DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	C 06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION & HEALTHCARE CENTER LLC	300 HATCHER STREET ROCKY MOUNT, VA 24151

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F 000	INITIAL COMMENTS An unannounced abbreviated Medicare and Medicaid survey was conducted 6/19/18 through 6/20/18. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 bed facility was 134 at the time of the survey. The survey sample consisted of 5 current Resident reviews (Resident # 1, Resident # 2, Resident # 3, Resident # 4, and Resident # 5) and 1 closed record review (Resident # 6).	F 000	Preparation and submission of this plan of correction by **Rocky Mount Rehabilitation and Healthcare, LLC**, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not	F 622	RECEIVED JUL 25 2018 VDH/OLC **F622** 1. Resident #1 and Resident #2 medical records were reviewed by the Director of Nursing on 6/20/18 related to the required identified hospital transfer paperwork. LPN #7 and LPN #2 were reeducated by the Director of Nursing and Staff Development Coordinator on 6/20/18 and 6/21/18 related to the required hospital transfer paperwork.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: Administrator — (X6) DATE: 7/24/18

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 622	Continued From page 1 submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).	F 622	The required hospital transfer paperwork procedure was reviewed and revised by the interdisciplinary team on 6/21/18 to ensure that the required paperwork includes: the residents' current medications and administration times, a list of the medication last administration times, transfer form, face sheet, physician order, recent labs, recent progress notes, code status and bed hold policy. 2. The Unit Managers on 6/21/18 completed an audit of the current residents' recent hospital transfers to ensure that the required hospital paperwork was provided. 3. Licensed Nurses' reeducation was completed on 7/21/18 by the Staff Development Coordinator related to the required hospital transfer paperwork. 4. The Assistant Director of Nursing and the Unit Managers will complete audits weekly for 4 weeks and monthly for 2 months to ensure the required transfer paperwork continues to be completed.	

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F 622	Continued From page 2 (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review and in the course of complaint investigation, the facility staff failed to ensure that appropriate information was provided to the receiving provider to ensure safe and effective transition of care for 2 of 6 Residents in the survey sample, Resident # 1 and Resident # 2. The findings included: 1. The facility staff failed to provide a medication list that included the most recent medication administration times upon transfer to the	F 622	The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months for review and recommendations. The Director of Nursing will be responsible for monitoring and follow up. Date of Compliance:	7/22/18

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emergency room for Resident # 1.

The clinical record for Resident # 1 was reviewed on 6/19/18 at 1:23pm. Resident # 1 is a 67-year-old-female who was originally admitted to the facility on 10/6/06 with a readmission date of 12/18/17. Diagnoses included but were not limited to: anxiety disorder, type 2 diabetes mellitus, epilepsy and recurrent seizures, schizophrenia, and hypothyroidism.

The most recent MDS (minimum data set) assessment for Resident # 1 is a quarterly assessment with an ARD (assessment reference date) of 5/20/18. Section C of the MDS assess cognitive patterns. In Section C0500, the facility staff documented that Resident # 1 had a BIMS (brief interview for mental status) score of 7 out of 15, which indicated that Resident # 1's cognitive status is severely impaired.

The surveyor observed a progress note in the clinical record for Resident # 1 that was written by LPN (licensed practical nurse) # 7 on 12/8/17 at 10:15. The progress note stated, "This nurse to eval rsd (resident) this am rsd resting with eyes closed rsd easy to arouse up talking at intervals wanting tv turned on and calls this nurse by name. no distress noted. After about 30 min (minutes) later can (certified nursing assistant) called this nurse into room to re eval states rsd is acting different. This nurse in room rsd with eyes closed arouses and is able to answer questions but breath sounds labored. rsd drooling at intervals. o2 (oxygen) applied o2 sats up to 92% (nurse practitioner's name withheld) in room and gave vo (verbal order) to send to er (emergency room) resp (respirations) at 38 p (pulse) at 132 bp (blood pressure) 152/88. Lung sounds with

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wheezing. noted bil (bilateral) report called to the hospital 911 notified family, left message no answer noted attempted several times also attempted (family members name withheld)."

On 6/19/18 at 1:50 pm, the survey team spoke with the administrator and LPN #4. The survey team asked what documentation the facility staff sent with a resident who is being transferred to the hospital. The administrator referred to the transfer policy. The survey team requested to see the policy.

On 6/19/18 at 2:00 pm the administrator provided the survey team with a typed document dated March 1, 2018, "Transfer Protocol" which the administrator stated is the facility protocol for transfers. The procedure for this policy includes but is not limited to:
" ...Day of transfer:
When resident is sent to the ER (emergency room), the following information will need to be completed immediately and printed: face sheet, hospital transfer evaluation, bed hold confirmation evaluation, list of medications & may include pertinent, recent labs. This set of copies should be placed in an envelope for the emergency room use ..."

This surveyor did not observe documentation to inform the staff to utilize "Transfer/Discharge Report" or instructions to handwrite medication times within this policy.

The survey team asked the administrator what the policy was prior to March 1, 2018. The administrator stated, "We didn't have one." The administrator stated that the nurses had a guideline to go by at the nurse's station. The

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survey team requested to see a copy of the guideline.

On 6/19/18 at 2:20 pm, LPN #4 provided the survey team with a typed list that contained the following information:
"Hospital Transfer
Items to send
1. List of meds
2. Transfer form
3. Face sheet
4. Recent labs
5. Recent progress notes
6. Order for ER (emergency room) eval"

This surveyor did not observe any instructions to use the "Transfer/Discharge Report" or instructions to handwrite medication times within the guidelines that was presented by the facility staff.

On 6/19/18 at 2:40 pm, LPN # 4 presented the survey team with an example of what the facility staff sends with the resident that is being sent out to the hospital. The packet included: Transfer/Discharge Report, Nursing Home to Hospital Transfer Form, Admission Record, Order Summary Report, Notice of Bed Hold Policy, The order to send to the ER for eval, Copy of DNR. LPN # 4 stated that the times that medications were last administered should be written on the Transfer/Discharge Report. LPN# 4 also stated that in addition to those documents, he would also send last progress note and recent labs. The survey team asked LPN # 5 if he was aware of any issues with the facility not sending medication information to the hospital. LPN # 4 denied knowing of any issues the facility had regarding communication medication information to a

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receiving facility. LPN # 4 stated if for some reason the nurses would not get the information, the facility would send over a copy of the "Transfer/Discharge Report" along with the physician's orders.

On 6/19/18 at 3:15 pm, the surveyor interviewed LPN # 1 about what paperwork is sent with a resident when they are transferred to the hospital. LPN # 1 stated that a face sheet, history and physical, medication list, bed hold policy, code status, and the transfer form in the computer is sent. LPN # 1 also stated that an order sheet that has the resident's diet, allergies and treatments is sent. LPN # 1 told the surveyor that there is a transfer sheet that comes from the computer with meds and times on it. The surveyor asked LPN # 1 if the times the medications were last given is already printed on the transfer sheet. LPN # 1 stated, "I'm pretty sure they are."

On 6/19/18 at 3:25 pm, the surveyor observed Resident # 1 lying in bed in her room. The surveyor knocked on the door and Resident # 1 gave the surveyor permission to enter her room. The room was neat, clean, and homelike. Resident # 1 was clean, well groomed and dressed in a hospital gown and was covered with a blanket. The call bell was within reach of the Resident # 1 and was secured on the left upper half side rail. The surveyor asked Resident # 1 if she was doing ok and Resident # 1 stated that she was doing fine and was going to take a nap. The surveyor thanked Resident # 1 for speaking with her and exited the room so that Resident # 1 could rest.

On 6/19/18 at 3:30 pm, the surveyor interviewed LPN # 2 and asked what paperwork is sent with a

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resident when they are transferred to the hospital. LPN # 2 went into the computer and pulled up a "Transfer Discharge Report." LPN # 2 stated to surveyor, "This sheet has the face sheet and all of the information on it." LPN # 2 pointed to the bottom of the sheet and stated, "The med rec (record) is here and I will handwrite the last time I gave the med on here." LPN # 2 then stated she would send the paperwork with the EMT (emergency medical technician) or fax it if it is an emergency and the paperwork is not ready in time. "Then I would call report and verbally discuss everything with them."

On 6/19/18 at 3:47 pm, the surveyor interviewed LPN # 6 and asked what paperwork the facility sends when a resident is transferred to the hospital. LPN # 6 stated, "The face sheet and the discharge transfer form." "It's a new form to PCC." (point click care) The surveyor then asked LPN # 6 how long the facility has been using the form. LPN # 6 stated, "We've been using it for a couple of months." LPN # 6 stated "If it's a real emergency we send the face sheet, the MAR (medication administration record), DNR (do not resuscitate) and call report, get the fax number and send the forms over." "Then we call the hospital and give report." The surveyor asked LPN # 6 if she sends the MAR to the hospital. LPN # 6 stated, "I don't print the actual MAR and send it." "I print out the transfer discharge form and write down the last time the medication was administered."

On 6/20/18 at 9:35 am, the surveyor spoke with the administrator and the director of nursing. The surveyor asked the director of nursing if she recalled having a meeting with the hospital staff regarding issues with getting the accurate

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medications lists and times from the facility. The director of nursing stated that she did have a meeting with the hospital staff and informed the hospital staff that it was against our cooperate policy to send the MAR. The surveyor requested to see the policy. The administrator stated, "We don't have one." The surveyor then asked if you do not have the policy, then how can you say that it is against the cooperate policy. The administrator stated and the director of nursing shook her head in agreement that "We have had several conference calls and they told us not to send the MAR." The administrator stated that the nurses send over a form that they print from PCC and the write the times last administered next to the medication. The surveyor asked when the facility did started using the form. The administrator stated last April. The surveyor confirmed that the administrator was referring to April of 2017 and administrator agreed. The administrator also stated that the nurses would call and give report to the emergency room as well. "We don't just send them." "We want to do everything to make sure our residents get good care."

On 6/20/18 at 10:13 am, the surveyor interviewed LPN #7 via telephone. The surveyor asked LPN # 7 if she was the nurse that had sent Resident #1 out to the hospital on 12/8/17 and if she remembered the incident. LPN # 7 confirmed that she was the nurse that sent Resident # 1 out on 12/8/17 and stated that she did remember the incident. The surveyor then asked LPN # 7 if she sent a copy of the medication list with Resident # 1. LPN # 7 stated, "In PCC (point click care) you can print out a medication list, I printed out the medication list and wrote the times beside it." The surveyor asked LPN #7 if the hospital staff called

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back to the facility to get information about Resident # 1 and if she had spoken to the hospital staff about Resident # 1's medications. LPN # 7 stated, "I did speak with the hospital," "They called a few times." LPN # 7 stated I verbally told them about her meds and then finally (employee name withheld) sent them a copy of the MAR with the initials blocked out."

On 6/20/18 at 10:50 am, RN (registered nurse) # 2 presented the surveyor with a "Transfer Policy" and in service documentation dated 2/18/18. The procedure for this policy includes but is not limited to:
" ...Day of transfer:
When resident is sent to the ER (emergency room), the following information will need to be completed immediately and printed: face sheet, hospital transfer evaluation, bed hold confirmation evaluation, list of medications & may include pertinent, recent labs. This set of copies should be placed in an envelope for the emergency room use ..."

The surveyor asked RN # 2 what the hospital transfer evaluation was. RN # 2 stated it's a form that we print from PCC that has the face sheet and medication list on it. LPN # 4 interjected and stated, "It's not that one." LPN # 4 stated that is the form that has information about the resident. The surveyor asked LPN # 4 if he was referring to the interact form. LPN # 4 stated "Yes." The surveyor spoke with RN # 2 and explained that of the persons that have been interviewed thus far, no one seems to be on the same page as to what is to be sent out with the resident. The surveyor then told RN # 2 that there was nothing in the policy about handwriting the time that the medication was last administered. RN # 2 stated,

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"I did notice that when I pulled the policy to bring it to you." RN # 2 then stated, "When the in services were done, me and LPN # 4 went to the nurse's stations and sat down with the nurses and verbally told them to include the times."

On 6/20/18 at 11:21 am, the complainant provided the surveyor with a copy of the information that the facility sent with Resident # 1 to the hospital on 12/8/17. The information sent from the facility is as follows:
"Admission Record"
"Clinical Physician Orders"- The surveyor observed that there is NOT any handwritten times written next to the medication times.
Also sent was a copy of the MAR with the nurse's initials blacked out.
The complainant also sent hospital progress notes dated 12/8/2017 at 1:45 pm, progress note stated, "Received this 67 year old female to IUC (intensive care unit) B as overflow status for pneumonia and UTI. (urinary tract infection) Speech is garbled, but able to understand a few words at a time. Obese, rapid respirations noted. O2 (oxygen) in place at 2 liters nasal cannula. Tachycardic. Patient is nursing home resident and does not have accompanying paperwork to complete her medication list."

Another hospital progress note dated 12/8/17 at 3:02 pm stated " Have attempted to call family listed on face sheet, with no answer at either number. Have attempted multiple calls to nursing home to get medication list faxed to no avail. Will continue to try to get this information."

Another hospital progress note dated 12/8/17 at 4:46 pm stated "Still unable to establish contact with nursing home regarding medications.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. BUILDING _____ B. WING _____	C 06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION & HEALTHCARE CENTER LLC	300 HATCHER STREET ROCKY MOUNT, VA 24151

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(employee name withheld) has spoken to someone who verbally reviewed medications, and this list has been entered into the medication reconciliation and reviewed with (physician's name withheld).

On 6/20/18 at 11:57 am, the surveyor requested a copy of the documentation that was sent to the hospital with Resident # 1 when she was transferred to the hospital on 12/8/17.

On 6/20/18 at 12:18 pm, RN # 3 provided the surveyor with a copy of the "Nursing Home to Hospital Transfer Form" that had been printed from the computer. The surveyor asked if there was a copy of the "Transfer/Discharge Report" with the times the medications were last administered. RN # 3 stated, "We don't usually make copies."

On 6/20/18 at 12:45 pm, the administrator and director of nursing was made aware of the findings as stated above.

No further information was provided to the survey team prior to the exit conference on 6/20/18.

This is a complaint deficiency.
2. Facility staff failed to provide a medication list, complete with the most recent administration times when Resident #2 was transferred to the local emergency room for evaluation and treatment. The resident's clinical record was reviewed on 6/19/18 at 3:00 pm.

Resident #2 was admitted to the facility on 12/2/16. Her diagnoses included hypertension, diabetes, anxiety, depression, chronic pain and gastrointestinal bleeding.

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The latest MDS (minimum data set) assessment, dated 5/12/18 coded the resident as cognitively unimpaired. She was able to function without nursing staff assistance for most of the ADLs (activities) of daily living independently, but required some assistance with hygiene requirements and a set-up for eating.

Resident #2 CCP (comprehensive care plan), reviewed and revised on 5/13/18, documented the resident as her own responsible party and as a full code. The resident was documented as a risk for rectal bleeding due to hemorroidal formation. The staff were to notify the physician of any changes.

The resident was observed in her bedroom on 6/19/18 at 3:40 PM. The resident was clean and neat and dressed appropriately for the season. Her room was neatly appointed and there was no odor.

Resident #2 invited the surveyor to come in and sit awhile. She was pleasant and well-spoken. This resident was alert and oriented to person, place and time. She had no complaints about the facility she was staying in and was very complimentary of staff that attended her daily.

Resident #2 was asked if she remembered her admission to the hospital on 11/14/17 and if there were any issues with her medications. (This resident was documented as her own responsible party.) She told the surveyor she didn't remember any issues during the three day stay. She said she was alone in the emergency room, prior to admission, and no relatives or friends were there that could could say if there were issues with her

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medication list.

Resident #2 discharged back to the facility from the local hospital on 11/17/2017. The discharge plan from the hospital physician, signed and dated on the same day, indicated she was treated for rectal bleeding and had a hemorrhoidectomy prior to discharge. No complications were indicated on the discharge summary.

On 6/19/18 at 2:29 PM the West Unit supervisor (LPN IV) was interviewed about the documentation sent out to the local hospital when a resident was sent to the emergency room. LPN IV stated, "We pull off a list of meds on the transfer/discharge form. They handwrite the last administration times next to the list of medications and treatments on that list. We hand that off to the EMTs (emergency medical techs) and then we follow up with a call to the hospital and make sure they got it."

LPN IV supplied the survey team with a current transfer/discharge form used by nursing staff since their computer program (Point Click Care) had been implemented in April 2017. It illustrated the last medication times were hand-written next to the med list on the transfer/discharge form submitted to the ER for review when residents were sent out.

On 6/19/18 the facility administrator brought the survey team a policy regarding instructions to nursing staff on discharges to the local hospital emergency room. The policy was dated March 1st 2018 and titled "Transfer Protocol." She told the survey team that prior to that policy--they didn't have a policy regarding transfers/discharges.

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The administrator said they had a list at each nursing desk--prior to March 2018 and the list was provided. It said, "Hospital transfer...Items to send:
1. List of meds
2. Transfer form
3. Face sheet
4. Recent labs
5. Recent progress notes
6. Order for ER eval"

The list did NOT include administration times for the latest medications provided.

The "Transfer Protocol" provided on 6/19 at 2:00 PM did include a policy date, March 1, 2018--but did not include the name of the facility. It included: Face sheet, hospital transfer evaluation, bed hold confirmation evaluation, list of medications & pertinent recent labs. This policy did not include the last administration times for medications. The policy did not include the name of the facility or when the policy was implemented.

The administrator said the staff had been inserviced on the new protocol of sending the new transfer/discharge list and a Medication a list and times when Point Click Care was implemented on April 2017. The administrator was asked to provide the inservice copies with the staff educated and their signatures from that inservice.

The staff education coordinator provided an inservice and training on the new facility policy implemented on 2/18/18. The training did not include the latest medication administration times were to be sent with the residents, because their

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policy did not include that item. The policy did not have the facility name or implementation date on it. This was a completely different policy from that provided by the administrator on the previous day.

On 6/20/18 at 12:45 PM the administrator was again questioned about the April 2017 inservice for "Point Click Care". She said she was mistaken and thought the survey team was asking about the inservice in 2/2018 when they had inserviced staff on the new policy for sending residents out to the emergency room. The administrator said when they started the new "Point Click Care" program they had not done a new inservice to tell nursing staff what to send from the electronic program. She apologized and said she "misunderstood."

On 6/20/18 at 12:45 PM the DON told the survey team members the corporate office said they could not send out the MAR (medication administration record) with the times intact. She said it was against their policy to turn over that document to the hospital and said nurses were required to hand-write the last medication times on the hospital transfer form. She said she didn't like doing that--because it took extra time and increased the likelihood of errors, but corporate left them no alternative.

The nursing staff was interviewed as to the process for sending residents out to the emergency room and the appropriate documentation to send with them. The responses varied:
1. On 6/19/18 at 2:45 PM LPN II was asked about the paperwork sent to the ER. She said the supervisor let her know to send someone. She

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said the medication and the last administration time was the most important thing to send....LPN II said some MARS, we cannot send because you have to mark this (administration times) out. The ones we are sending recently will say medications three times a day. It's a transfer sheet.
2. On 6/19/18 at 3:00 PM RN I was interviewed. She stated, "We send a transfer sheet. We've never sent out MARS (medication administration records). We send the discharge summary and hand write the last administration times on the discharge/transfer form. We hand that off to the EMTs and then call the hospital and give them a report." She said she didn't usually FAX them to the hospital.
3. On 6/19/18 at 3:15 PM LPN V was interviewed. She stated, "Yes, I do the paperwork if they need to go out. I send a face sheet, copy of labs, discharge/transfer paper on the computer. That has a copy of the medication list, we send the MD order sheet... DNR (do not resuscitate), a copy of the MAR (it has all the administration times on it, so they know when the last administration time was), the medication review report--it doesn't have the administration times on it. That's why I send the MAR. I don't block anything out."
4. On 6/19/18 at 3:35 PM LPN V was heard to ask LPN IV about whether or not she was sending the right list to the hospital. LPN IV was siting at the desk and heard the previous interview. He stated, "We're not supposed to send the MAR...." LPN V said she really didn't know that.
5. On 6/20/18 at 11:30 AM LPN III was interviewed. She said they sent the residents to the ER with a cover sheet, medications, diagnosis sheet, and an MAR intact with the times--because without the administration times, "They'd be completely blind and wouldn't know what they had

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or what to do!"

The complainant was contacted on 6/20/18 at 9:45 AM. She said the issue of not receiving the needed medication list and actual administration times from the facility was on-going. The complainant said they might send the appropriate information at times, but other times they do not. The complainant said when the EDS (emergency dept staff) call to complete the clinical picture for treatment (for medications) they are told they can't get that information.

The complainant stated, "Everything is blacked out and we can't read it. Sometimes when they send the whole MAR (medication administration record) the administration times are what we need. It's all blacked out. They said it's against corporate policy to send the MAR with all the documented medication times. They tell us--'We can't tell you that.' When they do write down the last administration times, it's not always an accurate list or we can't read what they wrote."

The complainant was asked if the hospital had the complete record of the facility's documentation scanned on their computer. The complainant said they did keep those records but she only sent the part related to medication administration to the complaint office. The complainant said she would review the records and send everything the facility sent over to the surveyor.

On 6/20/18 at 11:21 AM the entire file received by the hospital from the facility on 11/14/17 for Resident #2 was received by the surveyor. The fax also included a complete file for complaint #VA00040240. This was handled separately from

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this complaint investigation.

The surveyor reviewed the faxed info. The transfer discharge form did not contain a hand-written list of medications or the last administration times. The MAR contained a current list of medications--but the scheduled administration times as well as the actual administration times had been covered by a sheet of paper and blocked from the copier.

The hospital progress notes included the following with nursing communications with the nursing home staff:
1. 11/14/17 at 8:25 PM - "Called and spoke to (name of staff member at name of nursing home), states she is busy and could not verify all the patient's medications. I asked if she could fax a copy over with the last times taken, she states she needs to clear it with her manager. Gave FAX number and asked her to send ASAP, as she is being admitted and needed her nighttime medications."
2. 11/14/17 at 9:35 PM - "Attempted to call and obtain update MAR again from (name of nursing home). was on hold for an extended time then was disconnected....."
3. 11/14/17 at 10:02 PM - " I called (name of nursing home) about this patient's MAR. We received the MAR but all the dates and times were blocked out so you could not read them. Called requesting they fax us an MAR with the dates and times so I could do her admission database. I was advised it was against their corporate policy to give out that information."

On 6/20/18 at 12:35 PM LPN IV was asked if there was any documented evidence that the staff had actually sent the medication list intact with

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the last administration times. He said no, they did not keep that information on file after it was submitted to the hospital.

On 6/20/18 at 12:45 PM this information was reviewed with the administrator and DON. They had no additional evidence to offer.

This was a complaint deficiency.

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