STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495155	A. BUILDING _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE HEALTHCARE CENTER	6700 COLUMBIA PIKE ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 12/3/19 through 12/5/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four complaints were investigated during the survey. The census in this 222 certified bed facility was 202 at the time of the survey. The survey sample consisted of seven current Resident reviews and one closed record review.	F 000	**F 000** **The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.**	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and facility documentation review, the facility staff failed to assess 1 of 8 residents (Resident #4) to determine if self-administration of medications was clinically appropriate. The findings include: Resident #4 was admitted to the nursing facility on 5/16/17 with diagnoses that included diabetes with bilateral diabetic foot ulcers, diabetic neuropathy and right below the knee amputation. The most recant Minimum Data Set (MDS) assessment was a quarterly dated 9/5/19 and coded the resident on the Brief Interview for	F 554		01/06/2020

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] EXECUTIVE DIRECTOR 12/26/19

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 554	Continued From page 1 Mental Status with a score of 15 out of a possible score of 15 which indicated he was fully intact with the cognitive skills for daily decision making with no long or short term memory problems. Resident #4 was not care planned to self-administer medications. During a medication observation with Licensed Practical Nurse (LPN) #1 on 12/4/19 at 9:00 a.m., he poured the resident's medication and carried them to the resident's room. Resident #4 refused to accept the medications from the LPN and he brought them back to the nursing station to inform the East Wing Unit Manager. When asked of the Unit Manager why the resident would not accept the medications, she stated, "I don't know why at all, but I do know he wants you to leave the medications at the bedside and he takes them on his own. Maybe that's why?" When asked if the resident had been assessed to safely administer his medications, the Unit Manager stated, "I don't know what that entails, the nurses just leave the medications because the resident is so particular." An interview was conducted with Resident #4 on 12/3/19 at 12:00 p.m. He said in the 2.5 years he has been in the facility, no one had assessed him to be able to safely administer medications. He said, "I am pretty sure I could and I know all my medications. I would welcome an assessment so it would be registered I am capable." On 12/5/19 at 12:20 p.m., a debriefing interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and two Corporate Consultants. The DON stated that	F 554	1) Resident # 4 still resides in the facility. Self- administration of medication assessment was completed on 12/6/2019 and resident was found to be competent to self-administer his medications. On 12/7/2019 resident decline administering his insulin due to visual problems. 2). For Current resident residing in the facility 100% audit was conducted on 12/23/2019 no other residents were asking their nurse to leave medications at bedside so there were no other resident in need of self-administration of medications. New resident that request medications to be left at their bedside will be assessed for self-administration of medication and if it is determined that they can self-administer their medication based on the self-administration of medication assessment the resident will then self-administer their own medication.	01/06/2020

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F 554	Continued From page 2 there was a process to follow regarding the resident's right to self-administer medications and it did not include leaving medications at the bedside, which she was not aware was the nursing staff's practice. She stated she spoke to the resident and he wanted to conduct the assessment on 12/6/19. The facility policy titled Resident Self-Administration of Medications dated 8/1/16 indicated the interdisciplinary team will assess for safety of self-administering of medication including the following: cognitive functioning, physical ability and emotional ability. The policy indicated that it was the resident's right for self administration of their own medication that supports resident dignity and self determination.	F 554	3) License Nurses will be educated on the self-administration of medication assessment by SDC. 4). A weekly audit will be conducted by Unit Managers/ Shift supervisors on 25% of new admission to ensure that self- medication administration assessment are completed whenever resident request to have their medication left at the bedside This audit will be done weekly for one month then monthly for two months. Audits will be submitted to QAPI monthly for 2 months to ensure substantial compliance. 5). Date 01/06/2020	01/06/2020
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		

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F 580	Continued From page 3 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to ensure the physician was notified of elevated Finger Stick Blood Sugars per his orders, with a potential need to adjust or alter insulin dosage for 1 out of 8 residents (Resident #3) in the survey sample.	F 580	1) Resident # 3 still resides in the facility and his Lantus Insulin was adjusted on 12/6/2019, and his sliding scale insulin was discontinued on 12/6/2019. Resident # 4 was not on sliding scale insulin prior to December 2019. 2) For current resident residing in the facility receiving Insulin the physician will review all HgbA1c labs done within the last 30days and adjust insulin if needed. 100% audit will be completed on resident with finger stick reading out of normal range and the physician will be notified of finger stick ranges based on parameter that had the potential to be adjusted.	01/06/2020

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F 580	Continued From page 4 The findings include: Resident #3 was admitted to the nursing facility on 1/25/19 with insulin dependent type 2 diabetes and partial amputation of left foot, stroke, high blood pressure and peripheral vascular disease (PVD). The most recent Minimum Data Set (MDS) assessment was a quarterly dated 10/24/19 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated he was cognitively intact with the necessary skills for decision making and no problems with short or long term memory. This MDS coded the resident to receive insulin injections 6 out of 7 days. The care plan dated 1/26/19 identified diabetes as a focus area and the goal set by the staff was that he would have no complications relate to diabetes. One the approaches that staff would implement to accomplish this goal included to administer diabetes medication as ordered by the doctor. The physician's most recent progress notes dated 10/23/19 indicated that Resident #3's *Hemoglobin A1C (HgbA1C) level was elevated at 11.0 (4.0-6.0=normal) and increased the Lantus insulin dose and to monitor meals, give specialized diet. *The HgbA1C test measures what percentage of your hemoglobin, a protein in red blood cells that carries oxygen, is coated with sugar (glycated). The higher your A1C level, the poorer your blood sugar control and the higher your risk of diabetes complications	F 580	(continued) For New resident admitting to the facility with a diagnosis of diabetes the physician will be consulted for an order for hemoglobin A1C, the physician will be notified once the result of the lab is received for adjustment of Insulin based on the lab results, the physician will also be notified of all finger sticks within the parameter for notification. 3. License Nurses will be educated by SDC on notifying the physician of all finger stick ranges that have the potential to be adjusted based on finger stick results based on parameter for MD notification or hemoglobin A1c results, also on notifying the physician of finger stick reading based on the parameter as ordered by the physician that has the potential for an adjustment in insulin to be made.	01/06/2020

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F 580	Continued From page 5 (https://www.mayoclinic.org/tests-procedures/a1c-test/about/pac-20384643). Resident #3 had the following physician orders for insulin administration: -2/27/19-10/17/19, administer Novolog 100 units/milliliter (ml) per sliding scale based on the *fingerstick blood sugar (FSBS) via accuchecks at 7:30 a.m. and 9:00 p.m. Accucheck FSBS is one method of blood glucose monitoring before meals. 151-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units and call physician. -4/12/19 to 10/17/19, Lantus 100 units/ml, 25 units subcutaneous (subQ) at 7:30 a.m. and 12 units subQ at 9:00 p.m. Upon review of the FSBS via accuchecks from 1/26/19 to 12/5/19, the facility failed to notify the physician of the following results of blood sugars that fell within the range of 351-400: 1/29/19, FSBS=378 3/16/19, FSBS=363 3/15/99, FSBS=399 4/02/19, FSBS=398 9/17/19, FSBS=382 10/01/19, FSBS=380 11/17/19, FSBS=359 12/04/19, FSBS=398 12/5/19, FSBS=398 On 12/5/19 at 10:49 a.m. Licensed Practical Nurse (LPN) #4, who was assigned to give	F 580	4. A weekly audit will be conducted by Unit Managers or Shift Supervisors on 25% of resident on finger sticks and have results of hemoglobin A1c lab results to ensure that the physician is notified of all finger stick results based on parameters for notification and HgbA1c needing adjustment. This audit will be done weekly for one Month, then Monthly for two Months. The audit will be submitted to QAPI monthly for 2 months to ensure substantial compliance. 5. Date 01/06/2019	01/06/2020

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F 580	Continued From page 6 medications to include insulin to Resident #4, was asked to review Resident #4's sliding scale for the administration of Novolog insulin. After her review, the LPN was further asked when would she call the physician regarding the results of Resident #4's FSBS via accuchecks, she responded "When it is 400, I would give 10 units of the Novolog insulin and call the physician." The East Wing Registered Nurse (RN) Unit Manager joined the interview, reviewed the sliding scale orders for Resident #4 and stated, "The physician should be called for blood sugars from 351-400. He may or may not make changes, but we have to call him in case." The Unit Manager checked the nurse's notes and stated she did not know the aforementioned elevated blood sugars were not brought to the attention of the physician. She further stated she would be addressing the issue with the nurses on her unit. LPN #4 followed by saying, she had been caring for the resident for a while and stated, "Honestly, I interpreted the scale incorrectly all this time." On 12/5/19 at 12:20 p.m., a debriefing interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and two Corporate Consultants. The aforementioned issue was brought to their attention. No further documented evidence was brought to the survey team prior to exit. The facility's policy and procedure titled Physician Notification for Change in Condition Reporting dated 4/20/17 indicated it was the policy of the facility to promote resident centered care by using evidence based practice for notification of providers for changes in conditions and when to report signs and symptoms to the MD/NP/PA.	F 580		

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F 580	Continued From page 7 Specific to diabetic resident the nurse would report poorly controlled diabetes, hyperglycemic (elevated blood sugars) or hypoglycemic (low blood sugars).	F 580	1) Resident #3 has been receiving his insulin as ordered by the physician. Resident # 4 has been receiving his insulin as ordered by the physician. Resident # 6 has been receiving his Oxycontin as ordered by the physician. 2) For current resident residing in the facility receiving insulin 100% audit will be done to ensure that they received the insulin timely as ordered by the physician within the last 30 days. For current resident residing in the facility receiving oxycontin 100% audit will be done to ensure that they received their Oxycontin timely as ordered by the physician within the last 30 days. For New admission on Insulin and Oxycontin an audit will be done within 7 days of admission to ensure that they are receiving their Insulin and Oxycontin timely as ordered by the physician.	01/06/2020
F 658 SS=D	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 a Facility Reported Incident (FRI), clinical record review, staff and resident interview and facility documentation review, the facility staff failed to adhere to the professional standards of practice related to medication administration and obtaining accuchecks (blood sugar checks) per physician's orders for 3 out of 8 residents (Residents #3, #4, and #6) in the survey sample The findings include: 1. Resident #3 was not administered *Lantus and *Humalog insulin and FSBS's (finger stick blood sugar checks) per physician orders. Resident #3 was admitted to the nursing facility on 1/25/19 with insulin dependent type 2 diabetes and partial amputation of left foot, stroke, high blood pressure and peripheral vascular disease (PVD). The most recent Minimum Data Set (MDS) assessment was a quarterly dated 10/24/19 and coded the resident on the Brief Interview for	F 658		

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F 658	Continued From page 8 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated he was cognitively intact with the necessary skills for decision making and no problems with short or long term memory. This MDS coded the resident to receive insulin injections 6 out of 7 days. The care plan dated 1/26/19 identified diabetes as a focus area and the goal set by the staff was that he would have no complications relate to diabetes. One of the approaches that staff would implement to accomplish this goal included to administer diabetes medication as ordered by the doctor. The physician's most recent progress notes dated 10/23/19 indicated that Resident #3's *Hemoglobin A1C (HgbA1C) level was elevated at 11.0 (4.0-6.0=normal) and increased the Lantus insulin dose and to monitor meals, give specialized diet. *The HgbA1C test measures what percentage of your hemoglobin, a protein in red blood cells that carries oxygen, is coated with sugar (glycated). The higher your A1C level, the poorer your blood sugar control and the higher your risk of diabetes complications (https://www.mayoclinic.org/tests-procedures/a1c-test/about/pac-20384643). Resident #3 had the following physician orders for insulin administration: -2/27/19-10/17/19, administer Novolog 100 units/milliliter (ml) per sliding scale based on the *fingerstick blood sugar (FSBS) via accuchecks at 7:30 a.m. and 9:00 p.m.	F 658	3) License Nurses will be educated on administering insulin as ordered by the physician. License Nurses will be educated by SDC/Unit Manager/Shift Supervisor on administration of Oxycontin timely as ordered by the physician. 4) A weekly audit will be conducted by Unit Managers or Shift Supervisors on 25% of resident receiving Insulin and Oxycontin to ensure that Insulin and Oxycontin are administered timely as ordered by the physician. This audit will be done weekly for one Month, then Monthly for two Months. The audits will be submitted to QAPI monthly for two Months to ensure substantial compliance. 5) Date 01/06/2019	01/06/2020

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F 658	Continued From page 9 Accucheck FSBS is one method of blood glucose monitoring before meals. 151-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units and call physician. -4/12/19 to 10/17/19, Lantus 100 units/ml, 25 units subcutaneous (subQ) at 7:30 a.m. and 12 units subQ at 9:00 p.m. The FRI dated 10/21/19 indicated that the resident was sent to the local hospital on 10/17/19 for complaints of chest pain, and that the resident reported to the hospital staff that he was not given his insulin for three days by the nursing facility staff. Upon review of the nurse's notes dated 10/17/19, the resident complained of chest pain at 8:45 a.m. and the resident was sent out via 911 at 8:56 a.m. There was no evidence in the clinical record to include the nurse's notes or the Medication Administration Record that the resident was administered his a.m. Lantus scheduled for 7:30 a.m. or that a FSBS was obtained at 7:30 a.m. on 10/17/19 to determine if the resident required sliding scale coverage with Humalog. Resident #3 was evaluated in the Emergency Department (ED) on 10/17/19 and the labs drawn on 10/17/19 indicated the resident's blood sugar level was 399. On 12/4/19 at 10:30 a.m., an interview was conducted with Resident #3 to ascertain information about not receiving previous insulin	F 658		

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F 658	Continued From page 10	F 658		

administration for three days prior to his hospitalization. He stated he felt the nursing staff was not administering his morning insulin because it would be "Well after the time it was due."

Upon review of the review of the MAR for October 17, 2019, it had been determined that the Resident #3 did not receive his routine Lantus at 7:30 a.m. and should have received sliding scale coverage with Humalog insulin at 7:30 a.m., as well.

The MAR Administration Report for 10/16/19 indicated that the resident was administered routine 7:30 a.m. Lantus at 11:19 a.m., which was 3 hours and 49 minutes past due. The evening dose recorded administered at the time scheduled. Based on the FSBS obtained at 7:30 a.m. of 244, Resident #3 required 4 units of Humalog which was recorded as administered at 11:18, 3 hours and 48 minutes past due.

The MAR Administration Report for 10/15/19 indicated that the resident was administered routine 7:30 a.m. Lantus at 12:56 p.m., which was 5 hours and 26 minutes past due. The evening dose was recorded administered at the time scheduled. Based on the FSBS obtained at 7:30 a.m. of 254, Resident #3 required 6 units of Humalog which was recorded as administered at 12:56, 5 hours and 26 minutes past due.

The MAR Administration Report for 10/14/19 indicated that the resident was administered routine 7:30 a.m. Lantus at 10:29 a.m., which was 2 hours and 59 minutes past due. The evening dose was recorded administered at the time scheduled. Based on the FSBS obtained at 7:30

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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
F 658	Continued From page 11 a.m. of 224, Resident #3 required 4 units of Humalog which was recorded as administered at 10:29, 2 hours and 59 minutes past due. The nurse (LPN #6) that administered the aforementioned 7:30 a.m. Lantus insulin past due on 10/14-17/19, the Humalog insulin past due on 10/14-16/19, and failed to obtain a FSBS on 10/17/19 was not available for interview during the survey days (12/3-5/19). A six month review of the medication administration record of insulin for Resident #3 revealed it was LPN #6's practice of routinely administering Lantus and Humalog multiple hours past due, too numerous to count during every shift she worked, which was not in keeping with the physician's orders. On 12/5/19 at 10:49 a.m., Licensed Practical Nurse (LPN) #4 stated it is standard practice to sign off when medications are administered. She was able to show her prompt documentation of administration of insulin per the physician ordered times. She stated it was important to administer insulin according to when it is ordered to control their blood sugar levels throughout the day and especially around meals to maintain blood sugar levels in a normal range as much as possible. The East Wing Registered Nurse (RN) Unit Manager joined the interview and stated the Medication Administration Report is the actual time the medication is administered, "That's what I go by." When shown the late administration times for Resident #3, she stated, "It is important to administer all insulin on time. I did not know about this and I will be addressing the issue with the nurses on my unit."	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495155	A. BUILDING _____ B. WING _____	C 12/05/2019

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F 658	Continued From page 12 On 12/5/19, a debriefing interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and two Corporate Consultants. The DON stated, "The administration time recorded on the Medication Administration Record is considered the time the medication was administered per their policy. These late times for the insulin administration for (Resident #3's name) are not acceptable." The facility's policy and procedures titled Medication Administration dated 12/14/17 indicated medications are to be administered as prescribed by the provider, observe the five rights in giving each medication to include the "right time", and medications will be charted when given. *Lantus is a long-acting, parenteral blood-glucose-lowering agent in which small amounts of insulin glargine are slowly released, resulting in a relatively constant concentration/time profile over 24 hours with no pronounced peak. Administer Lantus subcutaneously at any time of day but at the same time every day. Individualize and adjust the dosage of Lantus based on the individual's metabolic needs, blood glucose monitoring results and glycemic control goal (https://www.rxlist.com/lantus-drug.htm#description). *Humalog (insulin lispro injection) is a rapid-acting human insulin analog used to lower blood glucose. Administer the dose of Humalog within fifteen minutes before a meal or immediately after a meal by injection into the subcutaneous tissue of the abdominal wall, thigh,	F 658		

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	495155	A. BUILDING _____ B. WING _____	C 12/05/2019

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F 658	Continued From page 13 upper arm, or buttocks. Humalog administered by subcutaneous injection should generally be used in regimens with an intermediate-or long-acting insulin (https://www.rxlist.com/humalog-drug.htm#indications). 2. Resident #4 was not administered *Lantus insulin per physician orders. *Lantus is a long-acting, parenteral blood-glucose-lowering agent in which small amounts of insulin glargine are slowly released, resulting in a relatively constant concentration/time profile over 24 hours with no pronounced peak. Administer Lantus subcutaneously at any time of day but at the same time every day. Individualize and adjust the dosage of Lantus based on the individual's metabolic needs, blood glucose monitoring results and glycemic control goal (https://www.rxlist.com/lantus-drug.htm#description). Resident #4 was admitted to the nursing facility on 5/16/17 with diagnoses that included diabetes with bilateral diabetic foot ulcers, diabetic neuropathy and right below the knee amputation. On 4/11/18, the resident was diagnosed with *osteomyelitis (OM) of the left foot and ankle. *Osteomyelitis is an infection in a bone. Infections can reach a bone by traveling through the bloodstream or spreading from nearby tissue. People who have diabetes may develop osteomyelitis in their feet if they have foot ulcers (https://www.mayoclinic.org/diseases-conditions/osteomyelitis/symptoms-causes/syc-20375913).	F 658		

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F 658	Continued From page 14 The most recent Minimum Data Set (MDS) assessment was a quarterly dated 9/5/19 and coded the resident on the Brief Interview for Mental Status with a score of 15 out of a possible score of 15 which indicated he was fully intact with the cognitive skills for daily decision making with no long or short term memory problems. The MDS assessed the resident to have received insulin injections and an antibiotic 7 out of 7 days during this assessment period. The care plan dated 1/30/18 identified diabetes mellitus as a focus area. The goal set by the staff for the resident was that Resident #4 would be free of complications from diabetes (hypoglycemic/hyperglycemic reactions). One of the approaches to accomplish this goal included administer diabetic medication as ordered by the physician. The resident was also care planned as having diabetic ulcers on left heel, left 2nd and 3rd toes and left medial foot, as well as osteomyelitis. The goal set by the staff was that the resident would have no complications related to the ulcers and would not develop any new ulcers. One of the approaches the staff would implement to accomplish this goal included administered medications as ordered. During an interview with Resident #4 on 12/3/19 at 12:00 p.m., he stated that the nursing staff does not often give his 9:00 a.m. Lantus insulin as ordered by the physician. He stated that one particular Licensed Practical Nurse (LPN) #6 routinely administered the 9:00 a.m. Lantus hours after it due. He stated he formally informed the Administrator of his concerns specific to 10/19/19 where his Lantus was "extremely late" and felt he was "brushed off" by the response from the Administrator, Director of Nursing and East Wing	F 658		

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F 658	Continued From page 15 Unit Manager. He said after their investigation, he was told the medications were signed off per the Medication Administration Record and testimony from the wound nurse and unit manager. During the interview, the resident expressed concerns of the possibility of losing his left leg due to diabetic complications and wanted his insulin administered timely. Upon review of the clinical record, specifically the MAR and Administration Report dated 10/19/19, the 9:00 a.m. Lantus was recorded as administered at 1:47 p.m., 4 hours and 47 minutes late. A three month review of the medication administration of Lantus insulin for revealed Resident #4 was administered Lantus administered late 21 times. All but two times, it was LPN #6's practice of routinely administering Lantus multiple hours past due, during every shift she worked, which was not in keeping with the physician's orders. On 12/5/19 at 10:49 a.m., the East Wing Registered Nurse (RN) Unit Manager stated the Medication Administration Report is the actual time the medication is administered, "that's what I go by." When shown the late administration times for Resident #4, she stated, "It is important to administer all insulin on time. I did not know about this and I will be addressing the issue with the nurses on my unit." On 12/5/19 at 12:20 p.m., a debriefing interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and two Corporate Consultants. The DON stated, "The	F 658		

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F 658	Continued From page 16 administration time recorded on the Medication Administration Record is considered the time the medication was administered per their policy. These late times for the insulin administration for (Resident #4's name) are not acceptable." They could not explain how the results of the resident's concern on 10/19/19 were dismissed as no problem with administration of the Lantus. 3. For Resident #6, the facility staff failed to adhere to the professional standard of administering the medication OxyCONTIN according to physician's orders. Resident #6's original admission to the facility occurred on 7/22/2019 with a readmission on 8/1/2019. His diagnoses included, but not limited to, osteomyelitis (OM) of vertebra, lumbar region, discitis, and methicillin susceptible staphylococcus aureus infection. Resident #6's most recent MDS (Minimum Data Set) was a quarterly review assessment with an ARD (Assessment Review Date) of 9/19/2019. Resident #6 was coded as cognitively intact, scoring 15 out of possible 15 on the BIMS (brief interview for mental status) exam. Resident #6's MDS indicates that he receives scheduled pain medication, and that he was offered and declined or currently receiving PRN pain medications. Resident #6's Care Plan revision dated 8/5/2019 addressed chronic pain related to low back pain due to fracture of Lumbar (L)3 and L3-L4 diskits/OM and left knee pain, left elbow pain as a focus of care, with a goal that Resident #6 will verbalize adequate relief of pain or ability to cope with incompletely relieved pain. The interventions/tasks for this goal include: Identify	F 658		

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F 658	Continued From page 17 and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effects and impact on function, monitor/document for side effects of pain medication, monitor/record pain characteristics (FREQ) and PRN (as needed), Quality, Severity (1 to 10 scale); anatomical location; onset, duration, aggravating factors, relieving factors; monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. A review of Resident #6's physician orders conducted 12/03/2019 at approximately12:45 p.m., revealed an order OxyCONTIN Tablet ER 12 Hour Abuse-Deterrent 10 mg dated as renewed on 11/22/19: Give 1 tablet by mouth two times a day related fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing. A review of Resident #6's nursing notes revealed that on 11/23/2019, 11/24/2019, 11/26/2019, 11/28/2019, and 11/29/2019, OxyCONTIN Tablet ER 12 Hour Abuse-Deterrent 10 mg was not administered, citing, pharmacy unable to deliver med due to insurance issue. Additionally, the Medication Administration Record records pain assessment results conducted during the day, evening and night shifts, for the above, identified dates as: 11/23/2019=5, 0, 3 11/24/2019=5, 0, 0 11/26/2019=6, 0, 0 11/28/2019=0, 0, 0 11/29/2019=6, 0, 0 An interview conducted with Resident #6 on	F 658		

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F 658	Continued From page 18 12/5/2019 at approximately 9:30 a.m. regarding any lapses in OxyCONTIN administration yielded the following response, "They were out of Oxycontin for about 2 weeks. That was about 3 weeks ago. I went a couple of days without the medication and thought I could make it, but realized that I needed the medication for my pain." Although the resident was offered a different pain medication in place of the Oxycontin, he stated it was not as effective. An interview with the Director Of Nursing (DON) was conducted on 12/05/2019 at approximately 10:20 a.m. regarding the facility procedure to procure medications not covered by insurance. The DON responded, "Normally if there are issues with insurance, we would pay for it and no one told me he did not have the Oxycontin." During a briefing with the Administrator, DON, ADON, corporate officials occurring on 12/5/2019 at approximately 12:20 p.m., the DON stated, "There is no policy regarding the supplementing of medications not provided by the facility, it is known facility-wide." A follow-up interview was held with the DON on 12/05/2019 at approximately 2:30 p.m. regarding the outcome of the administration of Oxycontin for Resident #6, she responded, "Upon review of the MAR (Medication Administration Record) and additional invoices, I am in agreement that the resident did not receive his medication Oxycontin for the dates in question." The Facility policy re: Pain Management and Assessment dated 5/29/2019 included: It is the policy of this facility to provide resident centered care that meets the psychosocial,	F 658		

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F 658	Continued From page 19 physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. The purpose of this policy is to provide guidance to the clinical staff to support the intent of §483.25(k) that based on the comprehensive assessment of a resident, the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management. II. Pain Scale for Assessing Pain a. The Pain AD Scale b. The Verbal-Descriptor Scale c. The 1-10 Pain Scale OxyCONTIN is a medication used to help relieve severe ongoing pain. OxyCONTIN belongs to a class of drugs known as opioid (narcotic) analgesics. It works in the brain to change how your body feels and responds to pain. Found on: https://www.rxlist.com/oxycontin-drug.htmw	F 658	1) Resident # 1 was seen by Speech Therapist on 12/2/2019 as ordered by the physician and is still on Speech Therapy case load with an expected discharged date of 12/27/2019. 2) No current resident affected. For new admissions the facility will audit all hospital orders to ensure that hospital orders with NPO and Speech Therapy orders are followed as ordered. 3) License Nurses will be educated on following all hospital orders for NPO and Speech Therapy by SDC. 4) A Weekly audit will be completed by unit managers/Shift Supervsiors on 25% of all hospital order related to NPO and Speech Therapy to ensure that all hospital orders related to Speech Therapy and NPO orders are followed. The audits will be submitted to QAPI monthly for 2 months 5) Date 01/06/2020	01/06/2020
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition	F 692		

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F 692	Continued From page 20 demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on family interivew, staff interview, clinical record review and facility documentation review, and in the course of a complaint invetigation, the facility staff failed to follow hospital discharge orders for one (Resident #1) of 8 residents in the survey sample to ensure the resident remained NPO (Nothing By Mouth) until cleared by Speech pathology. Resident #1 was provided oral nutrition (Breakfast and Lunch) by the facility staff. Resident #1 was admitted to the facility on 02/28/17 and readmitted on 11/29/19 with diagnoses that included but were not limited Dysphagia, Oropharyngeal phase. Resident #1's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 01/12/19. Resident #1 was coded as being moderately cognitively impaired in the ability to make daily decisions. "G" (Physical functioning) the resident was coded as requiring total dependence of one person with personal hygiene, eating, dressing, toileting and locomotion on the unit. Requiring total dependence of two persons with transferring and bed mobility. "K" (Swallowing/Nutritional Status) the resident was coded as requiring a	F 692		

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F 692	Continued From page 21 Feeding Tube. During the initial tour on 12/03/19 at approximately, 12:56 PM an interview was conducted with the resident's son. He stated that on November 30, 2019 Resident #1 was admitted back to the facility from a local hospital with discharge orders stating no food or drinks by mouth due to an increased risk of aspiration. "She's to remain NPO until she sees a speech therapist." The Resident's son stated that she was given solid foods for breakfast, lunch and dinner on November 30th. A review of progress notes revealed on 11/29/2019 at 11:50 PM that Resident #1 was readmitted from a local hospital, her nurse in the nursing facility noticed that her Gastric Tube (G-tube) had become dislodge. MD notified about G-tube out (dislodged). The MD gave an order to send resident to local hospital for G-tube replacement RP (Responsible Party) notified. Resident transferred by none emergency transportation. A review of progress notes revealed on 11/30/2019 at 5:13 PM, Resident returned from local hospital alert and awake accompanied by paramedics and her daughter to unit at 3:30 AM. A review of hospital discharge instructions dated 11/27/19 through 11/29/19 revealed: The Speech Pathologist that evaluated you in the hospital recommended that you do not eat or drink anything by mouth for now due to risk for aspiration. Continue Speech therapy 2-3 times per week and advance diet as recommended with ongoing sessions. Nutritionist recommendations for tube feeding regimen when discharged:	F 692		

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F 692	Continued From page 22 Glucerna 1.2 @ 70 ml/hr x 22 hours daily with 2 packets of prosource and 1 packet of Juven BID (Twice daily). Diet advancement per speech therapist recommendations. A review of the hospital admission report dated from 11/29/19 read: Aphasia. Nothing by mouth for Speech Language Pathologist. Continue aspiration and seizure precautions. *A review of the order summary revealed Residents regular diet is Dysphagia puree texture, Nectar consistency, for diet. Order date: 11/30/19. Start date: 11/30/19. A review of order summary revealed Enteral Feed Order in the evening infuse Glucerna 1.2 @ 83cc/hr. up at 6 PM down 12 AM. Order date 11/30/10. Start Date 11/30/19. A review of order summary reveals Enteral Feed Order one time a day glucerna infused @ 83cc/hr. down 12 AM. Order date 11/30/19. Start date 11/30/19. . The Physicians order summary states Resident is NPO by mouth until seen by Dietician and Speech Therapist tomorrow. Speech and dietary consult tomorrow. Order date: 12/01/19. Enteral Feed Order every shift related to Dysphagia, Oropharyngeal Phase. Start Glucerna 1.2 at 75 cc/hr x 20 hr. up at 15: PM down at 11:00 AM. Order date: 12/02/19. A review of progress notes revealed: On 11/30/19 at 5:13 AM, Resident #1 returned from the local hospital alert and awake	F 692		

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F 692	Continued From page 23	F 692		

accompanied by paramedics and her daughter to unit at 3:30 AM. G-Tube (Gastric Feeding Tube) given as directed and tolerated well.

On 12/1/2019 at 1:20 PM Residents son and the daughter came in to visit the resident, inquiring about the feeding. The writer, supervisor explained to them what the discharge order says to start glucerna at 6 PM and down time at 12 midnight. But the the son started screaming and pointing his fingers on the writers face to go ahead and start the mothers feeding now to be continuous. She explained to him that we can not do it on our own that I am going to call the Dr for that. Tried to calm him down but was so disrespectful and blocked the writer from going out of the office until his sister came and pulled him out off my face. Call placed to the Dr and Explained Tube feeding order we got from the hospital for Glucerna to start at 6 PM and off at 12 midnight, told the doctor the family wants it continuous. Dr. said to continue with the order resident came back with from the hospital that he is not going to change it and resident to be NPO (Nothing by Mouth) by mouth until seen by Speech/Dietitian tomorrow. Writer went and explained what the Doctor said to him and his sister. Dietary slip filled and dietary notified. Call placed to Dietitian, not available message left on voice mail to see resident in the morning. Message left for dietitian for speech. Resident is stable at the time of this report.

A review of progress notes read on 12/1/2019 at 3:01 PM, this writer spoke with doctor, to clarify that since resident is on NPO (nothing by mouth), should the tube feeding be continuous pending when speech therapy and dietary evaluation. The MD noted that resident should continue with the

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	495155	A. BUILDING _____ B. WING _____	C 12/05/2019

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ANNANDALE HEALTHCARE CENTER	6700 COLUMBIA PIKE ANNANDALE, VA 22003

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F 692	Continued From page 24 previous schedule of feeding up at 6:00 PM and down at 12:00 AM until evaluated. Progress note dated on 12/1/2019 at 5:41 PM, read: Resident is NPO. A review of nurses notes dated 12/03/19 at 5:06 PM revealed Resident has come back from the hospital with NPO order. Per Registered Dietitian Consult. On 12/04/19 at approximately, 10:48 AM An interview was conducted with Speech Language Pathologist concerning Resident #1 who stated "When Resident #1 returned to the facility from the hospital she was NPO." She stated "After the feeding tube became dislodge Resident #1 was taken back to the hospital but that she was not admitted." Resident remained under an NPO order until SLP (Speech Language Pathologist) consult." "I came in on Monday (12/02/19) to evaluate Resident #1 and decided to continue NPO order because it was not safe for intake." The SLP was asked if she had any concerns with Resident #1's family concerning her feeding status. She stated, "Yes." "The Resident's son was thinking that his mom was NPO." "I gave her puree foods." She was asked if Resident #1 was eating prior to her hospital admission? She stated, "Yes." "They suspected a stroke recently, but from the hospital report, she didn't have a stroke." An interview was conducted on 12/04/19 at approximately 11:00 AM with the Registered Dietitian (RD/Other staff #3) concerning the above issues with Resident #1. "She was NPO when she returned on Friday (11/29/19)." "The Gastric tube was not working and on 11/29/19	F 692		

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F 692	Continued From page 25	F 692		

she returned to the hospital and came back to the facility." "On 12/01/19 she came back from the hospital as outpatient with an order of glucerna (until midnight)." "When I came on Monday, the resident labs showed kidney concerns so I made the order glucerna 1.2 75cc/20 hrs. The resident tolerated that well." saying that his mom came back NPO the last hospital visit. "She returned to the facility at 3 AM on Saturday and I got a call from the facility on Sunday." "The son had discrepancies, he was angry after I put the nutrition orders in on Sunday (12/01/19), the staff started the orders right away."

On 12/05/19 at 10:46 AM the above concerns were shared with the Administrator, the DON (Director of Nursing), and the Corporate Nurse Consultant. The Corporate Nurse consultant stated that the Resident was able to eat on 11/30/19. The DON clarified the food consumption report and identified the Nursing aide staff involved in feeding the resident on 11/30/19.

On 12/05/19 at approximately 11:00 AM an interview was conducted with CNA (certified nursing assistant) #1. She was asked if she had documented that she fed resident by mouth on 11/30/19? She was shown the meal consumption sheet dated 11/30/19 revealing that Resident #1 consumed 51%-75% of her meal by mouth at 10:10 AM. She stated, "Yes."

On 12/05/19 at approximately 2:40 PM a telephone interview was conducted with LPN #5 concerning resident being fed on 11/30/19. He was asked if he fed Resident #1 by mouth on the said date. LPN #5 stated, "I fed her lunch and the CNA fed her breakfast." "She was not NPO," "I

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F 692	Continued From page 26 didn't get a report from the night shift nurse." A review of the meal consumption sheet dated 11/30/19 revealed that Resident #1 consumed 51%-75% of her meal by mouth at 1:07 PM. (lunch time). A review of the Speech Therapy Plan of care revealed the following: Dated 12/02/19 Patient introduced to safe swallowing strategies. Patient was presented p.o. (by mouth) trial. Given applesauce and bread. Overall patient is safest on puree intake. Patient with moderate to severe dysphagia requiring skilled speech therapy to improve swallowing abilities. Patient positioned at 90 degrees during and after intake. Patient with enteral feedings and feeding by mouth of puree. Complaint deficiency.	F 692		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		

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F 755	Continued From page 27 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on review of clinical records, review of facility documents, and staff interviews, the facility's staff failed to ensure routine prescribed medications were available for administration for 2 of 8 residents (Resident #2 and 6), in the survey sample. The findings included: 1. Resident #2 was originally admitted to the facility 8/11/18 and readmitted 8/27/19 after an acute care hospital stay. The current diagnoses included; artial fibrillation, bilateral lower extremity deep vein thrombosis, a history of a mini stroke and stroke. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/11/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were intact. In section "G"	F 755	1) Resident # 2 has been receiving his Xarelto as ordered by the physician. Resident # 6 has been receiving his Oxycontin as ordered by the physician. Medications carts were checked on 12/6/2019 by DON, resident #2 had his Xarelto available in the medication Cart, resident #6 had his Oxycontin available in the medication cart. 2. For current resident receiving Xarelto and Oxycontin 100% audit will be done by Unit Manager/Shift supervisors to ensure that they are receiving their Xarelto and Oxycontin as ordered by the pharmacy, medications carts will be checked weekly to ensure that Oxycontin and Xarelto are in the medication carts.	

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F 755	Continued From page 28 (Physical functioning) the resident was coded as requiring total care of one person with bathing and toileting, extensive assistance of one person with locomotion and dressing, and extensive assistance of one person with eating. Review of the local hospital history and physical stated Resident #2 "was evaluated by neurology and underwent a magnetic resonance imaging of the brain which showed small acute infarcts involving the left basal ganglia and left vertebral artery occlusion, left greater than right ophthalmic segment, carotid artery stenosis and incidential three milliliter ACOMM artery aneurysm (swelling in the anterior communicating artery in the brain"). The history and physical also stated the resident was to receive Xarelto 20 milligrams daily and the resident stated when asked, "I think the nurses gives me the Xarelto, but I'm not sure". Review of Resident #2's physician orders revealed the following order dated 8/11/18, which included, Xarelto tablet 20 milligrams. Give one tablet by mouth in the evening for deep vein thrombosis of bilateral lower extremities. Review of the medication administration record revealed signatures indicating administration of Xarelto 20 milligrams every day from 6/1/19 through 8/21/19. Review of the pharmacy invoices revealed fourteen Xarelto tablets 20 milligrams were delivered to the facility for Resident #2, on 6/14/19, a nurse removed one Xarelto tablet 20 milligrams from the emergency box 7/24/19, and the pharmacy delivered fourteen more tablets to the facility for Resident #2, 8/5/19. The facility's	F 755	(continued) For new admissions an audit will be conducted within 7 days by Unit Manager or Shift Supervisor to ensure that they are receiving their Xarelto and Oxycontin as ordered by the pharmacy, medications carts will be checked weekly to ensure that their Oxycontin and Xarelto are in the medication carts. 3. License Nurses will be educated by SDC on residents receiving their Xarelto and Oxycontin as ordered by the physician, and checking the medication carts weekly to ensure that their Oxycontin and Xerelto are in the medication carts.	01/06/20

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F 755	Continued From page 29 staff were unable to state where the nurses obtained Xarelto 20 milligram tablets from 6/28/19 through 7/23/19 and 7/25/19 through 8/4/19. The facility's staff provided statements of payment for medications for Resident #2 but the invoices provided the same data as the pharmacy invoices; Resident #2 received 14 tablets 6/14/19 and another supply wasn't sent to the facility for the resident until 8/5/19. From approximately 6/27/19 through 7/23/19 and 7/25/19 through 8/4/19 no Xarelto was administered to Resident #2, because it wasn't available to be administered. An interview was conducted with the Director of Nursing on 12/5/19, at approximately 2:00 p.m. The Director of Nursing stated the only reason a nurse would obtain a medication from the emergency box is because the medication was not available on the medication cart. The Director of Nursing was unable to state where the nurses obtained the medications from for which they signed on the medication administration record for Resident #2 when the pharmacy invoices doesn't reveal the medication was delivered to the facility 6/27/19 through 8/4/19. On 12/5/19 at approximately 12:20 p.m., the above findings were shared with the Administrator, the assistant Administrator, Director of Nursing, the assistant Director of Nursing and two Corporate Consultants. An opportunity was offered to the facility's staff to present additional information but no further information was provided. 2. The facility staff failed to procure medications necessary to complete physician's orders,	F 755	4. A weekly audit will be conducted by the Unit Manager or Shift supervisor on 25% of residents to ensure that their Xarelto and Oxycontin are administered as ordered by the physician and that their Xarelto and Oxycontin are available in the medication carts. This audit will be done weekly for one month then Monthly for two Months. The audits will be submitted to QAPI monthly for 2 months to ensure substantial compliance. 5. Date 01/06/2020	01/06/2020

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F 755	Continued From page 30 OxyCONTIN for Resident #6. Resident #6's original admission to the Facility occurred on 7/22/2019 with a readmission on 8/1/2019. His diagnoses included osteomyelitis (OM) of vertebra, lumbar region, discitis, methicillin susceptible staphylococcus aureus infection, fracture of third lumbar, vertebra, difficulty in walking, muscle weakness, gout and sciatica. Resident #6's most recent MDS (Minimum Data Set) was a quarterly review assessment with an ARD (Assessment Review Date) of 9/19/2019. Resident #6 was coded as cognitively intact, scoring 15 out of possible 15 on the BIMS (brief interview for mental status) exam. Resident #6's MDS indicates that he receives scheduled pain medication, and that he was offered and declined or received PRN pain medications. Resident #6's Care Plan revision dated 8/5/2019 addressed chronic pain related to low back pain due to fracture of Lumbar 3 and Lumbar 3-Lumbar 4 disk/(OM) and left knee pain, left elbow pain as a focus of care, with a goal that Resident #6 will verbalize adequate relief of pain or ability to cope with incompletely relieved pain. The interventions/tasks for this goal include: Identify and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effects and impact on function, monitor/document for side effects of pain medication, monitor/record pain characteristics (FREQ) and receiving as needed (PRN), Quality, Severity (1 to 10 scale); anatomical location; onset, duration, aggravating factors, relieving factors; monitor/record/report to nurse resident	F 755		

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F 755	Continued From page 31 complaints of pain or requests for pain treatment. A review of Resident #6's physician orders conducted 12/03/2019 at approximately12:45 p.m., revealed written orders for OxyCONTIN Tablet ER 12 Hour Abuse-Deterrent 10 mg renewed on 11/22/19: Give 1 tablet by mouth two times a day related to fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing. A review of Resident #6's nursing notes revealed that on the dates 11/23/2019, 11/24/2019, 11/26/2019, 11/28/2019 and 11/29/2019, OxyCONTIN Tablet ER 12 Hour Abuse-Deterrent 10 mg did not receive the physician-ordered OxyCONTIN, citing, pharmacy unable to deliver med due to insurance issue. An interview conducted with Resident #6 on 12/5/2019 at approximately 9:30 a.m. regarding any lapses in OxyCONTIN administration yielded the following response, "They were out of OxyCONTIN for about 2 weeks. That was about 3 weeks ago. I went a couple of days without the medication and thought I could make it, but realized that I needed the medication for my pain." Although the resident was offered a different pain medication absent the OxyCONTIN, he stated it was not as effective. An interview with the DON conducted on 12/05/2019 at approximately 10:20 a.m. regarding the facility procedure to procure medications not covered by insurance, responded, "Normally if there are issues with insurance, we would pay for it, but I was not informed that Resident #6 needed the medication and no one told me he did not have the	F 755		

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F 755	Continued From page 32 OxyCONTIN." An interview with Registered Nurse (RN) staff #2, a Nurse Manager in Resident #6's unit, conducted on 12/5/2019, at 11:00 a.m., when asked about the process to obtain medications not covered by insurance, responded, "We would call the pharmacy and ask regarding the cost which was $46.64. After informing my boss (DON), I was told to authorize the medication. This occurred this past Monday, (12/2/2019)", at which time, OxyCONTIN was resumed and administered according to facility records. During a briefing with the Administrator, Assistant Administrator, DON, ADON, and two corporate consultants occurring on 12/5/2019 at approximately 12:20 p.m., the DON stated, "There is no policy regarding the supplementing of medications not provided by the facility, it is known facility-wide." At approximately 2:00 p.m. on 12/5/2019, the Facility Administrator provided an invoice history for Resident #6's non-covered medications to include OxyCONTIN, revealing that the most recent procurement of OxyCONTIN for Resident #6 occurred on 11/17/2019, authorizing 10 tablets at a cost of $46.26, lasting through 11/22/2019. A follow-up interview was held with the DON on 12/05/2019 at approximately 2:30 p.m. regarding the outcome of the administration of OxyCONTIN for Resident #6, responded, "Upon review of the MAR (Medication Administration Record) and additional invoices, I am in agreement that the resident did not receive his medication OxyCONTIN on11/24/2019, 11/26/2019, 11/28/2019 and 11/29/2019."	F 755		

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F 755	Continued From page 33 OxyCONTIN is a medication used to help relieve severe ongoing pain. OxyCONTIN belongs to a class of drugs known as opioid (narcotic) analgesics. It works in the brain to change how your body feels and responds to pain. Found on: https://www.rxlist.com/oxycontin-drug.htmw.	F 755		