STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495311	A. BUILDING ______ B. WING ______	C 12/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/18/18 through 12/20/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/18/18 through 12/20/18. Two 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 31 certified bed facility was 28 at the time of the survey. The survey sample consisted of 15 current resident reviews (Resident #2, #6, #4, #13, #20, #78, #22, #128, #228, #15, #14, #19, #5, #10, and #11) and five closed record reviews (Resident #28, #30, #129, #29, and #80).	F 000		
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;	F 622		2/3/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/04/2019

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	F 622		

(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 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.

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F 622	Continued From page 2 (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). (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 staff interview, facility documentation review, and clinical record review, facility staff failed to evidence that the care plan goals were provided to the receiving facility for a facility-initiated transfer, for 2 of 20 residents	F 622	The filing of this plan of correction does not constitute an admission that the deficiencies alleged did in fact exist.	

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F 622	Continued From page 3 reviewed. 1. For Resident #30, the care plan goals were not sent to the hospital at the time of transfer to the hospital on 09/25/2018. 2. For Resident #10, the facility staff failed to evidence that the care plan goals were provided to the receiving provider for a facility initiated transfer dated 7/16/18. The findings included: 1. For Resident #30, the care plan goals were not sent to the hospital at the time of transfer to the hospital on 09/25/2018. Resident #30 was admitted to the facility on 09/14/2018. Her diagnoses included Atrial Fibrillation(1), Coronary Artery Disease (a hardening and/or blockage of the arteries that feed the heart), Hyperlipidemia (high levels of cholesterol in the blood), Arthritis, and Asthma. Resident #30's most recent Minimum Data Set (MDS) Assessment was a Medicare 5-Day Assessment with an Assessment Reference Date (ARD) of 09/21/2018. The Brief Interview for Mental Status (BIMS) coded Resident #30 at 15, indicating no impairment. Resident #30 was coded as requiring limited assistance of 1 person for ambulation, dressing, and hygiene, supervision and setup assistance for transfers, and was independent with setup assistance for bed mobility, dining, and toileting. Resident #30's closed record was reviewed on 12/19/2018. It was noted in the Progress Notes that Resident #30 was transferred to the hospital	F 622	This plan of correction is filed as evidence of Our Lady of Hope□s desire to comply with the requirements of participation and to continue to provide high-quality resident care. Upon discharge from the hospital Resident #30 went home to live with her daughter. Resident #10 was readmitted to this facility on 7/18/18 and continues to reside here as a long- term care resident. Any resident being transferred to the ER, or to another facility, has the potential for the care plan goals to be omitted from the transfer documents. Currently, none of our residents are in the hospital. The facility policy entitled Transfers/Discharges was updated to ensure the care plan goals would be sent with a resident in the event of discharge or transfer. Licensed nurses will be educated on the revised policy and protocols for sending all required information with the resident when being transferred / discharged.	

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F 622	Continued From page 4 on 09/25/2018. Progress Notes from the nursing staff did not have documentation of what was sent with the resident to the hospital. On 12/19/2018 at 2:33p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1 regarding the process for sending a resident to the hospital. When asked to what the process is for sending a resident to the hospital, and what gets send with them, LPN #1 stated, "Once we have the order to transfer from the doctor, we get the resident ready and send a facesheet, a copy of their meds, their current POS, a copy of the CCD (continuing care document) that shows when each med was last given, a transfer sheet, and then sometimes we send their progress notes if there is something related to them going to the hospital. We'll also send things like Xrays or labs if they are related." When asked if a copy of the Comprehensive Care Plan or Care Plan Goals were sent with the resident, LPN #1 replied "no". A review of the facility policy entitled "Transfers/Discharges" revealed no references to ensuring the care plan goals would be sent with the resident in the event of discharge or transfer. On 12/20/2018 at 2:57p.m., an interview was conducted with OSM (Other Staff Member) #2, the Director of Admissions. OSM #2 stated that she assists with transfers and discharges as well as admissions. When asked if a copy of the resident's care plan or care plan goals was sent with them to the hospital in the event of a transfer, OSM #2 stated that she wasn't sure, but would find out.	F 622	Twice weekly for 4 weeks, then monthly for 3 months, the DON, or designee, will audit to ensure that all required documents were sent with residents who were transferred or discharged. If variances are identified, proper information will be sent and responsible staff will be educated. An audit tool has been developed and will be implemented. This tool will be kept at the nurses station for the licensed nurses to use as a resource for residents being transferred/discharged. The findings of the audits will be reviewed by the QA committee at the monthly meeting. Any deficient findings will be addressed by an action plan.	

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F 622	Continued From page 5	F 622		

At 3:45p.m., OSM #2 followed up with survey staff regarding care plans, and stated that care plans and/or goals are not sent to the hospital when a resident is transferred.

ASM (Administrative Staff Member) #1, the facility Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 12/20/2018, at around 10:30am. No further documentation was provided.

1. An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. (https://medlineplus.gov/atrialfibrillation.html)

2. For Resident #10, the facility staff failed to evidence that the care plan goals were provided to the receiving provider for a facility initiated transfer on 7/16/18.

Resident #10 was admitted to the facility on 4/18/2013 with a most recent readmission date of 7/18/2018. Diagnoses included but were not limited to: diabetes, transient ischemic attack (1), gastro-esophageal reflux (2), depression, and chronic obstructive pulmonary disease (3).

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 10/19/18 coded the resident as having a score of 9 on the BIMS (brief interview for mental status) score, indicating the resident had moderate cognitive impairment for daily decision making.

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F 622	Continued From page 6 Review of Resident #10's clinical record revealed that she was sent to the hospital on 7/16/18. A nursing note dated 7/16/18 at 5:50 p.m. documented, "After medication discrepancy V/S (vital signs) taken blood pressure 137/83, pulse 72, respirations 18, Spo2 (peripheral oxygen saturation) 95% on room air, Temperature 96.4, MD (medical doctor) notified, new orders noted to monitor for signs and symptoms of diaphoresis, monitor vital signs every hour, call back with vital signs in 1 hour. RP (responsible party) called no answer left message awaiting return call. Approximately 6:45 p.m. vital signs obtained blood pressure 103/68 pulse 49 resident noted diaphoretic, writer called MD notify (Sic), new order to send to ER (emergency room) further evaluation. 911 called. Writer called RP notified of medication discrepancy and change of condition and new order to send to ER for evaluation. Resident states fells (Sic) nauseated, v/s taken blood pressure 82/62, resident noted pale increase sweating noted. Last set of V/S taken prior to EMS (emergency medical service) arriving noted 95/65 (blood pressure), pulse 47, resident sitting up in bed, responsive to verbal stimuli, no emesis noted. EMS arrived, resident left building with EMS approximately 7:40 p.m. to (name of the hospital) ER." There was no evidence in the clinical record that Resident #10's care plan goals were sent to the receiving provider for this facility- initiated transfer dated 7/16/18. On 12/19/2018 at approximately 2:33 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what documentation is provided to the receiving provider for a facility initiated hospital transfer.	F 622		

F 622 Continued From page 7 F 622

LPN #1, replied " A face sheet, medication list, physician order sheet, CCD (continuing care document) which shows when medication was last given, a transfer sheet, and then sometimes we send their progress notes." When asked if the facility provides the residents care plan goals to a receiving provider, LPN #1 replied "No."

On 12/19/2018 at approximately 2:57 p.m., an interview was conducted with OSM (other staff member) #2, Director of Admissions. OSM #2 was asked if the facility provides care plan goals to a receiving provider. OSM #2 replied, "I don't know, but I can check on that."

On 12/19/2018 at approximately 3:45 p.m., a follow up interview was conducted with OSM #2. When asked if the facility provides care plan goals to a receiving provider. OSM #2 replied, "No, we don't."

On 12/20/18 at approximately 11:08 a.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing, were made aware of the findings.

No further information was provided prior to exit.

1. A stroke lasts only a few minutes. It happens when the blood supply to part of the brain is briefly blocked. Symptoms of a TIA are like other stroke symptoms, but do not last as long. They happen suddenly, and include: Numbness or weakness, especially on one side of the body, confusion or trouble speaking or understanding speech, trouble seeing in one or both eyes, difficulty walking, dizziness and a loss of balance or coordination. This information was obtained from the website:

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https://medlineplus.gov/transientischemicattack.html.

2. Stomach contents leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

3. A disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

F 623 SS=D

Notice Requirements Before Transfer/Discharge
CFR(s): 483.15(c)(3)-(6)(8)

Completion date: 2/3/19

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.

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(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State

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F 623	Continued From page 10 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, facility staff	F 623	Upon discharge from the hospital Resident #30	

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failed to notify the resident, resident's representative, and the Ombudsman in writing of a facility-initiated discharge for 2 of 20 residents reviewed.

1. For Resident #30, facility staff did not notify the resident, their representative, or the Ombudsman of a facility-initiated transfer to the hospital on 09/25/2018.

2. For Resident #10, the facility staff failed to provide Resident #10 or the resident's representative (RP) and the ombudsman with written documentation of a facility initiated transfer dated 7/16/18.

The findings included:

1. For Resident #30, facility staff did not notify the resident, their representative, or the Ombudsman of a facility-initiated transfer to the hospital on 09/25/2018.

Resident #30 was admitted to the facility on 09/14/2018. Her diagnoses included Atrial Fibrillation(1), Coronary Artery Disease (a hardening and/or blockage of the arteries that feed the heart), Hyperlipidemia (high levels of cholesterol in the blood), Arthritis, and Asthma. Resident #30's most recent Minimum Data Set (MDS) Assessment was a Medicare 5-Day Assessment with an Assessment Reference Date (ARD) of 09/21/2018. The Brief Interview for Mental Status (BIMS) coded Resident #30 at 15, indicating no impairment. Resident #30 was coded as requiring limited assistance of 1 person for ambulation, dressing, and hygiene, supervision and setup assistance for transfers,

F 623

went home to live with her daughter.

Resident #10 was readmitted to this facility on 7/18/18 and continues to reside here as a long term care resident.

Residents being transferred to the ER or to another facility have the potential of the facility to fail to notify the resident representative or Ombudsman of the transfer. Currently, we have no residents in the hospital.

The Social Worker, or designee, will maintain a log of facility initiated transfers/discharges and notifications will be sent by FAX, with receipt confirmed on a monthly basis to the State Ombudsman.

Twice weekly for 4 weeks, then monthly for 3 months, the DON, or designee, will audit to ensure that the Resident Representative and State Ombudsman were notified of all residents who were transferred or discharged. If variances are identified, proper information will be sent and responsible staff will be educated.
An audit tool has been initiated and will be implemented to ensure that the ombudsman and Resident Representative

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

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and was independent with setup assistance for bed mobility, dining, and toileting.

Resident #30's closed record was reviewed on 12/20/2018. It was noted in the Progress Notes that Resident #30 was transferred to the hospital on 09/25/2018. Progress Notes from the nursing staff did not have documentation of what was sent with the resident to the hospital.

On 12/19/2018 at 2:33p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1 regarding the process for sending a resident to the hospital. When asked to what the process is for sending a resident to the hospital, and what gets send with them, LPN #1 stated:

"Once we have the order to transfer from the doctor, we get the resident ready and send a facesheet, a copy of their meds, their current POS, a copy of the CCD (continuing care document) that shows when each med was last given, a transfer sheet, and then sometimes we send their progress notes if there is something related to them going to the hospital. We'll also send things like Xrays or labs if they are related."

When asked if the resident or their Responsible Party was notified of the transfer, LPN #1 stated "yes of course, we call the family right away." When asked if a written notice was sent with the resident or sent to the Responsible Party, LPN #1 stated "no, not that I know of."

A review of the facility policy entitled "Transfers/Discharges" revealed the following under the heading "Procedure":

"1. Prior to transfer or discharge of a Resident,

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were notified of all transfers/discharges.

The audit findings will be Reviewed by the QA Committee at the monthly meeting. Any deficient findings will be addressed by an action plan.

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documentation will be made in the medical record that:
...
b. A family member who is the responsible party or other legal representative of the Resident was notified and identified.

...

6. ... The facility will send a copy of the Notice to a representative of the Office of the State Long Term Care Ombudsman."

On 12/20/2018 at 2:57p.m., an interview was conducted with OSM (Other Staff Member) #2, the Director of Admissions. OSM #2 stated that she assists with transfers and discharges as well as admissions. When asked if notices of transfers to the hospital are sent to the Long Term Care Ombudsman, OSM #2 replied "I don't think so, but I will check."

At 3:45p.m., OSM #2 followed up to state that notice of transfers was not sent to the Ombudsman.

ASM (Administrative Staff Member) #1, the facility Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 12/20/2018, at around 10:30am. No further documentation was provided.

1. An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. (https://medlineplus.gov/atrialfibrillation.html)

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2. The facility staff failed to provide Resident #10 or the resident's representative (RP) and the ombudsman with written documentation of a facility initiated transfer dated 7/16/18.

Resident #10 was admitted to the facility on 4/18/2013 with a most recent readmission date of 7/18/2018. Diagnoses included but were not limited to: diabetes, transient ischemic attack (1), gastro-esophageal reflux (2), depression and chronic obstructive pulmonary disease (3).

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 10/19/18 coded the resident as having a score of 9 on the BIMS (brief interview for mental status) score, indicating the resident had moderate cognitively impairment for daily decision making.

Review of Resident #10's clinical record revealed that she was sent to the hospital on 7/16/18. A nursing note dated 7/16/18 at 5:50 p.m. documented, "After medication discrepancy V/S (vital signs) taken blood pressure 137/83, pulse 72, respirations 18, Spo2 (peripheral oxygen saturation) 95% on room air, Temperature 96.4, MD (medical doctor) notified, new orders noted to monitor for signs and symptoms of diaphoresis, monitor vital signs every hour, call back with vital signs in 1 hour. RP (responsible party) called no answer left message awaiting return call. Approximately 6:45 p.m. vital signs obtained blood pressure 103/68 pulse 49 resident noted diaphoretic, writer called MD notify (Sic), new order to send to ER (emergency room) further evaluation. 911 called. Writer called RP notified of medication discrepancy and change of condition and new order to send to ER for evaluation.

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Resident states fells (Sic) nauseated, v/s taken blood pressure 82/62, resident noted pale increase sweating noted. Last set of V/S taken prior to EMS (emergency medical service) arriving noted 95/65 (blood pressure), pulse 47, resident sitting up in bed, responsive to verbal stimuli, no emesis noted. EMS arrived, resident left building with EMS approximately 7:40 p.m. to (name of the hospital) ER."

Clinical record failed to evidence documentation that Resident #10, the RP or the Ombudsman were given written notification regarding the facility initiated transfer dated 7/16/18.

On 12/19/18 at approximately 2:33 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked when a resident is transferred to the hospital, does the resident and/or the resident representative get anything in writing documenting why the resident was transferred. LPN #1, "No, we just call them."

On 12/19/2018 at approximately 2:53 p.m., an interview was conducted with OSM (other staff member) #1, Social Worker. OSM #1 was asked when a resident is transferred to the hospital, does the resident and/or the resident representative get anything in writing documenting why the resident was transferred. OSM #1 replied, "I am not involved with hospital transfers, the admissions department usually handles hospital transfers."

On 12/19/18 at approximately 2:57 p.m., an interview was conducted with OSM #2, Director of Admissions. OSM #2 was asked when a resident is transferred to the hospital, does the resident and/or the resident representative get anything in

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writing documenting why they are being transferred. OSM #2 replied, "We call them, but I don't believe we give them anything." When asked if she plays a role in notifying the ombudsman regarding a transfer to the hospital. OSM #3 replied, "I don't know, but I can check on that."

On 12/19/2018 at approximately 3:45 p.m., a follow up interview was conducted with OSM #2, Director of Admissions. When asked if she plays a role in notifying the ombudsman regarding a transfer to the hospital. OSM #2 replied, "No, we [the admissions department] don't."

On 12/20/18 at approximately 11:08 a.m., ASM (administrative staff member) #1, the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings.

No further information was provided prior to exit.

1. A stroke lasts only a few minutes. It happens when the blood supply to part of the brain is briefly blocked. Symptoms of a TIA are like other stroke symptoms, but do not last as long. They happen suddenly, and include: Numbness or weakness, especially on one side of the body, confusion or trouble speaking or understanding speech, trouble seeing in one or both eyes, difficulty walking, dizziness and a loss of balance or coordination. This information was obtained from the website: https://medlineplus.gov/transientischemicattack.html.

2. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website:

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F 623	Continued From page 17 https://www.nlm.nih.gov/medlineplus/gerd.html. 3. Disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625		2/3/19

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F 625	Continued From page 18 facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide a bed hold policy to the resident or the resident's representative upon a transfer to the hospital for three of 20 residents in the survey sample, Residents #'s 4, 30 and 10. 1. The facility staff failed to provide Resident # 4 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 09/16/18. 2. For Resident #30, a written copy of the bed hold policy was not provided to the Resident or their Representative at the time of transfer to the hospital. 3. For Resident #10, the facility staff failed to provide the resident and or the resident's representative (RP) with a written notice of bed-hold policy for a facility initiated hospital transfer dated 7/16/18. The findings include: 1. The facility staff failed to provide Resident # 4 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 09/16/18. Resident # 4 was admitted to the facility on	F 625	Resident #4 was readmitted to this facility from the hospital on 9/19/18 and continues her residence here receiving long term care. Resident #30 was discharged home after a hospital stay. Resident #10 was readmitted to this facility on 7/18/18 and continues to receive long term care services. Residents being transferred to the hospital have the potential for the facility to fail to provide bed hold notice to the resident representative. None of our residents are currently in the hospital. Licensed nurses will be inserviced on sending the Bed Hold notice with the resident when transfer-red to the hospital. The Admissions Team will follow up with the resident or resident representative to ensure that the bed hold notice was received, that the Resident Representative understands the policy, and whether the bed	

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F 625	Continued From page 19 12/07/16 with diagnoses that included but were not limited to chronic obstructive pulmonary disease (1), anxiety (2), hypertension (3) and anemia (4). Resident # 4's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 09/26/18, coded Resident # 4 as scoring a 12 on the brief interview for mental status (BIMS) of a score of 0 - 15, 12 - being moderately impaired of cognition for making daily decisions. Resident # 4 was coded as requiring extensive assistance of one staff member for activities of daily living and independent with eating. The nurse's "Progress Notes" for Resident # 4 dated 09/16/2018 documented, "11:07PM (p.m.) Called to resident room c/o (complaint of) difficulty breathing. Resident received a breathing rx [sic] (treatment), along with valium 5 (five) mg (milligram). Resident then c/o chest discomfort and requested to be taken to hospital. (Name od Company) contacted, spoke with (Name of Nurse Practitioner). Received an order to transfer resident to ed (emergency department) for evaluation and rx [sic]. Call placed to both son and daughter. Message left to contact (Name of Nursing Home) in reference to above. Resident transferred to (Name of Hospital) via (by) ambulance." Review of the EHR (electronic health record) and the clinical record for Resident # 4 failed to evidence that Resident # 4 or the resident's representative was provided a written notification of the bed hold policy when the resident was transferred to the hospital on 09/16/18.	F 625	is being held. An audit will be performed by the administrative team for all transfers/discharges for one month, then follow the recommendations from the QA Committee. The Admissions team will maintain an ongoing electronic log of emergent transfers of bed hold policy sent with the residents and the follow up information from the Resident Representative. The findings of the monthly audit will be reviewed by the monthly QA committee. Any deficient findings will be corrected by an action plan.	

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On 12/19/18 at approximately 2:57 p.m. an interview was conducted with OSM (other staff member) # 2, director of admissions regarding the facility's bed hold process. When asked how the bed hold policies are handled when a resident is transferred to the hospital OSM # 2 stated, "We usually reach out to the family after 24 hours to see if they want a bed hold." When asked how they reach out to the family OSM # 2 stated, "Usually by phone or email."

When asked if they send a written bed hold notice to the family or responsible party at the time of transfer to the hospital OSM # 2 stated, "No, the policy isn't sent at the time of discharge."

On 12/19/18 at 5:25 p.m. ASM (administrative staff member) # 1, acting administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

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(4) Low iron. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anemia.html
.

2. For Resident #30, a written copy of the bed hold policy was not provided to the Resident or their Representative at the time of transfer to the hospital.

Resident #30 was admitted to the facility on 09/14/2018. Her diagnoses included Atrial Fibrillation(1), Coronary Artery Disease (a hardening and/or blockage of the arteries that feed the heart), Hyperlipidemia (high levels of cholesterol in the blood), Arthritis, and Asthma. Resident #30's most recent Minimum Data Set (MDS) Assessment was a Medicare 5-Day Assessment with an Assessment Reference Date (ARD) of 09/21/2018. The Brief Interview for Mental Status (BIMS) coded Resident #30 at 15, indicating no impairment. Resident #30 was coded as requiring limited assistance of 1 person for ambulation, dressing, and hygiene, supervision and setup assistance for transfers, and was independent with setup assistance for bed mobility, dining, and toileting.

Resident #30's closed record was reviewed on 12/20/2018. It was noted in the Progress Notes that Resident #30 was transferred to the hospital on 09/25/2018. Progress Notes from the nursing staff did not have documentation of what was sent with the resident to the hospital.

On 12/20/2018 at 2:57p.m., an interview was conducted with OSM (Other Staff Member) #2, the Director of Admissions. OSM #2 stated that

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she assists with transfers and discharges as well as admissions. When asked how Bed Holds are handled in the event a resident is transferred to the hospital, OSM #2 replied:

"We usually reach out to the family after 24 hours to see if they want a bed hold."

When asked how this is communicated, OSM #2 stated:

"Usually by phone or email."

When asked if they ever send a written bed hold notice to the family or RP, or at the time of transfer to the ED, OSM #2 replied:

"No, the policy isn't sent at the time of discharge."

A review of the facility policy entitled "Transfers/Discharges" revealed that the facility provides a resident and/or their responsible party with notice of the bed hold policy at the time of admission, but it does not describe providing the resident and/or their representative with a written copy at the time of a transfer to the hospital.

ASM (Administrative Staff Member) #1, the facility Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 12/20/2018, at around 10:30am. No further documentation was provided.

1. An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. (https://medlineplus.gov/atrialfibrillation.html)

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3. For Resident #10, the facility staff failed to provide the resident and or the resident's representative (RP) with a written notice of bed-hold policy for a facility initiated hospital transfer dated 7/16/18.

Resident #10 was admitted to the facility on 4/18/2013 with a readmission date of 7/18/2018. Diagnoses included but were not limited to: diabetes, transient ischemic attack (1), gastro-esophageal reflux (2), depression and chronic obstructive pulmonary disease (3).

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 10/19/18 coded the resident as having a score of 9 of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions.

Review of Resident #10's clinical record revealed that she was sent to the hospital on 7/16/18. A nursing note dated 7/16/18 at 5:50 p.m. documented, "After medication discrepancy V/S (vital signs) taken blood pressure 137/83, pulse 72, respirations 18, Spo2 (peripheral oxygen saturation) 95% on room air, Temperature 96.4, MD (medical doctor) notified, new orders noted to monitor for signs and symptoms of diaphoresis, monitor vital signs every hour, call back with vital signs in 1 hour. RP (responsible party) called no answer left message awaiting return call. Approximately 6:45 p.m. vital signs obtained blood pressure 103/68 pulse 49 resident noted diaphoretic, writer called MD notify (Sic), new order to send to ER (emergency room) further evaluation. 911 called. Writer called RP notified of

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medication discrepancy and change of condition and new order to send to ER for evaluation. Resident states fells (Sic) nauseated, v/s taken blood pressure 82/62, resident noted pale increase sweating noted. Last set of V/S taken prior to EMS (emergency medical service) arriving noted 95/65 (blood pressure), pulse 47, resident sitting up in bed, responsive to verbal stimuli, no emesis noted. EMS arrived, resident left building with EMS approximately 7:40 p.m. to (name of the hospital) ER."

Clinical record failed to evidence that written notification of bed-hold policy was provided to Resident #10 or the resident's representative; regarding the facility- initiated transfer dated 7/16/18.

On 12/19/2018 at approximately 2:53 p.m., an interview was conducted with OSM (other staff member) #1, Social Worker. OSM #1 was asked when a resident is transferred to the hospital, is written notification of bed-hold policy provided to the resident and or the resident's representative, OSM #1 replied "I am not involved with hospital transfers, the admissions department usually handles hospital transfers."

On 12/19/2018 at approximately 2:57 p.m., an interview was conducted with OSM (other staff member) #2, Director of Admissions. OSM #2 was asked if residents and/or their representatives are provided written information regarding the bed hold policy when a resident is discharged to the hospital, OSM #2 replied "We usually reach out to the family by phone 24 hours after transfer to see if they want a bed hold." OSM #2 was asked if a written notice of bed hold policy is provided to the resident and or the RP at

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the time of a hospital transfer, OSM #2 replied "No, the policy isn't sent at the time of hospital transfer."

On 12/20/18 at approximately 11:08 a.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings.

No further information was provided prior to exit.

1. A stroke lasts only a few minutes. It happens when the blood supply to part of the brain is briefly blocked. Symptoms of a TIA are like other stroke symptoms, but do not last as long. They happen suddenly, and include: Numbness or weakness, especially on one side of the body, confusion or trouble speaking or understanding speech, trouble seeing in one or both eyes, difficulty walking, dizziness and a loss of balance or coordination. This information was obtained from the website: https://medlineplus.gov/transientischemicattack.html.

2. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

3. Disease that makes it difficult to breath that can lead to shortness of breath). The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		2/3/19

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care

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F 656	Continued From page 27 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. 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 implement the care plan for three of 20 residents in the survey sample, Residents #20, #128 and #22. 1. The facility staff failed to implement Resident #20's care plan for medication administration. 2. The facility staff failed to implement Resident #128's care plan for medication administration. 3. The facility staff failed to follow the comprehensive care plan for the implementation of non-pharmacological interventions prior to the administration of Resident # 22's prn (as needed) pain medication of Norco (hydrocodone-acetaminophen) [1]. The findings include: 1. The facility staff failed to implement Resident #20's care plan for medication administration. Resident #20 was admitted to the facility on 3/23/17. Resident #20's diagnoses included but were not limited to heart failure, high blood pressure and fracture of right lower leg. Resident #20's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference) date of 11/24/18, coded the resident's cognition as moderately impaired.	F 656	Resident #20 continues to reside in this facility on a long term basis. The facility nurse practitioner assessed the resident on 12/26/18 and wrote that her hypertension was chronic but stable. Nurse #3 was educated on following the resident plan of care for medication administration on 12/19/18. Resident #128 still resides in this facility receiving skilled services and receiving medications as per the physician orders and plan of care. On 12/19/18, Nurse #6 was educated on medication administration including following the resident□s plan of care. Resident #22 has continued to reside in this facility receiving skilled services. The resident□s care plan was updated to reflect non-pharmacological interventions should be attempted before administering PRN medications. Nurse #3 received education	

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Resident #20's comprehensive care plan with a problem start date of 4/4/17 documented, "Resident is at risk for dehydration R/T (related to) diuretic medication use...Medications per physician orders..."

Review of Resident #20's clinical record revealed a physician's order with a start date of 11/23/17 for bumetanide 2 mg (milligrams) once a day at 7:30 a.m. The order was discontinued 10/24/18.

Further review of Resident #20's clinical record revealed a physician's order dated 10/27/18 for bumetanide 1 mg- one tablet twice a day, scheduled at 9:00 a.m. and 5:00 p.m. for heart failure. Resident #20's December 2018 MAR (medication administration record) documented the same physician's order.

On 12/18/18 at 4:16 p.m., LPN #3 was observed preparing and administering Resident #20's medications. In addition to other medications, LPN #2 prepared and administered one tablet of bumetanide 2 mg to Resident #20.

On 12/19/18 at 3:05 p.m., an interview was conducted with LPN #5. LPN #5 was asked the purpose of a care plan. LPN #5 stated, "So you know how to take care of the residents while they are here." When asked how nurses ensure they follow residents' care plans, LPN #5 stated, "Well, nine times out of ten we have known the residents and are familiar with their care but it you are unfamiliar with their care plan it is right there at the desk. All you have to do is look it up."

On 12/19/18 at 3:36 p.m., an interview was conducted with LPN #3. LPN #3 was asked to

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on 12/19/18 on medication administration including following the resident plan of care. Residents receiving any medication have the potential for failure to have their care plan implemented for med administration or for the use of non-pharmacological interventions before use of PRN pain medications.

There have been no further reported medication errors. Licensed nurses will be inserviced on medication administration including the 5 Rights, the importance of reporting medication errors, following the protocol for use of any type of non-pharmacological interventions, and interpreting the effectiveness of these interventions. Certified nursing assistants will be inserviced on the importance of the implementation of non-pharmacological intervention.

Administrative nurses will perform observed medication passes with newly hired licensed nurses during the orientation process. Two to three current licensed nurses will be observed during a medication pass weekly x 4. The facility will continue to utilize the Pharmacy Consultant to conduct monthly med observation audits.

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explain Resident #20's bumetanide order. LPN #3 reviewed the resident's physician's orders and stated, "One tablet, one milligram twice a day at nine am and five pm." On 12/19/18 at 3:45 p.m., review of Resident #20's medications in the medication cart was conducted with LPN #3. A card of bumetanide 2 mg was observed and a card of bumetanide 1 mg was observed. LPN #3 was made aware this surveyor observed her prepare and administer one tablet of bumetanide 2 mg to Resident #20 on the previous day. LPN #3 confirmed she did not realize she did so.

On 12/19/18 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern

The facility policy titled, "RAI (Resident Assessment Instrument) and Plan of Care" documented, "ix. The plan of care is communicated to all appropriate facility personnel/volunteers/family/other parties as necessary. x. The care plan will be accessible to any person involved in the implementation of the care plan..."

No further information was presented prior to exit.

(1) Bumetanide is used to treat fluid retention caused by heart failure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684051.html

2. The facility staff failed to implement Resident #128's care plan for medication administration.

The results of the med pass audits will be reviewed at the monthly QA Committee meeting for further discussion or the need for an action plan.

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Resident #128 was admitted to the facility on 11/28/18. Resident #128's diagnoses included but were not limited to diabetes, pain and chronic kidney disease. Resident #128's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 12/12/18, coded the resident as being cognitively intact.

Resident #128's comprehensive care plan with a problem start date of 12/6/18 documented, "I am at risk for adverse side effects of 9+ meds (medications)...Administer medications as ordered..."

Review of Resident #128's clinical record revealed a physician's order dated 11/29/18 for senna s (a combination medication containing sennosides and colace) (1) 8.6/50 mg (milligrams)- two tablets once a day scheduled at 9:00 a.m. for constipation. Resident #128's December 2018 MAR (medication administration record) documented the same physician's order.

On 12/19/18 at 7:55 a.m., LPN (licensed practical nurse) #6 was observed preparing and administering Resident #128's medications. In addition to other medications, LPN #6 removed two tablets of senna (with no colace) (2) 8.6 mg from a package that was labeled with another resident's name. LPN #6 administered the medications (including the senna with no colace) to Resident #128.

On 12/19/18 at 10:43 a.m., an interview was conducted with LPN #6. LPN #6 was asked to show this surveyor Resident #128's senna with colace. LPN #6 entered the medication cart, reviewed packages of senna (with no colace) and

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stated, "I gave her (name of other resident's) senna 8.6 milligrams but that is the same dose that is ordered. I'm sorry." LPN #6 was asked to review Resident #128's physician orders. LPN #6 confirmed Resident #128's physician order was for two tablets of senna with colace 8.6/50 mg and she administered another residents' senna with no colace. LPN #6 confirmed she did not administer the correct medication to Resident #128. LPN #6 stated she should have double and tripled checked the medications especially since she prepared the medications on a hall with dark lighting. When asked if she should make sure the package has the correct resident's name on it, LPN #6 stated, "Yes."

On 12/19/18 at 3:05 p.m., an interview was conducted with LPN #5. LPN #5 was asked the purpose of a care plan. LPN #5 stated, "So you know how to take care of the residents while they are here." When asked how nurses ensure they follow residents' care plans, LPN #5 stated, "Well, nine times out of ten we have known the residents and are familiar with their care but it you are unfamiliar with their care plan it is right there at the desk. All you have to do is look it up."

On 12/19/18 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1)Senna S (senna with colace) is a combination medication containing senna (a laxative) and colace (a stool softener) and is used to treat constipation. This information was obtained from the websites:

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https://medlineplus.gov/druginfo/meds/a601113.html and https://medlineplus.gov/druginfo/meds/a601112.html

(2) Senna (sennosides with no colace) is a laxative used to treat constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601112.html

3. The facility staff failed to follow the comprehensive care plan for the implementation of non-pharmacological interventions prior to the administration of Resident # 22's prn (as needed) pain medication of Norco (hydrocodone-acetaminophen).

Resident # 22 was admitted to the facility on 11/07/18 with diagnoses that included but were not limited to spinal stenosis (2), diabetes mellitus without complications (3), hypertension (4) and anemia (5).

Resident # 22's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/14/18, coded Resident # 22 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 22 was coded as requiring extensive assistance of one staff member for activities of daily living and independent with eating. Section "J0400 Pain Frequency" it coded Resident # 22 as "2 (two) - Frequently, "

The POS (physician's order sheet) for Resident #

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22 dated "11/01/2018 - 12/19/2018" documented, "Norco (hydrocodone-acetaminophen) - Schedule II tablet 7.5-325 mg; 1 (one) tablet; oral. Special instructions: Give 1 tablet every 4 hours PRN (as needed) for breakthrough pain. Start Date: 11/11/2018."

The EMAR (electronic medication administration record) dated "11/01/18 to 11/30/2018" documented, "Norco (hydrocodone-acetaminophen) - Schedule II tablet 7.5-325 mg; amt (amount) 1 (one) tablet; oral. Every 4 hours -PRN." Review of the EMAR revealed the administration of Norco (hydrocodone-acetaminophen) on;
11/11/18 at 11:13 a.m.
11/12/18 at 1:21 a.m., 5:17 a.m., and at 2:27 p.m.
11/13/18 at 12:12 a.m., 7:36 a.m., and at 8:41 a.m.
11/14/18 at 4:10 a.m. and at 8:41 a.m.
11/15/18 at 6:12 a.m.
11/16/18 at 1:55 a.m. and at 6:20 a.m.
11/17/18 at 6:28 a.m. and at 12:28 p.m.
11/18/18 at 5:01 a.m. and at 9:26 a.m., and at 4:07 p.m.
11/19/18 at 12:59 a.m.
11/20/18 at 2:02 a.m. and at 6:17 a.m.
11/21/18 at 2:52 a.m.
11/22/18 at 5:49 a.m. and at 10:26 a.m.
11/23/18 at 5:39 a.m.
11/24/18 at 2:40 a.m. and at 1:17 p.m.
11/25/18 at 2:25 a.m.
11/26/18 at 5:12 a.m. and at 5:31 p.m.
11/27/18 at 5:19 a.m.
11/28/18 at 2:17 a.m. and at 6:31 a.m.
11/30/18 at 6:19 a.m.
Further review of the EMAR dated "11/01/18 to 11/30/2018" failed to evidence documentation of non-pharmacological interventions prior to the

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administration of Norco (hydrocodone-acetaminophen) for Resident # 22.

The EMAR (electronic medication administration record) dated "12/01/18 to 12/31/2018" documented, "Norco (hydrocodone-acetaminophen) - Schedule II tablet 7.5-325 mg; 1 (one) tablet; oral. Every 4 hours -PRN." Review of the EMAR revealed the administration of Norco (hydrocodone-acetaminophen) on;
12/01/18 at 6:56 a.m. and at 3:41 p.m.
12/02/18 at 9:20 a.m. and at 5:32 p.m.
12/03/18 at 7:49 a.m.
12/05/18 at 6:37 a.m. and at 2:06 p.m.
12/06/18 at 5:55 a.m. and at 2:21 p.m.
12/07/18 at 5:37 a.m.
12/08/18 at 5:30 a.m.
12/09/18 at 7:50 a.m.
12/10/18 at 6:07 a.m., 10:46 a.m. and at 5:08 p.m.
12/11/18 at 5:40 a.m.
12/13/18 at 6:00 a.m. and at 8:13 p.m.
12/14/18 at 5:52 a.m. and at 2:50 p.m.
12/15/18 at 8:48 a.m. and at 8:03 p.m.
12/16/18 at 5:24 a.m. and at 2:50 p.m.
12/17/18 at 4:47 p.m.
12/18/18 at 6:15 a.m. and at 5:24 p.m.
Further review of the EMAR dated "12/01/18 to 12/31/2018" failed to evidence documentation of non-pharmacological interventions prior to the administration of Norco (hydrocodone-acetaminophen) for Resident # 22.

Review of the nurse's "Progress Notes" for Resident # 22 dated 11/08/18 through 12/18/18 failed to evidence documentation of non-pharmacological interventions prior to the administration of Norco

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(hydrocodone-acetaminophen).

The comprehensive care plan for Resident # 22 dated "11/15/2018" documented, "Problem. Category: Pain. Resident shows evidence of acute pain AEB (as evidenced by) vocal complaints of pain, Neuropathy,, RLS (restless leg syndrome), Spinal stenosis, s/p (status post) spinal fusion, GERD (gastroesophageal reflux disease)." Under "Approach" it documented, "Monitor and report any complaints of pain: location, frequency, effects on function, alleviating factors, aggravating factors. Created: 11/15/2018."

On 12/18/18 at 4:23 p.m., an interview was conducted with Resident # 22. When asked if the nurse's try to alleviate her pain prior to administering of pain medication Resident # 22 stated, "No, not really. Therapy gives me ice when I get my therapy and it helps the pain but not from nursing."

On 12/19/18 at 3:17 p.m., an interview was conducted with LPN (licensed practical nurse) # 3 regarding the comprehensive care plan for Resident # 22. When asked about using non-pharmacological interventions to alleviate a resident's pain LPN # 3 stated, "Try those before giving the pain medication. When asked how often the non-pharmacological interventions should be attempted LPN # 3 stated, "Every time before giving the pain medication." When asked where it is documented that non-pharmacological interventions were attempted LPN # 3 stated, "It's on the eMAR and progress notes." LPN # 3 was asked to review the eMARs dated "11/01/18 to 11/30/2018", "12/01/18 to 12/31/2018" and the progress notes dated 11/08/18 through 12/18/18

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for Resident # 22. When asked if there was documented evidence of non-pharmacological interventions being attempted prior to the administration of Resident # 22's Norco (hydrocodone-acetaminophen) LPN # 3 stated, "No." LPN # 3 was then asked to review the comprehensive care plan for Resident # 22 dated "11/15/2018." When asked to explain the meaning of "alleviating factors" as stated in the care plan LPN # 3 stated that it was the same as non-pharmacological interventions. When asked if the care plan was being followed if there was no documented evidence of non-pharmacological interventions being attempted LPN # 3 stated, "No, it's not being followed."

On 12/19/18 at 5:25 p.m. ASM (administrative staff member) # 1, acting administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:

(1) Hydrocodone is an opioid pain medication. An opioid is sometimes called a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. The combination of acetaminophen and hydrocodone is used to relieve moderate to severe pain. This information was obtained from the website: https://www.rxlist.com/norco-5-325-drug/patient-images-side-effects.htm.

(2) A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal

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F 656	Continued From page 37 nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm. (3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html. (5) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .	F 656		
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of quality practice for two of 20 residents in the survey sample,	F 658	Resident #10 was readmitted to this facility and continues to receive long term care services without further medication administration error.	2/3/19

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Residents #10 and #128.

1. The facility staff failed to administer the correct physician ordered medications to Resident #10. LPN (Licensed practical nurse) #4 administered Resident #4's medications (clonidine, lorazepam and MS Contin) to Resident #10 on 7/16/18. This resulted in a change in condition (including diaphoresis, nausea, a lowered blood pressure and a lowered pulse) and Resident #10's hospitalization where the resident received Narcan, IV (intravenous) fluids and telemetry (heart) monitoring.

2. The facility staff failed to administer the correct physician ordered medication (senna s [senna with colace]) to Resident #128 on 12/19/18. LPN #6 administered Resident #78's senna with no colace to Resident #128.

The findings include:

1. The facility staff failed to administer the correct physician ordered medications to Resident #10. LPN (Licensed practical nurse) #4 administered Resident #4's medications (clonidine [1], lorazepam [2] and MS Contin [3]) to Resident #10 on 7/16/18. This resulted in a change in condition (including diaphoresis [sweating], nausea, a lowered blood pressure and a lowered pulse) and Resident #10's hospitalization where the resident received Narcan (4), IV (intravenous) fluids and telemetry (heart) monitoring.

Resident #4 was admitted to the facility on 12/7/16. Resident #4's diagnoses included but were not limited to anxiety disorder, high blood pressure and pain. Resident #4's most recent

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The nurse who administered the wrong medications to this resident is no longer employed by this facility.

Resident #128 continues to reside in this facility and continues to receive skilled services. The Senokot order was changed to PRN on 12/31/18, and the resident has received it as ordered.

Residents who receive medications, either scheduled, or on an as needed basis, have the potential to receive unnecessary medication.

Licensed nurses will receive a review of the facility□s medication adminis-tration policy emphasizing the rights to be observed before medication is administered to any resident, ie. the right dosage to the right resident, etc.

Nurses will be instructed to remove discontinued medications from the medication cart at the time the MD order is given to dis-continue that particular med type or dosage.
Administrative nurses will perform observed medication passes with newly hired licensed nurses during the orientation process. Two to three current licensed nurses will be observed during a medication pass weekly x 4.
The facility will continue to utilize

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F 658	Continued From page 39 MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 9/26/18, coded the resident's cognition as moderately impaired. Review of Resident #4's physician's orders revealed the following physician's orders: -5/30/18- clonidine 0.1 mg (milligrams) twice daily scheduled at 9:00 a.m. and 5:00 p.m. -5/30/18- lorazepam 0.5 mg twice daily scheduled at 6:00 a.m. and 6:00 p.m. -5/30/18- MS Contin 15 mg every 12 hours scheduled at 6:00 a.m. and 6:00 p.m. Resident #10 was admitted to the facility on 4/18/13. Resident #10's diagnoses included but were not limited to stroke, urinary tract infection and muscle weakness. Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/19/18, coded the resident's cognition as moderately impaired. Review of Resident #10's July 2018 physician's orders revealed the resident was not prescribed clonidine, lorazepam or MS Contin. Review of Resident #10's July 2018 MAR (medication administration record) revealed the resident's blood pressure was documented as 135/88 on 7/16/18 at 8:30 a.m. and 129/85 on 7/16/18 at 2:30 p.m. Review of Resident #10's vital sign record revealed the resident's pulse was documented as 82 on 7/16/18 at 8:56 a.m. A FRI (facility reported incident) submitted to the OLC (office of licensure and certification) on 7/16/18 documented, "On 7/16/18 during the 5 pm medication administration pass, the resident, (name of Resident #10), was administered	F 658	the Pharmacy Consultant to conduct monthly med observation audits. Med cart audits will be performed by the administration team weekly for one month and then as the QA Committee deems necessary to maintain compliance. The results of the med pass and med cart audits will be reviewed at the monthly QA Committee meeting. Nurses requiring more med pass training and observation will receive that instruction prior to administering meds independently.	

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medications ordered for another resident. The attending MD (medical doctor) was immediately notified of the incident and informed the nurse to monitor the resident and report back to him in an hour. The resident remained alert but did complain of nausea. Her blood pressure and pulse were below her normal range, so the MD ordered her to be sent to the ER (emergency room) to be evaluated. The responsible party was notified. An investigation is pending."

A nurse's note dated 7/16/18 documented, "After medication discrepancy V/S (vital signs) taken 137/83 (blood pressure), P (pulse) 72, R (respirations) 18, Spo2 (oxygen saturation) 95% RA (room air), Temp (temperature) 96.4, MD notified, new orders noted to monitor for s/sx (signs and symptoms) of diaphoresis, monitor V/S q (every) hr (hour), call back with V/S in 1 hr. RP (Responsible party) called no answer left message awaiting return call. Approx (Approximately) 645pm V/S obtained B/P (blood pressure) 103/68 P 49 resident noted diaphoretic, writer called MD notify, new order send resident to ER for eval (evaluation). Resident states fells (sic) nauseated, v/s taken B/P noted 82/62, resident noted pale increase (sic) sweating noted. Last set of V/S taken prior to EMS (emergency medical services) arriving noted 95/65 (blood pressure) P 47, resident noted sitting up in bed, responsive to verbal stimuli, no emesis noted. EMS arrived, resident left building with EMS approx 740PM to (name of hospital) ER."

A hospital history and physical dated 7/16/18 documented, "Chief complaint of changes in blood pressure and heart rate after receiving 0.5 mg of lorazepam, as well as 15 mg of MS Contin. Patient was given these medications at the (sic)

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approximately 5:50 p.m. tonight at the nursing home. Her blood pressure went from around 130 systolic to 103 systolic, and her heart rate went from the 70s down to the 50s so the patient was sent to the ER. I spoke to the nurse at the nursing home to obtain this history. She was not sure why the patient was given these medications, but states it may have been in error. No other reports of illness."

A medication discrepancy report signed by ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) on 7/17/18 documented, "RESIDENT NAME: (name of Resident #10). Immediate Action taken to counteract medication error: Vital signs immediately obtained, MD and family notified. Order obtained to monitor VS (vital signs) Q (every) 1 hr (hour). Outcome to Resident: felt nauseous and with VS changes. Doctor's Response: MD called with VS changes and order to send to ER for further evaluation. Family Response: Family responsive to orders. Name and Title of Staff Person Administering Medication: (Name and title of LPN #4). Check items that are applicable: (a check beside) The medication dosage was correct but given to the wrong resident..."

A follow up report submitted to the OLC on 7/18/18 documented, "Dear Sir/Madam, The purpose of this letter is to provide your agency with more information regarding the medication error report sent to your office on July, 16, 2018 involving the resident, (name of Resident #10). (Name of Resident #10) received MS Contin Extended Release 15 milligram tablet, Lorazepam 0.5 milligram tablet, and clonidine 0.1 milligram tablet which was prepared for

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F 658	Continued From page 42 administration for another resident, (name of Resident #4), during the 5 pm medication pass on 7/16/2018. (Name of LPN #4), LPN, was the nurse who administered the medication to (name of Resident #10). (Name of LPN #4) was hired on 7/11/2018 and has held an LPN license for 11 years. She completed her general orientation and (name of computer software program) training after hire at this facility on 7/13/2018. (Name of LPN #4) was administering medications under the supervision of (name and title of RN [registered nurse] #2), on the 3-11 shift on 7/16/2018. (Name of RN #2) has been employed at the facility since 1/23/2015 serving as the MDS coordinator. (Name of RN #2) was an LPN for 8 years and became an RN 10 years ago. (Name of RN #2) was observing (name of LPN #4) pour and pass each medication on one medication cart. That medication cart stores the medications for 20 residents on that hall. (Name of RN #2) is not routinely scheduled to administer medications, but does help pass medications when extra help is needed to adhere to the facility medication pass schedule. (Name of LPN #4) and (name of RN #2) selected (name of Resident #4's) medication profile on the Matrix screen. The medications were prepared following the facility policy. (Name of LPN #4) and (name of RN #2) entered the room together and (name of RN #2) identified (name of Resident #10). Immediately after (name of Resident #10) had swallowed the medications, the nurses realized that the meds (medications) prepared were those ordered for (name of Resident #4). This incident occurred at about 5:50 pm. (Name of Resident #10's) attending physician, (name of physician), was immediately notified of the medication error. (Name of physician) asked that the resident be monitored for diaphoresis and that her vital signs	F 658		

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F 658	Continued From page 43 be obtained every hour. (Name of Resident #10's) blood pressure at that time was 137/87 and her pulse was 72. At approximately 6:45 pm the resident was noted to be diaphoretic with a blood pressure of 103/68 and her pulse rate was 49. The resident, who was responsive to verbal stimuli, voiced a complaint of some nausea. (Name of physician) was notified of the findings of the ongoing physical assessment and ordered (name of Resident #10) be sent to (name of hospital) for evaluation. The resident was transported to (name of hospital) at 7:40 pm. The resident's daughter was notified of the incident and that the resident was being sent to the ER (emergency room)...INVESTIGATION/CONCLUSION: During their nursing career neither (name of LPN #4) nor (name of RN #2) have experienced a medication error which resulted in a resident being sent to the ER. The (name of pharmacy) 'General Dose Preparation and Medication Administration Policy' has been reviewed with both nurses. Facility nursing administration has observed a medication pass with (name of LPN #4) and will conduct an observed med pass with (name of RN #2) on her next scheduled day to work. (Name of LPN #4) exhibited proficiency with her observed med pass. The other facility licensed nurses will receive a review of the (name of pharmacy) med pass policy. Observed medication passes will continue to be ongoing for facility nurses. (Name of Resident #10) was kept at the hospital for observation and will be returning to this facility today. Facility staff met with the resident's son and daughter, explained the incident, and informed them of the actions being taken to prevent any further resident care issues..." The hospital discharge summary dated 7/18/18	F 658		

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documented, "BRIEF HOSPITAL COURSE: A 68-year-old with history of hypertension (high blood pressure), ischemic stroke, left-sided hemiplegia (paralysis), brought to the hospital from nursing home due to lethargy. The patient was given wrong medication MS Contin and Ativan (lorazepam). Family was notified as per the history and physical and patient was sent to the Emergency Room from the nursing home with lethargy. She had been evaluated in the Emergency Room. A CT (computed tomography) head showed old right MCA (middle cerebral artery) infarct. She received Narcan and was admitted to the telemetry, treated with IV fluids and was monitored on telemetry. Her lethargy improved while she was in the hospital. She is back to her baseline at this point..."

A note signed by the nurse practitioner on 7/18/18 documented, "CC (Chief complaint): Follow up from hospital. Interval History: Was asked to see patient to evaluate after admission to the hospital. Nursing reports that patient is returning to facility after staying overnight in the hospital. Patient had received another patient's medications and then started with hypotension (low blood pressure), bradycardia (low heart rate), diaphoresis and c/o (complaint of) nausea. Patient was monitored in the hospital and received IVF (intravenous fluids)..."

Resident #10's comprehensive care plan with a problem start date of 9/30/15 documented, "Resident is at risk for adverse side effects of 9+ meds (medications)...7/16/18 Medication discrepancy..."

The nurse who administered the wrong medications to Resident #10 was no longer

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employed at the facility and was not available for interview.

On 12/18/18 at 4:38 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked how she ensures she administers the correct medication to the correct resident. LPN #3 stated the resident's name is on the medication package and she writes the resident's room number on the medication cup. LPN #3 stated she compares the room number to what she writes on the medication cup and the medication package with the resident's name. LPN #3 also confirmed residents' pictures are located on the MAR (medication administration record).

On 12/19/18 at 8:18 a.m., an interview was conducted with LPN #6. LPN #6 was asked how she ensures she administers the correct medication to the correct resident. LPN #6 stated, "We have pictures and I also call them by name."

On 12/19/18 at 9:39 a.m., an interview was conducted with RN #2 (the MDS nurse who supervised LPN #4 on 7/16/18). RN #2 was asked to describe her experience with medication administration in the facility. RN #2 stated that during July 2018 she was "on the floor" a couple of times during that month. RN #2 stated she was not actually administering medications but she was overseeing other staff members administer medications. When asked why, RN #2 stated there were some staffing challenges and the supervisors were trying to get the newly hired nurses comfortable and acclimated to the residents so the nurses did not feel they were by themselves. When asked how nurses ensure the

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correct medication is administered to the correct resident, RN #2 stated, "Checking against the MARs, the medication packet. We have photos in the (name of computer MAR software program)." RN #2 was asked to describe the incident regarding Resident #10 on 7/16/18. RN #2 stated she was in the vicinity, of the medication cart but not actually standing at the cart when LPN #4 was preparing medications. RN #2 stated LPN #4 prepared medications and asked her to show her who Resident #10 was. RN #2 stated she walked LPN #4 over to Resident #10, introduced her to Resident #10 and LPN #4 administered medications to the resident. RN #2 stated LPN #4 went back to the medication cart and pulled the next medication listing minutes after administering medications to Resident #10. RN #2 stated she guessed this is when LPN #4 realized she administered Resident #4's medications to Resident #10 because LPN #4 came to her and said she gave Resident #4's medications to Resident #10. RN #2 stated after this, the nurses immediately obtained Resident #10's vital signs, which were stable so the nurses immediately notified the physician. RN #2 stated the physician responded by telling the nurses to monitor Resident #10's vital signs every hour and monitor the resident for diaphoresis. RN #2 stated she believed sometime afterward, Resident #10's blood pressure became low and the resident complained of not feeling well so LPN #4 notified the physician of the changes in condition and the physician ordered for Resident #10 to be sent to the emergency room.

On 12/19/18 at 10:16 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked the facility process for newly hired

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nurses administering medications. ASM #2 stated depending on the individual nurse's abilities, usually the nurse shadows another nurse on the medication cart during day two and day three then the nurse administers medications on day four. ASM #2 stated another nurse is present in the area if the newly hired nurse has questions or concerns but the other nurse is not with the newly hired nurse at all times. ASM #2 stated on 7/16/18, another nurse was overseeing LPN #4. ASM #2 was asked about the professional standard staff follows for resident identification during medication administration. ASM #2 stated many residents in the facility are able to state who they are. ASM #2 stated the facility does not use armbands but residents' names are documented outside their room doors and residents' pictures are located on the MARs.

ASM #2 was asked to describe the incident regarding Resident #10 that occurred on 7/16/18. ASM #2 stated she was not in the building at the time but LPN #4 called her so she asked LPN #4 what happened and made sure LPN #4 called the physician and family. ASM #2 stated she believed the physician told LPN #4 to do vital signs and monitor the resident. ASM #2 stated she guessed LPN #4 did not really know Resident #10 and Resident #10 was at her baseline the whole time. When asked if the resident's pulse of 49 was normal and at the resident's baseline, ASM #2 stated, "That wasn't normal." When asked to explain what she meant about Resident #10 being at her baseline the whole time, ASM #2 stated the resident's physical and activity of daily living presentation was at baseline and the resident always presented with a slumping posture and affected speech. When asked how she knew Resident #10 was at her baseline on

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F 658	Continued From page 48 7/16/18 if she was not in the building, ASM #2 stated she knew by the description LPN #4 gave her and there was another nurse (LPN #5) present that stated Resident #10 looked like her typical self. When asked if Resident #10's vital signs were at her typical baseline, ASM #2 confirmed they were not. ASM #2 stated LPN #4 monitored Resident #10 and said the resident's pulse was getting lower so she sent the resident to the ER. ASM #2 stated Resident #10 was gone by the time she got to the building. On 12/19/18 at 3:05 p.m., an interview was conducted with LPN #5. LPN #5 was asked to describe the incident regarding Resident #10 that occurred on 7/16/18. LPN #5 stated, "I called her name. She could respond. She wasn't talking but could say yes or no and (name of resident) has a really low voice so you have to lean in to actually hear her. She looked a little sleepy." When asked if she looked sleepier than her usual baseline, LPN #5 stated, "Yes." When asked if Resident #10's vital signs were at her baseline on 7/16/18, LPN #5 stated, "By the time I had gotten to the room the nurse had taken her vitals and called the doctor and called the ambulance." When asked if Resident #10 was typically diaphoretic, LPN #5 stated, "No." When asked if she recalled Resident #10 being diaphoretic, LPN #5 stated, "No." When asked if she recalled Resident #10 being nauseous, LPN #5 stated, "No. Like I said, the nurse had already assessed and called 911. I was in there for a couple minutes before 911 was there." When asked if Resident #10 was typically nauseous, LPN #5 stated, "No." When asked if Resident #10's pulse was typically 47, LPN #5 stated, "No." On 12/19/18 at 4:21 p.m., ASM #1 (the	F 658		

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administrator) and ASM #2 were made aware of the above concern and the concern for harm. ASM #1 and ASM #2 were asked to provide any further information.

On 12/20/18 at 10:15 a.m., ASM #2 confirmed the facility utilizes the policy titled, "Administration of Medications" as a standard of practice. The policy documented, "5. Before administering the medication or dietary supplement, check to see that the following are correct:
a. the right medication
b. the right dosage and strength
c. the right resident (photo identification with MAR or eMAR [electronic medication administration record])
d. the right time
e. the right route, and
f. the right form (i.e. tablet, liquid, capsule, or other)
g. no known allergy
h. the medication is not damaged, contaminated, or expired..."

The facility policy titled, "Orientation Outline Nursing" documented, "I. Administration of Medication- The employee is to follow the facility medication administration policy and procedure..."

On 12/20/18 at approximately 12:00 p.m., ASM #1 and ASM #2 provided an in-service meeting sign in sheet dated 7/17/18. The topic was "General Dose Preparation & Medication Administration." ASM #2 confirmed the in-service was not provided to all nurses.

No further information was presented prior to exit.

(1) Clonidine is used to treat high blood pressure.

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This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682243.html

(2) Lorazepam is used to relieve anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html

(3) MS Contin is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682133.html

(4) Narcan is used to treat opioid (including MS Contin) overdose. This information was obtained from the website: https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone

2. The facility staff failed to administer the correct physician ordered medication (senna s [senna with colace]) (1) to Resident #128 on 12/19/18. LPN #6 administered Resident #78's senna (2) with no colace to Resident #128.

Resident #78 was admitted to the facility on 12/17/18. Resident #78's diagnoses included but were not limited to major depressive disorder, high blood pressure and constipation. Resident #78's admission MDS (minimum data set) assessment was not complete. A nursing admission observation dated 12/17/18 documented Resident #78 as alert and oriented. Review of Resident #78's physician's orders dated 12/17/18 documented an order for senna 17.2 mg (milligrams) twice a day scheduled at

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9:00 a.m. and 5:00 p.m.

Resident #128 was admitted to the facility on 11/28/18. Resident #128's diagnoses included but were not limited to diabetes, pain and chronic kidney disease. Resident #128's most recent MDS, a 14 day Medicare assessment with an ARD (assessment reference date) of 12/12/18, coded the resident as being cognitively intact.

Resident #128's comprehensive care plan with a problem start date of 12/6/18 documented, "I am at risk for adverse side effects of 9+ meds (medications)...Administer medications as ordered..."

Review of Resident #128's clinical record revealed a physician's order dated 11/29/18 for senna s (a combination medication containing senna and colace) 8.6/50 mg- two tablets once a day scheduled at 9:00 a.m. for constipation. Resident #128's December 2018 MAR (medication administration record) documented the same physician's order.

On 12/19/18 at 7:55 a.m., LPN (licensed practical nurse) #6 was observed preparing and administering Resident #128's medications. In addition to other medications, LPN #6 removed two tablets of senna (with no colace) (2) 8.6 mg from a package that was labeled with Resident #78's name. LPN #6 administered the medications (including the senna with no colace) to Resident #128.

On 12/19/18 at 10:43 a.m., an interview was conducted with LPN #6. LPN #6 was asked to show this surveyor Resident #128's senna with colace. LPN #6 entered the medication cart,

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reviewed packages of senna (with no colace) and stated, "I gave her (Resident #78's) senna 8.6 milligrams but that is the same dose that is ordered. I'm sorry." LPN #6 was asked to review Resident #128's physician orders. LPN #6 confirmed Resident #128's physician order was for two tablets of senna with colace 8.6/50 mg and she administered Resident #78's senna with no colace. LPN #6 confirmed she did not administer the correct medication to Resident #128. LPN #6 stated she should have double and tripled checked the medications especially since she prepared the medications on a hall with dark lighting. When asked if she should make sure the package has the correct resident's name on it, LPN #6 stated, "Yes."

On 12/19/18 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1)Senna S (senna with colace) is a combination medication containing senna (a laxative) and colace (a stool softener) and is used to treat constipation. This information was obtained from the websites:
https://medlineplus.gov/druginfo/meds/a601113.html and
https://medlineplus.gov/druginfo/meds/a601112.html

(2) Senna (sennosides with no colace) is a laxative used to treat constipation. This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a601112.html

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(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, resident interview and facility document review it was determined that the facility staff failed to provide care and services for the prevention and treatment of a pressure injury for one of 20 residents in the survey sample, Resident #19. The facility staff failed to ensure complete skin assessments including measurements of the area on Resident #19's sacrum and left buttock area. The findings include: Resident #19 was admitted to the facility on 10/25/18. Diagnoses included but were not limited to: osteoarthritis (1), high blood pressure, atrial fibrillation (2), protein- calorie malnutrition, gastro-esophageal reflux disease (3), anemia (4), muscle weakness, dry eye, and insomnia.	F 686	Resident #19 continues to reside at this facility and receives skilled care services. The resident was admitted with sacral redness and excoriation. She continues to be followed by the wound MD who states the area is showing signs of improvement. Residents who are at risk of developing a pressure area, or who already developed a pressure area, are at risk for not receiving the care and services needed to pre-vent pressure areas or to heal existing pressure areas. Those residents identified as being at risk and those residents who actually have a pressure area are discussed at the weekly at risk meetings.	2/3/19

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F 686	Continued From page 54 The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 11/24/18, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living except eating as she only required supervision. In Section M - Skin Conditions, the resident was coded as having one unstageable pressure injury (5) (6). The admission nursing note dated 10/25/18 at 4:30 p.m., documented, "Sacrum area red and excoriated, barrier cream in place." The nursing note dated 10/28/18 at 2:06 p.m., documented, "Noted shearing to left buttock approximately 4cm (centimeters) x 5cm x 0.1cm. Cleansed with normal saline. Applied medihoney (7) and a dry protective dressing. RP (responsible party) and MD (medical doctor) notified." The nursing note dated 10/29/18 at 4:23 a.m., documented "Sheering to left buttock remains, day 1 shift 3 of monitoring. Resident turned and repositioned q2h (every two hours). Will continue to monitor." The NP (nurse practitioner) note dated 10/29/18 at 9:00 a.m., documented, "Was asked to see patient to evaluate shear to left buttocks. Nursing reports that patient was noted to have shear to left buttocks." The "Weekly Skin Observation" sheet dated 10/29/18 at 3:17 p.m., documented, "New area to the sacrum noted over the week. Tx. (treatment)	F 686	The facility uses the Braden assessment tool to identify those residents at risk for skin breakdown Licensed nurses and nursing assistants will receive education on the prevention of pressure areas. The HQI tool will be used to educate staff on the required documentation for recording the healing process. The DON, or designee, will review pressure area documentation weekly to ensure that the healing process is appropriately documented. The DON, or designee, will observe 2 nurses perform a treatment monthly x 3. The Nurse will be educated on observed opportunities. The findings of the pressure area observations and audits will be discussed at the monthly QA Committee meeting for additional oversight and/or action.	

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in place." Reviewed "Weekly Skin Observation" failed to record wound measurements.
The nursing note dated 11/4/18 at 4:46 p.m., documented, "Continue tx. (treatment) to sacral wound."

The "Weekly Skin Observation" sheet dated 11/5/18 at 2:15 p.m., documented, "No new areas noted, tx. remain to sacrum and BLE (bilateral [both] lower extremities)." Reviewed "Weekly Skin Observation" failed to record wound measurements.

The "Weekly Skin Observation" sheet dated 11/12/18 at 12:01 p.m., documented "No new areas noted. tx. remain to sacrum. Will continue to monitor." Reviewed "Weekly Skin Observation" failed to record wound measurements.

The wound care physician's note titled "Initial Wound Evaluation and Management Summary" dated 11/16/18 documented, "At the request of referring provider, (name of physician), a thorough wound care assessment and evaluation was performed today. She has a wound of the left buttock of at least 1 day duration." Three sites were identified: wound of the left buttock measured at 2.9cm x 2.7cm x 0.1cm, with light serous exudate and granulation tissue; unstageable (due to necrosis) sacrum, etiology (cause) pressure, wound size (L x W x D) 2.5cm x 3cm; wound of the right buttock wound size (L x W x D) 0.4cm x 0.4cm x 0.1cm." Wound care physician recommended continued treatment with "Leptospermum honey (7), gauze island dressing and off- load wound; reposition per facility protocol."

The "Weekly Skin Observation" sheet dated

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11/19/18 at 9:48 a.m., documented "No new areas noted tx. remain to sacrum." Reviewed "Weekly Skin Observation" failed to record wound measurements.

The "Weekly Skin Observation" sheet dated 11/20/18 at 2:23 a.m., documented "Treatment continues to sacrum." Reviewed "Weekly Skin Observation" failed to record wound measurements.

The "Weekly Skin Observation" sheet dated 12/4/18 at 6:55 a.m., documented "Open area to sacrum continues, treatment in place." Reviewed "Weekly Skin Observation" failed to record wound measurements.

The comprehensive care plan dated 11/6/18, documented "Skin: I am at risk for new pressure ulcers/impaired skin integrity due to: with skin tear/ shear and bruising present with admission (buttocks), impaired mobility, incontinence of bladder and bowels, decreased appetite, anemia, UST (unstageable) to sacrum, don't like to turn and prefer to stay on my back when in bed."

On 12/20/18 at approximately 8:07 a.m., an interview was conducted with ASM (administrative staff member) #3, the Assistant Director of Nursing. ASM #3 was asked to describe Resident #19's wound upon admission. ASM #3 stated, "The wound was an area of slough that happened in before she came. I think it happened while they were pulling her up in the bed." When asked where the wound was located, ASM #3 replied "It was at the upper gluteal crease and left buttock, there was just one spot." When asked how often the resident's skin is assessed, ASM #3 replied "She had a weekly skin assessment."

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When asked how a pressure wound is assessed, ASM #3 replied "It should be described, measured and you should document any treatment."

On 12/20/18 at approximately 8:49 a.m., an interview was conducted with LPN #9. When asked to describe Resident #19's wound. LPN #9 replied, "I saw the wound when the resident was admitted. It was the same area that was the sacrum and left buttock area. I measured it and started her on medihoney." When asked what a wound assessment consisted of, LPN #9 replied "A description of what the wound looks like, the wound bed measurements and any treatments that are being done." When asked how often wound assessments are done, LPN #9 replied "Weekly."

On 12/20/18 at approximately 9:12 a.m., an interview was conducted with RN (registered nurse) #5, Nurse Practitioner. RN #5 was asked what should a wound assessment consist of. RN #5 replied, "Any changes in the wound, any redness, measurements, orders, interventions, open skin and drainage.

On 12/20/18 at approximately 10:44 a.m., an interview was conducted with OSM (other staff member) #7, the Wound Care Physician. When asked how a wound assessment should be done, OSM #7 replied, "You note measurements, drainage, makeup of wound bed, whether is better or worse and the plan for treatment. When asked how often a wound should be assessed, OSM #7 replied, "Every facility is different."

The facility policy, "Pressure Ulcer and Skin Care" documented, "Documentation in a weekly

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narrative nurses notes of pressure ulcer to include: Description: anatomic location, stage, measurement in centimeters of each pressure ulcer (length, width, depth, undermining tunneling), description of wound bed, drainage, odor; and Intervention."

The Pressure Ulcer Treatment Quick Reference Guide by NPUAP states on page 8,"Assess and accurately document physical characteristics such as location, Category/Stage, size, tissue type (s), wound bed and periwound condition, wound edges, sinus tracts, undermining, tunneling, exudate, necrotic tissue, odor, presence/absence of granulation tissue, and epithelialization." Page 10 of this reference states, "Re-evaluate the pressure ulcer, the plan of care, and the individual if the pressure ulcer does not show progress toward healing within 2 weeks (or as expected given the individual's overall condition and ability to heal)...Signs of deterioration should be addressed immediately." This information was obtained from: National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel. Pressure Ulcer Prevention and Treatment: Clinical Practice Guideline. Washington, DC: National Pressure Ulcer Advisory Panel, Second edition published 2014.

On 12/20/18 at approximately 11:08 a.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing, were made aware of the findings.

No further information was provided prior to exit.

1. The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints.

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It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.

2. Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes the heart to beat much faster than normal, and the upper and lower chambers of the heart do not work together. When this happens, the lower chambers do not fill completely or pump enough blood to the lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in the heart, which increases your risk of having a stroke or other complications. This information was obtained from the website: https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation

3. A condition in which the stomach contents leak backwards from the stomach into the esophagus (the tube from the mouth to the stomach). This can irritate the esophagus and cause heartburn and other symptoms. This information was obtained from the website: https://medlineplus.gov/ency/article/000265.htm.

4. If you have anemia, your blood does not carry enough oxygen to the rest of your body. The most common cause of anemia is not having enough iron. Your body needs iron to make hemoglobin. Hemoglobin is an iron-rich protein that gives the red color to blood. It carries oxygen from the lungs to the rest of the body. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=

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medlineplus-bundle&query=anemia&_ga=2.71282640.1704263304.1542638661-1154288035.1542638661.

5. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. This information was obtained from the following website:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

6. A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. This information was obtained from the following website:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

7. Medical-grade honey is also standardized to have consistent germ-fighting activity. Some experts also suggest that medical-grade honey should be collected from hives that are free from germs and not treated with antibiotics, and that

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F 686	Continued From page 61 the nectar should be from plants that have not been treated with pesticides. Honey is also used as a source of carbohydrate during vigorous exercise or in people who are malnourished. It may also be used for wound healing. This information was obtained from the following website: https://medlineplus.gov/druginfo/natural/738.html	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide respiratory care and services consistent with professional standards of practice for one of 20 residents in the survey sample, Resident #228. The facility staff failed to provide respiratory services according to the physicians order for Resident #228. The findings include: Resident #228 was admitted to the facility on 12/16/18. Diagnoses included but were not limited to: chronic obstructive pulmonary disease	F 695	Resident #228 resides at this facility receiving skilled services. The resident□s oxygen settings have been observed since the survey and there has been no reported ill effects from the observation made during the survey. Any resident receiving oxygen therapy is at risk of not receiving the ordered liter amount. Nursing staff will be re-educated on the importance of frequently observing oxygen administration	2/3/19

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(COPD) (1), hypoxemia (2), pneumonia (3), atrial fibrillation (4) and high blood pressure.
At the time of the survey a MDS (minimum data set) had not been completed.

The physician order sheet dated December 2018 documented "Oxygen at 2 liters per minute via nasal cannula (A plastic tube with two prongs that inserts in the nose) Special Instructions: for less than 92% O2 sats (Oxygen saturation) or shortness of breath."

Reviewed baseline care plan dated 12/16/18 documented, "Oxygen 2L/min (liters/minute) via NC (nasal cannula) prn (as needed)."

Reviewed MAR (medication administration record) dated December 2018 documented, "Oxygen at 2 liters per minute via nasal, for less than 92% O2 sats or shortness of breath." was signed off as given 12/18/18.

On 12/18/18 at approximately 1:34 p.m., an observation was made of Resident #228's oxygen flow meter. Resident #228's oxygen flow rate was set with the ball between the 1.5L/min and 2L/min lines.

On 12/18/18 at approximately 4:34 p.m., a second observation was made of Resident #228's oxygen flow meter with another surveyor. Resident #228's oxygen flow rate was set with the ball between the 1.5L/min and 2L/min lines.

On 12/19/18 at approximately 12:48 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked how do set the rate on an oxygen flow meter. RN #1 replied, "You turn the dial until the line is in the middle of the

F 695

to ensure that residents receive oxygen therapy as ordered by the physician.

The DON or designee will conduct 5 observations weekly x 8 weeks of residents receiving oxygen therapy to ensure that the oxygen is being delivered per physician order. Any variances will be immediately corrected and assigned staff re-educated.

The findings of the oxygen equipment checks will be presented at the monthly QA meeting. Corrective action will ensue for any errors discovered.

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F 695	Continued From page 63	F 695		

ball."

On 12/19/18 at approximately 12:50 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked how do set the rate on an oxygen flow meter. LPN #2, replied "If the resident has 2 liters (2L/min) ordered then the 2 liter line should be in the middle of the ball."

The oxygen concentrator's manufacturer's instructions documented on page 10, "Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate."

According to the facilities oxygen administration policy, "The facility shall demonstrate that all staff responsible for assisting residents who use oxygen supplies have had training or instruction in the use and maintenance of resident specific equipment."

On 12/20/18 at approximately 11:08 a.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing, were made aware of the findings.

No further information was provided prior to exit.

1. A disease that makes it difficult to breath that can lead to shortness of breath. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. This information was obtained from the website:

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F 695	Continued From page 64 https://www.nlm.nih.gov/medlineplus/copd.html. 2. A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 3. An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: https://medlineplus.gov/pneumonia.html. 4. A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		2/3/19

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F 757	Continued From page 65 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 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 ensure a resident was free from unnecessary medication for one of 20 residents in the survey sample, Resident #20. The facility staff failed to administer the correct dose of bumetanide (1) to Resident #20 on 12/18/18. LPN #3 administered twice the physician ordered dose of bumetanide. The findings include: Resident #20 was admitted to the facility on 3/23/17. Resident #20's diagnoses included but were not limited to heart failure, high blood pressure and fracture of right lower leg. Resident #20's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference) date of 11/24/18, coded the resident's cognition as moderately impaired. Review of Resident #20's clinical record revealed a physician's order with a start date of 11/23/17 for bumetanide 2 mg (milligrams) once a day at 7:30 a.m. The order was discontinued 10/24/18. Further review of Resident #20's clinical record revealed a physician's order dated 10/27/18 for	F 757	Resident #20 continues to reside in this facility on a long term basis. The facility nurse practitioner assessed the resident on 12/26/18 and wrote that her hypertension was chronic but stable. Nurse #3 was educated on medication administration on 12/19/18. Residents who receive medications, either scheduled, or on a as needed basis, have the potential to receive unnecessary medication. Med carts have been inspected, and all meds not having current orders have been removed. Licensed nurses will receive a review of the facility□s medication administration policy. Nurses will be instructed to remove discontinued medications from the medication cart at the time the MD order is given	

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F 757	Continued From page 66 bumetanide 1 mg- one tablet twice a day, scheduled at 9:00 a.m. and 5:00 p.m. for heart failure. Resident #20's December 2018 MAR (medication administration record) documented the same physician's order. Resident #20's comprehensive care plan with a problem start date of 4/4/17 documented, "Resident is at risk for dehydration R/T (related to) diuretic medication use...Medications per physician orders..." On 12/18/18 at 4:16 p.m., LPN #3 was observed preparing and administering Resident #20's medications. In addition to other medications, LPN #2 prepared and administered one tablet of bumetanide 2 mg to Resident #20. On 12/19/18 at 3:36 p.m., an interview was conducted with LPN #3. LPN #3 was asked to explain Resident #20's bumetanide order. LPN #3 reviewed the resident's physician's orders and stated, "One tablet, one milligram twice a day at nine am and five pm." On 12/19/18 at 3:45 p.m., review of Resident #20's medications in the medication cart was conducted with LPN #3. A card of bumetanide 2 mg was observed and a card of bumetanide 1 mg was observed. LPN #3 was made aware this surveyor observed her prepare and administer one tablet of bumetanide 2 mg to Resident #20 on the previous day. LPN #3 confirmed she did not realize she did so. On 12/19/18 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern The facility policy titled, "Administration of	F 757	to discontinue that particular type or dosage. Administrative nurses will perform observed medication passes with newly hired licensed nurses during the orientation process. Two to three current licensed nurses will be observed during a medication pass weekly x 4. The facility will continue to utilize the Pharmacy Consultant to conduct monthly med observation audits. Nurses requiring more med pass training and observation will receive that instruction prior to administering meds independently. Medication carts will be inspected for any expired and/or discontinued medications weekly x 6 by DON or designee. Any observed discontinued and/or expired medications will be removed. The results of the med pass and med cart audits audits will be reviewed at the monthly QA Committee meeting.	

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F 757	Continued From page 67 Medications" documented, "5. Before administering the medication or dietary supplement, check to see that the following are correct: a. the right medication b. the right dosage and strength c. the right resident (photo identification with MAR or eMAR [electronic medication administration record]) d. the right time e. the right route, and f. the right form (i.e. tablet, liquid, capsule, or other) g. no known allergy h. the medication is not damaged, contaminated, or expired..." No further information was presented prior to exit. (1) Bumetanide is used to treat fluid retention caused by heart failure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684051.html	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; 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 ensure a medication error rate less than five	F 759	Resident #20 continues to reside in this facility on a long term basis. The facility nurse practitioner	2/3/19

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F 759	Continued From page 68 percent for two of 20 residents in the survey sample, Residents #20 and #128. Two errors out of 25 opportunities were observed during the medication administration observation. This resulted in a medication error rate of eight percent. 1. The facility staff failed to administer the correct dose of bumetanide to Resident #20 on 12/18/18. The physician ordered 1 mg (milligram) of bumetanide at 5:00 p.m. and LPN (licensed practical nurse) #3 administered 2 mg of bumetanide. 2. The facility staff failed to administer the correct medication (senna s [senna with colace]) to Resident #128 on 12/19/18. Instead, LPN #6 administered Resident #78's senna (with no colace) to Resident #128. The findings include: 1. The facility staff failed to administer the correct dose of bumetanide (1) to Resident #20 on 12/18/18. The physician ordered 1 mg (milligram) of bumetanide at 5:00 p.m. and LPN (licensed practical nurse) #3 administered 2 mg of bumetanide. Resident #20 was admitted to the facility on 3/23/17. Resident #20's diagnoses included but were not limited to heart failure, high blood pressure and fracture of right lower leg. Resident #20's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference) date of 11/24/18, coded the resident's cognition as moderately impaired. Review of Resident #20's clinical record revealed	F 759	assessed the resident on 12/26/18 and wrote that her hypertension was chronic but stable. Nurse #3 was educated on medication administration on 12/19/18. Resident #128 continues to reside in this facility and continues to receive skilled services. The Senokot order was changed to PRN on 12/31/18. Residents who receive medications, either scheduled, or on a as needed basis, have the potential to receive unnecessary medication. Licensed nurses will receive a review of the facility□s medication administration policy, emphasizing the importance of ensuring that the resident receive the right dosage and strength of the right medication at the right time by the right route. Nurses will be instructed to remove discontinued medications from the med cart at the time that the MD order is given to discontinue that particular type or dosage of medication. Administrative nurses will perform observed medication	

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F 759	Continued From page 69 a physician's order with a start date of 11/23/17 for bumetanide 2 mg (milligrams) once a day at 7:30 a.m. The order was discontinued 10/24/18. Further review of Resident #20's clinical record revealed a physician's order dated 10/27/18 for bumetanide 1 mg- one tablet twice a day, scheduled at 9:00 a.m. and 5:00 p.m. for heart failure. Resident #20's December 2018 MAR (medication administration record) documented the same physician's order. Resident #20's comprehensive care plan with a problem start date of 4/4/17 documented, "Resident is at risk for dehydration R/T (related to) diuretic medication use...Medications per physician orders..." On 12/18/18 at 4:16 p.m., LPN #3 was observed preparing and administering Resident #20's medications. In addition to other medications, LPN #2 prepared and administered one tablet of bumetanide 2 mg to Resident #20. On 12/19/18 at 3:36 p.m., an interview was conducted with LPN #3. LPN #3 was asked to explain Resident #20's bumetanide order. LPN #3 reviewed the resident's physician's orders and stated, "One tablet, one milligram twice a day at nine am and five pm." On 12/19/18 at 3:45 p.m., review of Resident #20's medications in the medication cart was conducted with LPN #3. A card of bumetanide 2 mg was observed and a card of bumetanide 1 mg was observed. LPN #3 was made aware this surveyor observed her prepare and administer one tablet of bumetanide 2 mg to Resident #20 on the previous day. LPN #3 confirmed she did not realize she did so.	F 759	passes with newly hired licensed nurses during the orientation process. Two to three current licensed nurses will be observed during a medication pass weekly x 4. The facility will continue to utilize the Pharmacy Consultant to conduct monthly med observation audits. Nurses requiring more med pass training and observation will receive that instruction prior to administering meds independently. Medication carts will be inspected for any expired and/or discontinued medications weekly x 6 by DON or designee. Any observed discontinued and/or expired medications will be removed. The results of the med pass And med cart audits will be reviewed at the monthly QA Committee meeting.	

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On 12/19/18 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern

The facility policy titled, "Administration of Medications" documented, "5. Before administering the medication or dietary supplement, check to see that the following are correct:
a. the right medication
b. the right dosage and strength
c. the right resident (photo identification with MAR or eMAR [electronic medication administration record])
d. the right time
e. the right route, and
f. the right form (i.e. tablet, liquid, capsule, or other)
g. no known allergy
h. the medication is not damaged, contaminated, or expired..."

No further information was presented prior to exit.

(1) Bumetanide is used to treat fluid retention caused by heart failure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684051.html

2. The facility staff failed to administer the correct medication (senna s [senna with colace]) (1) to Resident #128 on 12/19/18. Instead, LPN #6 administered Resident #78's senna (2) with no colace to Resident #128.

Resident #78 was admitted to the facility on

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12/17/18. Resident #78's diagnoses included but were not limited to major depressive disorder, high blood pressure and constipation. Resident #78's admission MDS (minimum data set) assessment was not complete. A nursing admission observation dated 12/17/18 documented Resident #78 as alert and oriented. Review of Resident #78's physician's orders dated 12/17/18 documented an order for senna 17.2 mg (milligrams) twice a day scheduled at 9:00 a.m. and 5:00 p.m.

Resident #128 was admitted to the facility on 11/28/18. Resident #128's diagnoses included but were not limited to diabetes, pain and chronic kidney disease. Resident #128's most recent MDS, a 14 day Medicare assessment with an ARD (assessment reference date) of 12/12/18, coded the resident as being cognitively intact.

Resident #128's comprehensive care plan with a problem start date of 12/6/18 documented, "I am at risk for adverse side effects of 9+ meds (medications)...Administer medications as ordered..."

Review of Resident #128's clinical record revealed a physician's order dated 11/29/18 for senna s (a combination medication containing senna and colace) 8.6/50 mg- two tablets once a day scheduled at 9:00 a.m. for constipation. Resident #128's December 2018 MAR (medication administration record) documented the same physician's order.

On 12/19/18 at 7:55 a.m., LPN (licensed practical nurse) #6 was observed preparing and administering Resident #128's medications. In addition to other medications, LPN #6 removed

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two tablets of senna (with no colace) (2) 8.6 mg from a package that was labeled with Resident #78's name. LPN #6 administered the medications (including the senna with no colace) to Resident #128.

On 12/19/18 at 10:43 a.m., an interview was conducted with LPN #6. LPN #6 was asked to show this surveyor Resident #128's senna with colace. LPN #6 entered the medication cart, reviewed packages of senna (with no colace) and stated, "I gave her (Resident #78's) senna 8.6 milligrams but that is the same dose that is ordered. I'm sorry." LPN #6 was asked to review Resident #128's physician orders. LPN #6 confirmed Resident #128's physician order was for two tablets of senna with colace 8.6/50 mg and she administered Resident #78's senna with no colace. LPN #6 confirmed she did not administer the correct medication to Resident #128. LPN #6 stated she should have double and tripled checked the medications especially since she prepared the medications on a hall with dark lighting. When asked if she should make sure the package has the correct resident's name on it, LPN #6 stated, "Yes."

On 12/19/18 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1)Senna S (senna with colace) is a combination medication containing senna (a laxative) and colace (a stool softener) and is used to treat constipation. This information was obtained from the websites:

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OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

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F 759	Continued From page 73 https://medlineplus.gov/druginfo/meds/a601113.html and https://medlineplus.gov/druginfo/meds/a601112.html (2) Senna (sennosides with no colace) is a laxative used to treat constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601112.html	F 759		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a resident was free from significant medication errors for one of 20 residents in the survey sample, Resident #10. The facility staff failed to administer the correct physician ordered medications to Resident #10. LPN (Licensed practical nurse) #4 administered Resident #4's medications (clonidine [1], lorazepam [2] and MS Contin [3]) to Resident #10 on 7/16/18. These significant medication errors resulted in a change in condition (including diaphoresis [sweating], nausea, a lowered blood pressure and a lowered pulse) and Resident #10's hospitalization where the resident received narcan (4), IV (intravenous) fluids and telemetry (heart) monitoring. The findings include:	F 760	Resident #10 was readmitted to this facility and continues to receive long term care services without further medication administration error. The nurse who administered the wrong medications to this resident is no longer employed by this facility. Residents who receive medications, either scheduled, or on an as needed basis, have the potential to receive unnecessary medication. Licensed nurses will receive a review of the facility□s medication administration policy emphasizing the rights to be observed before medication is administered to any	2/3/19

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F 760	Continued From page 74	F 760		

Resident #4 was admitted to the facility on 12/7/16. Resident #4's diagnoses included but were not limited to anxiety disorder, high blood pressure and pain. Resident #4's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 9/26/18, coded the resident's cognition as moderately impaired. Review of Resident #4's physician's orders revealed the following physician's orders:
-5/30/18- clonidine 0.1 mg (milligrams) twice daily scheduled at 9:00 a.m. and 5:00 p.m.
-5/30/18- lorazepam 0.5 mg twice daily scheduled at 6:00 a.m. and 6:00 p.m.
-5/30/18- MS Contin 15mg every 12 hours scheduled at 6:00 a.m. and 6:00 p.m.

Resident #10 was admitted to the facility on 4/18/13. Resident #10's diagnoses included but were not limited to stroke, urinary tract infection and muscle weakness. Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/19/18, coded the resident's cognition as moderately impaired.

Review of Resident #10's July 2018 physician's orders revealed the resident was not prescribed clonidine, lorazepam or MS Contin.

Review of Resident #10's July 2018 MAR (medication administration record) revealed the resident's blood pressure was documented as 135/88 on 7/16/18 at 8:30 a.m. and 129/85 on 7/16/18 at 2:30 p.m. Review of Resident #10's vital sign record revealed the resident's pulse was documented as 82 on 7/16/18 at 8:56 a.m.

Provider's plan of correction (F 760), continued:

resident, ie. the right dosage to the right resident, etc.

Nurses will be instructed to remove discontinued medications from the medication cart at the time the MD order is given to discontinue that particular med type or dosage.
Administrative nurses will perform observed medication passes with newly hired licensed nurses during the orientation process. Two to three current licensed nurses will be observed during a medication pass weekly x 4.
The facility will continue to utilize the Pharmacy Consultant to conduct monthly med observation audits.
Med cart audits will be performed by the administration team weekly for one month and then as the QA Committee deems necessary to maintain compliance

F 760 Continued From page 75 F 760

A FRI (facility reported incident) submitted to the OLC (office of licensure and certification) on 7/16/18 documented, "On 7/16/18 during the 5 pm medication administration pass, the resident, (name of Resident #10), was administered medications ordered for another resident. The attending MD (medical doctor) was immediately notified of the incident and informed the nurse to monitor the resident and report back to him in an hour. The resident remained alert but did complain of nausea. Her blood pressure and pulse were below her normal range, so the MD ordered her to be sent to the ER (emergency room) to be evaluated. The responsible party was notified. An investigation is pending."

A nurse's note dated 7/16/18 documented, "After medication discrepancy V/S (vital signs) taken 137/83 (blood pressure), P (pulse) 72, R (respirations) 18, Spo2 (oxygen saturation) 95% RA (room air), Temp (temperature) 96.4, MD notified, new orders noted to monitor for s/sx (signs and symptoms) of diaphoresis, monitor V/S q (every) hr (hour), call back with V/S in 1 hr. RP (Responsible party) called no answer left message awaiting return call. Approx (Approximately) 645pm V/S obtained B/P (blood pressure) 103/68 P 49 resident noted diaphoretic, writer called MD notify, new order send resident to ER for eval (evaluation). Resident states fells (sic) nauseated, v/s taken B/P noted 82/62, resident noted pale increase (sic) sweating noted. Last set of V/S taken prior to EMS (emergency medical services) arriving noted 95/65 (blood pressure) P 47, resident noted sitting up in bed, responsive to verbal stimuli, no emesis noted. EMS arrived, resident left building with EMS approx 740PM to (name of hospital) ER."

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A hospital history and physical dated 7/16/18 documented, "Chief complaint of changes in blood pressure and heart rate after receiving 0.5 mg of lorazepam, as well as 15 mg of MS Contin. Patient was given these medications at the (sic) approximately 5:50 p.m. tonight at the nursing home. Her blood pressure went from around 130 systolic to 103 systolic, and her heart rate went from the 70s down to the 50s so the patient was sent to the ER. I spoke to the nurse at the nursing home to obtain this history. She was not sure why the patient was given these medications, but states it may have been in error. No other reports of illness."

A medication discrepancy report signed by ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) on 7/17/18 documented, "RESIDENT NAME: (name of Resident #10). Immediate Action taken to counteract medication error: Vital signs immediately obtained, MD and family notified. Order obtained to monitor VS (vital signs) Q (every) 1 hr (hour). Outcome to Resident: felt nauseous and with VS changes. Doctor's Response: MD called with VS changes and order to send to ER for further evaluation. Family Response: Family responsive to orders. Name and Title of Staff Person Administering Medication: (Name and title of LPN #4). Check items that are applicable: (a check beside) The medication dosage was correct but given to the wrong resident..."

A follow up report submitted to the OLC on 7/18/18 documented, "Dear Sir/Madam, The purpose of this letter is to provide your agency with more information regarding the medication error report sent to your office on July, 16, 2018

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F 760	Continued From page 77 involving the resident, (name of Resident #10). (Name of Resident #10) received MS Contin Extended Release 15 milligram tablet, Lorazepam 0.5 milligram tablet, and clonidine 0.1 milligram tablet which was prepared for administration for another resident, (name of Resident #4), during the 5 pm medication pass on 7/16/2018. (Name of LPN #4), LPN, was the nurse who administered the medication to (name of Resident #10). (Name of LPN #4) was hired on 7/11/2018 and has held an LPN license for 11 years. She completed her general orientation and (name of computer software program) training after hire at this facility on 7/13/2018. (Name of LPN #4) was administering medications under the supervision of (name and title of RN [registered nurse] #2), on the 3-11 shift on 7/16/2018. (Name of RN #2) has been employed at the facility since 1/23/2015 serving as the MDS coordinator. (Name of RN #2) was an LPN for 8 years and became an RN 10 years ago. (Name of RN #2) was observing (name of LPN #4) pour and pass each medication on one medication cart. That medication cart stores the medications for 20 residents on that hall. (Name of RN #2) is not routinely scheduled to administer medications, but does help pass medications when extra help is needed to adhere to the facility medication pass schedule. (Name of LPN #4) and (name of RN #2) selected (name of Resident #4's) medication profile on the Matrix screen. The medications were prepared following the facility policy. (Name of LPN #4) and (name of RN #2) entered the room together and (name of RN #2) identified (name of Resident #10). Immediately after (name of Resident #10) had swallowed the medications, the nurses realized that the meds (medications) prepared were those ordered for (name of Resident #4). This incident	F 760		

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F 760	Continued From page 78 occurred at about 5:50 pm. (Name of Resident #10's) attending physician, (name of physician), was immediately notified of the medication error. (Name of physician) asked that the resident be monitored for diaphoresis and that her vital signs be obtained every hour. (Name of Resident #10's) blood pressure at that time was 137/87 and her pulse was 72. At approximately 6:45 pm the resident was noted to be diaphoretic with a blood pressure of 103/68 and her pulse rate was 49. The resident, who was responsive to verbal stimuli, voiced a complaint of some nausea. (Name of physician) was notified of the findings of the ongoing physical assessment and ordered (name of Resident #10) be sent to (name of hospital) for evaluation. The resident was transported to (name of hospital) at 7:40 pm. The resident's daughter was notified of the incident and that the resident was being sent to the ER (emergency room)...INVESTIGATION/CONCLUSION: During their nursing career neither (name of LPN #4) nor (name of RN #2) have experienced a medication error which resulted in a resident being sent to the ER. The (name of pharmacy) 'General Dose Preparation and Medication Administration Policy' has been reviewed with both nurses. Facility nursing administration has observed a medication pass with (name of LPN #4) and will conduct an observed med pass with (name of RN #2) on her next scheduled day to work. (Name of LPN #4) exhibited proficiency with her observed med pass. The other facility licensed nurses will receive a review of the (name of pharmacy) med pass policy. Observed medication passes will continue to be ongoing for facility nurses. (Name of Resident #10) was kept at the hospital for observation and will be returning to this facility today. Facility staff met with the resident's son	F 760		

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and daughter, explained the incident, and informed them of the actions being taken to prevent any further resident care issues..."

The hospital discharge summary dated 7/18/18 documented, "BRIEF HOSPITAL COURSE: A 68-year-old with history of hypertension (high blood pressure), ischemic stroke, left-sided hemiplegia (paralysis), brought to the hospital from nursing home due to lethargy. The patient was given wrong medication MS Contin and Ativan (lorazepam). Family was notified as per the history and physical and patient was sent to the Emergency Room from the nursing home with lethargy. She had been evaluated in the Emergency Room. A CT (computed tomography) head showed old right MCA (middle cerebral artery) infarct. She received Narcan and was admitted to the telemetry, treated with IV fluids and was monitored on telemetry. Her lethargy improved while she was in the hospital. She is back to her baseline at this point..."

A note signed by the nurse practitioner on 7/18/18 documented, "CC (Chief complaint): Follow up from hospital. Interval History: Was asked to see patient to evaluate after admission to the hospital. Nursing reports that patient is returning to facility after staying overnight in the hospital. Patient had received another patient's medications and then started with hypotension (low blood pressure), bradycardia (low heart rate), diaphoresis and c/o (complaint of) nausea. Patient was monitored in the hospital and received IVF (intravenous fluids)..."

Resident #10's comprehensive care plan with a problem start date of 9/30/15 documented, "Resident is at risk for adverse side effects of 9+

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meds (medications)...7/16/18 Medication discrepancy..."

The nurse who administered the wrong medications to Resident #10 was no longer employed at the facility and was not available for interview.

On 12/18/18 at 4:38 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked how she ensures she administers the correct medication to the correct resident. LPN #3 stated the resident's name is on the medication package and she writes the resident's room number on the medication cup. LPN #3 stated she compares the room number to what she writes on the medication cup and the medication package with the resident's name. LPN #3 also confirmed residents' pictures are located on the MAR (medication administration record).

On 12/19/18 at 8:18 a.m., an interview was conducted with LPN #6. LPN #6 was asked how she ensures she administers the correct medication to the correct resident. LPN #6 stated, "We have pictures and I also call them by name."

On 12/19/18 at 9:39 a.m., an interview was conducted with RN #2 (the MDS nurse who supervised LPN #4 on 7/16/18). RN #2 was asked to describe her experience with medication administration in the facility. RN #2 stated that during July 2018 she was "on the floor" a couple of times during that month. RN #2 stated she was not actually administering medications but she was overseeing other staff members administer medications. When asked why, RN

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F 760	Continued From page 81 #2 stated there were some staffing challenges and the supervisors were trying to get the newly hired nurses comfortable and acclimated to the residents so the nurses did not feel they were by themselves. When asked how nurses ensure the correct medication is administered to the correct resident, RN #2 stated, "Checking against the MARs, the medication packet. We have photos in the (name of computer MAR software program)." RN #2 was asked to describe the incident regarding Resident #10 on 7/16/18. RN #2 stated she was in the vicinity, of the medication cart but not actually standing at the cart when LPN #4 was preparing medications. RN #2 stated LPN #4 prepared medications and asked her to show her who Resident #10 was. RN #2 stated she walked LPN #4 over to Resident #10, introduced her to Resident #10 and LPN #4 administered medications to the resident. RN #2 stated LPN #4 went back to the medication cart and pulled the next medication listing minutes after administering medications to Resident #10. RN #2 stated she guessed this is when LPN #4 realized she administered Resident #4's medications to Resident #10 because LPN #4 came to her and said she gave Resident #4's medications to Resident #10. RN #2 stated after this, the nurses immediately obtained Resident #10's vital signs, which were stable so the nurses immediately notified the physician. RN #2 stated the physician responded by telling the nurses to monitor Resident #10's vital signs every hour and monitor the resident for diaphoresis. RN #2 stated she believed sometime afterward, Resident #10's blood pressure became low and the resident complained of not feeling well so LPN #4 notified the physician of the changes in condition and the physician ordered for Resident #10 to be sent to the emergency room.	F 760		

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F 760	Continued From page 82 On 12/19/18 at 10:16 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked the facility process for newly hired nurses administering medications. ASM #2 stated depending on the individual nurse's abilities, usually the nurse shadows another nurse on the medication cart during day two and day three then the nurse administers medications on day four. ASM #2 stated another nurse is present in the area if the newly hired nurse has questions or concerns but the other nurse is not with the newly hired nurse at all times. ASM #2 stated on 7/16/18, another nurse was overseeing LPN #4. ASM #2 was asked how nurses are supposed to ensure they administer the correct medications to the correct resident. ASM #2 stated many residents in the facility are able to state who they are. ASM #2 stated the facility does not use armbands but residents' names are documented outside their room doors and residents' pictures are located on the MARs. ASM #2 was asked to describe the incident regarding Resident #10 that occurred on 7/16/18. ASM #2 stated she was not in the building at the time but LPN #4 called her so she asked LPN #4 what happened and made sure LPN #4 called the physician and family. ASM #2 stated she believed the physician told LPN #4 to do vital signs and monitor the resident. ASM #2 stated she guessed LPN #4 did not really know Resident #10 and Resident #10 was at her baseline the whole time. When asked if the resident's pulse of 49 was normal and at the resident's baseline, ASM #2 stated, "That wasn't normal." When asked to explain what she meant about Resident #10 being at her baseline the whole time, ASM #2 stated the resident's physical and activity of daily living presentation was at	F 760		

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baseline and the resident always presented with a slumping posture and affected speech. When asked how she knew Resident #10 was at her baseline on 7/16/18 if she was not in the building, ASM #2 stated she knew by the description LPN #4 gave her and there was another nurse (LPN #5) present that stated Resident #10 looked like her typical self. When asked if Resident #10's vital signs were at her typical baseline, ASM #2 confirmed they were not. ASM #2 stated LPN #4 monitored Resident #10 and said the resident's pulse was getting lower so she sent the resident to the ER. ASM #2 stated Resident #10 was gone by the time she got to the building.

On 12/19/18 at 3:05 p.m., an interview was conducted with LPN #5. LPN #5 was asked to describe the incident regarding Resident #10 that occurred on 7/16/18. LPN #5 stated, "I called her name. She could respond. She wasn't talking but could say year or no and (name of resident) has a really low voice so you have to lean in to actually hear her. She looked a little sleepy." When asked if she looked sleepier than her usual baseline, LPN #5 stated, "Yes." When asked if Resident #10's vital signs were at her baseline on 7/16/18, LPN #5 stated, "By the time I had gotten to the room the nurse had taken her vitals and called the doctor and called the ambulance." When asked if Resident #10 was typically diaphoretic, LPN #5 stated, "No." When asked if she recalled Resident #10 being diaphoretic, LPN #5 stated, "No." When asked if she recalled Resident #10 being nauseous, LPN #5 stated, "No. Like I said, the nurse had already assessed and called 911. I was in there for a couple minutes before 911 was there." When asked if Resident #10 was typically nauseous, LPN #5 stated, "No." When asked if Resident #10's pulse

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was typically 47, LPN #5 stated, "No."

On 12/19/18 at 4:21 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern and the concern for harm. ASM #1 and ASM #2 were asked to provide any further information.

The facility policy titled, "Administration of Medications" documented, "5. Before administering the medication or dietary supplement, check to see that the following are correct:
a. the right medication
b. the right dosage and strength
c. the right resident (photo identification with MAR or eMAR [electronic medication administration record])
d. the right time
e. the right route, and
f. the right form (i.e. tablet, liquid, capsule, or other)
g. no known allergy
h. the medication is not damaged, contaminated, or expired..."

The facility policy titled, "Orientation Outline Nursing" documented, "I. Administration of Medication- The employee is to follow the facility medication administration policy and procedure..."

On 12/20/18 at approximately 12:00 p.m., ASM #1 and ASM #2 provided an in-service meeting sign in sheet dated 7/17/18. The topic was "General Dose Preparation & Medication Administration." ASM #2 confirmed the in-service was not provided to all nurses.

No further information was presented prior to exit.

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

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F 760	Continued From page 85	F 760		

(1) "Clonidine used to treat high blood pressure. Side effects are usually mild and include sedation, fatigue, bradycardia (slow heartbeat), dry mouth, headaches, dizziness, postural hypotension, male impotence and gastrointestinal upset." https://livertox.nih.gov/Clonidine.htm

(2) "Ativan (lorazepam) is a benzodiazepine used to treat anxiety: Clinically Significant Drug Interactions: The benzodiazepines, including Ativan (lorazepam), produce increased CNS-depressant effects when administered with other CNS depressants such as alcohol, barbiturates, antipsychotics, sedative/hypnotics, anxiolytics, antidepressants, narcotic analgesics, sedative antihistamines, anticonvulsants, and anesthetics." This information was obtained from the website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ba6ce50e-c5a9-47ca-9803-a1ed82172b0e

(3) MS CONTIN is an opioid agonist indicated for the management of pain. "BOXED WARNING: WARNING" in part: LIFE-THREATENING RESPIRATORY DEPRESSION; and RISKS FROM CONCOMITANT USE WITH BENZODIAZEPINES OR OTHER CNS DEPRESSANTS
Life-Threatening Respiratory Depression
Serious, life-threatening, or fatal respiratory depression may occur with use of MS CONTIN. Monitor for respiratory depression, especially during initiation of MS CONTIN.."
Risks From Concomitant Use With Benzodiazepines Or Other CNS Depressants
Concomitant use of opioids with benzodiazepines or other central nervous system (CNS)

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F 760	Continued From page 86 depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death. Clinically Significant Drug Interactions with MS CONTIN: Due to additive pharmacologic effect, the concomitant use of benzodiazepines or other CNS depressants, including alcohol, can increase the risk of hypotension, respiratory depression, profound sedation, coma, and death." This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=e0472c35-3f44-42e2-9b75-37b2e9ff65f6#boxedwarning (4) Narcan is used to treat opioid (including MS Contin) overdose. This information was obtained from the website: https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone	F 760		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		2/3/19

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F 880	Continued From page 87	F 880		

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;

§483.80(a)(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 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.

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

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F 880	Continued From page 88 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, facility staff failed to maintain an air gap in a sanitary manner for 1 of 2 ice machines. The Ice Machine located in the 2nd Floor Kitchenette did not have an air gap. The Findings Included: On 12/18/2018, an inspection of the kitchen and dining facilities was conducted. At approximately 2:30p.m, the 2nd floor kitchenette, which services the Long Term Care residents, was inspected. It was noted that a white, PVC-style pipe exited from the back of the machine. The pipe extended down the wall, then proceeded along the base of the wall to a grated floor drain. The floor drain had a grated covering with a circular hole in the center. The PVC-style pipe from the ice machine extended through the center hole, extending below the level of the floor. ASM (Administrative Staff Member) #1, the facility Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 12/19/2018, at around 5:15p.m. No further documentation was provided.	F 880	On 12/19/18 the Maintenance Department corrected the PVC style piping to connect the air gap to the ice machine in the 2nd floor kitchenette. All other ice machines were inspected. None were found to be in violation of policy. Any resident residing in this facility has the potential to be affected by this breach in infection control policy. There has been no report of any resident□s experiencing any ill effects from the observation of the air gap during the survey. Maintenance staff will be inserviced by the Maintenance Director in regard to the air gap compliance for ice machines. Maintenance staff will audit ice machines□ air gap to ensure compliance once weekly x 4 weeks	

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F 880	Continued From page 89	F 880	then one time a month for 3 months, then added to their routine preventative maintenance plan/procedure.	