STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

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

An unannounced Medicare/Medicaid standard survey was conducted 10/17/17 through 10/19/17. Three complaints were investigated during the survey. 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 120 certified bed facility was 95 at the time of the survey. The survey sample consisted of 17 current resident reviews (Residents #1 through #17) and five closed record reviews (Residents #18 through #22).

F 157 SS=D 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

Preparation, submission and implementation of this plan of correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our plan of corrections prepared and executed as a means to continuously improve quality of care and to comply with applicable State and Federal regulatory requirements.

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VDH/OLC

F 157

F157

1. The physician was notified of the resident's dialysis schedule and Resident #10's medication times have been changed.
2. An audit of residents who are on dialysis will be done to ensure they are receiving their medications as ordered.
3. The Licensed Nursing staff will be re-educated on the notification policy.
4. The Director Of Nursing, or designee will review patients on dialysis and ensure these patients are receiving their medication as ordered daily for 2 weeks, then weekly for 3 months to ensure proper compliance. Findings will be reported to the monthly QAPI meeting.
5. November 27, 2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Reid Nichols, LNHA	ADMINISTRATOR	NOV 10, 2017

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

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F 157	Continued From page 1	F 157		

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to notify the physician of a need to alter treatment for one of 22 residents in the survey sample, Resident #10.

The facility staff failed to collaborate with Resident #10's physician to ensure the resident received medications as ordered. Resident #10 did not receive medications while out of the facility at dialysis (1) and the staff failed to notify the physician and discuss this matter with him.

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The findings include:

Resident #10 was admitted to the facility on 6/17/15. Resident #10's diagnoses included stroke, chronic kidney disease and difficulty swallowing. Resident #10's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/10/17, coded the resident's cognition as moderately impaired.

Review of Resident #10's clinical record revealed a physician's order that documented, "Dialysis Q (every) Tuesday, Thursday and Saturday. Family will pick up at 0930 (9:30 a.m.) and transport."

Review of Resident #10's clinical record revealed the following medication orders:
-6/16/15: Furosemide (2) 40 mg (milligrams) by mouth one time a day
-6/16/15: Tamsulosin (3) 0.4 mg by mouth one time a day
-6/16/15: Allopurinol (4) 100 mg by mouth two times a day

Resident #10's October 2017 MAR (medication administration record) documented the resident was at dialysis during the day shift on 10/3/17, 10/7/17, 10/14/17 and 10/17/17. The furosemide, tamsulosin and allopurinol were scheduled at 9:00 a.m. on the MAR. On 10/3/17, 10/14/17 and 10/17/17 the nurses documented the computerized code, "5= LOA (leave of absence)" for those medications (indicating the resident was out of the facility). On 10/7/17 the nurse documented the computerized code, "7=Other/See Nurse Notes." The nurse's notes documented by that nurse on 10/7/17

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F 157	Continued From page 3	F 157		

documented, "dialysis."

Resident #10's comprehensive care plan initiated on 7/29/15 documented, "Alteration in Kidney Function evidenced by hemodialysis...Interventions: Administer medications as ordered collaborating with Physician and/or pharmacist for optimal medication dose times..."

Further review of Resident #10's clinical record (including October 2017 physician's notes and nurse's notes) failed to reveal the facility staff notified the physician or collaborated with him to ensure Resident #10 received medications as ordered.

On 10/18/17 at 1:47 p.m. an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked how nurses ensure residents who go out for dialysis receive their medications as ordered. LPN #3 stated the orders should be put in (the computer system) to reflect the resident's dialysis schedule. LPN #3 stated this also depends on the medications and nurses should consult with the physician to see how he wants the medications scheduled in relation to dialysis. LPN #3 stated some residents have their medications sent with them to dialysis and this is evidenced by a physician's order. LPN #3 was asked if medications are sent with Resident #10 to dialysis. LPN #3 stated she didn't believe so. LPN #3 was shown Resident #10's October 2017 MAR. LPN #3 agreed that it appeared the resident was not consistently receiving his medications due to being at dialysis. LPN #3 stated the physician needed to be made aware and could possibly schedule the medications at a different time.

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F 157	Continued From page 4	F 157		

On 10/18/17 at 6:24 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. A policy regarding physician notification was requested.

On 10/19/17 at 7:46 a.m. an interview was conducted with LPN #1 (the nurse responsible for the 10/7/17 nurse's note). LPN #1 stated she usually works the night shift but will administer the morning medications when needed. LPN #1 was shown Resident #10's October 2017 MAR and asked if the resident was administered his 9:00 a.m. medications on the days he goes to dialysis. LPN #1 stated, "We keep them on the cart in case he needs them when he gets back. We hold them until he gets back." LPN #1 stated Resident #10 has a medication scheduled at 5:00 p.m. to "cover his hypertension (high blood pressure)." LPN #1 was asked if the medications are administered to Resident #10 when he returns from dialysis. LPN #1 stated she didn't know because she only covers the morning portion of the day shift when another nurse doesn't show up. LPN #1 was asked if Resident #10 was administered his 9:00 a.m. scheduled medications when he returned from dialysis on 10/7/17. LPN #1 stated she didn't administer the medications and she wasn't at the facility when the resident returned from dialysis. LPN #1 stated more often than not, the medications due at 9:00 a.m. are still in the medication cart when she reports to work at night. LPN #1 was asked if there was a physician's order to hold the resident's medications while at dialysis or if she was aware whether there had been a collaboration with the physician regarding this matter. LPN #1 stated, "No."

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F 157	Continued From page 5	F 157		

On 10/19/17 at 10:11 a.m. ASM #2 stated the facility did not have a policy regarding physician notification.

No further information was presented prior to exit.

(1) "When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dialysis

(2) Furosemide is used to treat high blood pressure and/or swelling. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682858.html

(3) Tamsulosin is used to treat symptoms on an enlarged prostate. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698012.html

(4) Allopurinol is used to treat high levels of uric acid in the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682673.html

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F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	F 167		

(g)(10) The resident has the right to-

(i) 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; and

(g)(11) The facility must--

(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.

(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and

(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

(iv) The facility shall not make available identifying information about complainants or residents.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to have survey reports for the three preceding years available for review and post notice of the availability of such reports.

The findings include:

Observation of the facility survey reports was

F167

1. The past three years of surveys and a notice of availability has been posted.
2. An audit will be conducted of the survey book to ensure there are three years of surveys and a notice of availability is present.
3. The Interdisciplinary team will be re-educated on the survey results policy.
4. The Administrator, or designee, will review the survey binder to ensure it is in compliance with state and federal guidelines for three months. Findings will be reported to the monthly QAPI meeting.
5. November 27, 2017

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F 167	Continued From page 7 conducted on 10/17/17 at 11:25 a.m. and 10/18/17 at 4:30 p.m. The reports were in a binder on a table by the receptionist desk in the lobby. The front of the binder documented, "Annual Survey Report." The binder contained the survey reports for a standard survey completed on 10/22/15, a standard survey completed on 10/27/16, a life safety code survey completed on 11/14/16 and a minimum data set focus survey completed on 2/1/17. A sign in the lobby documented, "The Annual Survey is Located at the Reception Desk." On 10/18/17 at 6:24 p.m. an interview was conducted with ASM (administrative staff member) #1 (the executive director and the person responsible for the availability and posting of the survey reports) and ASM #2 (the director of nursing) ASM #1 was asked the process for the posting of the availability of survey reports. ASM #1 stated the notice has to be posted in an unobscured area that is easily viewed and describes where the reports are located. ASM #1 was asked the process for making survey reports available for review. ASM #1 stated the most recent life safety report, any complaint survey reports or special focus survey reports for one year and the last standard survey report should be made available. At this time, ASM #1 and ASM #2 were made aware of the above concern. On 10/19/17 at 10:11 a.m. ASM #2 stated the facility did not have a policy regarding the survey reports. No further information was presented prior to exit.	F 167		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC	F 226		

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F 226	Continued From page 8 POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to implement policies for abuse to screen employees prior to employment for two of five	F 226	F226 1. The facility now has a copy of LPN #9's license and CNA #8's license. 2. An audit of employees hired in the past 4 months will be done to ensure licenses are in their employee file. 3. The Human Resource Manager will be re-educated on the Resident Abuse Policy. 4. The Administrator, or designee, will review new hire employee files to ensure compliance with the Resident Abuse Policy for three months. Findings will be reported to the monthly QAPI meeting. 5. November 27, 2017	

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employee records reviewed.

Facility staff failed to obtain LPN (licensed practical nurse) #9's license prior to employment on 8/1/17 and failed to obtain CNA (certified nursing assistant) #8's license prior to employment on 8/8/17.

The findings include:

Review of LPN # 9's employment file documented that the employee started employment at the facility on 8/1/17. Review of the employee's nursing license documented that the license verification was obtained on 9/8/17. Review of the employee's work schedule documented that the employee had provided hands on care to residents on 28 shifts prior to the license verification.

Review of CNA #8's employment file documented that the employee started employment at the facility on 8/8/17. The file did not evidence documentation that the CNA's license had been verified.

An interview was conducted on 10/18/17 at 9:05 a.m. with OSM (other staff member) #8, the human resources coordinator. When asked when the staff's licenses were verified, OSM #8 stated, "Like when they come in I pull it." When asked why the licenses were verified prior to caring for residents, OSM #8 stated, "To make sure it's valid and there's no pending charges and she's able to work in the facility." A request was made for CNA #8's license lookup and the work schedule.

On 10/18/17 at 9:15 a.m. OSM #8 returned and stated, "I just did the license lookup for (name of

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CNA #8)." When asked if it had been done prior to today, OSM #8 stated it had not.

Review of CNA #8's work schedule documented that the employee had provided hands on care to residents on 44 shifts prior to the license verification.

An interview was conducted on 10/18/17 at 9:20 a.m. with ASM (administrative staff member) #2, the interim director of nursing. When asked why staffs' licenses were verified prior to caring for residents, ASM #2 stated, "To make sure they have a valid license and it's not expired." When asked if staff were allowed to work before the license had been verified, ASM #1 stated, "Without a license? No."

On 10/18/17 at 6:45 p.m. ASM #1, the executive director and ASM #2, the interim director of nursing were made aware of the findings.

Review of the facility's policy titled, "Resident Abuse" documented, "POLICY: It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The management of the facility recognizes these rights and hereby established the following statement, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse. PROCEDURE: II. Screening. Persons applying for employment with Facility will be screened for a history of abuse, neglect or mistreating residents to include: ...E. Verify license or registration prior to hire."

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F 226	Continued From page 11 No further information was provided prior to exit.	F 226		
F 252 SS=D	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a clean, comfortable, homelike environment for one of 22 residents in the survey sample, Resident #2.	F 252	F252 1. Resident #2's privacy curtain has been changed. 2. An audit will be completed on privacy curtains in the building to ensure they are clean. 3. The Housekeeping staff will be re-educated on the privacy curtain maintenance policy. 4. The Interdisciplinary Team Members that conduct care keeper assignments will review their assigned rooms to ensure privacy curtains are clean. Findings will be reported to QAPI for 3 months. 5. November 27, 2017	

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Multiple stains were observed on Resident #2's privacy curtain.

The findings include:

Resident #2 was admitted to the facility on 5/21/09. Resident #2's diagnoses included but were not limited to: paranoid schizophrenia (1), major depressive disorder and diabetes. Resident #2's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/1/17 coded the resident as cognitively intact. Section G coded Resident #2 as totally dependent on two or more staff with transfers and as requiring extensive assistance of one staff with bed mobility and locomotion.

On 10/17/17 at 3:07 p.m. and 10/18/17 at 12:02 p.m. observation of Resident #2's privacy curtain was conducted. An orange stain (approximately one and a half inch vertical by one inch horizontal) and multiple brown splattered stains were observed.

On 10/18/17 at 1:47 p.m. an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked if the nursing staff was responsible for the cleanliness of privacy curtains. LPN #3 stated, "Not typically. Of course if you notice they are soiled you would let housekeeping know."

On 10/18/17 at 4:23 p.m. an interview was conducted with OSM (other staff member) #1 (the laundry and housekeeping manager). OSM #1 was asked the facility process for maintaining clean privacy curtains. OSM #1 stated, "We go

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around and see which ones need to be changed." OSM #1 stated this is completed during daily cleaning. OSM #1 was shown Resident #2's privacy curtain. OSM #1 stated, "I should be notified. I'm going to take it down, get it washed and bring it back."

On 10/18/17 at 6:24 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility's contracted housekeeping company's document titled, "(Name of company) JOB TO BE DONE: CLEAN CUBICLE CURTAINS" documented, "If curtain is stained, remove immediately..."

No further information was presented prior to exit.

(1) "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia&_ga=2.42985063.35045279.1508851348-139120270.1477942321

F 254 SS=D — 483.10(i)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION — F 254

(i)(3) Clean bed and bath linens that are in good condition;
This REQUIREMENT is not met as evidenced

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by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain linen in good condition for one of 22 residents in the survey sample, Resident #2.

A torn hole (approximately two inches in diameter) was observed in a facility bath blanket covering Resident #2's bed.

The findings include:

Resident #2 was admitted to the facility on 5/21/09. Resident #2's diagnoses included but were not limited to: paranoid schizophrenia (1), major depressive disorder and diabetes. Resident #2's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/1/17 coded the resident as cognitively intact. Section G coded Resident #2 as totally dependent on two or more staff with transfers and as requiring extensive assistance of one staff with bed mobility and locomotion.

On 10/17/17 at 2:12 p.m. a torn hole (approximately two inches in diameter) was observed in a bath blanket covering Resident #2's bed. The resident was out of the room.

On 10/17/17 at 3:07 p.m. Resident #2 was observed lying in bed. The bath blanket with the torn hole was observed covering the resident.

On 10/18/17 at 12:02 p.m. Resident #2 was out of the room. The bath blanket with the torn hole was observed covering the resident's bed.

F254

1. Resident #2's linen has been changed on the day it was brought to the facility's attention.
2. An audit will be completed on linen in the building to ensure linens are free from torn holes.
3. The housekeeping staff will be re-educated on the Linen Rag-out/Discard Policy and Procedure.
4. The Interdisciplinary Team Members that conduct care keeper assignments will review their assigned rooms to ensure linens are free from torn holes. Findings will be reported to QAPI for 3 months.
5. November 27, 2017

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On 10/18/17 at 1:47 p.m. an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked if the nursing staff was responsible for ensuring linens were in good condition. LPN #3 stated, "If they get clean linen off the cart and it was torn they would let housekeeping and laundry know."

On 10/18/17 at 4:23 p.m. an interview was conducted with OSM (other staff member) #1 (the laundry and housekeeping manager). OSM #1 was asked the facility process for maintaining linens in good condition. OSM #1 stated, "We pick dirty linens up from the units every hour and inspect then wash and fold and store for the next shift." OSM #1 was asked what should be done with a blanket that contains a torn hole approximately two inches in diameter. OSM #1 stated the blanket should be discarded and put on the "rag out form" (a form that tracks discarded linen). OSM #1 was shown the blanket on Resident #2's bed. OSM #1 stated, "It's a bath blanket." OSM #1 confirmed the blanket should have been discarded.

On 10/18/17 at 6:24 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility's contracted housekeeping company's document titled, "LINEN RAG-OUT/DISCARD POLICY AND PROCEDURE" documented, "All Laundry staff is required to look for various defects, once linen is removed from the dryer and is placed in the folding area. General linens found to have defects or irremovable stains will be discarded or ragged-out per the employee's discretion..."

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F 254	Continued From page 16 No further information was presented prior to exit. (1) "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia&_ga=2.42985063.35045279.1508851348-139120270.1477942321	F 254		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 22 residents in the survey sample, Resident #11. The facility staff failed to clarify Resident #11's physicians order for an iron supplement, with the physician, to ensure the order included the dosage to be administered to the resident.	F 281	F281 1. Resident #11's iron supplement now includes a dosage to be administered. 2. An audit of new orders written in the last 14 days will be done to ensure applicable medication has a dosage included. 3. The Licensed Nursing staff will be re-educated on Medication Administration General Guidelines Policy. 4. The DON, or designee, will review new orders in the morning clinical meeting to ensure applicable medications include a dosage daily for three months. Findings will be reported to QAPI 5. November 27, 2017	

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The findings include:

Resident #11 was admitted to the facility on 9/29/14 with a readmission on 2/20/17 with diagnoses that included, but were not limited to: Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, shuffling gain, stooped posture, rolling motions of the fingers, drooling, and muscle weakness (1)), Bipolar disorder (a mental disorder characterized by episodes of mania and depression (2)), depression, COPD (chronic obstructive pulmonary disease - a general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (3)), gastroesophageal reflux disease, high blood pressure and anemia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/16/17, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions. Resident #11 was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living.

The physician order dated, 2/20/17, documented, "FerrouSul Tablet (Ferrous Sulfate) (iron supplement given for anemia (4)); give 1 tablet by mouth one time a day for supplement."

The August, September and October 2017 MAR (medication administration record) documented, "FerrouSul Tablet (Ferrous Sulfate); give 1 tablet by mouth one time a day for supplement." All three MARs documented that the Ferrous Sulfate was administered every day.

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Review of the comprehensive care plan dated, 4/30/15 and revised on 8/21/17, did not evidence documentation of anemia or the resident taking iron supplements.

An interview was conducted with LPN (licensed practical nurse) #6, the nurse who cares for Resident #11, on 10/18/17 at 10:48 a.m. The above order for Ferrous Sulfate was reviewed with LPN #6. When asked what is wrong with this order, LPN #6 stated, "It doesn't state a dose." The MARs were reviewed with LPN #6. When asked if she had signed the MAR indicating she gave this medication, LPN #6 stated, "Yes, Ma'am." When asked what she was administering when her initials were signed off as having given the medication, LPN #6 stated, "The stock iron supplement." When asked if she should have a dose for the medication, LPN #6 stated, "Yes, Ma'am."

An interview was conducted with LPN #3, the unit manager, on 10/18/17 at approximately 11:05 a.m. LPN #3 was asked to read Resident #11's physician order for the Ferrous Sulfate. When asked what was missing from the order, LPN #3 stated, "The dosage." When asked if there should be a dosage for the medication, LPN #3 stated, "Yes, Ma'am."

An interview was conducted with administrative staff member (ASM) #2, the interim director of nursing, on 10/18/17 at 2:32 p.m. ASM #2 was asked to review Resident #11's physician order for Ferrous Sulfate. After reviewing the order, ASM #2 was asked if anything was missing from the order, ASM #2 stated, "There's no dosage." When asked if there should be a dosage, ASM #2

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stated, "Yes, there should always be a dosage." When asked the facility standard of professional practice, ASM #2 stated, "If it's not our policy then it's Lippincott."

The facility document titled, "Preventing Medication Errors ABC's Quick Reference" documented in part, "Eight Recognized Standards: Right Drug. Right Dose. Right Patient. Right Route. Right Time. Right Dosage Form. Right Response. Right Record." The facility documented titled, "Medication Administration - General Guidelines" documented in part, "4. Five Rights - right resident, right drug, right dose, right route, and right time, are applied for each medication being administered."

The executive director and the interim director of nursing were made aware of the above findings on 10/18/17 at 6:16 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 436.

(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 73.

(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.

(4) This information was obtained from the following website:

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F 281	Continued From page 20 https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?id=37597.	F 281		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to follow the written plan of care for five of 22 residents in the survey sample, Residents #11, #1, #7, #10 and #21.

1. The facility staff failed to follow Resident #11's plan of care to implement non-pharmacological pain relief prior to administering narcotic pain medication.

2. The facility staff failed to follow Resident #1's plan of care to implement non-pharmacological pain relief prior to administering narcotic pain medication.

3. The facility staff failed to follow Resident #7's care plan for evaluating the effectiveness of anti-psychotic medication as evidenced by the lack of adequate targeted behavior monitoring for the medication.

F282

1. Care plans for Residents #11, #1, #7, #10, and #21 were reviewed and updated as necessary.
2. An audit of residents' care plans will be done by the Interdisciplinary team members to ensure interventions are being followed.
3. The Licensed Nursing staff will be re-educated on the Care Plan Policy, as well as communication with physician and the notification policy.
4. The DON, or designee, will ensure the Interdisciplinary Team members review care plans based on the 24 hour report being reviewed during morning meeting to ensure compliance. Findings will be reported to QAPI for 3 months.
5. November 27, 2017.

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4. The facility staff failed to follow Resident #10's dialysis care plan for collaborating with the physician and administering medications.

5. The facility staff failed to follow Resident #21's dialysis care plan for collaborating with the physician and administering medications.

The findings include:

1. The facility staff failed to follow Resident #11's plan of care to implement non-pharmacological pain relief prior to administering narcotic pain medication.

Resident #11 was admitted to the facility on 9/29/14 with a readmission on 2/20/17 with diagnoses that included, but were not limited to: Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, shuffling gain, stooped posture, rolling motions of the fingers, drooling, and muscle weakness (1)), Bipolar disorder (a mental disorder characterized by episodes of mania and depression (2)), depression, COPD (chronic obstructive pulmonary disease - a general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (3)), gastroesophageal reflux disease, high blood pressure and anemia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 8/16/17, coded Resident #11 as scoring a 14 on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions. Resident #11 was coded as requiring

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extensive assistance of one or more staff members for most of her activities of daily living.

The comprehensive care plan dated, 12/2/16 and revised on 8/21/17 documented in part, "Focus: Needs Pain management and monitoring related to: dx (diagnosis) generalized." The "Interventions" documented in part: "Administer pain medication as ordered. Coordinate with patient/Family/RP (responsible party) to identify patient's favorite items/activities that could serve to distract from pain. Implement the patient's preferred non-pharmacological pain relief strategies."

The physician orders dated, 2/23/17, documented, "Hydrocodone - Acetaminophen Tablet (used to treat moderate to moderately severe pain (4)) 5 - 325 MG (milligrams); Give 1 tablet by mouth every 6 hours as needed for pain 5 - 10."

Resident #11's August 2017 MAR was reviewed and revealed the resident had received Vicodin 47 times during this month.

Review of the nurse's progress notes and the August 2017 eMAR (electronic medication administration record) did not reveal any documentation of offering non-pharmacological interventions prior to the administration of Vicodin.

The September 2017 MAR was reviewed and revealed the resident had received Vicodin 54 times during this month.

Review of the nurse's progress notes and the September 2017 eMAR revealed on two

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occasions, 9/2/17 at 1:55 p.m. and 9/22/17 at 1:51 p.m. the nurse documented, "Repositioning not effective." There was no further documentation of any non-pharmacological interventions.

The October 2017 MAR was reviewed and revealed the resident had received Vicodin 37 times during this month.

Review of the nurse's progress notes and the October 2017 eMAR revealed on two occasions, 10/12/17 at 1:16 p.m. and 10/16/17 at 1:56 p.m. the nurse documented, "Repositioning not effective." There was no further documentation of any non-pharmacological interventions.

An interview was conducted with LPN (licensed practical nurse) #6 on 10/18/17 at 10:48 a.m., regarding the steps she takes when a resident complains of pain. LPN #6 stated, "I ask them [resident] to rate their pain, 0 -10. I ask where the pain is located. Then I go to the chart for what medication is available for them and administer the medication appropriately and if they have nothing ordered for pain, I call the physician." When asked if the resident gets a pain pill if they complain of pain, LPN #6 stated, "Yes if it's in the time frame and in the parameters." When asked if anything is offered before giving the pain mediation, LPN #6 stated, "Like non-pharmacologic, it should be documented in a note but I don't always do that." When asked to describe what a non-pharmacological intervention is, LPN #6 stated, "Turn and repositioning or rubbing the area of concern." LPN #6 stated, "Well, if it's not documented then it wasn't done." LPN #6's initials were verified on the October MAR, evidencing she had administered pain

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medication to Resident #11 and no non-pharmacological interventions were documented at the times of administration.

An interview was conducted with ASM (administrative staff member) #2, the interim director of nursing, on 10/18/17 at 2:32 p.m. regarding the process staff follows when a resident complains of pain, ASM #2 stated, "First you have the resident to rate the pain on the pain scale. Ask them where the pain is. We notify the doctor. I would like to think they'd give them some kind of pain medication." When asked if staff do anything before administering pills, ASM #2 stated, "I've overheard some of the nurse's doing it (non-pharmacological interventions) but they aren't documenting it. I don't know if it's 100% of the time."

An interview was conducted with LPN #2 on 10/18/17 at 3:34 p.m. When asked the purpose of the care plan, LPN #2 stated, "It's the guidelines of what residents need. Whatever is set up for them, you make sure it's in place." When asked if the care plan should be followed, LPN #2 stated, "Yes."

An interview was conducted with LPN #3 on 10/18/17 at 3:39 p.m. When asked the purpose of the care plan, LPN #3 stated, "It's to make sure we are giving individualized care to each resident." When asked if the care plan should be followed, LPN #3 stated, "Yes."

The executive director, ASM #1 and the interim director of nursing, ASM #2, were made aware of the above findings on 10/18/17 at 6:16 p.m. A copy of the policy on following the care plan was

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requested.

An interview was conducted with Resident #11 on 10/19/17 at 8:22 a.m. When asked if staff offers to reposition her or massage the area that hurts, when she complains of pain, Resident #11 stated, "They couldn't rub the area that hurts because it's (the pain) is all over." When asked if the staff offers to reposition her to see if that relives the pain, Resident #11 stated, "No, they don't offer that."

The facility provided on 10/19/17 at 9:00 a.m. an excerpt from the RAI (resident assessment instrument) manual dated October 2016. The form documented in part, "Federal statute and regulations require nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review and revise the resident's plans of care that will be used to provide services to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders."

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No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 436.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 73.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(4) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b165dffd-1550-4d8d-a8ea-fe83512c34e6

2. The facility staff failed to follow Resident #1's plan of care to implement non-pharmacological pain relief prior to administering narcotic pain medication.

Resident #1 was admitted to the facility on 2/19/15 and readmitted on 7/29/17 with diagnoses that included but were not limited to: leukemia, irregular heartbeat, diabetes, heart failure and kidney disease.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 8/7/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview of mental status) indicating the resident was cognitively intact to make daily decisions. Resident #1 was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the meal tray was prepared. The

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resident was coded as having an unstageable wound on the left foot.

Review of Resident #1's care plan initiated on 2/2/7/17 and revised on 8/10/17 documented, "Focus. Needs Pain management and monitoring...Interventions. Implement the patient's preferred non-pharmacological pain relief strategies."

Review of the physician's orders for October 2017 documented, "Norco Tablet 5-325 MG (milligrams) (Hydrocodone-Acetaminophen (1)) Give 2 tablet (sic) by mouth every 4 hours as needed for pain (level) 8-10."

Review of the September 2017 MAR (medication administration record) documented, "Norco Tablet 5-325 MG (milligrams) (Hydrocodone-Acetaminophen) Give 2 tablet (sic) by mouth every 4 hours as needed for pain 8-10." The Norco was documented as being given on 9/4/17 at 9:26 a.m. and 9/14/17 at 9:35 a.m. There was no documentation related to any non-pharmacological interventions being attempted or the resident's pain level.

Review of Resident #1's nurses' notes for September 2017 did not evidence documentation regarding the resident receiving non-pharmacological interventions prior to the pain medication or the resident's reported level of pain.

An interview was conducted on 10/18/17 at 10:45 a.m. with LPN (licensed practical nurse) #6, the nurse who administered pain medication to Resident #1 on 9/14/17. When asked the process staff followed for pain management, LPN #6

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stated, "If it's pain, ask what the pain level is on a scale of one to ten (ten being the worst possible pain) and where the pain is. Go to their chart to see what's available for them and give accordingly. If they have nothing (no pain medication) I'd call the physician." When restated that if the resident complained of pain the process would be to give the resident a pain pill, LPN #6 stated, "Yes if it's within the time frame and if it's within the parameters, yes ma'am." When asked if anything would be offered prior to medicating with the pain medication, LPN #6 stated she would attempt non-pharmacological interventions. When asked what those were, LPN #6 stated, "Turning, repositioning, rubbing the area of concern." When asked where this would be documented, LPN #6 stated, "Well, I should document it in the note but I don't always do that." When asked if Resident #1 had been offered non-pharmacological interventions, LPN #6 stated, "Yes I do. I don't document it and that means it's not done."

An interview was conducted on 10/18/17 at 2:35 p.m. with ASM (administrative staff member) #2, the interim director of nursing. When asked about the process followed by staff for pain management, ASM #2 stated, "If the resident complains of pain, find out first of all what it is on the pain scale and give some kind of pain medication management." When asked if staff should do anything prior to giving the pain medication, ASM #2 stated, "Non-pharmacological (interventions). I have overheard some of the nurses doing that but I don't think they're documenting it and taking credit for what they actually are doing." ASM #2 was asked to review Resident #1's Norco administration on 9/27/17 at 10:47 a.m. When

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asked how staff would know what non-pharmacological interventions were attempted and what the resident's pain level was, ASM #2 stated, "That's a very good question. You'd know if they documented it in the record." ASM #2 was made aware of the findings at that time.

An interview was conducted on 10/19/17 at 7:15 a.m. with LPN #4, the nursing supervisor. When asked why residents had care plans, LPN #4 stated, "Lots of reasons. It's basically to let us know things to be responsible for the resident." When asked who used the care plan, LPN #4 stated, "Really everybody." When asked if staff were expected to follow the care plan, LPN #4 stated, "Yes. The care plan would be updated with falls, elopement, anything that pertains to the plan of care." When asked if there was a time staff did not follow the care plan, LPN #4 stated, "No, not really."

On 10/18/17 at 6:45 p.m. ASM #1, the executive director and ASM #2, the interim director of nursing were made aware of the findings.

On 10/19/17 two attempts were made to interview Resident #1 regarding the staff offering non-pharmacological interventions. The resident was sleeping on each occasion.

Review of the facility's policy titled, "DOCUMENTATION" documented, "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed charting shows the extent and quality of the care that nurses provide, the outcomes of that care, and treatment and

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education that the patient still needs.... In a court of law, the patient's health record serves as the legal record of the care provided to that patient. Accrediting agencies and risk managers use the medical record to evaluate the quality of care a patient receives."

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

(1) Norco -- NORCO® (Hydrocodone bitartrate and acetaminophen) is supplied in tablet form for oral administration. Hydrocodone bitartrate is an opioid analgesic and antitussive and occurs as fine, white crystals or as a crystalline powder. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=44b86290-2391-4b02-abd4-b1c0c611891e(2) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

3. The facility staff failed to follow Resident #7's care plan for evaluating the effectiveness of anti-psychotic medication as evidenced by the

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lack of adequate targeted behavior monitoring for the medication.

Resident #7 was admitted to the facility on 5/4/17. Resident #7's diagnoses included but were not limited to: dementia, diabetes and seizures. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/4/17 coded the resident's cognition as moderately impaired. Section N documented Resident #7 received anti-psychotic medication seven out of the last seven days.

Review of Resident #7's clinical record revealed a physician's order dated 7/13/17 for Risperdal (1) 0.5 mg (milligrams) by mouth two times a day for behavioral and psychological symptoms of dementia.

A progress note signed by the psychological nurse practitioner on 8/1/17 documented, "Asked to evaluate the patient's mental status and adjust medications if needed. Assess confusion and anxiety. HPI (history of present illness)/Interval History: Follow up, medication review. Patient alternates between sleeping to periods of anxiety and wandering unit via w/c (wheelchair), going into other resident's rooms. No extrapyramidal side effects noted...Treatment Plan/Recommendations...risperdal for delusional disorder..."

Resident #7's MARs (medication administration records) for August 2017 through October 2017 revealed the resident received Risperdal 0.5 mg by mouth two times a day each day.

Resident #7's behavior monthly flowsheets for

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August 2017 and September 2017 documented staff monitored for the targeted behavior symptom coded as "12" which according to the flowsheet key indicated the behavior of depressed/withdrawn. Resident #7's behavior monthly flowsheet for October documented staff monitored for the targeted behaviors coded as "12" depressed/withdrawn and "7" continuous crying. The behavior flowsheets failed to document monitoring for delusions.

Resident #7's comprehensive care plan initiated on 5/4/17 documented, "Potential for drug related complications associated with use of psychotropic medications related to: Anti-Anxiety medication, antipsychotics, antidepressants...Interventions: Provide Medications as ordered by physician and evaluate for effectiveness..."

On 10/18/17 at 1:47 p.m. an interview was conducted with LPN (licensed practical nurse) #3 regarding the facility process for behavior monitoring. LPN #3 stated the monthly behavior flowsheets are filled out each shift. Resident #7's September 2017 flowsheet was reviewed with LPN #3. LPN #3 stated the resident was monitored for "12- depressed/withdrawn." and each shift, staff documented if the resident experienced that symptom. LPN #3 was asked why Resident #7 was monitored for that behavior. LPN #3 stated, "For the medication she is on." LPN #3 stated the resident was receiving Risperdal and Remeron (2). LPN #3 stated staff decides what behaviors will be monitored according to the medication that is prescribed and "12 (depressed/withdrawn)" was the behavior Resident #7 was being monitored for. LPN #3 stated the former assistant director of nursing was responsible for deciding which targeted

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behaviors would be monitored for on the flowsheets. LPN #3 was asked what Risperdal was prescribed for. LPN #3 reviewed a drug book and stated Risperdal was an anti-psychotic that was prescribed for schizophrenia or bipolar. LPN #3 was asked to describe the behaviors Resident #3 presents with. LPN #3 stated Resident #7 presented with behaviors prior to moving to a room on a different unit but now is tearful and occasionally yells. LPN #3 stated she thought the resident used to climb out of bed a lot. When asked the purpose of behavior monitoring, LPN #3 stated it was to make sure the medication residents are on address those issues and are therapeutic. LPN #3 was made aware of the above psychological nurse practitioner's note that documented Resident #7 was prescribed Risperdal for delusional disorder and asked what behaviors the resident should be monitored for. LPN #3 stated, "Delusional disorder." LPN #3 was asked how a resident can be monitored for the effective use of an anti-psychotic medication if the behaviors monitored are not the behaviors the resident is prescribed the medication for. LPN #3 confirmed the resident cannot.

On 10/18/17 at 3:34 p.m. an interview was conducted with LPN #2. LPN #2 was asked the purpose of a care plan. LPN #2 stated the care plan sets the guidelines for what residents need and their standards of care. When asked if the care plan should be followed, LPN #2 stated, "Yes. Whatever is set up for them, make sure the aides and nurses know and make sure it is being done."

On 10/18/17 at 6:24 p.m. ASM (administrative staff member) #1 (the executive director) and

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ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) "Risperidone (Risperdal) is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in adults and teenagers 13 years of age and older. It is also used to treat episodes of mania (frenzied, abnormally excited, or irritated mood) or mixed episodes (symptoms of mania and depression that happen together) in adults and in teenagers and children 10 years of age and older with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). Risperidone is also used to treat behavior problems such as aggression, self-injury, and sudden mood changes in teenagers and children 5 to 16 years of age who have autism (a condition that causes repetitive behavior, difficulty interacting with others, and problems with communication). Risperidone is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain...
IMPORTANT WARNING:
Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as risperidone have an increased risk of death during treatment. Older adults with dementia may also have a greater chance of having a stroke or ministroke during treatment.

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Tell your doctor and pharmacist if you are taking furosemide (Lasix).
Risperidone is not approved by the Food and Drug Administration (FDA) for the treatment of behavior problems in older adults with dementia. Talk to the doctor who prescribed this medication if you, a family member, or someone you care for has dementia and is taking risperidone. For more information, visit the FDA website: http://www.fda.gov/Drugs." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694015.html

(2) Remeron is used to treat depression. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697009.html

4. The facility staff failed to follow Resident #10's dialysis (1) care plan for collaborating with the physician and administering medications.

Resident #10 was admitted to the facility on 6/17/15. Resident #10's diagnoses included stroke, chronic kidney disease and difficulty swallowing. Resident #10's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/10/17, coded the resident's cognition as moderately impaired.

Review of Resident #10's clinical record revealed a physician's order that documented, "Dialysis Q (every) Tuesday, Thursday and Saturday. Family will pick up at 0930 (9:30 a.m.) and transport."

Review of Resident #10's clinical record revealed the following medication orders:

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-6/16/15: Furosemide (2) 40 mg (milligrams) by mouth one time a day
-6/16/15: Tamsulosin (3) 0.4 mg by mouth one time a day
-6/16/15: Allopurinol (4) 100 mg by mouth two times a day

Resident #10's October 2017 MAR (medication administration record) documented the resident was at dialysis during the day shift on 10/3/17, 10/7/17, 10/14/17 and 10/17/17. The furosemide, tamsulosin and allopurinol were scheduled at 9:00 a.m. on the MAR. On 10/3/17, 10/14/17 and 10/17/17 the nurses documented the computerized code, "5= LOA (leave of absence)" for those medications (indicating the resident was out of the facility). On 10/7/17 the nurse documented the computerized code, "7=Other/See Nurse Notes." The nurse's notes documented by that nurse on 10/7/17 documented, "dialysis."

Resident #10's comprehensive care plan initiated on 7/29/15 documented, "Alteration in Kidney Function evidenced by hemodialysis...Interventions: Administer medications as ordered collaborating with Physician and/or pharmacist for optimal medication dose times..."

On 10/18/17 at 1:47 p.m. an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked how nurses ensure residents who go out for dialysis receive their medications as ordered. LPN #3 stated the orders should be put in (the computer system) to reflect the resident's dialysis schedule. LPN #3 stated this also depends on the medications and nurses should consult with the physician to see how he

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wants the medications scheduled in relation to dialysis. LPN #3 stated some residents have their medications sent with them to dialysis and this is evidenced by a physician's order. LPN #3 was asked if medications are sent with Resident #10 to dialysis. LPN #3 stated she didn't believe so. LPN #3 was shown Resident #10's October 2017 MAR. LPN #3 agreed that it appeared the resident was not consistently receiving his medications due to being at dialysis. LPN #3 stated the physician needed to be made aware and could possibly schedule the medications at a different time.

On 10/18/17 at 3:34 p.m. an interview was conducted with LPN #2. LPN #2 was asked the purpose of a care plan. LPN #2 stated the care plan sets the guidelines for what residents need and their standards of care. When asked if the care plan should be followed, LPN #2 stated, "Yes. Whatever is set up for them, make sure the aides and nurses know and make sure it is being done."

On 10/18/17 at 6:24 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

On 10/19/17 at 7:46 a.m. an interview was conducted with LPN #1 (the nurse responsible for the 10/7/17 nurse's note). LPN #1 stated she usually works the night shift but will administer the morning medications when needed. LPN #1 was shown Resident #10's October 2017 MAR and asked if the resident was administered his 9:00 a.m. medications on the days he goes to dialysis. LPN #1 stated, "We keep them on the cart in case he needs them when he gets back. We

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hold them until he gets back." LPN #1 stated Resident #10 has a medication scheduled at 5:00 p.m. to "cover his hypertension (high blood pressure)." LPN #1 was asked if the medications are administered to Resident #10 when he returns from dialysis. LPN #1 stated she didn't know because she only covers the morning portion of the day shift when another nurse doesn't show up. LPN #1 was asked if Resident #10 was administered his 9:00 a.m. scheduled medications when he returned from dialysis on 10/7/17. LPN #1 stated she didn't administer the medications and she wasn't at the facility when the resident returned from dialysis. LPN #1 stated more often than not, the medications due at 9:00 a.m. are still in the medication cart when she reports to work at night. LPN #1 was asked if there was a physician's order to hold the resident's medications while at dialysis or if she was aware whether there had been a collaboration with the physician regarding this matter. LPN #1 stated, "No."

No further information was presented prior to exit.

(1) "When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dialysis

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(2) Furosemide is used to treat high blood pressure and/or swelling. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682858.html

(3) Tamsulosin is used to treat symptoms on an enlarged prostate. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698012.html

(4) Allopurinol is used to treat high levels of uric acid in the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682673.html

5. The facility staff failed to follow Resident #21's dialysis (1) care plan for collaborating with the physician and administering medications.

Resident #21 was admitted to the facility on 10/20/16. Resident #21's diagnoses included but were not limited to: stroke, end stage renal disease and difficulty swallowing. Resident #21's five day Medicare MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/26/16 coded the resident's cognitive skills for daily decision making as modified independence- some difficulty in new situations only.

Resident #21's comprehensive care plan initiated on 10/21/16 documented, "Alteration in Kidney Function evidenced by hemodialysis...Interventions: Resident specific dialysis schedule. Notify physician and dialysis

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center if unable to make appointment. Location: (name of dialysis center). Days: Monday Wednesday friday (sic). Time: 0900 (9:00 a.m.) unless otherwise specified..." The care plan further documented, "Administer medications as ordered collaborating with Physician and/or pharmacist for optimal medication dose times..."

Review of Resident #21's clinical record revealed the following physician's orders:

-10/20/16: Heparin Sodium (2)- Inject 5,000 units every 12 hours. The morning dose was scheduled for 9:00 a.m.
-10/26/16 at 8:12 a.m.: Clonidine (2) 0.1 mg (milligrams) every eight hours. Hold prior to dialysis on Mondays, Wednesdays and Fridays. The mid-day dose was scheduled for 2:00 p.m.
-10/26/16 at 5:07 a.m.: Baclofen (3) 10 mg two times a day. The morning dose was scheduled for 9:00 a.m.
-10/26/16 at 5:13 a.m.- Levetiracetam (5) 500 mg two times a day. The morning dose was scheduled for 9:00 a.m.
-10/26/16 at 8:13 a.m.- Labetalol (6) 300 mg three times a day. Hold prior to dialysis on Mondays, Wednesdays and Fridays. The mid-day dose was scheduled for 2:00 p.m.

Resident #21's October 2016 MAR (medication administration record) documented the following on 10/26/16 (the resident's scheduled dialysis day):
-For the 9:00 a.m. scheduled dose of Heparin, Baclofen and Levetiracetam, the nurse documented the code "5=LOA (leave of absence)" indicating the resident was out of the facility. For the 2:00 p.m. dose of Clonidine and Labetalol, the nurse documented the code

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"5=LOA."

A nurse's note dated 10/26/16 at 10:37 a.m. documented, "Resident alert and oriented x (times) 1, does not voice needs and concerns, can be redirected, pleasant with staff, skin warm and dry to touch, all meds (medications) held prior to leaving for Dialysis this AM at 8 (8:00 a.m.) ..." Note: although there was a physician's order to hold blood pressure medications prior to dialysis there was no order to hold other medications before dialysis and there was no documentation (including nurse's notes or physician's notes) to evidence the facility staff had collaborated with the physician in regards as to how to ensure the resident received his scheduled 2:00 p.m. medications if he was still out of the facility at that time.

The nurse responsible for the above note was not available for interview.

On 10/18/17 at 1:47 p.m. an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked how nurses ensure residents who go out for dialysis receive their medications as ordered. LPN #3 stated the orders should be put in (the computer system) to reflect the resident's dialysis schedule. LPN #3 stated this also depends on the medications and nurses should consult with the physician to see how he wants the medications scheduled in relation to dialysis. LPN #3 stated some residents have their medications sent with them to dialysis and this is evidenced by a physician's order. LPN #3 was shown Resident #21's October 2016 MAR. LPN #3 agreed Resident #21 did not receive his medications as ordered. LPN #3 stated the physician or nurse practitioner should have been

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notified and the documentation should be in a nurse's note or a physician's progress note.

On 10/18/17 at 3:34 p.m. an interview was conducted with LPN #2. LPN #2 was asked the purpose of a care plan. LPN #2 stated the care plan sets the guidelines for what residents need and their standards of care. When asked if the care plan should be followed, LPN #2 stated, "Yes. Whatever is set up for them, make sure the aides and nurses know and make sure it is being done."

On 10/18/17 at 6:24 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was obtained prior to exit.

COMPLAINT DEFICIENCY

(1) "When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dialysis

(2) Heparin is used to prevent blood clots. This information was obtained from the website:

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https://medlineplus.gov/druginfo/meds/a682826.html

(3) Clonidine is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682243.html

(4) Baclofen is used to treat muscle spasms. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682530.html

(5) Levetiracetam is used to treat seizures. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a699059.html

(6) Labetalol is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a685034.html

F 309 SS=D — 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING — F 309

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to

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facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide the necessary treatment and services to maintain the resident's highest level of physical well-being for three of 22 residents in the survey sample, Resident #1, #11 and #10.

1. The facility staff failed to attempt non-pharmacological interventions prior to administering narcotic pain medication on 9/4/17 and 9/14/17 to Resident #1.

2. a. The facility staff failed to administer a pain medication per the physician order for Resident #11.

F309

1. The facility has documented not attempting non-pharmacological interventions prior to administering pain medication for Resident #1 and Resident #11. The physician has been notified and the facility has documented not administering a pain medication per the physician's order for Resident #11. The physician has been notified of Resident #10's dialysis schedule and their medication times have been changed to accommodate their schedule.
2. An audit will be done of pain medications distributed in the past 14 days to ensure non-pharmacological intervention have been used prior to administering pain medications. An audit of dialysis patients' medication times will be done to ensure medication times do not interfere with their dialysis schedule.
3. The Licensed Nursing staff will be re-educated on the Pain Management and the Medication Administration policy.
4. The DON, or designee, will review the Medication Administration Report each morning to ensure patients are offered a non-pharmacological interventions prior to pain medication administration and that their dialysis times do not interfere with their medication times.
5. November 27, 2017

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2. b. The facility staff failed to offer non-pharmacological interventions prior to administering pain medications for Resident #11.

3. The facility staff failed to ensure Resident #10 was administered physician ordered medications that were scheduled the same time the resident was out of the facility at dialysis.

The findings include:

1. Resident #1 was admitted to the facility on 2/19/15 and readmitted on 7/29/17 with diagnoses that included but were not limited to: leukemia, irregular heartbeat, diabetes, heart failure and kidney disease.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 8/7/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview of mental status) indicating the resident was cognitively intact to make daily decisions. Resident #1 was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the meal tray was prepared. The resident was coded as having an unstageable wound on the left foot.

Review of Resident #1's care plan initiated on 2/2/7/17 and revised on 8/10/17 documented, "Focus. Needs Pain management and monitoring...Interventions. Implement the patient's preferred non-pharmacological pain relief strategies."

Review of the physician's orders for October 2017

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documented, "Norco Tablet 5-325 MG (milligrams) (Hydrocodone-Acetaminophen (1)) Give 2 tablet (sic) by mouth every 4 hours as needed for pain (level) 8-10."

Review of the September 2017 MAR (medication administration record) documented, "Norco Tablet 5-325 MG (milligrams) (Hydrocodone-Acetaminophen) Give 2 tablet (sic) by mouth every 4 hours as needed for pain 8-10." The Norco was documented as being given on 9/4/17 at 9:26 a.m. and 9/14/17 at 9:35 a.m. There was no documentation related to any non-pharmacological interventions being attempted or the resident's pain level.

Review of Resident #1's nurses' notes for September 2017 did not evidence documentation regarding the resident receiving non-pharmacological interventions prior to the pain medication or the resident's reported level of pain.

An interview was conducted on 10/18/17 at 10:45 a.m. with LPN (licensed practical nurse) #6, the nurse who administered pain medication to Resident #1 on 9/14/17. When asked the process staff followed for pain management, LPN #6 stated, "If it's pain, ask what the pain level is on a scale of one to ten (ten being the worst possible pain) and where the pain is. Go to their chart to see what's available for them and give accordingly. If they have nothing (no pain medication) I'd call the physician." When restated that if the resident complained of pain the process would be to give the resident a pain pill, LPN #6 stated, "Yes if it's within the time frame and if it's within the parameters, yes ma'am." When asked if anything would be offered prior to

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medicating with the pain medication, LPN #6 stated she would attempt non-pharmacological interventions. When asked what those were, LPN #6 stated, "Turning, repositioning, rubbing the area of concern." When asked where this would be documented, LPN #6 stated, "Well, I should document it in the note but I don't always do that." When asked if Resident #1 had been offered non-pharmacological interventions, LPN #6 stated, "Yes I do. I don't document it and that means it's not done."

An interview was conducted on 10/18/17 at 2:35 p.m. with ASM (administrative staff member) #2, the interim director of nursing. When asked about the process followed by staff for pain management, ASM #2 stated, "If the resident complains of pain, find out first of all what it is on the pain scale and give some kind of pain medication management." When asked if staff should do anything prior to giving the pain medication, ASM #2 stated, "Non-pharmacological (interventions). I have overheard some of the nurses doing that but I don't think they're documenting it and taking credit for what they actually are doing." ASM #2 was asked to review Resident #1's Norco administration on 9/27/17 at 10:47 a.m. When asked how staff would know what non-pharmacological interventions were attempted and what the resident's pain level was, ASM #2 stated, "That's a very good question. You'd know if they documented it in the record." ASM #2 was made aware of the findings at that time.

On 10/18/17 at 6:45 p.m. ASM #1, the executive director and ASM #2, the interim director of

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nursing were made aware of the findings.

On 10/19/17 two attempts were made to interview Resident #1 regarding the staff offering non-pharmacological interventions. The resident was sleeping on each occasion.

Review of the facility's policy titled, "Pain Assessment" documented, "POLICY: Residents will be assessed for pain upon admission, readmission, quarterly, annually, upon significant change, when a resident experiences a new onset of pain or experiencing uncontrolled pain. PROCEDURE: 4. A Pain Flow Record will be maintained with the resident's Medication Administration Record. This is to be completed when the resident has identified they have pain. Record the following: d. Intensity. f. Interventions -- non-med (medication) / medication."

Review of the facility's policy titled, "PAIN MANAGEMENT" documented, "Interventions used to manage pain include analgesics, emotional support, comfort measures, and complementary and alternative therapies such as cognitive techniques to distract the patient."

No further information was provided prior to exit.

(1) Norco -- NORCO® (Hydrocodone bitartrate and acetaminophen) is supplied in tablet form for oral administration. Hydrocodone bitartrate is an opioid analgesic and antitussive and occurs as fine, white crystals or as a crystalline powder. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=44b86290-2391-4b02-abd4-b1c0c611891e (1) Norco -- NORCO® (Hydrocodone

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bitartrate and acetaminophen) is supplied in tablet form for oral administration. Hydrocodone bitartrate is an opioid analgesic and antitussive and occurs as fine, white crystals or as a crystalline powder. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=44b86290-2391-4b02-abd4-b1c0c611891e
2. a. The facility staff failed to administer a pain medication per the physician order for Resident #11.

Resident #11 was admitted to the facility on 9/29/14 with a readmission on 2/20/17 with diagnoses that included, but were not limited to: Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, shuffling gain, stooped posture, rolling motions of the fingers, drooling, and muscle weakness (1)), Bipolar disorder (a mental disorder characterized by episodes of mania and depression (2)), depression, COPD (chronic obstructive pulmonary disease - a general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (3)), gastroesophageal reflux disease, high blood pressure and anemia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 8/16/17, coded Resident #11 as scoring a 14 on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions. Resident #11 was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living.

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The physician orders dated, 2/23/17, documented, "Hydrocodone - Acetaminophen Tablet (used to treat moderate to moderately severe pain (4)) 5 - 325 MG (milligrams); Give 1 tablet by mouth every 6 hours as needed for pain 5 - 10."

"The numbers between 0 and 10 represent all the pain a person could have. Zero means no pain and 10 means pain as bad as it could be. You can use any number between 0 and 10 to let me know how much pain you have right now." Fundamentals of Nursing, 5th edition, Lippincott, Williams & Wilkins, page 1186.

Resident #11's August 2017 MAR (medication administration record) documented, "Hydrocodone - Acetaminophen Tablet (also known as Vicodin) 5 - 325 MG; Give 1 tablet by mouth every 6 hours as needed for pain 5 - 10." The Vicodin was documented as administered for a pain level of 2 on 8/16/17 at 1:33 p.m. The Vicodin was documented as administered for a pain level of 3 on 8/8/17 at 1:31 p.m. The Vicodin was documented as administered for a pain level of 4 on 8/19/17 at 1:08 p.m. and on 8/20/17 at 1:16 p.m.

Resident #11's September 2017 MAR documented, "Hydrocodone - Acetaminophen Tablet 5 - 325 MG; Give 1 tablet by mouth every 6 hours as needed for pain 5 - 10." The Vicodin was documented as administered on 9/2/17 at 1:55 p.m. for a pain level of 4.

Resident #11's October 2017 MAR documented, "Hydrocodone - Acetaminophen Tablet 5 - 325 MG; Give 1 tablet by mouth every 6 hours as needed for pain 5 - 10." The Vicodin was

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documented as administered on 10/1/17 at 4:37 a.m. for a pain level of 4.

The comprehensive care plan dated, 12/2/16 and revised on 8/21/17, documented in part, "Focus: Needs pain management and monitoring related to DX (diagnosis) generalized." The "Interventions" documented in part, "Administer pain medication as ordered."

An interview was conducted with LPN (licensed practical nurse) #6, the nurse who cares for Resident #11, on 10/18/17 at 10:48 a.m. The physician order above was reviewed with LPN #6. When asked if a nurse could administer the Vicodin if the residents pain level was less than 5, LPN #6 stated, "You shouldn't."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 10/18/17 at 2:32 p.m. When asked if the physician order for Vicodin states to give pain medication for a pain level of 5 - 10, can it be given for a pain level of 2, 3 or 4, ASM #2 stated, "No, not if the order is for 5 - 10."

The facility document titled, "Preventing Medication Errors ABC's Quick Reference" documented in part, "Eight Recognized Standards: Right Drug. Right Dose. Right Patient. Right Route. Right Time. Right Dosage Form. Right Response. Right Record."

The facility documented titled, "Medication Administration - General Guidelines" documented in part, "4. Five Rights - right resident, right drug, right dose, right route, and right time, are applied for each medication being administered."

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In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

The executive director, ASM #1 and the director of nursing, ASM #2 were made aware of the above findings on 10/18/17 at 6:16 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 436.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 73.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(4) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b165dffd-1550-4d8d-a8ea-fe83512c34e6

2. b. The facility staff failed to offer non-pharmacological interventions prior to administering pain medications for Resident #11.

The physician orders dated, 2/23/17, documented, "Hydrocodone - Acetaminophen (Vicodin) Tablet 5 - 325 MG; Give 1 tablet by mouth every 6 hours as needed for pain 5 - 10."

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Resident #11's August 2017 MAR was reviewed and revealed the resident had received Vicodin 47 times during this month.

Review of the nurse's progress notes and the August 2017 eMAR (electronic medication administration record) did not reveal any documentation of offering non-pharmacological interventions prior to the administration of Vicodin.

The September 2017 MAR was reviewed and revealed the resident had received Vicodin 54 times during this month.

Review of the nurse's progress notes and the September 2017 eMAR revealed on two occasions, 9/2/17 at 1:55 p.m. and 9/22/17 at 1:51 p.m. the nurse documented, "Repositioning not effective." There was no further documentation of any non-pharmacological interventions.

The October 2017 MAR was reviewed and revealed the resident had received Vicodin 37 times during this month.

Review of the nurse's progress notes and the October 2017 eMAR revealed on two occasions, 10/12/17 at 1:16 p.m. and 10/16/17 at 1:56 p.m. the nurse documented, "Repositioning not effective." There was no further documentation of any non-pharmacological interventions.

The comprehensive care plan dated, 12/2/16 and revised on 8/21/17 documented in part, "Focus: Needs Pain management and monitoring related to: dx (diagnosis) generalized." The

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"Interventions" documented in part, "Administer pain medication as ordered. Coordinate with patient/Family/RP (responsible party) to identify patient's favorite items/activities that could serve to distract from pain. Implement the patient's preferred non-pharmacological pain relief strategies."

An interview was conducted with LPN (licensed practical nurse) #6 on 10/18/17 at 10:48 a.m., regarding the steps she takes when a resident complains of pain. LPN #6 stated, "I ask them [resident] to rate their pain, 0 -10. I ask where the pain is located. Then I go to the chart for what medication is available for them and administer the medication appropriately and if they have nothing ordered for pain, I call the physician." When asked if the resident gets a pain pill if they complain of pain, LPN #6 stated, "Yes if it's in the time frame and in the parameters." When asked if anything is offered before giving the pain mediation, LPN #6 stated, "Like non-pharmacologic, it should be documented in a note but I don't always do that." When asked to describe what a non-pharmacological intervention is, LPN #6 stated, "Turn and repositioning or rubbing the area of concern." LPN #6 stated, "Well, if it's not documented then it wasn't done." LPN #6's initials were verified on the October MAR, evidencing she had administered pain medication to Resident #11 and no non-pharmacological interventions were documented at the times of administration.

An interview was conducted with LPN #3 on 10/18/17 at approximately 11:05 a.m., regarding the process staff follow for resident complaints of pain. LPN #3 stated, "You ask where the pain is.

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When it started. You ask the level of the pain and see what may alleviate it, repositioning then if that doesn't work you go to the MAR and see if they have anything prescribed for pain. If they don't you call the doctor." When asked if repositioning was attempted prior to the administration of medication, is this documented, LPN #6 stated, "Yes, in a note."

An interview was conducted with ASM (administrative staff member) #2, the interim director of nursing, on 10/18/17 at 2:32 p.m. regarding the process staff follows when a resident complains of pain, ASM #2 stated, "First you have the resident to rate the pain on the pain scale. Ask them where the pain is. We notify the doctor. I would like to think they'd give them some kind of pain medication." When asked if staff do anything before administering pills, ASM #2 stated, "I've overheard some of the nurse's doing it (non-pharmacological interventions) but they aren't documenting it. I don't know if it's 100% of the time."

An interview was conducted with Resident #11 on 10/19/17 at 8:22 a.m. When asked if staff offers to reposition her or massage the area that hurts, when she complains of pain, Resident #11 stated, "They couldn't rub the area that hurts because it's (the pain) is all over." When asked if the staff offers to reposition her to see if that relives the pain, Resident #11 stated, "No, they don't offer that."

The executive director, ASM #1 and the interim director of nursing, ASM #2 were made aware of the above findings on 10/18/17 at 6:16 p.m.

No further information was provided prior to exit.

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3. The facility staff failed to ensure Resident #10 was administered physician ordered medications that were scheduled the same time the resident was out of the facility at dialysis (1).

Resident #10 was admitted to the facility on 6/17/15. Resident #10's diagnoses included stroke, chronic kidney disease and difficulty swallowing. Resident #10's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/10/17, coded the resident's cognition as moderately impaired.

Review of Resident #10's clinical record revealed a physician's order that documented, "Dialysis Q (every) Tuesday, Thursday and Saturday. Family will pick up at 0930 (9:30 a.m.) and transport."

Review of Resident #10's clinical record revealed the following medication orders:
-6/16/15: Furosemide (2) 40 mg (milligrams) by mouth one time a day
-6/16/15: Tamsulosin (3) 0.4 mg by mouth one time a day
-6/16/15: Allopurinol (4) 100 mg by mouth two times a day

Resident #10's October 2017 MAR (medication administration record) documented the resident was at dialysis during the day shift on 10/3/17, 10/7/17, 10/14/17 and 10/17/17. The furosemide, tamsulosin and allopurinol were scheduled at 9:00 a.m. on the MAR. On 10/3/17, 10/14/17 and 10/17/17 the nurses documented the computerized code, "5= LOA (leave of absence)" for those medications (indicating the resident was out of the facility). On 10/7/17 the nurse documented the computerized code,

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"7=Other/See Nurse Notes." The nurse's notes documented by that nurse on 10/7/17 documented, "dialysis."

Resident #10's comprehensive care plan initiated on 7/29/15 documented, "Alteration in Kidney Function evidenced by hemodialysis...Interventions: Administer medications as ordered collaborating with Physician and/or pharmacist for optimal medication dose times..."

On 10/18/17 at 1:47 p.m. an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked how nurses ensure residents who go out for dialysis receive their medications as ordered. LPN #3 stated the orders should be put in (the computer system) to reflect the resident's dialysis schedule. LPN #3 stated this also depends on the medications and nurses should consult with the physician to see how he wants the medications scheduled in relation to dialysis. LPN #3 stated some residents have their medications sent with them to dialysis and this is evidenced by a physician's order. LPN #3 was asked if medications are sent with Resident #10 to dialysis. LPN #3 stated she didn't believe so. LPN #3 was shown Resident #10's October 2017 MAR. LPN #3 agreed that it appeared the resident was not consistently receiving his medications due to being at dialysis. LPN #3 stated the physician needed to be made aware and could possibly schedule the medications at a different time.

On 10/18/17 at 6:24 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. A policy regarding

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following physician's orders was requested.

On 10/19/17 at 7:46 a.m. an interview was conducted with LPN #1 (the nurse responsible for the 10/7/17 nurse's note). LPN #1 stated she usually works the night shift but will administer the morning medications when needed. LPN #1 was shown Resident #10's October 2017 MAR and asked if the resident was administered his 9:00 a.m. medications on the days he goes to dialysis. LPN #1 stated, "We keep them on the cart in case he needs them when he gets back. We hold them until he gets back." LPN #1 stated Resident #10 has a medication scheduled at 5:00 p.m. to "cover his hypertension (high blood pressure)." LPN #1 was asked if the medications are administered to Resident #10 when he returns from dialysis. LPN #1 stated she didn't know because she only covers the morning portion of the day shift when another nurse doesn't show up. LPN #1 was asked if Resident #10 was administered his 9:00 a.m. scheduled medications when he returned from dialysis on 10/7/17. LPN #1 stated she didn't administer the medications and she wasn't at the facility when the resident returned from dialysis. LPN #1 stated more often than not, the medications due at 9:00 a.m. are still in the medication cart when she reports to work at night. LPN #1 was asked if there was a physician's order to hold the resident's medications while at dialysis or if she was aware whether there had been a collaboration with the physician regarding this matter. LPN #1 stated, "No."

On 10/19/17 at 10:11 a.m. ASM #2 stated the facility did not have a policy regarding following physician's orders.

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No further information was presented prior to exit.

(1) "When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dialysis

(2) Furosemide is used to treat high blood pressure and/or swelling. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682858.html

(3) Tamsulosin is used to treat symptoms on an enlarged prostate. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698012.html

(4) Allopurinol is used to treat high levels of uric acid in the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682673.html

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(b) Skin Integrity -

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(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-

(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and

(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined facility staff failed to provide the necessary treatment and services to promote healing, and prevent infection of a pressure sore for one of 22 residents in the survey sample, Resident #1.

The facility staff LPN (licensed practical nurse) #7 failed to use proper handwashing techniques during wound care to promote healing and prevent infection of Resident #1's pressure wounds on 10/17/17.

The findings include:

Resident #1 was admitted to the facility on 2/19/15 and readmitted on 7/29/17 with diagnoses that included but were not limited to: leukemia, irregular heartbeat, diabetes, heart failure and kidney disease.

F314

1. The facility has documented that LPN #7 did not wash their hands prior to putting clean gloves on.
2. An audit of wound treatments will be done to ensure wound care compliance.
3. The Licensed Nursing staff will be re-education on the Wound Care policy, specifically the Disposable Non-Sterile Gloves Policy.
4. The DON, or designee, will review wound treatments daily for 2 weeks, then weekly for 2 months to ensure compliance. Findings will be reported to QAPI.
5. November 27, 2017

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The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 8/7/17 coded the resident as having a 15 out of 15 on the brief interview for mental status exam indicating that the resident was cognitively intact to make daily decisions. The resident was coded as requiring staff assistance for all activities of daily living except for eating which the resident could perform after the meal tray was prepared. The resident was coded as having an unhealed Stage 3 or 4 pressure ulcer on the left foot measuring 3.5 cm (centimeters) by 4.0 cm.

Review of the October 2017 physician's orders documented, "Cleanse left lateral foot with normal saline, pat dry, apply calcium alginate (1), santyl (2) to wound bed and cover with dry dressing, change daily. Start Date. 9/20/2017. Cleanse area to right knee with wound cleanser, pat dry, apply silver alginate (3) and foam dressing. Change daily and PRN (as needed) Start Date. 9/9/2017."

Review of the October 2017 treatment administration record documented, "Cleanse left lateral foot with normal saline, pat dry, apply calcium alginate, santyl to wound bed and cover with dry dressing. change daily. Cleanse area to right knee with wound cleanser, pat dry, apply silver alginate and foam dressing. Change daily and PRN."

An observation of Resident #1's wound care was conducted on 10/17/17 at 4:35 p.m. with LPN (licensed practical nurse) #7. LPN #7 gathered the wound care supplies and entered the room. LPN #7 washed her hands and put on a pair of

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gloves. LPN #7 removed the right knee dressing. The wound was clean and without drainage. LPN #7 removed her gloves and reached into her pocket and retrieved another pair of gloves and applied them. LPN #7 did not wash her hands after removing the gloves. LPN #7 cleansed the wound and patted it dry. LPN #7 put her gloved hand into her pocket and retrieved a marking pen and labeled the dressing with the date. LPN #7 then applied the calcium alginate to the wound and the dressing. LPN #7 then removed the gloves, washed her hands and applied gloves. She removed the foam boot from the resident's left foot and removed the dressing. There were two small clean pressure wounds on the side of the resident's foot. LPN #7 cleansed the two pressure wounds, dried them and removed her gloves. She then put on another pair of gloves and put the calcium alginate on one of the pressure wounds and applied santyl to the other pressure wound. The dressing was applied and the foam boot was reapplied. LPN #7 collected the trash and removed it from the room. She then removed the gloves and washed her hands.

An interview was conducted on 10/18/17 at 10:40 a.m. with LPN #7. When asked when staff washed their hands, LPN #7 stated, "Before and after care." When asked what staff were to do after removing gloves, LPN #7 stated, "You're supposed to wash." When the wound care observation was discussed, LPN #7 stated, "So between there (changing gloves) I should have washed my hands." When asked why staff washed their hands, LPN #7 stated, "Of course to stop the bacteria from crossing over, be it ourselves, the resident or other residents."

An interview was conducted on 10/18/17 at 11:20

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a.m. with ASM (administrative staff member) #2, the interim director of nursing. When asked when staff were to wash their hands, ASM #2 stated, "In between every patient and if they go from dirty to clean." When asked what staff should do when gloves were removed, ASM #2 stated, "Wash their hands."

On 10/18/17 at 6:45 p.m. ASM #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Disposable Non-Sterile Gloves" documented, POLICY: Personnel will wear disposable non-sterile gloves when a barrier between the resident and health care provider is necessary to prevent the transmission of blood and bodily fluids or when handling soiled articles or equipment. PROCEDURE: 5. Remove gloves and dispose of. 6. Wash hands."

According to the CDC website on hand hygiene, page 34, "Decontaminate hands after removing gloves. This information was obtained from: https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf

(1) Calcium Alginate - Hydrocolloid and calcium alginate are used to treat cutaneous injuries and many health professionals do not know about its cicatrization effects. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/24217762

(2) Santyl -- Collagenase Santyl® Ointment is a sterile enzymatic debriding ointment which contains 250 collagenase units per gram of white petrolatum USP. The enzyme collagenase is derived from the fermentation by Clostridium

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histolyticum. It possesses the unique ability to digest collagen in necrotic tissue. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a7bf0341-49ff-4338-a339-679a3f3f953d

(3) Silver Alginate - Antimicrobials, in particular silver, are incorporated into wound dressings, including alginates, for use in the treatment of "at risk" or infected chronic wounds. Silver is used to both reduce the dressing and wound microbial bioburden. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4486446/

F 322 SS=G 483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS F 322

(g) Assisted nutrition and hydration.
(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to provide care and services for a feeding tube for one of 22 residents in the survey sample, Resident #21.

Resident #21 was admitted to the facility with a feeding tube on 10/20/16. The facility staff failed to clean the resident's feeding tube site during the resident's stay until 10/26/16 when the resident was transferred to the hospital and admitted with sepsis due to an infection of the feeding tube site, resulting in harm.

The findings include:

Resident #21 was admitted to the facility on 10/20/16. Resident #21's diagnoses included but were not limited to: stroke, end stage renal disease and difficulty swallowing. Resident #21's five day Medicare MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/26/16 coded the resident's cognitive skills for daily decision making as modified independence- some difficulty in new situations only. Section G coded Resident #21 as totally dependent on two or more staff with transfers and bathing, totally dependent on one staff with locomotion and requiring extensive assistance of one staff with personal hygiene. Section K documented Resident #21 had a feeding tube (1).

Review of Resident #21's admission clinical health status assessment failed to reveal documentation regarding a feeding tube. The admitting nurse's note documented, "Resident

Past noncompliance: no plan of correction required.

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has a g-tube (type of feeding tube) in place. Resident receives nepro (nutrition) q (every) 8 hours via tube. Resident received 150 cc (cubic centimeters) free water flushes x (times) 4 a day..."

Resident #21's clinical record failed to reveal skin assessments.

Resident #21's comprehensive care plan initiated on 10/20/16 failed to reveal documentation regarding the cleaning of the resident's feeding tube site.

Review of Resident #21's physician's orders during the resident's stay revealed orders for tube feedings and flushes but failed to reveal orders for cleaning the feeding tube site.

Resident #21's October 2016 MAR (medication administration record)/TAR (treatment administration record) revealed physician's orders for tube feedings and flushes but failed to reveal orders for cleaning the feeding tube site.

Nurses' notes during Resident #21's stay revealed documentation regarding feeding tube patency, flushes and feedings but failed to reveal documentation regarding the cleaning of the resident's feeding tube site until 10/26/16 when the resident was sent to the hospital.

A nurse's note dated 10/26/16 documented, "Situation: Elevated Temp (temperature) and B/P (blood pressure) with PEG tube (type of feeding tube) drainage...Assessment: Upon assessment resident alert and oriented x (times) 2, lethargic, able to voice needs and concerns, easily redirected, pleasant with staff, denied SOB

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(shortness of breath), total assist with ADL's (activities of daily living) and transfers, PEG tube has brown drainage around site, site cleansed and adherent dressing applied, Elevated B/P 160/84 with increased Temp of 100.4, c/o (complained of) slight discomfort to ABD (abdomen) where PEG located, resident receives Glucerna (nutrition) 1.5 mL (milliliters) runs at 84ml/Hr (hour) 6a-6p and continues with Dialysis (2), resident emesis (vomit) x 1 this shift, breath sounds with crackles in upper lobes, active bowel sounds x4 quads (quadrants), pupils PERRLA (pupils equal, round, reactive to light and accommodation). Response: MD (medical doctor) aware and notified with new orders for CBC (complete blood count) (3), UA (urinalysis) C&S (Culture and sensitivity) (4), Omeprazole (5) 40 mg (milligrams) Q (every) Day, wound nurse to eval (evaluate) PEG site, order for dressing changes, and CXR (chest x-ray) 2 views to assess the ABD wall around site to check for ABD abscess, Family aware of condition and requested to be sent 911, MD called back and notified of request, care plan revised and reviewed."

A nursing home to hospital transfer form that documented a telephone report was called into the hospital on 10/26/16, and also documented, "Reason(s) for transfer: Other- PEG tube site infected with increased temp and elevated blood pressure..."

An emergency department physician's note dated 10/26/16 documented, "(Name of Resident #21) is a 50 y.o. (year old) male who presents with a feeding tube problem. Family states he had this placed 2 weeks ago. He is currently residing at (name of facility). Family is very concerned about

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the care he is receiving there. His feeding tube was not cleaned until today. They report swelling around the insertion site as well as drainage. They also report abdominal pain, nausea, vomiting, and a fever...Physical Exam: Abdominal: Feeding tube in place. There is a 3x3 area of swelling around the tube. There is mild drainage coming from the insertion site...The patient presents to the Emergency Department with abdominal pain. Treatment has been initiated in the ER (emergency room), but the patient has not had significant improvement in symptoms, appears ill enough and/or has illness/findings/co-morbidities that make admission for IV (intravenous) medications, possible surgical consult, and further management the most appropriate disposition..."

The hospital history and physical dated 10/27/16 documented IV antibiotic medications were initiated in the ED and continued. The history and physical further documented, "Assessment and Plan: 1 Sepsis with leukocytosis (6) with fever and tachycardia (7) with nausea due to PEG site infection/infectious myositis (8) ..."

On 10/18/17 at 10:52 a.m. an interview was conducted with LPN (licensed practical nurse) #1 regarding the care that should be provided to residents with feeding tubes. LPN #1 stated the tube should be checked for placement, should be flushed in between each medication and observed for signs/symptoms of infection. LPN #1 was asked if the feeding tube site should be cleaned. LPN #1 stated, "That should be done every shift and as needed." LPN #1 was asked if the cleaning of the feeding tube site should be documented. LPN #1 stated there usually is documentation such as verification of feeding

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tube placement and documentation that the site was cleaned on the TAR and nurses have to sign off the completion of those tasks.

On 10/18/17 at 1:47 p.m. an interview was conducted with LPN #3 regarding the care that should be provided to residents with feeding tubes. LPN #3 stated usually the physician will write specific treatment orders. When asked if the feeding tube site should be cleaned, LPN #3 stated the area is usually cleaned with soap and water then patted dry. LPN #3 stated a majority of residents with feeding tubes have a drain sponge on the site that will be changed every shift or twice a day depending on what the physician requests. LPN #3 was asked if the cleaning of feeding tube sites is physician ordered or if it is just done as a nursing intervention. LPN #3 stated, "No. There should be an order to clean the site." When asked what should be done if there isn't an order, LPN #3 stated, "Talk to the nurse practitioner or physician." LPN #3 was asked where evidence of the cleaning of a resident's feeding tube site should be documented and stated, "In the TAR." LPN #3 was asked if this process was in place in October 2016 and stated, "Yeah." LPN #3 stated there was no guarantee that nurses were cleaning residents' feeding tube sites if there was no order and if this was not documented on the TAR or in the nurse's notes. LPN #3 stated CNAs (certified nursing assistants) were not allowed to clean feeding tube sites.

On 10/18/17 at 4:01 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings and the concern for harm. ASM #1 confirmed Resident #21 resided

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at the facility when the facility was owned by the previous company. A new company took ownership of the facility on 12/16/16. ASM #1 and ASM #2 were asked for a policy regarding the care of feeding tubes. The new company referenced Lippincott's Nursing Procedures for care of feeding tubes. Lippincott's Nursing Procedures sixth edition documented, "Once daily, clean the peristomal skin with mild soap and water or povidone-iodine solution, and let the skin air-dry for 20 minutes to avoid skin irritation..." ASM #1 was asked when the new policies were effective and stated they were uploaded to the computer system for administration and staff use on 5/30/17. On 10/18/17 at 4:35 p.m. ASM #1 presented a tube feeding audit that was completed/reviewed by facility staff on 8/14/17. Also, ASM #1 stated the current medical director is affiliated with the local hospital and reviews/evaluates all re-hospitalizations. ASM #1 stated because of this process, the medical director would identify any concerns related to residents with feeding tubes. A "Inservice Education" document dated 6/22/17 documented the following: "Subject covered: Tube feeding Care- See Attached. Monitor peg site for any signs and symptoms of infection and report any to MD (medical doctor). Reaction from Participants: Understanding. Summary and Conclusions: Will monitor tube feeding for compliance." The "Inservice Education" sheet further documented the signatures of staff and attached was a policy and procedure addressing "Tube Feedings". Two residents with feeding tubes resided at the facility during the survey. Both residents' feeding tube sites were observed. The residents' clinical records were also reviewed and contained documentation that the feeding tube sites were

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cared for each day. No deficiencies regarding the care of current residents with feeding tubes were identified.

No further information was presented prior to exit.

COMPLAINT DEFICIENCY

PAST-NON-COMPLIANCE

(1) A feeding tube is a plastic tube placed into the stomach that delivers nutrition and medication. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000333.htm

(2) "When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dialysis

(3) A CBC (complete blood count) is a blood test that can diagnose diseases and conditions. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=cbc

(4) A UA C&S (urinalysis with culture and

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sensitivity) is a urine test that is completed to check for infection, kidney problems and diabetes. This information was obtained from the website: https://medlineplus.gov/urinalysis.html

(5) "Prescription omeprazole is used alone or with other medications to treat gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube between the throat and stomach) ..." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693050.html

F 323 SS=D — 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES — F 323

(d) Accidents.
The facility must ensure that -

(1) The resident environment remains as free from accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain

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informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. 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 provide adequite supervision to prevent accidents and ensure a safe enviorment for one of 22 residents in the survey sample, Resident #18.

The facility staff failed to supervise Resident #18's activities on 5/24/17 at approximately 11:00 p.m. when the resident went through the alarmed dining room door into the enclosed courtyard and fell out of his wheelchair into the bushes. The resident was found when an aide who went outside to discard trash heard the resident chanting and the chair belt alarm sounding from the courtyard.

The findings include:

Resident #18 no longer resided at the facility. The closed record was reviewed.

Resident #18 was admitted to the facility on 5/4/17 and readmitted on 7/28/17 with diagnoses that included but were not limited to: cognitive communication deficit, Parkinson's disease (1), diabetes, dementia and heart failure.

The most recent minimum data set (MDS), a 30 day assessment, with an assessment reference date (ARD) of 8/24/17 coded the resident as having scored a four out of 15 on the brief interview for mental status indicating the resident

F323

1. The facility documented that Resident #18 had a fall on 5/24/17. It is noted that Resident #18 was no longer in facility during the time of inspection.
2. Residents with documented exit seeking behavior in the past 30 days will be reviewed by the Interdisciplinary Team. An audit of residents with falls in the past 14 days will be done to ensure they were screened by therapy. Care plans will be updated to reflect the interventions.
3. The Licensed nursing staff will be re-educated on the fall prevention program.
4. The DON, or designee, will review falls daily in the clinical start up meeting, and then weekly in the falls committee meeting. Findings will be reported to QAPI.
5. November 27, 2017

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was severely impaired cognitively. Resident #18 was coded as requiring assistance from staff for all activities of daily living.

Review of the care plan initiated on 5/23/17 and updated on 7/28/17 documented, "Focus. At risk for falls related to: New environment, history of falls, d/t (due to) meds (medications) and decreased safety awareness. Interventions. Velcro seatbelt alarm Resident able to release seatbelt on command (not restraining)."

Review of the clinical record for May 2017 did not evidence documentation regarding the resident's elopement risk.

Review of the nurse's notes dated 5/24/17 at 5:37 p.m. documented, Resident out of bed for meals. use (sic) of Velcro belt alarm on w/c (wheelchair) cont (continues) to need close supervision due to unsteadiness and confusion. needs (sic) frequent reminding to ask for assistance....will continue to monitor."

Review of the nurse's notes for 5/24/17 at 11:50 p.m. documented, "Resident outside on patio sitting on ground. Wheelchair several feet away from him. Resident had seatbelt alarm on. Resident noted to have scraped area to lower back, bilateral knee bruising with multiple scratches. Resident covered in leaves and dirt. Shower given and areas cleaned. VSS (vital signs stable). No c/o (complaints of) pain. NP (nurse practitioner) called and made aware. Family made aware...Tylenol given and resident in bed."

Review of the 5/25/17 incident report documented, "3. What is the resident's cognition? Confused/disoriented. 12. What was resident

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doing prior to fall? In w/c (wheelchair) in hallway. 13. Is bed check/chair alarm used? (Yes) X. Did staff verify it was working before resident placed in bed or chair? (Yes) X. Did it function properly? (Yes) X. SUPERVISOR REPORT. 1. Did resident sustain injury (line was left blank). 2. If so, what was the injury and how was it treated? Abrasion to back & bilateral scraped knees - bruises. 3. Further investigation of fall required? No. 4. Have falls been Care Planned? Yes. Fall Committee Review / Recommendations: Frequent observation checks. Wanderguard placement. Assist resident to high visibility area such (sic) nurses station + activities."

An interview was conducted on 10/18/17 at 12:10 p.m. with ASM (administrative staff member) #1, the executive director. When asked why the door to the courtyard had an alarm, ASM #1 stated, "Just in case we hear anyone go out we can hear someone's out there." When asked why staff needed to know if a resident was outside, ASM #1 stated, "Because they could get out there and fall like (name of Resident #1) did. We added the alarm this month." When asked if the door had an alarm before the resident got out into the courtyard on 5/24/17, ASM #1 stated, "It didn't work properly. It didn't alarm and sometimes it wouldn't lock. We put a temporary magnetic lock on it." When asked when that occurred, ASM #1 stated, "A day after (the resident's fall)." A request for the investigation completed on 5/24/17 was requested at that time.

An interview was conducted on 10/18/17 at 12:30 p.m. with OSM (other staff member) #6, the director of maintenance. When asked how the dining room door leading to the courtyard was secured, OSM #6 stated, "That door was always

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key pad alarmed. It never had a lock." When asked if there was a time when the door would not alarm, OSM #6 stated, "No." OSM #6 showed this writer the maintenance log that the door's alarm had been checked and found to be working correctly everyday for May 2017. When asked if he was aware of Resident #1's fall in the courtyard on 5/24/17, OSM #6 stated, "Yes. We checked the door the very next day and the alarm was working." When asked where the alarm sounded, OSM #6 stated, "It goes off at that door." When asked where the alarm could be heard, OSM #6 stated, "It's pretty loud you can hear it down the hall."

On 10/18/17 at 12:40 p.m. ASM #1 stated, "I misspoke, it did alarm it just wasn't locked." When asked how they were verifying that the alarms were working and staff were responding to them, ASM #1 stated, "We would do an observation. We would press on the door and just time it (for staff response). Our guideline is five minutes. That's our benchmark. We didn't necessarily document it." A request for a policy on alarms was made. ASM #1 stated they did not have one. ASM #1 gave this writer the facility's incident report and one witness statement. When asked if there were other witness statements taken, ASM #1 stated, "This is the only one I could find."

An interview was conducted on 10/18/17 at 4:30 p.m. with CNA (certified nursing assistant) #5, an aide who had worked with the resident. When asked how often residents were checked, CNA #5 stated, "Every two hours and when answering call bells." When asked when the resident checks started, CNA #5 stated, "As soon as you walk through the door." When asked if she

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remembered Resident #18, CNA #5 stated, "Yes. He was a one assist. He liked to set off his alarm a lot and we would go running." When asked if the resident would go anywhere in particular in his wheelchair, CNA #5 stated, "No, he'd just go wherever." When asked what staff did if they heard an alarm at 11:00 p.m., CNA #5 stated, "Run." When asked how the resident could have gotten out of the alarmed dining room door and into the courtyard, CNA #5 stated, "If it was change of shift and they (staff) were doing walking rounds they might have thought the other person got it."

An interview was conducted on 10/18/17 at 4:35 p.m. with CNA #6, an aide who had worked with the resident. When asked how often residents were checked, CNA #6 stated, "At least every two hours but it's more than that." When asked if she remembered Resident #18, CNA #6 stated, "Yes." When asked if she was aware of the resident's fall in the courtyard on 5/24/17, CNA #6 stated she was not. When asked what the resident's routine was, CNA #6 stated, "He was pretty mobile when he wanted to be. He wandered a lot. He didn't go anywhere specific." When asked about the alarm on the dining room door, CNA #6 stated, "It was a fast alarm. It kept going for about 30 seconds after it (the door) was opened (and then it turned off)." When asked what staff would do if the alarm went off at 11:00 p.m., CNA #6 stated, "If it's that late at night there was no one going out there except one resident who had the code but she doesn't have it anymore. Nobody should be out there that late at night. Someone should have checked."

On 10/18/17 at 6:45 p.m. ASM #1, the executive director and ASM #2 the director of nursing were

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made aware of the findings.

An interview was conducted on 10/19/17 at 7:15 a.m. with LPN (licensed practical nurse) #4, the nursing supervisor on 5/24/17 at 11:00 p.m. When asked what she remembered about that night, LPN #4 stated, "He was rolling around in the wheelchair. (Name of CNA #4) went down the service hallway and heard the alarm. It was pouring down with rain. We had to shower him when we brought him in he was covered with leaves and mud. We actually had to clean him up and wrapped them (the scratches) because they were on his legs." When asked how the resident seemed, LPN #4 stated, "Confused. His norm (normal)." When asked how long the resident had been missing before he was found, LPN #4 stated, "I would say roughly 15 to 20 minutes. He was at the nurses' station most of the evening." When asked what staff did when an alarm sounded, LPN #4 stated, "We would go check the alarm to see."

An interview was conducted on 10/19/17 at 7:20 a.m. with CNA #4, the CNA who cared for the resident on 5/24/17. When asked what she remembered about that night, CNA #4 stated, "He was very confused. I can't remember if I had him." When asked how often she would check on residents, CNA #4 stated, "Usually every hour and a half to two hours." When asked what Resident #18 did the evening of 5/24/17, CNA #4 stated, "He was in the hallway all that night. I remember I was outside taking the trash out and I heard his chair alarm from outside. He was chanting because he was a band director. I ran inside through the dining room and I opened the door and called for help. The alarm doesn't stop the door from opening so after 15 seconds the

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alarm would cut itself off." When asked why staff wouldn't respond to the door alarm, CNA #4 stated, "I think they thought it was somebody who was allowed to smoke unsupervised." When asked the last time she had seen the resident prior to finding him in the courtyard, CNA #4 stated, "I know I did tell them I was going to take out the trash. He was there when I left. Probably around 10:45 (p.m.) to 10:50 p.m."

No further information was provided prior to exit.

(1) Parkinson's disease -- 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. Sometimes it is genetic, but most cases do not seem to run in families. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html

F 329 SS=D 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS F 329

483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

(5) In the presence of adverse consequences

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which indicate the dose should be reduced or discontinued; or

(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

483.45(e) Psychotropic Drugs.
Based on a comprehensive assessment of a resident, the facility must ensure that--

(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a resident was free from unnecessary medication for one of 22 residents in the survey sample, Resident #7.

The facility staff failed to provide adequate behavior monitoring for the use of Resident #7's anti-psychotic medication from August 2017 through October 2017.

The findings include:

Resident #7 was admitted to the facility on 5/4/17. Resident #7's diagnoses included but were not

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1. The facility is now conducting behavior monitoring on Resident #7's Risperdal.
2. An audit will be completed on residents who have received anti-psychotic medications in the last 30 days to ensure the facility is monitoring the residents' behavior.
3. The Licensed Nursing Staff will be educated on the Centers for Medicare and Medicaid Services guidelines for psych services.
4. The DON, or designee, will review anti-psychotic medication administrations weekly, for 4 weeks, then monthly for 2 months to ensure the facility is monitoring the behavior of residents who receive anti-psychotics. Findings will be reported to QAPI.
5. November 27, 2017

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limited to: dementia, diabetes and seizures. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/4/17 coded the resident's cognition as moderately impaired. Section N documented Resident #7 received anti-psychotic medication seven out of the last seven days.

Review of Resident #7's clinical record revealed a physician's order dated 7/13/17 for Risperdal 0.5 mg (milligrams) by mouth two times a day for behavioral and psychological symptoms of dementia.

A progress note signed by the psychological nurse practitioner on 8/1/17 documented, "Asked to evaluate the patient's mental status and adjust medications if needed. Assess confusion and anxiety. HPI (history of present illness)/Interval History: Follow up, medication review. Patient alternates between sleeping to periods of anxiety and wandering unit via w/c (wheelchair), going into other resident's rooms. No extrapyramidal side effects noted...Treatment Plan/Recommendations...risperdal (1) for delusional disorder..."

Resident #7's MARs (medication administration records) for August 2017 through October 2017 revealed the resident received Risperdal 0.5 mg by mouth two times a day each day.

Resident #7's behavior monthly flowsheets for August 2017 and September 2017 documented staff monitored for the targeted behavior symptom coded as "12" which according to the flowsheet key indicated the behavior of depressed/withdrawn. Resident #7's behavior

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monthly flowsheet for October documented staff monitored for the targeted behaviors coded as "12" depressed/withdrawn and "7" continuous crying. The behavior flowsheets failed to document monitoring for delusions.

Resident #7's comprehensive care plan initiated on 5/4/17 documented, "Potential for drug related complications associated with use of psychotropic medications related to: Anti-Anxiety medication, antipsychotics, antidepressants...Interventions: Provide Medications as ordered by physician and evaluate for effectiveness..."

On 10/18/17 at 1:47 p.m. an interview was conducted with LPN (licensed practical nurse) #3 regarding the facility process for behavior monitoring. LPN #3 stated the monthly behavior flowsheets are filled out each shift. Resident #7's September 2017 flowsheet was reviewed with LPN #3. LPN #3 stated the resident was monitored for "12- depressed/withdrawn." and each shift, staff documented if the resident experienced that symptom. LPN #3 was asked why Resident #7 was monitored for that behavior. LPN #3 stated, "For the medication she is on." LPN #3 stated the resident was receiving Risperdal and Remeron (2). LPN #3 stated staff decides what behaviors will be monitored according to the medication that is prescribed and "12 (depressed/withdrawn)" was the behavior Resident #7 was being monitored for. LPN #3 stated the former assistant director of nursing was responsible for deciding which targeted behaviors would be monitored for on the flowsheets. LPN #3 was asked what Risperdal was prescribed for. LPN #3 reviewed a drug book and stated Risperdal was an anti-psychotic that was prescribed for schizophrenia or bipolar.

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LPN #3 was asked to describe the behaviors Resident #3 presents with. LPN #3 stated Resident #7 presented with behaviors prior to moving to a room on a different unit but now is tearful and occasionally yells. LPN #3 stated she thought the resident used to climb out of bed a lot. When asked the purpose of behavior monitoring, LPN #3 stated it was to make sure the medication residents are on address those issues and are therapeutic. LPN #3 was made aware of the above psychological nurse practitioner's note that documented Resident #7 was prescribed Risperdal for delusional disorder and asked what behaviors the resident should be monitored for. LPN #3 stated, "Delusional disorder." LPN #3 was asked how a resident can be monitored for the effective use of an anti-psychotic medication if the behaviors monitored are not the behaviors the resident is prescribed the medication for. LPN #3 confirmed the resident cannot.

On 10/18/17 at 6:24 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. A policy regarding behavior monitoring for the use of anti-psychotic medication in residents with dementia was requested.

On 10/19/17 at 10:11 a.m. ASM #2 stated the facility did not have the requested policy. ASM #2 stated the facility staff follows CMS (Centers for Medicare and Medicaid Services) guidelines and residents are followed by psych services.

No further information was presented prior to exit.

(1) "Risperidone (Risperdal) is used to treat the

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symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in adults and teenagers 13 years of age and older. It is also used to treat episodes of mania (frenzied, abnormally excited, or irritated mood) or mixed episodes (symptoms of mania and depression that happen together) in adults and in teenagers and children 10 years of age and older with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). Risperidone is also used to treat behavior problems such as aggression, self-injury, and sudden mood changes in teenagers and children 5 to 16 years of age who have autism (a condition that causes repetitive behavior, difficulty interacting with others, and problems with communication). Risperidone is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain...
IMPORTANT WARNING:
Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as risperidone have an increased risk of death during treatment. Older adults with dementia may also have a greater chance of having a stroke or ministroke during treatment.
Tell your doctor and pharmacist if you are taking furosemide (Lasix).
Risperidone is not approved by the Food and Drug Administration (FDA) for the treatment of behavior problems in older adults with dementia.
Talk to the doctor who prescribed this medication

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if you, a family member, or someone you care for has dementia and is taking risperidone. For more information, visit the FDA website: http://www.fda.gov/Drugs." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694015.html

(2) Remeron is used to treat depression. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697009.html

(6) Leukocytosis is an increase in the number of white blood cells and often occurs during an infection. This information was obtained from the website: https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/412/leukocytosis

(7) Tachycardia is a fast heart rate. This information was obtained from the website: http://www.heart.org/HEARTORG/Conditions/Arrhythmia/AboutArrhythmia/Tachycardia_UCM_302018_Article.jsp#.We9EWdKotKY

(8) "Myositis means inflammation of the muscles that you use to move your body..." This information was obtained from the website: https://medlineplus.gov/myositis.html

F 425 SS=D — 483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH — F 425

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

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

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide pharmaceutical services for one of 22 residents in the survey sample, Resident #10.

The facility staff failed to acquire Resident #10's 9:00 a.m. dose of physician prescribed metoprolol (1) from the pharmacy Alixa machine (a machine in the facility that dispenses medications) on 10/9/17.

The findings include:

Resident #10 was admitted to the facility on 6/17/15. Resident #10's diagnoses included stroke, chronic kidney disease and difficulty swallowing. Resident #10's most recent MDS (minimum data set) an annual assessment with an ARD (assessment reference date) of 8/10/17 coded the resident's cognition as moderately impaired.

Review of Resident #10's clinical record revealed a physician's order dated 12/13/15 for metoprolol succinate extended release- 25 mg (milligrams) by mouth two times a day every Sunday, Monday, Wednesday and Friday.

Resident #10's October 2017 MAR (medication

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1. The facility has noted that Resident #10 did not receive his medication on 10/9/17.
2. An audit will be completed of current residents for missed medication in the past 14 days to validate medication availability and identified concerns will be addressed as indicated.
3. Licensed nurses will be re-educated regarding the process for obtaining medications from the ADU and the process for obtaining medications that are not available in the ADU.
4. Orders will be reviewed daily during clinical meeting by the DON, or designee, to ensure medication is being administered per physician order. Missed physician ordered medication will have appropriate follow up by the Unit Manager, or designee. The results of the audit will be reviewed by the QAPI committee monthly for 3 months.
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administration record) documented, "Metoprolol Succinate ER (extended release) Tablet Extended Release 24 Hour 25 MG. Give 25 mg by mouth two times a day every Sun, Mon, Wed, Fri..." On 10/9/17 at 9:00 a.m. the nurse documented, "7=Other/See Nurse Note."

A nurse's note dated 10/9/17 documented, "Medication was not in Alixa and did not dispense out, pharmacy notified."

Resident #10's comprehensive care plan initiated on 7/29/15 documented, "Impaired neurological status related to: Cerebrovascular accident (stroke), cognitive loss...Interventions: Medication as ordered by physician..."

On 10/18/17 at 3:34 p.m. an interview was conducted with LPN (licensed practical nurse) #2 (the nurse who documented the above note). LPN #2 stated Resident #10's daytime dose of metoprolol didn't dispense out of Alixa and she attempted to re-dispense the medication but the machine said the container was empty. LPN #2 stated Alixa was "jammed" and the pharmacy thought they would have to send someone to the facility but another nurse was able to "un-jam" the machine with instructions over the phone from someone at the pharmacy. LPN #2 stated by the time the machine was fixed, it was too late to give Resident #2 the metoprolol because of the time the next dose was due (note-the morning dose was due at 9:00 a.m. and the next dose was not due until 9:00 p.m.).

On 10/18/17 at 6:24 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings.

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The facility pharmacy policy titled, "Ordering and Receiving Non-Controlled Medications From the Dispensing Pharmacy" failed to document information regarding the above concern.

No further information was presented prior to exit.

(1) "Metoprolol is used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682864.html

F 428 SS=D 483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON — F 428

c) Drug Regimen Review

(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

(4) The pharmacist must report any irregularities to the attending physician and the

F428

1. Resident #5 pharmacist's recommendation has been completed.
2. An audit of the most current pharmacist's recommendations will be completed to ensure recommendations have been addressed.
3. The Licensed Nursing staff will be re-educated on the communication of Consultant Pharmacist Recommendations Policy.
4. The DON, or designee, will review the pharmacist's recommendation sheet monthly to ensure recommendations have been addressed for 3 months. Findings will be reported to QAPI.
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facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
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 follow a pharmacy recommendation for one of 22 residents in the survey sample.

The facility staff failed to change the milk of

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magnesium (MOM) order per the pharmacist's recommendation on 2/10/17 for Resident #5.

The findings include:

Resident #5 was admitted to the facility on 1/12/15 with diagnoses that included but were not limited to: chest pain, dementia, depression and high blood pressure.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/26/17 coded the resident as having scored a 13 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the medical record did not evidence documentation regarding the February 2017 pharmacy medication regimen review. A request was made on 10/18/17 at 8:30 a.m. to ASM #2, the director of nursing for a copy of the review.

On 10/18/17 at 1:05 p.m. ASM #1, the executive director stated, "We just got this from the pharmacy."

Review of the document received from the pharmacy documented, "Summary of Nursing and Physician Recommendations. CURRENT ORDERS: Resident has an order for Milk of magnesium which was entered into (name of software) as the MOM (milk of magnesium) concentrated. The facility stocks the 1200 mg (milligram)/15 ml (milliliter) not the concentrate. RECOMMENDATION: Please update the MOM order in (name of software) and use the product

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MOM 1200 mg/15 ml. MRR (monthly regimen review) 2/10/2017."

Review of the physician's orders dated February 2017 documented, "Milk of Magnesia Concentrate Suspension Give 30 ml by mouth every 24 hours as needed for constipation. Order Date. 1/16/2015."

Review of the February 2017 MAR (medication administration record) documented, "Milk of Magnesia Concentrate Suspension (Magnesium Hydroxide) Give 30 ml by mouth every 24 hours as needed for constipation. Order Date 01/15/2015. D/C (discontinue) Date - 04/11/2017." There was no documentation that the medication order had been corrected as recommended by the pharmacy. The medication had not been administered.

Review of the March 2017 and April 2017 MARs documented, "Milk of Magnesia Concentrate Suspension (Magnesium Hydroxide) Give 30 ml by mouth every 24 hours as needed for constipation. Order Date 01/15/2015. D/C (discontinue) Date - 04/11/2017." There was no documentation that the medication order had been corrected as recommended by the pharmacy. The medication had not been administered.

An interview was conducted on 10/18/17 at 2:35 p.m. with ASM (administrative staff member) #2, the interim director of nursing. When asked the process staff followed for pharmacy recommendations, ASM #2 stated, "The pharmacy comes in and sends a recommendation out to the unit manager. The unit manager sends it to the doctors or if it's a

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nursing recommendation they take care of those and they put them on the chart."

An interview was conducted on 10/18/17 at 2:45 p.m. with LPN (licensed practical nurse) #3, the unit manager. When asked the process staff follow for a pharmacy recommendation, LPN #3 stated, "My understanding is that they email them out and then we print them out. We distribute them to the nurses on the unit or we just take care of it. I think the DON (director of nursing) and the ADON (assistant director of nursing) were doing it but they left and it may not have been done (printed and acted on)." When asked to review the 2/10/17 pharmacy recommendation for Resident #5's MOM, LPN #3 stated, "No. That wasn't completed."

An interview was conducted on 10/18/17 at 3:45 p.m. OSM (other staff member) #2, the pharmacist. When asked the process for completing the monthly regimen review, OSM #2 stated, "If there's no note it's more than unusual. It's very rare but I know I saw her because I had a nursing recommendation (for the milk of magnesia) for her."

Review of the facility's policy titled, "DOCUMENTATION AND COMMUNICATION OF CONSULTANT PHARMACIST RECOMMENDATIONS" documented, "Policy. The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding resident's medication therapies are communicated to those with authority and/or responsibility to implement the recommendations, and are responded to in an appropriate and timely fashion. Procedures. This should include: C.

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F 428	Continued From page 93 Recommendations are acted upon and documented by the facility staff and/or the prescriber. No further information was provided prior to exit.	F 428		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 441	F441 1. The facility has documented that LPN #7 did not wash their hands prior to putting clean gloves on. 2. An audit of wound treatments will be done to ensure wound care compliance. 3. The Licensed Nursing staff will be re-education on the Wound Care policy, specifically the Disposable Non-Sterile Gloves Policy and the Hand Washing Policy. 4. The DON, or designee, will review wound treatments daily for 2 weeks, then weekly for 2 months to ensure compliance. Findings will be reported to QAPI. 5. November 27, 2017	

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to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which 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; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to follow infection control practices during wound care for one of 22 residents in the survey sample, Resident #1.

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The facility staff failed to provide proper hand washing in the prevent of infection in a pressure wound during Resident #1's wound care on 10/17/17.

The findings include:

Resident #1 was admitted to the facility on 2/19/15 and readmitted on 7/29/17 with diagnoses that included but were not limited to: leukemia, irregular heartbeat, diabetes, heart failure and kidney disease.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 8/7/17 coded the resident as having a 15 out of 15 on the BIMS (brief interview of mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the meal tray was prepared. The resident was coded as having an unstageable wound on the left foot.

Review of Resident #1's care plan initiated on 2/6/17 and revised on 8/11/17 did not specifically address using infection control practices when providing wound care.

Review of the October 2017 physician's orders documented, "Cleanse left lateral foot with normal saline, pat dry, apply calcium alginate (1), santyl (2) to wound bed and cover with dry dressing, change daily. Start Date. 9/20/2017. Cleanse area to right knee with wound cleanser, pat dry, apply silver alginate (3) and foam dressing.

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Change daily and PRN (as needed) Start Date. 9//9/2017."

Review of the October 2017 treatment administration record documented, "Cleanse left lateral foot with normal saline, pat dry, apply calcium alginate, santyl to wound bed and cover with dry dressing. change daily. Cleanse area to right knee with wound cleanser, pad dry, apply silver alginate and foam dressing. Change daily and PRN."

An observation of Resident #1's wound care was conducted on 10/17/17 at 4:35 p.m. with LPN #7. LPN #7 gathered the wound care supplies and entered the room. LPN #7 washed her hands and put on a pair of gloves. LPN #7 removed the right knee dressing. The wound was clean and without drainage. LPN #7 removed her gloves and reached into her pocket and retrieved another pair of gloves and applied them. LPN #7 did not wash her hands after removing the gloves. LPN #7 cleansed the wound and patted it dry. LPN #7 put her gloved hand into her pocket and retrieved a marking pen and labeled the dressing with the date. LPN #7 then applied the calcium alginate to the wound and the dressing. LPN #7 then removed the gloves, washed her hands and applied gloves. She removed the foam boot from the resident's left foot and removed the dressing. There were two small clean wounds on the side of the resident's foot. LPN #7 cleansed the two wounds, dried them and removed her gloves. She then put on another pair of gloves and put the calcium alginate on one of the wounds and applied santyl to the other wound with her gloved finger. The dressing was applied and the foam boot was reapplied. LPN #7 collected the trash and removed it from the room. She then removed

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the gloves and washed her hands.

An interview was conducted on 10/18/17 at 10:40 a.m. with LPN #7. When asked when staff washed their hands, LPN #7 stated, "Before and after care." When asked what staff were to do after removing gloves, LPN #7 stated, "You're supposed to wash." When the wound care observation was discussed, LPN #7 stated, "So between there (changing gloves) I should have washed my hands." When asked why staff washed their hands, LPN #7 stated, "Of course to stop the bacteria from crossing over, be it ourselves, the resident or other residents."

An interview was conducted on 10/18/17 at 11:20 a.m. with ASM (administrative staff member) #2, the interim director of nursing. When asked when staff were to wash their hands, ASM #2 stated, "In between every patient and if they go from dirty to clean." When asked what staff should do when gloves were removed, ASM #2 stated, "Wash their hands."

On 10/18/17 at 6:45 p.m. ASM #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Disposable Non-Sterile Gloves" documented, POLICY: Personnel will wear disposable non-sterile gloves when a barrier between the resident and health care provider is necessary to prevent the transmission of blood and bodily fluids or when handling soiled articles or equipment. PROCEDURE: 5. Remove gloves and dispose of. 6. Wash hands."

According to the CDC website on hand hygiene,

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page 34, "Decontaminate hands after removing gloves. This information was obtained from: https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf

(1) Calcium Alginate - Hydrocolloid and calcium alginate are used to treat cutaneous injuries and many health professionals do not know about its cicatrization effects. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/24217762

(2) Santyl -- Collagenase Santyl® Ointment is a sterile enzymatic debriding ointment which contains 250 collagenase units per gram of white petrolatum USP. The enzyme collagenase is derived from the fermentation by Clostridium histolyticum. It possesses the unique ability to digest collagen in necrotic tissue. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a7bf0341-49ff-4338-a339-679a3f3f953d

(3) Silver Alginate - Antimicrobials, in particular silver, are incorporated into wound dressings, including alginates, for use in the treatment of "at risk" or infected chronic wounds. Silver is used to both reduce the dressing and wound microbial bioburden. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4486446/

F 503 SS=D 483.50(a)(i)-(iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT — F 503

(a) Laboratory Services

(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493

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F 503	Continued From page 99 of this chapter. (ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter. (iii) 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 accordance with the requirements of part 493 of this chapter. (iv) 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to discard expired laboratory supplies in one of two medication rooms, the North unit medication room. Facility staff failed to discard nine expired laboratory blood tubes in the North unit medication room. The findings include: An observation of the North unit medication room was made on 10/19/17 at 8:40 a.m. with LPN (licensed practical nurse) #8. In the lower cabinet there was a red basket containing laboratory tubes. There were seven blue top tubes that had an expiration date of 12/2016, one red top tube	F 503	F503 1. The facility has disposed of the expired lab equipment. 2. An audit of the medication rooms will be completed to ensure lab equipment is in good condition and not expired. 3. The Licensed Nursing staff will be educated on checking the lab equipment and proper disposal of expired lab equipment. 4. The Unit Managers, or designee, will check the medication rooms monthly, for 3 months to ensure lab equipment is up to date. Findings will be reported to QAPI. 5. November 27, 2017	

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F 503	Continued From page 100 with an expiration date of 5/2017 and one purple top tube with an expiration date of 5/2017. An interview was conducted at that time with LPN #8. When asked who used the supplies in the red basket, LPN #8 stated, "We sometimes draw blood." When asked the process for checking for expired laboratory supplies in the medication rooms, LPN #8 stated, "The night shift is responsible for checking on anything expired." When asked why they discarded expired laboratory supplies, LPN #8 stated, "Because once you put the blood in the tube it's not going to be accurate." On 10/19/17 at 9:10 a.m. a request was made of ASM (administrative staff member) #2, the interim director of nursing for a policy on discarding expired laboratory supplies. On 10/19/17 at 10:30 a.m. ASM #2, stated, "We don't have a policy on expired supplies." ASM #2 was made aware of the findings at that time. No further information was provided prior to exit.	F 503		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 514		

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(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for four of 22 residents in the survey sample, Residents, #5, #11, #3 and #10.

1. For Resident #5 facility staff failed to file the February 2017 pharmacy medication regimen review in the clinical record.

2. The facility staff failed to file Resident #11's July 2017 Medication Regimen Review in the clinical record.

F514

1. The facility has included the February 2017 pharmacy medication regimen in Resident #5 clinical record. The facility has included the July 2017 pharmacy regimen in Resident's #11 clinical record. The facility has documented that Resident #3's urine output is unavailable. The facility has included that the physician was notified when Resident #10 did not receive their medication on 10/9/17.
2. An audit will be completed to validate that
   - residents who have a pharmacy medication regimen, in the last 30 days, are included in their chart
   - Patients in the last 30 days who require urine output documentation is included
   - and any missed Medication Administration, in the last 30 days, includes Physician notification
3. The Medical Records Clerk will be re-educated on maintaining accurate and complete records. Licensed Nurses will be re-educated on accuracy of documentation and physician notification.
4. The DON, or designee, will review documentation and physician orders daily in morning meeting. The results of the audit will be reviewed in QAPI.
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3. The facility staff failed to document Resident #3's urinary output as ordered by the physician.

4. The facility staff failed to document Resident #10's physician was notified on 10/9/17 when the resident was not administered a medication.

The findings include:

1. For Resident #5 facility staff failed to document the February 2017 pharmacy monthly medication review in the clinical record.

Resident #5 was admitted to the facility on 1/12/15 with diagnoses that included but were not limited to: chest pain, dementia, depression and high blood pressure.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/26/17 coded the resident as having scored a 13 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the medical record did not evidence documentation regarding the February 2017 pharmacy medication regimen review. A request was made on 10/18/17 at 8:30 a.m. to ASM #2, the director of nursing for a copy of the review.

On 10/18/17 at 1:05 p.m. ASM #1, the executive director stated, "We just got this from the pharmacy."

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Review of the document received from the pharmacy documented, "Summary of Nursing and Physician Recommendations. CURRENT ORDERS: Resident has an order for Milk of magnesium which was entered into (name of software) as the MOM (milk of magnesium) concentrated. The facility stocks the 1200 mg (milligram)/15 ml (milliliter) not the concentrate. RECOMMENDATION: Please update the MOM order in (name of software) and use the product MOM 1200 mg/15 ml. MRR (monthly regimen review) 2/10/2017."

An interview was conducted on 10/18/17 at 3:45 p.m. with OSM (other staff member) #2, the pharmacist. OSM #2 stated, "I know I saw her because I had a nursing recommendation (for the milk of magnesium). If there's not a note it's more than unusual. It's very rare, but I know I saw her."

A repeated request was made on 10/18/17 at 4:40 p.m. of ASM #2, the interim director of nursing for a copy of the February 2017 pharmacy monthly medication review. No review was received.

Review of the facility's policy titled, "DOCUMENTATION AND COMMUNICATION OF CONSULTANT PHARMACIST RECOMMENDATIONS" documented, "Policy. The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding resident's medication therapies are communicated to those with authority and/or responsibility to implement the recommendations, and are responded to in an appropriate and timely fashion. Procedures. A. A record of the consultant pharmacist's observations and recommendations

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is made available in an easily retrievable form to nurses, prescribers, and the care planning team. This should include: 1) Documentation on the appropriate form of the date each medication regimen review is completed and notation of the findings in the medical record or other designated site."

No further information was provided prior to exit.
2. The facility staff failed to file Resident #11's July 2017 Medication Regimen Review in the clinical record.

Resident #11 was admitted to the facility on 9/29/14 with a readmission on 2/20/17 with diagnoses that included, but were not limited to: Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, shuffling gain, stooped posture, rolling motions of the fingers, drooling, and muscle weakness (1)), Bipolar disorder (a mental disorder characterized by episodes of mania and depression (2)), depression, COPD (chronic obstructive pulmonary disease - a general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (3)), gastroesophageal reflux disease, high blood pressure and anemia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 8/16/17, coded Resident #11 as scoring a 14 on the BIMS (brief interview for mental status) score, indicating that she was cognitively intact to make daily decisions. Resident #11 was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living.

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The clinical record, both electronic and paper records, were reviewed. The July 2017 MRR (monthly regimen review) report could not be located.

On 10/17/17 at 1:05 p.m. the executive director (administrative staff member - ASM) #1, presented a form, "Consultant Pharmacist report to Director of Nursing" dated, 7/1/17 - 7/19/17. Resident #11's name was not the only resident's name on this paper. ASM #1 stated, "It wasn't in the record, we just called and had it sent over from the pharmacy." There was a recommendation on the paper for Resident #11. Review of the clinical record revealed that the recommendation was completed on 8/7/17.

An interview was conducted with administrative staff member (ASM) #2, the interim director of nursing, on 10/18/17 at 2:32 p.m. When asked the process for the MRR, ASM #2 stated, "The pharmacist comes in and does her review. She sends them to the unit managers. The unit managers deliver them to the physician's or if a nursing recommendation, they take care of it. Then they are filed in the record after they were completed. I think medical records files them. My understanding is that they (the reports) are emailed to the staff."

An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 10/18/17 at 3:12 p.m. When asked about the process followed for the MRR reports from the pharmacist, LPN #3 stated, "Either the ADON (assistant director of nursing) or DON (director of nursing) has them emailed from the pharmacist and they distributed them to me and the other unit manager. There are three things that come in

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those reports, nursing recommendations, physician recommendations and a summary report." When asked who filed them in the clinical record, LPN #3 stated, "The nurses on the unit. If it's a physician recommendation, we were told by the previous DON that we didn't have to save them." LPN #3 stated, "If we got them (MRR), with the changes in the ADON (assistant director of nursing) and DON resigning, staff may not have been aware they were supposed to be printing them."

An interview was conducted with other staff member (OSM) #2, the consultant pharmacist, on 10/18/17 at 3:53 p.m. When asked why this report was not in the electronic record as most of her other reports were before the July and after the August report, OSM #2 stated, "There have been a couple of times when (name of computer system) was not available to me. It is possible that I did it but I signed it in the paper chart. I do toggle between two computers and two systems. It may have happened that I didn't put it in both systems."

The executive director and the interim director of nursing were made aware of the above findings on 10/18/17 at 6:16 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 436.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 73.
(3) Barron's Dictionary of Medical Terms for the

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Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
3. The facility staff failed to document Resident #3's urinary output as ordered by the physician.

Resident # 3 was admitted to the facility on 3/30/17 and most recently on 5/10/17 with diagnoses that included but were not limited to: colon cancer, hypothyroidism, arthritis, deep venous thrombosis, anxiety, depression, hydronephrosis (1) with renal and ureteral calculous obstruction.

Resident # 3's most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 9/1/17 coded Resident # 3 as understood by others and as able to understand others. Resident # 3 was coded as being cognitively impaired for making daily decisions, scoring 3 out of 15 on the BIMS (brief interview for mental status).

Review of the clinical record documented the following physician order: "Monitor Nephrostomy (2) output every shift" original order date 5/10/17 with the order most recently signed by the physician on 10/1/17.

Review of the October 2017 TAR (Treatment Administration Record) lacked documentation of the Nephrostomy tube output on 10/8/17 for the 7-3 shift and the 11-7 shift and on 10/11/17 for the 7-3 shift.

During an observation on 10/18/17 at 1:45 p.m. CNA (Certified Nurse's Assistant) # 1 emptied Resident # 3's Nephrostomy collection bag. When CNA # 1 was asked where she

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documented the output, CNA # 1 stated that it was documented on the CNAs' Assignment Sheet. CNA # 1 further stated that the CNAs' assignment sheet is never thrown out. When CNA # 1 was asked about the CNAs' Assignment Sheet and where it was kept. CNA # 1, joined by CNA # 2, presented the book with the CNAs' Assignment Sheet located in the clean utility room. With the help of both CNAs, Resident # 3's missing outputs were located. Both CNAs # 1 and # 2 stated that the information was documented on the Assignment Sheets and that the nurses were verbally told the outputs.

During an interview on 10/18/17 at 2:45 p.m. with LPN (Licensed Practical Nurse) # 2 and LPN # 7 the blanks in Resident # 3's TAR were discussed. Both LPN # 2 and LPN # 7 acknowledged that the CNAs would verbally tell them but that they knew that the outputs were on the CNA's Assignment Sheets. Both acknowledged that the nurse is the person to document on the TAR. During this interview RN (Registered Nurse) # 2, the Unit Manager, joined the group and was made aware of the missing documentation.

During the end of day interview on 10/18/17 at approximately 6:15 p.m. the ASM (Administrative staff member) # 1, the Executive Director, and ASM # 2, the interim Director of Nurses, were made aware of the missing documentation.

Review of the facility policy documented: "Documentation is the process of preparing a completed record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed charting shows the extent and quality of the care that nurses provide, the outcomes of that care, and treatment and

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education that the patient still needs. Through, accurate documentation decreases the potential for miscommunication and errors."

"Recording fluid intake and output Accurate intake and output records help evaluate a patient's fluid and electrolyte balance, suggest various diagnoses, and influence the choice of fluid therapy."

No further information was provided prior to exit.

References:

1. Hydronephrosis: Abnormal enlargement or swelling of a KIDNEY due to dilation of the KIDNEY CALICES and the KIDNEY PELVIS. It is often associated with obstruction of the URETER or chronic kidney diseases that prevents normal drainage e of urine into the URINARY BLADDER. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/medgen/42531

2.nephrostomy involves a small tube inserted through the skin directly into a kidney. The nephrostomy tube drains urine from the kidney into an external drainage pouch. Nephrostomy tubes are often used for less than a week after a percutaneous nephrolithotomy-a surgical procedure to break up and remove a kidney stone. This information was obtained from the website: https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-diversion

4. The facility staff failed to document Resident #10's physician was notified on 10/9/17 when the resident was not administered a medication.

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Resident #10 was admitted to the facility on 6/17/15. Resident #10's diagnoses included stroke, chronic kidney disease and difficulty swallowing. Resident #10's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/10/17, coded the resident's cognition as moderately impaired.

Review of Resident #10's clinical record revealed a physician's order dated 12/13/15 for metoprolol succinate (1) extended release- 25 mg (milligrams) by mouth two times a day every Sunday, Monday, Wednesday and Friday.

Resident #10's October 2017 MAR (medication administration record) documented, "Metoprolol Succinate ER (extended release) Tablet Extended Release 24 Hour 25 MG. Give 25 mg by mouth two times a day every Sun, Mon, Wed, Fri..." On 10/9/17 at 9:00 a.m. the nurse documented, "7=Other/See Nurse Note."

A nurse's note dated 10/9/17 documented, "Medication was not in Alixa (a machine in the facility that dispenses medications) and did not dispense out, pharmacy notified." The note failed to document the physician was notified.

Resident #10's comprehensive care plan initiated on 7/29/15 documented, "Impaired neurological status related to: Cerebrovascular accident (stroke), cognitive loss...Interventions: Medication as ordered by physician..."

On 10/18/17 at 3:34 p.m. an interview was conducted with LPN (licensed practical nurse) #2 (the nurse who documented the above note). LPN #2 stated Resident #10's daytime dose of

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metoprolol didn't dispense out of Alixa and she attempted to re-dispense the medication but the machine said the container was empty. LPN #2 stated Alixa was "jammed" and the pharmacy thought they would have to send someone to the facility but another nurse was able to "un-jam" the machine with instructions over the phone from someone at the pharmacy. LPN #2 stated by the time the machine was fixed, it was too late to give Resident #2 the metoprolol because of the time the next dose was due (note- the morning dose was due at 9:00 a.m. and the next dose was not due until 9:00 p.m.). LPN #2 was asked if she notified the nurse practitioner or physician. LPN #2 stated she was pretty sure she did. LPN #2 was asked if the notification should have been documented. LPN #2 stated she should have documented in the progress note.

On 10/18/17 at 6:24 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings.

No further information was presented prior to exit.

(1) "Metoprolol is used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682864.html