continued From page 12<br>one of 11 residents in the survey sample, Resident #3.<br><br>Resident #3's Foley catheter drainage bag was observed from the hallway on separate occasions during the days of the survey with urine in the bag and no privacy covering in place.<br><br>The findings include:<br><br>Resident #3 was admitted to the facility on 2/16/16 with diagnoses that included but were not limited to: constipation, sacral pressure sore, chronic obstructive pulmonary disease, dysphagia, prostate cancer, anemia, high blood pressure and obstructive reflux uropathy (backwards flow obstruction of the flow of urine) (1).<br><br>The most recent MDS (minimum data set) assessment, a Medicare 90 day assessment, with an assessment reference date of 9/9/16 coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance to being totally dependent on one or more staff members for all of his activities of living except eating in which he required supervision after set up assistance was provided. In Section H - Bladder and Bowel, the resident was coded as having an indwelling catheter.<br><br>Observation was made on 10/12/16 at 2:09 p.m. Resident #3 was in bed. The indwelling catheter bag was hanging off the bed frame. There was no privacy bag covering the bag which was observed to contain urine. An observation was made from the doorway and the bag with urine was visible from the doorway. | F 241 | drainage bags to ensure they have privacy covers.<br><br>**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**<br>Licensed nurses and CNAs will be educated regarding Residents Rights to Dignity including covering all Foley collection bags.<br><br>**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**<br>The DON/Designee will round on residents with Foley catheters weekly for the next 4 weeks then monthly to ensure privacy bags are in place. The DON/Designee will report findings to the QA Committee for the next 12 months. | |

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Observation was made on 10/13/16 at 8:06 a.m. of the resident in his bed. The indwelling catheter bag was hanging off the bed frame. There was no privacy bag covering the bag with urine. An observation was made with another surveyor from the doorway. The bag was observed to contain urine and was visible from the doorway.

The comprehensive care plan dated, 11/19/15 and revised on 10/10/16, documented in part, "Problem: Resident is at risk for UTIs (urinary tract infections) due to indwelling Foley catheter use related to obstructive uropathy/neurogenic bladder and with prostate CA (cancer) with mets (metastasis)." The "Approach" documented in part, "Foley cath (catheter) care QS (every shift) and as needed. Maintain a closed system and keep drainage bag below bladder level. Manage tubing so it does not cause pressure to skin."

An interview was conducted with LPN (licensed practical nurse) #1, on 10/13/16 at 9:36 a.m. When asked how an indwelling catheter bag should be stored, LPN #1 stated, "It should be in a privacy bag, on the side of the bed if in bed and below the waist if in a wheelchair.

An interview was conducted with RN (registered nurse) #1, the supervisor, on 10/13/16 at 9:55 a.m. When asked how an indwelling catheter bag should be stored, RN #1 stated, "Below the bed and in a privacy bag."

A policy on the storage of an indwelling catheter bag was requested on 10/13/16 at approximately 10:30 a.m.

On 10/13/16 at 11:51 a.m. administrative staff

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| F 241 | Continued From page 14<br>member (ASM) 1, the administrator stated, "There was no policy on the storage of an indwelling catheter bag, it's a standard of practice."<br><br>On 10/13/16 at 12:42 p.m. ASM #2, the director of nursing, was asked what standard of practice do they follow, ASM #2 stated, "We follow our policies but have a Lippincott (Fundamentals of Nursing Practice) on the shelf. ASM #2 returned approximately at 1:00 p.m. and stated, "We don't follow Lippincott, we follow 'Clinical Nursing Skills; 4th edition by Smith and Duell."<br><br>"The Client's Bill of Rights: 5. The client has the right to every consideration of privacy concerning his or her own medical care programs." Clinical Nursing Skills; 4th edition by Smith and Duell, page 7.<br><br>ASM #1 and ASM #2 were made aware of the above concerns on 10/13/16 at 2:06 p.m.<br><br>No further information was provided prior to exit.<br><br>(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, pages 411, 499 and 593. | F 241 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, | F 281 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>For Resident #6 the physician's order for Midodrine was clarified 11/3/16, requiring a task in the electronic medical record to obtain blood pressures every 8 hours. Education was provided to the physician who entered the order regarding entering tasks into the system when the order requires taking a vital sign. The MD and RP were notified of the error 11/3/16. | 11/26/16 |

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| F 281 | Continued From page 15<br>facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for three of 11 residents in the survey sample, Residents #6, #7 and #1.<br><br>1. The facility staff failed to accurately transcribe the physician's order for Midodrine (1) for Resident #6.<br><br>2. The facility staff failed to accurately transcribe admission orders for Coreg (1), Eliquis (2) and Calcium Carbonate (3) on 10/12/16 for Resident #7. The inaccurate transcription resulted in the failure of the facility to administer these medications to Resident #7 on the evening of 10/12/16.<br><br>3a. The facility staff failed to correctly transcribe a physician ordered medication, Naproxen (1) for administration to Resident #1, causing Resident #1 to receive two additional doses of Naproxen that were not prescribed<br><br>3b. The facility staff failed to correctly transcribe a physician ordered medication, Prednisone (2) for administration to Resident #1, causing Resident #1 to receive an additional dose of Prednisone on 5/4/16 and 5/5/16 that were not prescribed<br><br>The findings include:<br><br>1. The facility staff failed to accurately transcribe the physician's order for Midodrine (1) for Resident #6.<br><br>Resident #6 was admitted to the facility on 9/23/16 with diagnoses including, but not limited | F 281 | For Resident # 7, the admitting nurse received a corrective action for not administering medications on the day of admission. The MD and RP were notified of medications not being administered on 10/12/2016. For Resident #1, the MD was notified 11/2/16 and RP was notified 11/3/16 of resident receiving additional doses of Naproxen and Prednisone.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>The DON/Designee will conduct an audit of current residents who received new orders over the last 90 days to review for transcription errors. Infractions will be reported to MD and RP. The DON/Designee will conduct an audit of current residents who were admitted over the last 30 days to determine if day one admission meds were administered. Those not having received day one admission medications will have MD/RP notifications made.<br><br>**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**<br>Licensed nurses will be inserviced regarding transcription of physicians' orders, correctly entering orders into the Matrix electronic medical record, and receiving medications from pharmacy for new admissions. If medications are unavailable for administration, the nurses will notify the MD and RP and will call the pharmacy for STAT delivery. | |

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| F 281 | Continued From page 16 | F 281 | **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The night shift licensed nurses will review all new medication orders daily, including new admissions, to ensure transcription accuracy. A second review will be completed by the DON/Designee. The DON/Designee will review all new admissions for the next 30 days to ensure medication availability for the day of arrival, per the MD order. The DON/Designee will monitor results and report findings to the QA committee for the next 12 months. | |

to: end-stage Parkinson's disease (2), difficulty swallowing and arthritis. On the most recent MDS (minimum data set), an admission assessment with an assessment reference date of 9/30/16, Resident #6 was coded as having severe cognitive impairment, having scored zero out of 15 on the BIMS (brief interview for mental status). He was coded as having a PEG tube (3) in place: as receiving greater than 51% of his nutrition through the PEG tube, and as receiving greater than 501 mls (milliliters) of fluid daily through the PEG tube.

A review of Resident #6's physician's orders revealed, in part, the following order written and signed by the physician on 9/26/16: "Midodrine tablet 10 mg (milligrams) 1 tablet oral as needed for systolic blood pressure (4) less than 90 every 8 hours."

A review of Resident #6's MARs (medication administration records) revealed that he had not received Midodrine since the date it had been ordered. Review of the MARs and facility vital signs records failed to reveal evidence that Resident #6's blood pressure was assessed three times a day on the following dates: 9/27/16; 9/28/16; 9/29/16; 9/30/16; 10/2/16; 10/3/16; 10/7/16; 10/8/16; 10/9/16; 10/10/16; 10/11/16.

A review of Resident #6's comprehensive care plan dated 10/3/16 revealed, in part, the following: "Risk for impaired cardiac (heart) function...Administer meds (medications) as ordered."

On 10/13/16 at 10:00 a.m., LPN (licensed practical nurse) #1 was interviewed. She reviewed the above-referenced Midodrine order

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and stated that, based on the order; she would give the medication if Resident #6's systolic blood pressure was under 90. When asked how she would know if Resident #6 needed the medication, LPN #1 stated: "I would take his blood pressure." LPN #1 was asked, according to this order, how often should the blood pressure be taken. LPN #1 stated: "Every eight hours, if needed. The way the order reads, it only should be taken if needed. But that doesn't make any sense. We should be taking his blood pressure every eight hours to see if he needs it (the medication)." She stated it is a facility practice, although not a written policy, residents who are newly-admitted should have their vital signs taken every shift. When asked if this is an official physician's order, LPN #1 stated: "No." When asked what needed to be done about this order, she stated that the vital signs should be scheduled every shift, and not be left on an as-needed basis.

On 10/13/16 at 10:35 a.m., RN (registered nurse) #1, the unit manager, was interviewed. RN #1 was asked to review the order for Midodrine. After reviewing the order, RN #1 stated: "We need to track the blood pressure every shift." She stated there is no specific order for the blood pressures, but since the resident is a newly-admitted resident on the skilled nursing unit, the staff should be checking his vital signs every shift anyway. RN #1stated: "As far as this order goes, we need something to cue us. We need an actual order for the blood pressures every shift."

On 10/13/16 at 2:05 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these

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concerns. ASM #2 stated that the facility staff uses Clinical Nursing Skills: Basic to Advanced Skills, Smith and Duell, Fourth Edition, as the professional standard of practice for nurses. She acknowledged that this textbook is located in her office, and is not generally available to staff in the evenings, nights and on weekends.

Clinical Nursing Skills: Basic to Advanced Skills, Smith and Duell, Fourth Edition, page 357: "If you find an error in a drug order, such as an inaccurate dose of method of administration, it is your responsibility to question the order. If you cannot understand or read the order, verify it with the physician."

A review of the facility policy entitled "Checking Accuracy of Physician Orders" revealed, in part, the following: "Check that all orders are complete and properly worded...Check that all nursing clinical standards of practice are included on MARs."

No further information was provided prior to exit.

(1) "Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine is in a class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure." This information is taken from the website https://medlineplus.gov/druginfo/meds/a616030.html.
(2) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine." This information is

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taken from the website https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.
(3) "Percutaneous endoscopic gastrostomy tube - a tube placed in the stomach for the purpose of temporary or permanent nutrition." This information is taken from the website http://www.asge.org/patients/patients.aspx?id=394.

(4) "Blood pressure is the pressure, measured in millimeters of mercury, within the major arterial system of the body. It is conventionally separated into systolic and diastolic determinations. Systolic pressure is the maximum blood pressure during contraction of the ventricles; diastolic pressure is the minimum pressure recorded just prior to the next contraction." This information is taken from the website http://www.ncbi.nlm.nih.gov/books/NBK268/.

2. The facility staff failed to accurately transcribe admission orders for Coreg (1), Eliquis (2) and Calcium Carbonate (3) on 10/12/16 for Resident #7. The inaccurate transcription resulted in the failure of the facility to administer these medications to Resident #7 on the evening of 10/12/16.

Resident #7 was admitted to the facility on 8/24/16 and most recently readmitted on 10/12/16 with diagnoses including, but not limited to: heart failure, diabetes, high blood pressure and normal pressure hydrocephalus. On the most recent MDS (minimum data set), a five-day Medicare assessment with an assessment reference date of 9/30/16, Resident #7 was coded as having no cognitive impairment for making daily decisions.

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On 10/13/16 at 9:35 a.m., Resident #7's daughter stopped this surveyor in the hallway and stated Resident #7 did not receive her evening medications the night before (10/12/16) even though she had returned to the facility sometime around 4:00 p.m.

A review of the local hospital's discharge medication summary for Resident #7 dated 10/12/16 revealed, in part, the following:
"- Apixaban (Eliquis) 2.5 mg (milligrams) oral twice a day.
- Carvedilol (Coreg) 3.125 mg oral BID (twice a day) at 0600 (6:00 a.m.) and 1800 (6:00 p.m.
- Calcium Carbonate 600 mg oral twice a day."
The discharge medication orders contained the name of the facility's nurse practitioner, but no date. The nurse practitioner was not available for interview by the surveyor.

A review of the facility's physician's orders revealed, in part, the following:
"- Start date 10/13/16 Calcium Carbonate 600 mg 1 tablet oral twice a day 9:00 a.m., 5:00 p.m.
- Start date 10/13/16 Carvedilol 3.125 mg 1 tablet oral twice a day 9:00 a.m., 5:00 p.m.
- Start date 10/13/16 Eliquis 2.5 mg 1 tablet oral twice a day 9:00 a.m., 5:00 p.m."

On 10/13/16 at 3:15 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated that the facility receives the discharge medication summary from the discharging hospital, and then verifies those orders with the facility physician or nurse practitioner. She stated if a resident has been receiving a medication in the morning and in the evening in the hospital and if the resident is back in the facility in time for the evening

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administration, then the facility should administer the evening medication to the resident. LPN #1 stated: "We will give it (the medication) as long as it is available." When shown the above-referenced hospital discharge medication list and the facility's admission orders for Resident #7, LPN #1 stated: "Yes. Those medicines should have been given."

On 10/13/16 at 3:35 p.m., RN (registered nurse) #1 was interviewed. She stated that the facility staff uses the hospital discharge medication list as the basis for facility admission orders. She stated if a medicine has previously been given twice a day, it should continue to be given twice a day by the facility. When shown the above-referenced hospital discharge medication list and the facility's admission orders for Resident #7, RN #1 stated: "Yes. Those medicines should have been started last evening, not this morning."

On 10/13/16 at 3:45 p.m., Resident #7 was interviewed. She stated she did not get her medications the night before. She stated she could not remember whether or not she asked a facility staff member about the medications at the time.

On 10/13/16 at 2:05 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. ASM #2 stated that the facility staff uses Clinical Nursing Skills: Basic to Advanced Skills, Smith and Duell, Fourth Edition, as the professional standard of practice for nurses. She acknowledged that this textbook is located in her office, and is not generally available to staff in the evenings, nights and on weekends.

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Clinical Nursing Skills: Basic to Advanced Skills, Smith and Duell, Fourth Edition, pages 101-102: Admission and Transfer...Complete a general nursing assessment. Check physician's orders for treatments to be instituted immediately. Rationale: This prevents delays of treatments that could affect client's condition."

No further information was provided prior to exit.

(1) "Carvedilol (Coreg) is used to treat heart failure (condition in which the heart cannot pump enough blood to all parts of the body) and high blood pressure. It also is used to treat people who have had a heart attack. Carvedilol is often used in combination with other medications. Carvedilol is in a class of medications called beta-blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure." This information was taken from the website https://medlineplus.gov/druginfo/meds/a697042.html.
(2) "Apixaban (Eliquis) is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having hip replacement or knee replacement surgery. Apixaban is in a class of medications called factor Xa inhibitors. It works by blocking the action of a certain natural substance that helps blood clots to form." This information is taken from the website

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https://medlineplus.gov/druginfo/meds/a613032.html.
(3) "Calcium carbonate is a dietary supplement used when the amount of calcium taken in the diet is not enough. Calcium is needed by the body for healthy bones, muscles, nervous system, and heart. Calcium carbonate also is used as an antacid to relieve heartburn, acid indigestion, and upset stomach." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601032.html.
(4) "Normal pressure hydrocephalus (NPH) is an abnormal buildup of cerebrospinal fluid (CSF) in the brain's ventricles, or cavities. It occurs if the normal flow of CSF throughout the brain and spinal cord is blocked in some way. This causes the ventricles to enlarge, putting pressure on the brain. Normal pressure hydrocephalus can occur in people of any age, but it is most common in the elderly. It may result from a subarachnoid hemorrhage, head trauma, infection, tumor, or complications of surgery." This information is taken from the website http://www.ninds.nih.gov/disorders/normal_pressure_hydrocephalus/normal_pressure_hydrocephalus.htm.
3a. The facility staff failed to correctly transcribe a physician ordered medication, Naproxen (1) for administration to Resident #1, causing Resident #1 to receive two additional doses of Naproxen that were not prescribed

Resident #1 was admitted to the facility on 5/21/14 with diagnoses that included but were not limited to; chronic obstructive pulmonary disease, chronic pain, peripheral vascular disease, depression, osteoporosis (a condition where bones become brittle) and anxiety.

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Resident #1's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 9/30/16, coded Resident #1 as scoring a 13, out of a possible score of 15, on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating that Resident #1 was unable to complete the interview. The staff assessment was completed and coded Resident #3 as being cognitively intact in her cognitive skills for daily decision making.

A review of Resident #1's clinical record revealed, in part, the following written order; "3/11/16 Naproxen (a mild pain reliever (1)) 500 mg (milligrams) PO (by mouth) BID (two times per day) x (times) 4 (four) days. Dx (diagnosis): OA (osteoarthritis)." Signed and dated by the physician on 3/11/15.

Further review of Resident #1's clinical record revealed a MAR (medication administration record) dated 3/1/2016 - 3/31/2016, that documented, in part, the following order: "Naproxen tablet; 500 mg; Amount to Administer: 1 tablet; oral. Twice A Day." The following dates contain initials indicating that Resident #1 received Naproxen twice a day for five days starting on 3/12/16 and ending on 3/16/16.

A meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, on 10/13/16 at 1:30 p.m. ASM #1 and ASM #2 were made aware that there was a concern that Resident #1 had received Naproxen for an extra day. At this time a policy was requested regarding order transcription.

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On 10/13/16 at 2:50 p.m. an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to describe the process for entering a medication into the electronic medical record that contained a specific time parameter for administration. RN #2 stated, "When inputting a date range for a medication the nurse should count the dates as on a calendar, so if the medication is for seven days the nurse would count the start date as day one and then count off seven days, the end date would be the eighth day." RN #2 was then shown the MAR for Resident #1 and the medication administration history of naproxen administered to Resident #1. RN #2 stated, "She (Resident #1) got it for too many days, this should have been stopped after 3/15/16."

On 10/13/16 at 4:00 p.m. an interview was conducted with RN #3, a floor nurse. RN #3 was asked how she would enter an order that contained a time parameter into the electronic medical record. RN #3 stated that she would enter the medication with a start date and then count the days to the end date. When asked how she would ensure that the time frame was accurate, RN #3 stated, "I count like on a calendar." RN #3 was shown Resident #1's MAR and the administration history of the naproxen. RN #3 stated, "I entered it wrong, the end date should have been 3/15/16 and not 3/16/16.

A review of the facility policy titled "Administration of Medications" revealed, in part, the following documentation: "Policy: All medications will be given per physician, Nurse Practitioner (NP), or Physician Assistant (PA) written, verbal or telephone order and shall not be started, changed or discontinued by the facility without an order

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from the physician, NP or PA. 17. When transcribing orders, the licensed nurse will appropriately "mark" the MAR, including "stop dates" as defined by facility protocols. For facilities utilizing electronic records, enter the order utilizing vendor instructions."

No further information was provided prior to the end of the survey process.

3b. The facility staff failed to correctly transcribe a physician ordered medication, Prednisone (2) for administration to Resident #1, causing Resident #1 to receive an additional dose of Prednisone on 5/4/16 and 5/5/16 that were not prescribed.

A review of Resident #1's clinical record revealed, in part the following written order:

"4/27/16. Prednisone (a steroidal medication (2)) 40 mg PO (by mouth) X 1 (one time) today, then 20 mg po daily x 7 days, then 15 mg po daily x 7 days, then 10 mg po daily x seven days then 5 mg po daily thereafter. Dx: COPD (chronic obstructive pulmonary disease)." Signed and dated by the physician on 4/27/16.

Further review of Resident #1's clinical record revealed a MAR (medication administration record) 4/1/2016 - 4/30/2016 that documented, in part, the following order: "Prednisone tablet; 5 mg; Amount to Administer: 20 mg; oral." The MAR is initialed for Prednisone 20 mg as given on the dates 4/28/16 through 5/5/16, eight days. A review of Resident #1's MAR dated 5/1/2016 - 5/31/2016 revealed the following order: "Prednisone tablet; 15 mg; Amount to Administer: 15; (sic) oral. Once a Day." The MAR is initiated

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on each day starting on 5/4/16 through 5/10/16, seven days. On May 4, 2016 and on May 5, 2016 Resident #1 received Prednisone 20 mg and Prednisone 15 mg. Per the physician order dated 4/27/16 Resident #1 should have received Prednisone 20 mg through 5/4/16 and started Prednisone 15 mg on 5/5/16.

A meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, on 10/13/16 at 1:30 p.m. ASM #1 and ASM #2 were made aware that there was a concern that Resident #1 had received an extra dose of prednisone for two days, 5/4/16 and 5/5/16. At this time this surveyor asked to speak to the nurse who had entered the prednisone order on 4/27/16 into the computer, ASM #2 stated that the nurse who had entered the order into the electronic medical record was no longer in the facility.

On 10/13/16 at 2:50 p.m. an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to describe the process for entering a medication into the electronic medical record that contained a specific time parameter for administration. RN #2 stated, "When inputting a date range for a medication the nurse should count the dates as on a calendar, so if the medication is for seven days the nurse would count the start date as day one and then count off seven days, the end date would be the eighth day."

On 10/13/16 at 3:10 p.m. ASM #2 was asked if she was able to explain the prednisone administration, ASM #2 stated that she was not.

No further information was provided prior to the

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| F 281 | Continued From page 28<br>end of the survey process.<br>(1) Naproxen is used to relieve pain, tenderness, swelling, and stiffness caused by osteoarthritis. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681029.html<br>(2) Prednisone works to treat patients with low levels of corticosteroids by replacing steroids that are normally produced naturally by the body. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601102.html | F 281 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services to attain or maintain the highest level of well-being for three of 11 residents in the survey sample. Resident # 4, Resident #2 and Resident #1.<br><br>1. Facility staff failed to monitor and assess Resident #4's INR [International Normalized | F 309 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>For Resident #4, the MD and RP were notified of failure to obtain lab results from the INR on 8/29. INR results were received on 10/13/2016 and placed in the medical record after physician review. For Resident # 2, the MD and RP were notified 11/2/16 of failure to obtain vital signs per MD order on 7/4/16 and 7/5/16 and the weekly weight on 9/13/2016. For Resident #1, the MD and RP were notified 11/3/16 of the resident not receiving Keflex per physician order on 6/2/2016. The Licensed nurse assigned to resident #1 received corrective action on 11/3/16.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>The DON/Designee will conduct an audit | 11/26/16 |

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Ration (1)] level on 8/29/16.

2. The facility staff failed to obtain Resident #2's vital signs per physician's orders on 7/4/16 and 7/5/16, and failed to obtain a weekly weight per physician's orders during the week of 9/13/16.

3. The facility staff failed to administer Keflex (an antibiotic (1)) to Resident #1 as ordered by the physician.

The findings include:

1. Resident #4 was admitted to the facility on 4/18/13 with diagnoses that included but were not limited to: stroke, depression, high blood pressure and irregular heart beat.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 9/7/16 coded the resident as having a 12 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired to make daily decisions.

Review of Resident #4's care plan initiated on 3/13/15 and edited on 6/13/16 documented, "Problem. Resident is at risk for bleeding and bruising due to anticoagulant therapy (1). Approach. Monitor lab (laboratory) work as ordered. Administer anticoagulants as ordered."

Review of the resident's coumadin (2) flow sheet documented, "Date. 8/17 Current Dose 7 (milligrams) x (with a line over it indicating except) 6 (milligrams) M (Monday)/Th (Thursday). Next INR 8/29. Initials (physician's assistant)." The next documentation on the flow sheet was dated 9/15/16.

of labs ordered for current residents for the last 6 months to ensure results have been received. The MD and RP will be notified of labs not received. The DON/Designee will conduct an audit of current residents having had physicians' orders for specific vital signs and/or weights for the last 90 days to ensure they were obtained per physician order. The MD and RP will be notified if they were not obtained. The DON/Designee will perform an audit of current residents to ensure medications have been given per physicians' orders for the last 90 days. The MD and RP will be notified of missed administrations.

**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**
Licensed nurses will receive education regarding obtaining lab results from the lab and notifying the MD and RP of results, ensuring all tasks are performed as ordered in the EMAR system including vital signs and weights, and administering medications per physicians' orders. CNAs will be educated regarding obtaining and documenting vital signs and weights per the direction of the licensed nurse.

**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**
The DON/Designee will review lab results 5 times per week for 4 weeks then weekly to confirm results have been received with MD/RP notification of

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Review of the clinical record did not evidence documentation of the 8/29/16 INR result.

Review of the nurse's notes for 8/29/16 to 9/2/16 did not evidence documentation of the 8/29/16 INR.

On 10/13/16 at 8:45 a.m. a request was made to ASM (administrative staff member) #2, the director of nursing for the 8/29/16 INR results. At 9:40 a.m. a copy of the INR results were obtained from ASM #2. There was a fax date and time of 10/13/16 at 9:32 a.m. noted on the INR result. ASM #2 stated that they had the laboratory send them the results that day as they could not locate them in the facility. The INR result was 1.36.

Review of the facility's coumadin protocol documented, "INR less than 2.0 Give Same Dose of Coumadin plus 1 mg more for 1 night."

Review of the 8/29/16 medication administration record did not evidence documentation that the resident received an additional one milligram of coumadin.

An interview was conducted on 10/13/16 at 10:25 a.m. with LPN (licensed practical nurse) #2 regarding the process staff follows for monitoring INR tests. LPN #2 stated, "The doctor writes the order for the lab (laboratory), we put it in (the facility's software), we fill out a lab slip and log it in the lab book. When we get the lab back we follow the (coumadin) protocol and if it's critical (very high result) or abnormal we call the MD (medical doctor)." When asked the process staff followed if the laboratory test was not received. LPN #2 stated, "We call and get it from the lab."

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When asked why it was important to monitor the resident's INR result, LPN #2 stated, "Because they could bleed out (bleed to death)."

An interview was conducted on 10/13/16 at 10:35 a.m. with RN (registered nurse) #1, the nursing supervisor, regarding the process staff follows for monitoring INR tests. RN #1 stated, "We get the results faxed, if it's not critical we put it in (name of doctor) box. We have a protocol and it tells us what to do." When asked if the physician had been notified of the 8/29/16 INR result, RN #1 stated, "Umm, I can't say." When asked if the protocol had been followed, RN #1 stated, "I can't say."

An interview was conducted on 10/13/16 at 3:25 p.m. with LPN #1. LPN #1 was asked what staff would do if a resident's INR was 1.38 and the resident was on the coumadin protocol. LPN #1 stated, "This is (name of doctor) protocol order. I would give the same dose of coumadin and one milligram more for one night and then we can put it (the laboratory result) in his box so he can evaluate it tomorrow." When asked what would happen after that, LPN #1 stated, "If (name of doctor) doesn't come in before the next dose is due we have to call him and ask him what he wants us to do because this (the protocol) is only good for one night."

An interview was conducted on 10/13/16 at 3:35 p.m. with ASM #2, the director of nursing. ASM #2 was asked what staff would do with an INR result of 1.38. ASM #2 stated, "It's less than two so they would give the same dose of coumadin plus one milligram for one night." When asked if this was done ASM #2 stated no. When asked if the physician would be notified, ASM #2 stated,

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"He prefers to be notified by the communication book the next morning." When asked to review the communication book for the 8/29/16 INR result, ASM #2 stated, "He was not notified." ASM #2 was made aware of the findings at that time.

An interview was conducted on 10/13/16 at 3:50 p.m. with ASM #3, the physician. When asked the process he and his staff follow for reviewing laboratory orders, ASM #3 stated, "We always look at the labs, they are put in my folder and I would look in my folder." When asked about the 8/29/16 INR result of 1.38 and why there was no additional orders until 9/15/16, ASM #3 stated, "That must have been my NP (nurse practitioner) or PA (physician's assistant) who must have found it and wrote an order then. There are flaws in the protocol. It all goes to the nurses going behind and making sure the labs were received."

Review of the facility's policy titled, "Administration of Medications" did not evidence documentation regarding the coumadin protocol.

No further information was provided prior to exit.

(1) INR -- International Normalized Ration (INR and Prothrombin Time (PT) are laboratory test values; obtained from measurement of the time it takes blood to clot. This information was obtained from:
http://cc.nih.gov/ccc/patient_education/drug_nutrient/coumadin1.pdf

(2) Coumadin -- Prevents and treats blood clots. This information was obtained from:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012678/?report=details

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2. The facility staff failed to obtain Resident #2's vital signs per physician's orders on 7/4/16 and 7/5/16, and failed to obtain a weekly weight per physician's orders during the week of 9/13/16.

Resident #2 was admitted to the facility on 1/11/11. Resident #2's diagnoses included but were not limited to: chronic kidney disease, heart failure and high blood pressure. Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/2/16 coded the resident's cognition as being moderately impaired.

Review of Resident #2's clinical record revealed a physician's assistant progress note dated 6/29/16 that documented, "Pt (Patient) seen and examined due to report of increased edema (swelling) and SOB (shortness of breath). Pt does feel she is more SOB than usual. Staff also notes increased LE (lower extremity) edema around ankles...A/P (Assessment and Plan): vital signs q (every) shift and weekly weight..."

Physician's orders dated 6/29/16 documented orders for vital signs including pulse oximetry every shift for seven days and weekly weights.

Further review of Resident #2's clinical record (including weight records, vital signs records, nurses' notes and treatment administration records) failed to reveal a weekly weight for the week of 9/13/16 and failed to reveal the following vital signs:
7/4/16 (second shift)- no temperature, respirations or pulse oximetry
7/5/16 (third shift)- no temperature, pulse, blood pressure, respirations or pulse oximetry

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7/5/16 (second shift)- no temperature, pulse, blood pressure, respirations or pulse oximetry

Resident #2's comprehensive care plan dated 9/10/15 documented in part, "Resident is at risk for dehydration R/T (related to) diuretic medication use. Has dx (diagnosis) of CKD (chronic kidney disease) stage IV (four)...Approach: Monitor and record vital signs per protocol...Monitor weights per protocol..."

On 10/13/16 at 10:00 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked how nurses ensure they follow physician's orders for vital signs and weights. RN #1 stated vital sign orders should be entered into the computer system as tasks that would display and prompt the nurses to obtain the vital signs. RN #1 stated weekly weights are obtained by CNAs (certified nursing assistants) every Tuesday. At this time, RN #1 was asked to provide the above missing weekly weight and vital signs.

On 10/13/16 at 2:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. ASM #2 stated the facility did not have a policy regarding following physician's orders.

No further information was provided prior to exit.
3. The facility staff failed to administer Keflex (an antibiotic) (1) to Resident #1 as ordered by the physician.

Resident #1 was admitted to the facility on 5/21/14 with diagnoses that included but were not limited to; chronic obstructive pulmonary disease,

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chronic pain, peripheral vascular disease, depression, osteoporosis (a condition where bones become brittle) and anxiety.

Resident #1's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 9/30/16, coded Resident #1 as scoring a 13, out of a possible score of 15, on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating that Resident #1 was cognitively intact to make daily decisions. The staff assessment was completed and coded Resident #1 as being cognitively intact in her cognitive skills for daily decision making.

A review of Resident #1's clinical record revealed, in part, the following written order; "5/30/16 1600 (4:00 p.m.) Keflex (1) 500 mg (milligrams) po (by mouth) TID (three times a day) x (times) 10 days. Dx (diagnosis): cellulitis." Signed and dated by the physician on 6/13/16.

A review of Resident #1's MAR (medication administration record) dated 5/1/16 - 5/31/16 revealed, in part, the following: "Keflex (cephalexin) capsule; 500 mg (milligrams); Amount to Administer: 1 capsule; oral. Three times a day. Administer 1 (one) capsule by mouth three times daily x 10 days." The MAR is initialed as administered on 5/31/16 at 8:00 a.m., 1:00 p.m., and 6:00 p.m. Resident #1's MAR dated 6/1/16 - 6/30/16 documents the continuation of Keflex administration from 6/1/16 through 6/9/16. There are no initials documenting that Keflex was administered to Resident #1 on 6/2/16 at 8:00 a.m. and 1:00 p.m.

On 10/13/16 at 1:30 p.m. a meeting was

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conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware that Resident #1 had not received Keflex as ordered on June 2, 2016. The nurse that was working on dayshift June 2, 2016 was not available for interview.

On 10/13/16 at 2:50 p.m. an interview was conducted with RN (registered nurse) #2. RN #2 was asked what blank spaces on the MAR indicated. RN #2 stated, "Missed doses, the medication was supposed to be given but it was not." RN #2 was shown Resident #1's MAR for June 2, 2016 and RN #3 stated, "The medication was not given.

On 10/13/16 at 4:00 p.m. an interview was conducted with RN #3. RN #3 was asked what a blank area indicated on the MAR. RN #3 stated, "It's a documentation error, when not signed then the med was not given." RN #3 was shown Resident #1's MAR for June 2, 2016 and RN #3 stated, "The medication was not given."

Further review of Resident #1's clinical record did not reveal any documentation regarding the administration of Keflex.

A review of the facility policy titled "Administration of Medications" revealed, in part, the following documentation: "Policy: All medications will be given per physician, Nurse Practitioner (NP), or Physician Assistant (PA) written, verbal or telephone order and shall not be started, changed or discontinued by the facility without an order from the physician, NP or PA. 17. When transcribing orders, the licensed nurse will appropriately "mark" the MAR, including "stop

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| F 309 | Continued From page 37<br>dates" as defined by facility protocols. For facilities utilizing electronic records, enter the order utilizing vendor instructions."<br><br>No further information was provided prior to the end of the survey process.<br><br>(1) Keflex is used to treat a wide variety of bacterial infections. This information was obtained from the following website: http://reference.medscape.com/drug/keflex-cephalexin-342490#91 | F 309 | | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility policy review and clinical record review, it was determined that the facility staff failed to provide care for the prevention of pressure ulcers.<br><br>The facility staff failed to float Resident #4's heels per the physician's order.<br><br>The findings include: | F 314 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>Heel floaters were obtained for the resident 10/13/16, and the nurse and CNA assigned to Resident #4 on 10/12/16 and 10/13/16 received corrective actions.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>The DON/Designee will conduct an audit of all current residents with orders to float heels and will ensure floating devices are present and applied per orders.<br><br>**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**<br>Licensed nurses and CNAs will be educated regarding the importance of pressure ulcer prevention, including heel floatation, to ensure care is provided. | 11/26/16 |

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| F 314 | Continued From page 38 | F 314 | **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The DON/Designee will make rounds three times a week for 4 weeks then weekly for the next 4 months to ensure residents with orders to float heels while in bed are properly positioned with floaters. Infractions will result in re-education or corrective action. The DON/Designee will monitor and report findings to the QA Committee for the next 12 months. | |

Resident #4 was admitted to the facility on 4/18/13 with diagnoses that included but were not limited to: stroke, depression, high blood pressure and irregular heart beat.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 9/7/16 coded the resident as having a 12 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as being at risk to develop pressure ulcers. The resident was coded as not having pressure ulcers.

Review of the resident's care plan initiated on 4/10/14 and edited on 6/13/16 documented, "Problem. Resident is noted to be at risk for skin breakdown and pressure ulcer due to decrease in mobility. Approach. Float heels while in bed."

Review of the physician's orders for October 2016 documented, "04/13/2013 Float heels when in bed Every Shift; Days, Evenings, Nights."

An observation was made on 10/12/16 at 2:00 p.m. Resident #4 was lying in bed on her back with her heels directly on the mattress.

An observation was made on 10/12/16 at 4:31 p.m. the resident was lying in bed on her back with her heels directly on the mattress.

An observation was made on 10/13/16 at 7:51 a.m. the resident was lying in bed on her back with her heels directly on the mattress.

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Review of Resident #4's October 2016 treatment administration record documented, "Float heels when in bed." From 10/1/16 to 10/13/16 it was documented that the heels were floated as ordered.

An interview was conducted on 10/13/16 at 10:15 a.m. with CNA (certified nursing assistant) #2, the aide caring for Resident #4. When asked how she knew what care the residents needed, CNA #2 stated, "I look in the care plan chart, it lets you know what they need to do with that resident." When asked to look at the care plan book CNA #2 could not locate it. When asked what care Resident #4 required, CNA #2 stated, "We bathe her, dress her. She's supposed to have a wedge for turning; we make sure we turn her every two hours." When asked if the resident was to have her heels floated, CNA #2 stated, "It would be in the care plan and the nurse is supposed to inform us." When asked if the resident had her heels floated, CNA #2 stated, "No."

An interview was conducted on 10/13/16 at 10:25 a.m. with LPN (licensed practical nurse) #2. When asked how staff knew what care a resident needed, LPN #2 stated, "Start by getting report. We also have the care plan and the resident's chart." When asked what it meant if it was documented on the treatment administration record that a resident's heels were floated, LPN #2 stated that the heels would be floated when the resident was in bed.

An interview was conducted on 10/13/16 at 10:50 a.m. with RN (registered nurse) #1. When asked how staff knew what care a resident needed, RN #1 stated, "They (the CNAs) have a matrix they chart on their residents." When asked what it

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| F 314 | Continued From page 40<br>meant if it was documented on the treatment administration record that a resident's heels were floated, RN #1 stated, "They check to see it is done or they tell the CNAs to do it." RN #1 was made aware of the findings at that time. A request for the CNAs charting was requested.<br><br>On 10/13/16 at 2:45 p.m. ASM #2 stated there was no CNA charting.<br><br>A request was made on 10/13/16 at 2:45 p.m. of ASM #2 to assess Resident #4's heels. An observation was made at 3:05 p.m. with RN #1 of the resident. The resident's heels were exposed and found to be in good condition.<br><br>On 10/13/16 at 4:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. | F 314 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review | F 315 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>The MD and RP were notified 11/3/16 of the Bladder Scan not being completed per order. The Licensed Nurse who wrote the order received a corrective action.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>The DON/Designee will review orders of all current residents for the last 90 days to ensure any orders for bladder scans have been completed. | 11/26/16 |

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and clinical record review, it was determined that the facility staff failed to assess bladder function for one of 11 residents in the survey sample, Resident #1.

On 9/1/16 the physician ordered that a bladder scan be conducted on Resident #1 following voiding and the facility staff failed to conduct the bladder scan.

The findings include:

Resident #1 was admitted to the facility on 5/21/14 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease, chronic pain, peripheral vascular disease, depression, osteoporosis (a condition where bones become brittle) and anxiety.

Resident #1's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 9/30/16, coded Resident #1 as scoring a 13, out of a possible score of 15, on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating that Resident #1 was unable to complete the interview. The staff assessment was completed and coded Resident #3 as being cognitively intact in her cognitive skills for daily decision making.

A review of Resident #1's clinical record revealed the following physician order; "9/1/16 8:23 p.m. (sign for check) bladder scan (abbreviation for following) voiding. Leave written notice re: (regarding) results." The order was signed and dated by the physician on 9/1/16.

Further review of Resident #1's clinical record

F 315 **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**

Licensed nurses will be educated on how to use the bladder scanner, how to create a task in Matrix to show the amount of urine documented when the bladder scan is completed, and on following physicians' orders.

**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**

The DON/Designee will review new orders daily through the Facility Activity Report to ensure orders for bladder scans have been carried out. The DON/Designee will monitor results and report findings to the QA Committee for the next 12 months.

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revealed a resident progress note written by the physician dated 9/1/2016 at 4:33 p.m., which documented, in part, the following; "Chief complaint: abdominal discomfort. A/P (assessment/plan) Check post void residual bladder scan."

A review of Resident #1's nurse's notes revealed, in part, the following documentation; "9/1/2016 8:32 PM resident has new orders for bladder scanning after voiding and leave written message for the doctor. RP (responsible party) made aware. no (sic) c/o (complaint of) pain when voiding at this time." This note was created by LPN (licensed practical nurse) #3.

On 10/13/16 at 1:30 p.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware that there was no evidence in the clinical record that Resident #1 had received a bladder scan as ordered by the physician on 9/1/16. ASM #2 stated that she would look into it.

On 10/13/16 at 2:10 p.m. ASM #2 stated, "There is no evidence that the bladder scan was done. The nurse who wrote the note was shadowing and didn't know, and apparently did not do the scan." ASM #2 was asked the expectation of a nurse who writes a note regarding an order for an intervention. ASM #2 stated, "The nurse should carry out the order."

On 10/13/16 at 3:55 p.m. an interview was conducted with LPN #3. LPN #3 was asked if she remembered writing the progress note regarding a bladder scan for Resident #1. LPN #3 stated, "I took the order from the physician

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| F 315 | Continued From page 43<br>and put the note in the system. I made an error and put the scan in "as needed" so it didn't populate on the nurse's notes to be done. I was learning and just trying to help. Night shift is supposed to do chart checks and catch those errors." LPN #3 asked whether or not she attempted to do the bladder scan. LPN #3 stated, "I did not, I didn't even know how to work the bladder scan machine."<br><br>No further information was provided prior to the end of the survey process. | F 315 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>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.<br><br>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. | F 329 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>For Resident #1, the MD and RP were notified of the resident receiving additional doses of Naproxen and Prednisone. The nurse who transcribed the orders received a corrective action.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>The DON/Designee will conduct an audit of current residents who received new orders over the last 90 days to review for transcription errors.<br><br>**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**<br>Licensed nurses will be inserviced regarding transcription of physicians' orders and correctly entering orders into the Matrix electronic medical record. | 11/26/16 |

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| F 329 | Continued From page 44 | F 329 | **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The night shift licensed nurses will review all new medication orders daily to ensure transcription accuracy. A second review will be completed by the DON/Designee. The DON/Designee will monitor results and report findings to the QA Committee for the next 12 months. | |

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure the drug regimen was free from unnecessary drugs for one of eleven residents in the survey sample, Resident #1.

a. The facility staff failed to correctly transcribe a physician ordered medication, Naproxen (1) for administration to Resident #1, causing Resident #1 to receive two additional doses of Naproxen that were not prescribed

b. The facility staff failed to correctly transcribe a physician ordered medication, Prednisone (2) for administration to Resident #1, causing Resident #1 to receive an additional dose of Prednisone on 5/4/16 and 5/5/16 that were not prescribed

The findings include:

a. The facility staff failed to correctly transcribe a physician ordered medication, Naproxen (1) for administration to Resident #1, causing Resident #1 to receive two additional doses of Naproxen that were not prescribed

Resident #1 was admitted to the facility on 5/21/14 with diagnoses that included but were not limited to; chronic obstructive pulmonary disease, chronic pain, peripheral vascular disease, depression, osteoporosis (a condition where bones become brittle) and anxiety.

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Resident #1's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 9/30/16, coded Resident #1 as scoring a 13, out of a possible score of 15, on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating that Resident #1 was unable to complete the interview. The staff assessment was completed and coded Resident #3 as being cognitively intact in her cognitive skills for daily decision making.

A review of Resident #1's clinical record revealed, in part, the following written order; "3/11/16 Naproxen (a mild pain reliever (1)) 500 mg (milligrams) PO (by mouth) BID (two times per day) x (times) 4 (four) days. Dx (diagnosis): OA (osteoarthritis)." Signed and dated by the physician on 3/11/15.

Further review of Resident #1's clinical record revealed a MAR (medication administration record) dated 3/1/2016 - 3/31/2016, that documented, in part, the following order: "Naproxen tablet; 500 mg; Amount to Administer: 1 tablet; oral. Twice A Day." The following dates contain initials indicating that Resident #1 received Naproxen twice a day for five days starting on 3/12/16 and ending on 3/16/16.

A meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, on 10/13/16 at 1:30 p.m. ASM #1 and ASM #2 were made aware that there was a concern that Resident #1 had received Naproxen for an extra day. At this time a policy was requested regarding order transcription.

On 10/13/16 at 2:50 p.m. an interview was

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conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to describe the process for entering a medication into the electronic medical record that contained a specific time parameter for administration. RN #2 stated, "When inputting a date range for a medication the nurse should count the dates as on a calendar, so if the medication is for seven days the nurse would count the start date as day one and then count off seven days, the end date would be the eighth day." RN #2 was then shown the MAR for Resident #1 and the medication administration history of naproxen administered to Resident #1. RN #2 stated, "She (Resident #1) got it for too many days, this should have been stopped after 3/15/16."

On 10/13/16 at 4:00 p.m. an interview was conducted with RN #3, a floor nurse. RN #3 was asked how she would enter an order that contained a time parameter into the electronic medical record. RN #3 stated that she would enter the medication with a start date and then count the days to the end date. When asked how she would ensure that the time frame was accurate, RN #3 stated, "I count like on a calendar." RN #3 was shown Resident #1's MAR and the administration history of the naproxen. RN #3 stated, "I entered it wrong, the end date should have been 3/15/16 and not 3/16/16.

A review of the facility policy titled "Administration of Medications" revealed, in part, the following documentation: "Policy: All medications will be given per physician, Nurse Practitioner (NP), or Physician Assistant (PA) written, verbal or telephone order and shall not be started, changed or discontinued by the facility without an order from the physician, NP or PA. 17. When

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transcribing orders, the licensed nurse will appropriately "mark" the MAR, including "stop dates" as defined by facility protocols. For facilities utilizing electronic records, enter the order utilizing vendor instructions."

No further information was provided prior to the end of the survey process.

b. The facility staff failed to correctly transcribe a physician ordered medication, Prednisone (2) for administration to Resident #1, causing Resident #1 to receive an additional dose of Prednisone on 5/4/16 and 5/5/16 that were not prescribed.

A review of Resident #1's clinical record revealed, in part the following written order:

"4/27/16. Prednisone (a steroidal medication (2)) 40 mg PO (by mouth) X 1 (one time) today, then 20 mg po daily x 7 days, then 15 mg po daily x 7 days, then 10 mg po daily x seven days then 5 mg po daily thereafter. Dx: COPD (chronic obstructive pulmonary disease)." Signed and dated by the physician on 4/27/16.

Further review of Resident #1's clinical record revealed a MAR (medication administration record) 4/1/2016 - 4/30/2016 that documented, in part, the following order: "Prednisone tablet; 5 mg; Amount to Administer: 20 mg; oral." The MAR is initialed for Prednisone 20 mg as given on the dates 4/28/16 through 5/5/16, eight days. A review of Resident #1's MAR dated 5/1/2016 - 5/31/2016 revealed the following order: "Prednisone tablet; 15 mg; Amount to Administer: 15; (sic) oral. Once a Day." The MAR is initiated on each day starting on 5/4/16 through 5/10/16,

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seven days. On May 4, 2016 and on May 5, 2016 Resident #1 received Prednisone 20 mg and Prednisone 15 mg. Per the physician order dated 4/27/16 Resident #1 should have received Prednisone 20 mg through 5/4/16 and started Prednisone 15 mg on 5/5/16.

A meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, on 10/13/16 at 1:30 p.m. ASM #1 and ASM #2 were made aware that there was a concern that Resident #1 had received an extra dose of prednisone for two days, 5/4/16 and 5/5/16. At this time this surveyor asked to speak to the nurse who had entered the prednisone order on 4/27/16 into the computer, ASM #2 stated that the nurse who had entered the order into the electronic medical record was no longer in the facility.

On 10/13/16 at 2:50 p.m. an interview was conducted with RN (registered nurse) #2, a floor nurse. RN #2 was asked to describe the process for entering a medication into the electronic medical record that contained a specific time parameter for administration. RN #2 stated, "When inputting a date range for a medication the nurse should count the dates as on a calendar, so if the medication is for seven days the nurse would count the start date as day one and then count off seven days, the end date would be the eighth day."

On 10/13/16 at 3:10 p.m. ASM #2 was asked if she was able to explain the prednisone administration, ASM #2 stated that she was not.

No further information was provided prior to the end of the survey process.

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| F 329 | Continued From page 49<br><br>(1) Naproxen is used to relieve pain, tenderness, swelling, and stiffness caused by osteoarthritis. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681029.html<br>(2) Prednisone works to treat patients with low levels of corticosteroids by replacing steroids that are normally produced naturally by the body. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601102.html | F 329 | | |
| F 332 SS=D | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure that two of seven residents in the Medication Administration observation (Residents #3, and #9) were free of a medication error rate of 5% or greater. There were two errors out of 28 opportunities and the error rate was 7.14%.<br><br>1. For Resident #3, the facility staff administered Coreg (a blood pressure medication (1) without food, as ordered.<br><br>2. For Resident #9, the facility staff administered | F 332 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>The MD and RP of Resident #3 and Resident #9 who received medications without food per order were notified 11/3/16. The Registered Nurse received a corrective action.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>The DON/Designee will conduct an audit of all current residents with orders to give medications with food/meals and highlight these residents on the shift report sheet for the nurses to utilize.<br><br>**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**<br>Licensed nurses will be educated | 11/26/16 |

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| F 332 | Continued From page 50<br>Ferrous Sulfate (an iron supplement) without food, as ordered.<br><br>The findings include:<br><br>1. For Resident #3, the facility staff did not administer Coreg with a meal as ordered by the physician.<br><br>Resident #3 was admitted to the facility on 11/11/15 with a readmission on 2/16/16 with diagnoses that included, but not limited to: chronic obstruction pulmonary disease, anemia, prostate cancer and heart failure.<br><br>Resident #3's most recent comprehensive MDS (minimum data set) was a 90 day assessment with an ARD (assessment reference date) of 9/9/16. Resident #3 was coded on the MDS as having a BIMS (Brief Interview for Mental Status) score of 13 out of 15. The MDS manual documents that a score of 13 indicates that the resident's cognition is intact.<br><br>On 10/13/16 at 8:10 a.m., the medication administration observation was conducted with RN #2 (registered nurse). RN #2 was observed preparing the following medications for Resident #3:<br><br>Coreg 3.125 mg (milligrams) (a blood pressure medication (1))<br>Ferrous Sulfate 325 mg (an iron supplement to treat anemia (2))<br>Furosemide 40 mg (a medication to reduce fluid (3))<br>Magnesium oxide 400 mg (a dietary supplement (4))<br>Renal caps soft gel 1 mg (used for chronic renal | F 332 | regarding medication administration following physicians' orders.<br><br>**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**<br>The DON/Designee will conduct medication pass observations for residents with orders to have medication administered with meals/food 3 times a week for 4 weeks then at least monthly to ensure medications are being given per order. The DON/Designee will review the Facility Activity report daily to ensure orders written to be given with food will be highlighted on the shift report sheets. The DON/Designee will monitor results and report findings to the QA Committee for the next 12 months. | |

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failure (5))
Oyster Shell Calcium 500/400 (used to treat and prevent calcium deficiencies (6))
Potassium Chloride 20 meq (millequivalents) (to treat low levels of potassium in blood stream (7))
Hydrocodone 7.5/325 (a narcotic pain medication (8))

RN #2 administered the Coreg and did not offer food or a meal to Resident #3 prior to administering the medication.

A review of Resident #3's clinical record revealed a physician order summary report which documented, in part, the following physician/prescription order: "Coreg tablet: 3.125 mg: amt (amount): 1 tab oral. Twice a day at 9:00 AM and 5:00 PM. Special Instructions: Give with meals." Signed by the physician on 3/21/16.

On 10/13/16 at approximately 10:20 a.m. an interview was conducted with RN #2. RN #2 was asked whether or not she remembered administering Coreg to Resident #3. RN #2 stated that she did. RN #2 was asked whether or not there were any special instructions regarding the administration of Coreg to Resident #3. RN #2 reviewed Resident #3's electronic medical record and stated, "I was supposed to give him the Coreg with food or wait for his breakfast tray." RN #2 was asked whether or not she gave food with the administration of Coreg. RN #2 stated that she did not.

On 10/13/16 at 1:30 p.m. a meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concern and made aware of the

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medication error rate of 7.14%.

No further information was provided prior to the end of the survey process.

(1) Coreg used to treat mild to severe heart failure. This information was obtained from the following website: http://www.rxlist.com/coreg-drug/indications-dosage.htm

(2) Ferrous Sulfate provides iron needed by the body to produce red blood cells. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682778.html#why

(3) Furosemide is a diuretic that prevents your body from absorbing too much salt. This information was obtained from the following website: https://www.drugs.com/furosemide.html

(4) Magnesium Oxide this information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601074.html

(5) Renal Caps used in chronic renal failure. This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=e7a81dfd-7591-442f-b839-4fb2fc79af98

(6) Oyster shell calcium is used to treat and prevent calcium deficiencies. This information was obtained from the following website: https://www.drugs.com/mtm/oyster-shell-calcium-500.html

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(7) Potassium chloride treats hypokalemia and prevents potassium depletion when taking a diuretic. This information was obtained from the following website: http://www.rxlist.com/klor-con-drug/indications-dosage.htm

(8) Hydrocodone is a narcotic pain medication used to treat moderate and moderate to severe pain. This information was obtained from the following website: http://www.mayoclinic.org/drugs-supplements/hydrocodone-and-acetaminophen-oral-route/description/drg-20074089

2. For Resident #9, the facility staff administered Ferrous Sulfate (an iron supplement (1)) without food, as ordered.

Resident #9 was admitted to the facility on 4/24/15 with diagnoses that included, but not limited to; chronic obstruction pulmonary disease, Parkinson's disease and shortness of breath.

Resident #9's most recent comprehensive MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 8/1/16. Resident #9 was coded on the MDS as having a BIMS (Brief Interview for Mental Status) score of 10 out of 15. The MDS manual documents that a score of 10 indicates that the resident's cognition is moderately impaired.

On 10/13/16 at 7:45 a.m., the medication administration observation was conducted with RN #2 (registered nurse). RN #2 was observed preparing the following medications for Resident #9:

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Ferrous Sulfate 325/65 mg (iron replacement to treat anemia (1))
Albuterol 25 mg inhalation treatment (used for breathing difficulties (2))

RN #2 was observed to administer the ferrous sulfate without offering any food or a meal.

A review of Resident #9's clinical record revealed the following physician order dated 10/12/16 with a start date of 10/13/16: "Ferrous sulfate. 325 mg (65 mg iron). Route oral. 1 tab (tablet) Frequency: with meals. Special Instructions: give with food."

On 10/13/16 at approximately 10:20 a.m. an interview was conducted with RN #2. RN #2 was asked whether or not she remembered administering ferrous sulfate to Resident #9. RN #2 stated that she did. RN #2 was asked whether or not there were any special instructions regarding the administration of ferrous sulfate to Resident #9. RN #2 reviewed Resident #9's electronic medical record and stated, "I was supposed to give her the iron tablet (ferrous sulfate) with food or wait for her breakfast tray." RN #2 was asked whether or not she gave food with the administration of ferrous sulfate. RN #2 stated that she did not.

On 10/13/16 at 1:30 p.m. a meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concern and made aware of the medication error rate of 7.14%.

No further information was provided prior to the end of the survey process.

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| F 332 | Continued From page 55<br><br>(1) Furosemide is a diuretic that prevents your body from absorbing too much salt. This information was obtained from the following website: https://www.drugs.com/furosemide.html<br><br>(2) Albuterol is a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs. This information was obtained from the following website: https://www.drugs.com/albuterol.html | F 332 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store food in a safe manner.<br><br>The facility staff failed to store food in the freezer at an appropriate temperature to maintain it in a frozen state and keep a thermometer in the ice cream freezer.<br><br>The findings include: | F 371 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>A thermometer was added to the ice cream freezer. A vendor repaired the walk-in freezer on the evening of 10/12/16 so that it maintained a temperature of 0 and below. All food that was in the freezer prior to 10/12 was discarded. Items that were delivered in the 10/12 delivery were refrigerated and thawed. Menus were reviewed to ensure food items served following 10/12 had not been subjected to freezer temperatures out of compliance.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>All residents consuming food could be at risk related to foods stored at temperatures out of compliance.<br><br>**Address what measures will be put into place or systemic changes** | 11/26/16 |

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| F 371 | Continued From page 56<br>Observation was made of the kitchen on 10/12/16 at 11:10 a.m. accompanied by other staff member (OSM) #1, the assistant food service director. There was one walk in freezer in the kitchen. The freezer outside thermometer was reading 33 degrees. There were boxes of food in the center aisle. OSM #1 stated, "We just got our shipment in this morning." The inside thermometer reading was 32 degrees. There were eight ice cream sandwiches on a serving tray on a shelf. When picked up the ice cream was soft and liquid and the melting ice cream ran out the end of the ice cream sandwich. There were six nut topped ice cream cones on the serving tray. When one was picked up, the ice cream was soft and melted. A three gallon tub of vanilla ice cream was on the shelf below the ice cream sandwiches and ice cream cones. This surveyor was able to press the sides of the container, in the middle section, and make an indentation with her knuckle. When asked if the ice cream sandwiches, cones and tub of ice cream should be solid if stored at the correct temperature, OSM #1 stated, "Yes, Ma'am."<br><br>A designated ice cream freezer was located on the other side of the kitchen. All of the ice cream in the freezer was frozen. There was no thermometer located inside the freezer. This freezer was not equipped with an outside thermometer. When asked if a thermometer should be in the freezer, OSM #1 stated, "Yes, it's usually right on top."<br><br>The walk in freezer was rechecked on 10/12/16 at 4:10 p.m. The outside thermometer reading was registered as 24 degrees. The inside thermometer was also reading 24 degrees. | F 371 | **made to ensure that the deficient practice will not recur.**<br>All refrigerators and freezers were checked to ensure the presence of a functioning thermometer. Rounds will be conducted 5 days a week for the next 4 weeks and then at least weekly for the next 5 months to ensure each area has a thermometer. Education was provided to kitchen staff on correct temperatures for the freezer, documenting these on the temperature sheet, and the correct process for alerting management if the freezer temperature is not at 0 degrees or below. The Food Service Director (FSD) or Assistance Food Service Director (AFSD) will check the temperature log for all freezers and refrigerators at least 5 times per week for the next 4 weeks to ensure temperatures are within the correct range. Following this, the FSD or AFSD will check freezer temperature logs weekly to ensure compliance.<br><br>**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**<br>Compliance with the presence of a thermometer in each area and correct temperatures will be reviewed at QA meetings for the next 4 meetings. Additional monitoring will occur as needed. | |

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When asked what the temperature should be, OSM #2, the Food Service Director, stated, "It's supposed to be less than zero degrees." When asked if this surveyor should be able to put her knuckle in a three gallon container of ice cream and leave an indentation, OSM #2 stated, "No, Ma'am." When asked what the staff should do when the freezer temperature is noted to be out of range for the required readings for maintaining freezer temperature, OSM #2 stated, "We call maintenance."

An interview was conducted with OSM #3, a dietary cook, on 10/12/16 at 4:17 p.m. When asked when she checks the temperature in the freezer, OSM #3 stated, "I check it around 4:00 p.m." When asked what she does if it's not reading at the appropriate temperature, OSM #3 stated, "First, I don't let anyone go in it and then recheck it, if it's still too high, I notify my manager (OSM #2)."

An interview was conducted with OSM #1 on 10/12/16 at 4:21 p.m. When asked if any of the dietary staff have told her the temperature of the freezer was out of range, OSM #1 stated, "No. I'm more concerned about the temperatures first thing in the morning because it's (the freezer) has been closed all night and should be at the correct temperature."

An interview was conducted with OSM #2 on 10/12/16 at 4:24 p.m. When asked if any of his staff had told him of the temperatures not being in range for the freezer, OSM #2 stated, "No."

The freezer temperature logs were reviewed for August, September and October of 2016. At the top of the log sheets under "Freezer" was

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documented, "-10 (minus 10 degrees) Degrees - (to) + 0 degrees F (Fahrenheit).
The August 2016 logs failed to document the temperature of the freezer on 14 of the 62 opportunities for documentation. Of the documented readings, none of these readings were at or below zero degrees.
The September 2016 logs failed to document the temperature of the freezer on 21 of the 60 opportunities for documentation. Of the documented readings, none were at or below zero degrees.
The October 2016 logs failed to document the temperature on one of the 23 opportunities for documentation. Of the documented readings, only two were at zero or below.

The facility policy, "Freezer Storage" documented, "Freezer storage units should have accurate thermometers; freezers must be checked daily to ensure that they are operating correctly and that proper temperature are being maintained. Interior temperatures in the freezer storage unit should be O (degrees) or lower."

The administrator was made aware of the above findings on 10/12/16 at 4:57 p.m.

The freezer temperatures were checked on 10/13/16 at 8:30 a.m. OSM #2 informed this surveyor that the serviceman had come to repair the freezer. The temperature readings on the outside was -2 and the inside temperature was registering, -4 degrees.

No further information was provided prior to exit.

F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS — F 431

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| F 431 | Continued From page 59<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined that the facility staff failed to secure | F 431 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>A new refrigerator, narcotic box for the interior of the refrigerator, and lock for the exterior door have been purchased and are in place.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>There is only one medication room in the Nursing Center so no other refrigerators would be affected by this practice.<br><br>**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**<br>Licensed Nurses will be educated on the importance of narcotic medication storage and the expectation of keeping the refrigerator and refrigerated narcotic box locked at all times.<br><br>**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**<br>The DON/Designee will check the medication room refrigerator and locks 5 times weekly for 4 weeks then at least weekly to ensure locks are in place. The DON/Designee will monitor results and report findings to the QA Committee for the next 12 months. | 11/26/16 |

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| F 431 | Continued From page 60 | F 431 | | |

narcotic medications in the medication room. .

The facility staff failed to have a locked narcotic drawer in the medication room refrigerator and the refrigerator was unlocked.

The findings include:

On 10/13/16 at 3:40 p.m. an observation was made of the facility medication room. LPN (licensed practical nurse) #3 was in attendance during the observation. The medication room was locked and the refrigerator that contained medications was not locked. There was a drawer in the refrigerator that contained four bottles of Ativan (1) and this drawer did not contain a locking device. LPN #3 was asked whether or not the refrigerator should be locked or the drawer inside the refrigerator. LPN #3 stated that the medications in the drawer should be under a double lock, the refrigerator and the drawer inside of the refrigerator.

On 10/13/16 at 3:50 p.m. RN (registered nurse) #1 was asked whether or not the refrigerator was supposed to be locked, RN #1 stated that it should and she didn't know why the narcotic drawer did not have a lock.

On 10/13/16 at 4:15 p.m. ASM (administrative staff member) #2, the director of nursing, was made aware of the refrigerator not having a lock, ASM #2 stated she was working on getting it fixed at that time. When asked for a policy regarding the securing of narcotic medications in the medication room, ASM #2 stated she did not have one.

ASM #1, the administrator, was made aware of

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| F 431 | Continued From page 61<br>the findings on 10/13/16 at approximately 4:45 p.m.<br><br>No further information was provided prior to the end of the survey process. | F 431 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. | F 441 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>A corrective action was given 11/3 to the nurse creating the deficient practice.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>Medication pass audits will occur on licensed nurses to check for correct infection control techniques.<br><br>**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**<br>Licensed nurses will be educated regarding proper medication administration protocols including infection control practices.<br><br>**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**<br>The DON/Designee will conduct medication pass observations on licensed nurses and then will conduct monthly observations at random to ensure proper infection control practices are being maintained. The | 11/26/16 |

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| F 441 | Continued From page 62<br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow infection control practices for the administration of medication for one of seven residents in the Medication Administration observation; Resident #8.<br><br>For Resident #8, the facility staff dropped a medication onto the top of the medication cart, picked it up with a spoon, and administered it to the resident.<br><br>The findings include:<br><br>Resident #8 was admitted on 3/14/15 with the diagnoses of, but not limited to: Parkinson's disease, osteoporosis (a condition that causes brittle bones), venous insufficiency (concerns blood flow return to the heart), anemia and low potassium levels in the blood stream.<br><br>Resident #8's most recent MDS (Minimum Data Set) was five day assessment with an ARD (Assessment Reference Date) of 10/4/16. Resident #8 was coded as cognitively intact in ability to make daily life decisions, scoring a 13 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. | F 441 | DON/Designee will monitor results and report findings to the QA Committee for the next 12 months. | |

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On 10/12/16 at 4:45 p.m., the Medication Administration observation was conducted with RN #3 (Registered Nurse #3). She was observed to prepare the following medications for Resident #8:

Warfarin 4 mg (a blood thinner (1))
Magnesium Oxide (a replacement supplement (2))
Metoprolol Tartrate 25 mg (a blood pressure medication (3))
Calcium Carbonate 500 mg (a replacement supplement (4))
Docusate 100 mg (a stool softener (5))
Tylenol 650 mg (a pain medication (6))

RN #3 was observed to "pop" each pill from a blister pack into a medicine cup on the surface of the medication cart. As she popped the calcium carbonate from the blister pack the pill landed on the surface of the medication cart. RN #3 took a spoon and scooped up the calcium carbonate pill and placed it into the medication cup with the other medication. Once all the above pills were in the medication cup RN #3 administered them to Resident #8.

RN #3 had not been observed to clean the surface of the medication cart throughout the medication administration observation beginning at 4:15 p.m. There were four other residents that RN #3 had prepared medications for prior to Resident #8 and the surface was not cleaned.

On 10/13/16 at 1:30 p.m. a meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concern. ASM #2 stated that the

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nurse should have thrown the pill away and not put it back into the cup.

On 10/13/16 at 4:00 p.m. an interview was conducted with RN #3. RN #3 was asked what she would do when she dropped a pill onto the surface. RN #3 stated that she would take a spoon and put it back into the dispensing cup. RN #3 was asked whether or not the surface of the medication cart was clean. RN #3 stated, "I do clean the top of my cart, but I can't say that it was clean when I dropped the pill yesterday. I should have wasted the pill."

A review of the facility's "Medication Administration" policy checklist for "Medication Administration Observation Audit" failed to reveal any directions for discarding dropped medications.

According to Potter and Perry's, Fundamentals of Nursing, 6thedition, page 847, "For safe administration, the nurse uses aseptic technique when handling and giving medications."

(1) Warfarin is an anticoagulant and is used to prevent blood clots from forming or growing larger in your blood and blood vessels. This information was obtained from the following website:
https://medlineplus.gov/druginfo/meds/a682277.html
(2) Magnesium Oxide this information was obtained from the following website:
https://medlineplus.gov/druginfo/meds/a601074.html

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| F 441 | Continued From page 65<br>(3) Metoprolol Tartrate is used to lower blood pressure. This information was obtained from the following website: http://www.pdr.net/drug-summary/Metoprolol-Tartrate-metoprolol-tartrate-3114#3<br>(4) Calcium Carbonate is a calcium replacement for people with brittle bones. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601032.html<br><br>(5) Docusate is a stool softener. This information was obtained from the following website: http://www.healthline.com/drugs/docusate/oral-capsule#Highlights1<br><br>(6) Tylenol is a pain medication/fever reducer. This information was obtained from the following website: http://www.webmd.com/drugs/2/drug-7076/tylenol-oral/details | F 441 | | |
| F 503 SS=D | 483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT<br><br>If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.<br><br>If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter.<br><br>If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in | F 503 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>All expired lab materials have been discarded and new materials ordered.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>There is only one medication room (lab storage area) in the nursing center. All lab materials were reviewed for expiration date and expired items discarded.<br><br>**Address what measures will be put** | 11/26/16 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 503 | Continued From page 66<br>accordance with the requirements of part 493 of this chapter.<br><br>If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and review of facility documents, it was determined that the facility staff failed to dispose of expired, outdated laboratory medical supplies in the medication and laboratory supply room.<br><br>The medical supply cabinets in the medication room were observed to contain expired laboratory supplies that were available for resident use.<br><br>The findings include:<br><br>On 10/13/16 from 3:30 p.m. to 4:00 p.m. during the inspection of the medication room that contained cabinets for medical laboratory supplies the following items were found to be expired and or outdated in two of those areas:<br><br>One Coaguchek system with an expiration date 12/31/15<br>Two red topped tubes used for blood samples with an expiration date of 10/2015.<br>Six lavender topped tubes used for blood samples with an expiration date of 11/2014<br>One purple topped tube used for blood samples with an expiration date of 12/2015<br>One small red topped tube used for blood | F 503 | **into place or systemic changes made to ensure that the deficient practice will not recur.**<br>Licensed nurses will be educated regarding disposal of expired /outdated medical lab supplies.<br><br>**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**<br>The DON/Designee will observe medication room lab supplies weekly for 4 weeks then at least monthly to ensure no outdated supplies are present. The RN Unit manager will be assigned to check items as part of rounds. The DON/Designee will monitor results and report findings to the QA Committee for the next 12 months. | |

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|---|---|---|---|
| | 495311 | A. BUILDING _____ B. WING _____ | 10/13/2016 |

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| F 503 | Continued From page 67 | F 503 | | |

samples with an expiration date of 7/2011
Seven safety needles used for blood collection with an expiration date of 4/2015
Ten hema screen cards used to test stool samples for blood with an expiration date of 7/2014

At the time of these observations RN (registered nurse) #1 was asked to look at the dates on the items observed to be expired. RN #1 confirmed that the items were expired. An interview was conducted at this time. She stated that these medical supplies were generally only brought to the unit by the laboratory staff. RN #1 was asked how she thought these items came to be in the drawer with the medical supplies, RN #1 stated, "I don't know."

On 10/13/16 at approximately 4:15 p.m., the administrative staff was apprised of these findings. ASM (administrative staff member) #2, the director of nursing, was asked who was responsible for checking expiration dates on the laboratory supplies, ASM #2 stated that the staff were supposed to check the dates and that she thought it had been done.

No further information was provided prior to the end of the survey process.

According to applicable requirements for laboratories specified in Part 493 of this chapter:
§ 493.1252 Standard: Test systems, equipment, instruments, reagents, materials, and supplies. (4)
d) Reagents, solutions, culture media, control materials, calibration materials, and other supplies must not be used when they have exceeded their expiration date, have deteriorated,

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| F 503 | Continued From page 68<br>or are of substandard quality. | F 503 | **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.**<br>For Resident #4, the MD and RP were notified of the failure to obtain lab results from INR on 8/29. INR results were received on 10/13/2016 and placed in the medical record after physician review.<br><br>**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**<br>The DON/Designee will conduct an audit of labs ordered for current residents for the past 6 months to ensure results have been received. The MD and RP will be notified of labs not received.<br><br>**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**<br>Licensed nurses will receive education regarding obtaining lab results from the lab and notifying MD and RP of results. The RN Unit Manager will be responsible for monitoring the completion of labs and receiving of results.<br><br>**Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**<br>The DON/Designee will review lab results 5 times a week for 4 weeks and then weekly to confirm results have been received with MD/RP notification of abnormalities and the lab result is filed in | 11/26/16 |
| F 507 SS=D | 483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS<br><br>The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review and clinical record review it was determined facility failed to file a laboratory result on the clinical record for one of 11 residents in the survey sample, Resident #4.<br><br>Facility staff failed to file the 8/29/16 INR results on Resident#4's clinical record.<br><br>The findings include:<br><br>Resident #4 was admitted to the facility on 4/18/13 with diagnoses that included but were not limited to: stroke, depression, high blood pressure and irregular heart beat.<br><br>The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 9/7/16 coded the resident as having a 12 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.<br><br>Review of Resident #4's care plan initiated on | F 507 | | |

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3/13/15 and edited on 6/13/16 documented, "Problem. Resident is at risk for bleeding and bruising due to anticoagulant therapy (1). Approach. Monitor lab (laboratory) work as ordered."

Review of the resident's coumadin (2) flow sheet documented, "Date. 8/17 Current Dose 7 (milligrams) x (with a line over it indicating except) 6 (milligrams) M (Monday)/Th (Thursday). Next INR 8/29. Initials (physician's assistant)." The next documentation on the flow sheet was dated 9/15/16.

Review of the clinical record did not evidence documentation of the 8/29/16 INR result.

Review of the nurse's notes for 8/29/16 to 9/2/16 did not evidence documentation of the 8/29/16 INR.

On 10/13/16 at 8:45 a.m. a request was made to ASM (administrative staff member) #2, the director of nursing for the 8/29/16 INR results. At 9:40 a.m. a copy of the INR results were obtained from ASM #2. There was a fax date and time of 10/13/16 at 9:32 a.m. noted on the INR result. ASM #2 stated that they had the laboratory send them the results that day as they could not locate them in the facility.

An interview was conducted on 10/13/16 at 10:25 a.m. with LPN (licensed practical nurse) #2. When asked the process staff follows for monitoring INR tests, LPN #2 stated, "The doctor writes the order for the lab (laboratory), we put it in (the facility's software), we fill out a lab slip and log it in the lab book. When we get the lab back we follow the (coumadin) protocol and if it's

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the medical record. The DON/Designee will monitor results and report findings to the QA committee for the next 12 months.

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critical (very high result) or abnormal we call the MD (medical doctor)." LPN #2 was asked what process staff follows if the laboratory test was not received. LPN #2 stated, "We call and get it from the lab."

An interview was conducted on 10/13/16 at 10:35 a.m. with RN (registered nurse) #1, the nursing supervisor. When asked the process staff follows for monitoring INR tests, RN #1 stated, "We get the results faxed, if it's not critical we put it in (name of doctor) box. The doctor notes it and puts it in the box to be filed in the chart."

On 10/13/16 at 4:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

A review of the facility's policy titled, "General Policy for Documentation in an Electronic Medical Record (EMR)" documented, "PURPOSE: To ensure complete, accurate, and timely electronic medical records. DEFINITION OF TERMS: 1. Medical Record: The chronological documentation (paper or electronic format) of health care and medical treatment given to a patient by professional members of the health care team."

No further information was provided prior to exit.

(1) INR -- International Normalized Ration (INR and Prothrombin Time (PT) are laboratory test values; obtained from measurement of the time it takes blood to clot. This information was obtained from:
http://cc.nih.gov/ccc/patient_education/drug_nutrient/coumadin1.pdf

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(2) Coumadin -- Prevents and treats blood clots.
This information was obtained from:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012678/?report=details

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| F 000 | Initial Comments | F 000 | | |

An unannounced biennial State Licensure Inspection was conducted 10/12/16 through 10/13/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 60 bed certified and non-certified facility was 51 residents at the time of the survey. The certified survey sample consisted of nine current resident reviews (Residents #1 through #9) and two closed record reviews (Residents #10 through #11). The non-certified survey sample consisted of six current residents (Resident #1 through #6).

| | | | |
|---|---|---|---|
| F 001 | Non Compliance | F 001 | |

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
12 VAC 5 - 371 - 340 cross references to Federal Deficiency 371

Please refer to Plan of Correction for F371

12VAC5-371-200B. Director of Nursing
Cross reference to F-281
12VAC5-371-140 Policies and Procedures cross referenced to F176, F503

Please refer to Plan of Correction for F281

Please refer to Plan of Correction for F176, F503

12VAC5-371-200 Director of Nursing cross referenced to F281

Please refer to Plan of Correction for F281

12VAC-371-220 Nursing Services cross referenced to F309, F315, F329, F332

Please refer to Plan of Correction for F309, 315, 329, 332

12 VAC 5 - 220 B cross references to federal deficiency 309

Please refer to Plan of Correction for F309

12 VAC 5 - 220 C.1. cross references to federal

Please refer to Plan of Correction for F314

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Administrator | 11-4-16 |

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| F 001 | Continued From Page 1<br><br>deficiency 314<br>12 VAC 5 - 360 E.10 cross references to federal deficiency 507 | F 001 | Please refer to Plan of Correction for F507 | |