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CONSULATE HEALTH CARE OF WOODSTOCK	803 SOUTH MAIN ST WOODSTOCK, VA 22664

(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 10/6/2020 through 10/9/2020. Complaints [VA0004973 unsubstantiated and VA00048671 unsubstantiated] were investigated during the survey. Corrections are required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). The census in this 88 certified bed facility was 70 at the time of the survey. The survey sample consisted of three current Resident reviews (Residents #3 through #5), and two closed record reviews (Residents #1 and #2).	F 000		
F 580 SS=D	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 resident from the facility as specified in §483.15(c)(1)(ii).	F 580		11/10/20

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

Electronically Signed | 10/27/2020

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 580	Continued From page 1 (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 staff interview, clinical record review and facility document review, it was determined that the facility staff failed to notify /consult the physician or nurse practitioner when multiple prescribed medications were not administered or available for administration as ordered for one of five residents in the survey sample, Resident #5. A. The facility staff failed to notify the physician or nurse practitioner when multiple prescribed were	F 580	1. Resident #5 medicine given as ordered. No ill effect noted. 2. All residents have the potential to be affected. Quality review of residents' MARs of the past 7 days to be completed by October 30, 2020 to verify proper timely notification to physician or nurse practitioner of medication not administered or not available per MD	

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F 580	Continued From page 2 not administered to Resident #5 on 9/30/2020. B. The facility staff failed to notify the physician or nurse practitioner when Gabapentin 300 mg ordered three times daily was not available for administration as prescribed on 9/24/20 through 5:00 PM on 9/28/20, for a total of 12 missed doses. The findings include: Resident #5 was admitted to the facility on 9/24/20 with the diagnoses of but not limited to alcohol cirrhosis with liver ascites, depression, and diabetes. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/3/20, coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as being independent for all areas of activities of daily living, with only set-up assistance required, and was coded as continent of bowel and bladder. A. Notification of medications not administered: A review of the clinical record revealed the September 2020 EMAR (electronic medication administration record). This review revealed the resident was not administered the following medications the morning of 9/30/20 as ordered: Aspirin (1) 325 mg (milligrams), once daily at 9:00 AM Multivitamin (2), once daily at 9:00 AM Folic Acid (3) 1 mg, once daily at 9:00 AM Furosimide (4) 80 mg, once daily at 9:00 AM Potassium (5) chloride ER, 20 meq (milliequivalents), once daily at 9:00 AM	F 580	orders. 3. Licensed nurses to be re-educated by DON/Designee By October 30, 2020 on administering medications per MD/NP orders including notification of medications not administered or not available per MD/NP orders. New orders will be monitored during clinical meeting to ensure notification and implementation. 4. DON/Designee will conduct quality review of 10% of residents' MARs to ensure compliance of proper timely notification to physician or nurse practitioner of medication not administered or not available per MD orders weekly times 4 weeks then monthly x 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Date of compliance November 10, 2020.	

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Spironolactone (6) 100 mg, once daily at 9:00 AM
Thiamine (7) 100 mg, once daily at 9:00 AM
Zoloft (8) 50 mg, once daily at 9:00 AM
Metoprolol (9) 25 mg, twice daily at 9:00 AM and 9:00 PM
Gabapentin (10) 300 mg, three times daily at 9:00 AM, 1:00 PM, and 5:00 PM
Lispro (11) insulin, 5 units three times daily before meals, at 7:30 AM, 11:30 AM, and 4:30 PM
Lactulose (12) 10 GM (grams) / 15 ml (milliliters), three times daily at 9:00 AM, 1:00 PM, and 5:00 PM

A review of the electronic POS (Physician's Order Sheet) of current medications revealed that each of the above medications were ordered on 9/24/20, the date of admission.

For the above medications, the 7:30 AM dose of insulin, and the 9:00 AM dose of all the other medications were not administered on 9/30/20.

A review of the clinical record revealed nurses notes by LPN #3 (Licensed Practical Nurse) dated 9/30/20 with times ranging from 2:39 PM to 2:42 PM. These notes were linked to the EMAR for each of the above medications; with each note documenting, "Due to time taken (sic) over cart medication was not given."

A nurse's note dated 10/1/20 at 3:06 AM documented, "Resident expressed being upset that he did not get his morning medications and wanted me to give him his potassium. I explained that due to the time they are scheduled I would not be able to give them to him as it would require an order from the doctor. He appeared to understand yet after I gave him PM medications he asked me when I was bringing his potassium

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F 580	Continued From page 4 so we discussed it a second time and it appeared he fully understood at that time as he relayed to me he knew he would not receive it until morning when it was due per orders." There were no notes evidencing any further information, including consultation/notification to the physician / nurse practitioner regarding the prescribed medications not being administered as ordered. On 10/8/20 at 12:23 PM, in an interview with LPN (licensed practical nurse) #3, the unit manager, she stated that on the morning of 9/30/20 she was called in and did not arrive to the facility until about 10:30 AM. LPN #3 stated that when she took over the cart, it was time for his [Resident #5] next scheduled meds [medications]. LPN #3 that, "I was always told you can't give AM meds when giving 1:00 PM meds. If they are not given on time you cannot give them at a later time." She stated that the night nurse was still working when she was called around 10:00 AM and that the day shift nurses did not show up. LPN #3 stated that she did not know why the night nurse did not give the medications, since she still was on the cart at the scheduled medication time. She stated that the nurse practitioner was in the building and she notified her. LPN #3 stated that she was told not to give him any of the morning meds. On 10/9/20 at 10:47 AM in a follow up interview with LPN #3, she stated that when she got report from LPN #5, that LPN #5 stated she had given 9:00 AM meds to everyone but 3 residents. LPN #3 stated that she notified the nurse practitioner who was in the building that Resident #5 did not	F 580		

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get any of his morning meds but that she did not give any specifics about which meds were not given and that the nurse practitioner stated ok. LPN #3 stated that if a nurse has to work over and is still on the clock when the next scheduled medications are due, they are to administer them until relief shows up.

A review of the physician's orders failed to reveal any dated for 9/30/20 to hold all the morning medications.

On 10/9/20 at 8:38 AM an interview was conducted with LPN #5, the night nurse from 9/29/20 who worked over on 9/30/20 and was still on duty when the 9:00 AM medications were due. LPN #5 stated that LPN #3 came in around 9:30 AM (about an hour before LPN #3 stated she arrived), and that the day shift nurses did not show up. She stated that no one notified her until about 9:15 AM that anyone was coming to take over for day shift. LPN #5 stated she was supposed to get off duty at 7:00 AM and was never told that no one was coming. She stated that she did not give Resident #5 his 7:30 AM insulin or 9:00 AM medications because she was not supposed to be there at that time. LPN #5 was asked if it was her responsibility to provide ongoing care until another staff arrived to relieve her, even if it is past time for the end of her shift. LPN #5 stated, "Someone has to let me know that a nurse is not coming. If someone let me know I can step in and do whatever I have to do until they get there. But I was not aware anyone called out and was not prepared to be giving more meds because no one notified me that no one else was coming." She stated that when she was notified around 9:15 AM that someone would be coming, she started to give 9:00 AM meds and

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F 580	Continued From page 6 got through 3 residents before LPN #3 arrived. She stated she reported to LPN #3 that she gave meds to only 3 residents. LPN #5 stated that she did not notify the nurse practitioner or physician regarding any medications she did not administer. On 10/8/20 at 4:22 PM an interview was conducted with LPN #4, who was the nurse that worked the night of 9/30/20 to the morning of 10/1/20 and wrote the note on 10/1/20 at 3:06 AM. She stated that Resident #5 asked about his morning meds and she checked the computer for them and saw the documentation that they were not given. LPN #4 stated she told the resident he could not have them at this time (nighttime when she gave him his nighttime meds). She stated that she did not call and consult the doctor when the resident asked to have the meds, to see if he could have any of them. On 10/9/20 at 9:52 AM an interview was conducted with ASM #4 (Administrative Staff Member) the nurse practitioner. ASM #4 stated that she does not recall having a conversation with the nurse about the missed morning meds. ASM #4 stated, "It would be in my nature if somebody said (a resident) did not get meds this morning, to ask which meds and based on that, what the next step would be. If it is once a day, go ahead and give it. I would hold something that is every 4-6 hours....I can't tolerate someone just saying 'I held all his meds.' I would want to know what meds and why. I would ask which meds because I would need to know what he did not get before deciding to hold anything or what further to do....I do not specifically recall a conversation with her (LPN #3) that day. It could be because it never happened. The evidence	F 580		

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shows it did not happen. Diuretics should have been given." Regarding the evening nurse's conversation with the resident when he asked for his medications, ASM #4 stated, "No one called. If she could have called me then he could have gotten them that night and I would have discussed them and he could have gotten them. The diuretics would have been important to help with his ascites....."

On 10/9/20 at 11:45 AM, ASM #1 (the Administrator) and ASM #2 (the Director of Nursing) were notified of the concern. Policies regarding physician notification was requested. None were provided.

B. Notification of medications unavailable:

A review of the current physician's orders revealed one dated 9/24/20 for Gabapentin 300 mg three times daily. A review of the September 2020 EMAR revealed that it was not administered until the 5:00 PM dose on 9/28/20. The resident missed 12 doses between admission on 9/24/20 and 5:00 PM on 9/28/20.

A review of the nurse's notes revealed multiple notations of medication not available, linked to the EMAR for a medication that was not administered, for the dates the Gabapentin was missed. There was no evidence that the physician / nurse practitioner were consulted or notified of the unavailable medication and an alternative ordered.

On 10/8/20 at 9:49 AM an interview was conducted with LPN #2. She stated that the

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Gabapentin required a hard script and that she did notify the doctor / nurse practitioner but did not document it. She could not recall what the doctor said. She stated the hospital did not send a hard script and it was a few days before the doctor / nurse practitioner came in to sign it. She stated that another nurse called the hospital to get it but that they did not send it. She stated that they were not given instructions of what to do in the meantime. LPN #2 stated the facility has struggles getting medication from this pharmacy and the doctor / nurse practitioner is not in every day. LPN #2 stated they try to get the hospital to send scripts for meds that require them until the doctor comes in. LPN #2 stated she should have made a note that she notified them.

On 10/8/20 at 4:10 PM ASM #2 the director of nursing was made aware of the concern for physician / nurse practitioner notification for medications that were unavailable for administration as ordered. ASM #2 stated that she recalled the resident did not get the Gabapentin for 4 or 5 days. She stated she would look into the concern for additional information. In a follow up interview on 10/9/20 at 8:22 AM ASM #2 stated that there was a prescription written on 9/28/20 or 9/29/20 but she had no proof it was faxed to the pharmacy. A copy of the prescription was provided and it was dated 9/27/20 and signed by the nurse practitioner. There was no evidence that the physician / nurse practitioner were notified that the Gabapentin was not administered until 5:00 PM on 9/28/20.

On 10/9/20 at 10:47 AM, an interview was conducted with LPN #3, the unit manager. LPN #3 stated that "we had an issue with the

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pharmacy. One nurse practitioner does not have a prescription pad where she can write a script so we printed one out and had her fill it in and the pharmacy would not use it so we had to get another order and I don't know why it took that long to get it into the building. We have it in the stat box but we cannot pull it from the stat box until the pharmacy has a prescription. It would be procedure to notify the nurse practitioner or physician if meds are not available. It is procedure to document everything."

A review of the facility policy, "Medication Shortages/Unavailable Medications" documented, "....6. If the medication is unavailable from Pharmacy due to formulary coverage, contraindication, drug-drug interaction, drug-disease interaction, allergy or other clinical reason, Facility should collaborate with Pharmacy and Physician/Prescriber to determine a suitable therapeutic alternative....8. When a missed dose is unavoidable, Facility nurse should document the missed dose and the explanation for such missed dose on the MAR or TAR and in the nurse's notes per Facility policy. Such documentation should include the following information: 8.1 A description of the circumstances of the medication shortage; 8.2 A description of Pharmacy's response upon notification; and 8.3 Action(s) taken."

On 10/9/20 at 11:45 AM, ASM #1 and ASM #2 were made aware of the findings. No further information was provided.

References:

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F 580	Continued From page 10 1. Aspirin - is used to prevent strokes. Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html 2. Multivitamin - used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-9038/multivitamin-oral/multivitamins-includes-prenatal-vitamins-oral/details 3. Folic Acid - helps the body make healthy new cells. Information obtained from https://medlineplus.gov/folicacid.html 4. Furosimide - is a diuretic used to treat high blood pressure and edema. Information obtained from https://medlineplus.gov/druginfo/meds/a682858.html 5. Potassium - is a type of electrolyte. It helps your nerves to function and muscles to contract. It helps your heartbeat stay regular. It also helps move nutrients into cells and waste products out of cells. Information obtained from https://medlineplus.gov/potassium.html 6. Spironolactone - is used to treat fluid retention. Information obtained from https://medlineplus.gov/druginfo/meds/a682627.html	F 580		

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F 580	Continued From page 11 7. Thiamine - is a vitamin used in the body to break down sugars in the diet. Information obtained from https://medlineplus.gov/druginfo/meds/a682586.html 8. Zoloft - is an antidepressant. Information obtained from https://medlineplus.gov/druginfo/meds/a697048.html 9. Metoprolol - is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html 10. Gabapentin - is used to treat seizures and neuralgic pain. Information obtained from https://medlineplus.gov/druginfo/meds/a694007.html 11. Lispro - is an insulin used to treat diabetes. Information obtained from https://medlineplus.gov/druginfo/meds/a697021.html 12. Lactulose - is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/meds/a682338.html	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		11/10/20

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F 656	Continued From page 12 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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 656		

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	495315	A. BUILDING _____ B. WING _____	C 10/09/2020

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CONSULATE HEALTH CARE OF WOODSTOCK	803 SOUTH MAIN ST WOODSTOCK, VA 22664

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F 656	Continued From page 13 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement the comprehensive care plan for one of 5 residents in the survey sample, Resident #5. The findings include: Resident #5 was admitted to the facility on 9/24/20 with the diagnoses of but not limited to alcohol cirrhosis with liver ascites, depression, and diabetes. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/3/20, coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as being independent for all areas of activities of daily living, with only set-up assistance required, and was coded as continent of bowel and bladder. A review of the electronic orders of current medications revealed the following medication orders, all dated 9/24/20: Aspirin (1) 325 mg (milligrams), once daily at 9:00 AM Multivitamin (2), once daily at 9:00 AM Folic Acid (3) 1 mg, once daily at 9:00 AM Furosimide (4) 80 mg, once daily at 9:00 AM Potassium (5) chloride ER, 20 meq (milliequivalents), once daily at 9:00 AM Spironolactone (6) 100 mg, once daily at 9:00 AM Thiamine (7) 100 mg, once daily at 9:00 AM Zoloft (8) 50 mg, once daily at 9:00 AM Metoprolol (9) 25 mg, twice daily at 9:00 AM and 9:00 PM Gabapentin (10) 300 mg, three times daily at 9:00 AM, 1:00 PM, and 5:00 PM	F 656	1. Resident #5 care plan has been reviewed for any needed updates regarding medications. 2. All residents have the potential to be affected. Quality review of residents' MARs of the past 7 days to be completed by October 30, 2020 to verify care plan is being followed. 3. Licensed nurses to be re-educated by DON/ Designee October 30, 2020 on administering medications per MD/NP orders including notification of medications not administered or not available per MD/NP orders. New orders will be monitored during clinical meeting to ensure notification and implementation. 4. DON/Designee will conduct a quality review of residents' MARs to ensure compliance of proper timely notification to physician or nurse practitioner of medication not administered or not available per MD orders weekly times 4 weeks then monthly x 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Date of compliance of November 10, 2020	

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F 656	Continued From page 14 Lispro (11) insulin, 5 units three times daily before meals, at 7:30 AM, 11:30 AM, and 4:30 PM Lactulose (12) 10 GM (grams) / 15 ml (milliliters), three times daily at 9:00 AM, 1:00 PM, and 5:00 PM A review of the clinical record revealed the September 2020 EMAR (electronic medication administration record). This review revealed that for the above medications, the 7:30 AM dose of insulin, and the 9:00 AM dose of all the other medications were not administered on 9/30/20. A review of the baseline care plan dated 9/24/20 included one for "Metabolic / Diabetic" that included the goal "Medication as ordered." A review of the clinical record revealed nurses notes by LPN #3 (Licensed Practical Nurse) dated 9/30/20 with times ranging from 2:39 PM to 2:42 PM. These notes were linked to the EMAR for each of the above medications; with each note documenting, "Due to time taken (sic) over cart medication was not given." A review of the comprehensive care plan revealed the following: - One for potential fluid deficit r/t (related to) fluid restriction....and diuretic use..." dated 10/8/20 which included the intervention dated 10/8/20 for "Administer medications as ordered...." - One for Diabetes dated 10/8/20 which included the intervention dated 10/8/20 for "Diabetes medication as ordered by doctor...." - One for liver disease r/t alcoholic liver cirrhosis dated 10/8/20 which included the intervention dated 10/8/20 for "Give medications as	F 656		

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F 656	Continued From page 15 ordered...." - One for use of antidepressant medication dated 10/8/20 which included the intervention dated 10/8/20 for "Administer antidepressant medications as ordered by physician." - One for potential for nutritional problem related to alcoholic liver cirrhosis with ascites, diabetes, hypokalemia, hypomagnesaemia, edema and depression, dated 10/8/20 which included the intervention dated 10/8/20 for "Administer medications as ordered...." On 10/9/20 at 8:38 AM an interview was conducted with LPN (licensed practical nurse) #5, the night nurse from 9/29/20 who worked over on 9/30/20 and was still on duty when the 9:00 AM medications were due. LPN #5 stated that LPN #3 came in around 9:30 AM (about an hour before LPN #3 stated she arrived), and that the day shift nurses did not show up. She stated that no one notified her until about 9:15 AM that anyone was coming to take over for day shift. She stated she was supposed to get off duty at 7:00 AM and was never told that no one was coming. LPN #5 stated that she did not give Resident #5 his 7:30 AM insulin or 9:00 AM medications because she was not supposed to be there at that time. LPN #5 was asked if it was her responsibility to provide ongoing care until another staff arrived to relieve her, even if it is past time for the end of her shift. LPN #5 stated, "Someone has to let me know that a nurse is not coming. If someone let me know I can step in and do whatever I have to do until they get there. But I was not aware anyone called out and was not prepared to be giving more meds because no one notified me that no one else was coming."	F 656		

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F 656	Continued From page 16 On 10/9/20 at 10:47 AM in an interview with LPN #3, she stated that the purpose of a care plan was "what we are going to do for the resident to be sure they are maintained as best quality of life as they can while they are in the building." When asked if Resident #5's comprehensive care plan was followed, LPN #3 stated it was not. On 10/9/20 at 11:45 AM, ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (the Director of Nursing) were notified of the concern. Policies regarding following care plans was requested. A review of the facility policy, "Plans of Care" documented, "An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements....Develop and implement an individualized Person-Centered baseline plan of care within 48 hours of admission....Develop and implement an individualized Person-Centered comprehensive plan of care by the Interdisciplinary Team...." No further information was provided by the end of the survey. References: 1. Aspirin - is used to prevent strokes. Information obtained from https://medlineplus.gov/druginfo/meds/a682878.h	F 656		

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F 656	Continued From page 17 tml 2. Multivitamin - used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-9038/multivitamin-oral/multivitamins-includes-prenatal-vitamins-oral/details 3. Folic Acid - helps the body make healthy new cells. Information obtained from https://medlineplus.gov/folicacid.html 4. Furosimide - is a diuretic used to treat high blood pressure and edema. Information obtained from https://medlineplus.gov/druginfo/meds/a682858.html 5. Potassium - is a type of electrolyte. It helps your nerves to function and muscles to contract. It helps your heartbeat stay regular. It also helps move nutrients into cells and waste products out of cells. Information obtained from https://medlineplus.gov/potassium.html 6. Spironolactone - is used to treat fluid retention. Information obtained from https://medlineplus.gov/druginfo/meds/a682627.html 7. Thiamine - is a vitamin used in the body to break down sugars in the diet. Information obtained from	F 656		

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F 656	Continued From page 18 https://medlineplus.gov/druginfo/meds/a682586.html 8. Zoloft - is an antidepressant. Information obtained from https://medlineplus.gov/druginfo/meds/a697048.html 9. Metoprolol - is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html 10. Gabapentin - is used to treat seizures and neuralgic pain. Information obtained from https://medlineplus.gov/druginfo/meds/a694007.html 11. Lispro - is an insulin used to treat diabetes. Information obtained from https://medlineplus.gov/druginfo/meds/a697021.html 12. Lactulose - is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/meds/a682338.html	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		11/10/20

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F 684	Continued From page 19 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure care was provided in accordance with the comprehensive person-centered plan of care for one of 5 residents in the survey sample, Resident #5. The facility staff failed to administer multiple medications to Resident #5 on 9/30/2020, as prescribed by the physician. The findings include: Resident #5 was admitted to the facility on 9/24/20 with the diagnoses of but not limited to alcohol cirrhosis with liver ascites, depression, and diabetes. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/3/20, coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as being independent for all areas of activities of daily living, with only set-up assistance required, and was coded as continent of bowel and bladder. A review of the clinical record revealed the September 2020 EMAR (electronic medication administration record). This review revealed the resident was not administered the following medications the morning of 9/30/20 as ordered: Aspirin (1) 325 mg (milligrams), once daily at 9:00 AM Multivitamin (2), once daily at 9:00 AM Folic Acid (3) 1 mg, once daily at 9:00 AM	F 684	1. Resident #5 medicine given as ordered. No ill effect noted. 2. All residents have the potential to be affected. Quality review of residents' MARs of the past 7 days to be completed by October 30, 2020 to verify proper timely notification to physician or nurse practitioner of medication not administered or not available per MD orders. 3. Licensed nurses to be re-educated by DON/ Designee by October 30, 2020 on administering medications per MD/NP orders including notification of medications not administered or not available per MD/NP orders. New orders will be monitored during clinical meeting to ensure notification and implementation. 4. DON/Designee will conduct a quality review of 10% of residents' MARs to ensure compliance of proper timely notification to physician or nurse practitioner of medication not administered or not available per MD orders weekly times 4 weeks then monthly x 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Date of compliance November 10, 2020	

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F 684	Continued From page 20 Furosimide (4) 80 mg, once daily at 9:00 AM Potassium (5) chloride ER, 20 meq (milliequivalents), once daily at 9:00 AM Spironolactone (6) 100 mg, once daily at 9:00 AM Thiamine (7) 100 mg, once daily at 9:00 AM Zoloft (8) 50 mg, once daily at 9:00 AM Metoprolol (9) 25 mg, twice daily at 9:00 AM and 9:00 PM Gabapentin (10) 300 mg, three times daily at 9:00 AM, 1:00 PM, and 5:00 PM Lispro (11) insulin, 5 units three times daily before meals, at 7:30 AM, 11:30 AM, and 4:30 PM Lactulose (12) 10 GM (grams) / 15 ml (milliliters), three times daily at 9:00 AM, 1:00 PM, and 5:00 PM A review of the electronic orders of current medications revealed that each of the above medications were ordered on 9/24/20, the date of admission. For the above medications, the 7:30 AM dose of insulin, and the 9:00 AM dose of all the other medications were not administered. A review of the clinical record revealed nurses notes by LPN #3 (Licensed Practical Nurse) dated 9/30/20 with times ranging from 2:39 PM to 2:42 PM. These notes were linked to the EMAR for each of the above medications; with each note documenting, "Due to time taken (sic) over cart medication was not given." A nurse's note dated 10/1/20 at 3:06 AM documented, "Resident expressed being upset that he did not get his morning medications and wanted me to give him his potassium. I explained that due to the time they are scheduled I would not be able to give them to him as it would require	F 684		

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F 684	Continued From page 21	F 684		

an order from the doctor. He appeared to understand yet after I gave him PM medications he asked me when I was brining his potassium so we discussed it a second time and it appeared he fully understood at that time as he relayed to me he knew he would not receive it until morning when it was due per orders."

There were no notes documenting any further information regarding the medications that were not administered.

On 10/8/20 at 12:23 PM, in an interview with LPN (licensed practical nurse) #3, the unit manager, she stated that on the morning of 9/30/20 she was called in and did not arrive to the facility until about 10:30 AM. LPN #3 stated that when she took over the cart, it was time for his [Resident #5] next scheduled meds [medications]. LPN #3 that, "I was always told you can't give AM meds when giving 1:00 PM meds. If they are not given on time you cannot give them at a later time." She stated that the night nurse was still working when she was called around 10:00 AM and that the day shift nurses did not show up. LPN #3 stated that she did not know why the night nurse did not give the medications, since she still was on the cart at the scheduled medication time.

On 10/9/20 at 10:47 AM in a follow up interview with LPN #3, she stated that when she got report from LPN #5, that LPN #5 stated she had given 9:00 AM meds to everyone but 3 residents. LPN #3 stated that if a nurse has to work over and is still on the clock when the next scheduled medications are due, they are to administer them until relief shows up.

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F 684	Continued From page 22 On 10/9/20 at 8:38 AM an interview was conducted with LPN #5, the night nurse from 9/29/20 who worked over on 9/30/20 and was still on duty when the 9:00 AM medications were due. LPN #5 stated that LPN #3 came in around 9:30 AM (about an hour before LPN #3 stated she arrived), and that the day shift nurses did not show up. She stated that no one notified her until about 9:15 AM that anyone was coming to take over for day shift. LPN #5 stated she was supposed to get off duty at 7:00 AM and was never told that no one was coming. She stated that she did not give Resident #5 his 7:30 AM insulin or 9:00 AM medications because she was not supposed to be there at that time. LPN #5 was asked if it was her responsibility to provide ongoing care until another staff arrived to relieve her, even if it is past time for the end of her shift. LPN #5 stated, "Someone has to let me know that a nurse is not coming. If someone let me know I can step in and do whatever I have to do until they get there. But I was not aware anyone called out and was not prepared to be giving more meds because no one notified me that no one else was coming." She stated that when she was notified around 9:15 AM that someone would be coming, she started to give 9:00 AM meds and got through 3 residents before LPN #3 arrived. She stated she reported to LPN #3 that she gave meds to only 3 residents. On 10/9/20 at 9:52 AM an interview was conducted with ASM #4 (Administrative Staff Member) the nurse practitioner. ASM #4 stated that she does not recall having a conversation with the nurse about the missed morning meds. ASM #4 stated, "It would be in my nature if somebody said (a resident) did not get meds this	F 684		

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F 684	Continued From page 23 morning, to ask which meds and based on that, what the next step would be. If it is once a day, go ahead and give it. I would hold something that is every 4-6 hours....I can't tolerate someone just saying 'I held all his meds.' I would want to know what meds and why. I would ask which meds because I would need to know what he did not get before deciding to hold anything or what further to do....I do not specifically recall a conversation with her (LPN #3) that day. It could be because it never happened. The evidence shows it did not happen. Diuretics should have been given." Regarding the evening nurse's conversation with the resident when he asked for his medications, ASM #4 stated, "No one called. If she could have called me then he could have gotten them that night and I would have discussed them and he could have gotten them. The diuretics would have been important to help with his ascites....." On 10/9/20 at 11:45 AM, ASM #1 (the Administrator) and ASM #2 (the Director of Nursing) were notified of the concern. Policies regarding following physician's orders was requested. None were provided. References: 1. Aspirin - is used to prevent strokes. Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html 2. Multivitamin - used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good	F 684		

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F 684	Continued From page 24 health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-9038/multivitamin-oral/multivitamins-includes-prenatal-vitamins-oral/details 3. Folic Acid - helps the body make healthy new cells. Information obtained from https://medlineplus.gov/folicacid.html 4. Furosimide - is a diuretic used to treat high blood pressure and edema. Information obtained from https://medlineplus.gov/druginfo/meds/a682858.html 5. Potassium - is a type of electrolyte. It helps your nerves to function and muscles to contract. It helps your heartbeat stay regular. It also helps move nutrients into cells and waste products out of cells. Information obtained from https://medlineplus.gov/potassium.html 6. Spironolactone - is used to treat fluid retention. Information obtained from https://medlineplus.gov/druginfo/meds/a682627.html 7. Thiamine - is a vitamin used in the body to break down sugars in the diet. Information obtained from https://medlineplus.gov/druginfo/meds/a682586.html 8. Zoloft - is an antidepressant. Information obtained from https://medlineplus.gov/druginfo/meds/a697048.h	F 684		

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	495315	A. BUILDING _____ B. WING _____	C 10/09/2020

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F 684	Continued From page 25 tml 9. Metoprolol - is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html 10. Gabapentin - is used to treat seizures and neuralgic pain. Information obtained from https://medlineplus.gov/druginfo/meds/a694007.html 11. Lispro - is an insulin used to treat diabetes. Information obtained from https://medlineplus.gov/druginfo/meds/a697021.html 12. Lactulose - is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/meds/a682338.html	F 684		
F 755 SS=D	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,	F 755		11/10/20

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F 755	Continued From page 26 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 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 staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure physician prescribed medications were available for administration for one of 5 residents in the survey sample, Resident #5. The facility staff failed to ensure Resident #5's Gabapentin 300 mg (milligrams) was available for administration three times daily between admission on 9/24/20 and 5:00 PM on 9/28/20, for a total of 12 missed doses. The findings include: Resident #5 was admitted to the facility on 9/24/20 with the diagnoses of but not limited to alcohol cirrhosis with liver ascites, depression,	F 755	1. Resident #5 Gabapentin given as ordered. No ill effects noted. 2. All residents have the potential to be affected. Quality review of residents' MARs of the past 7 days to be completed to verify medication available per MD orders. 3. Licensed nurses to be re-educated by DON/ Designee by October 30, 2020 on administering medications per MD/NP orders including notification of medications not administered or Pharmacy notification on medications not available per MD/NP orders. Daily clinical review of medication administration to ensure that medication given per the MD	

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F 755	Continued From page 27 and diabetes. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/3/20, coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as being independent for all areas of activities of daily living, with only set-up assistance required, and was coded as continent of bowel and bladder. A review of the current physician's orders revealed one dated 9/24/20 for Gabapentin 300 mg (milligrams) three times daily. A review of the September 2020 EMAR revealed that it was not administered until the 5:00 PM dose on 9/28/20. The resident missed 12 doses between admission on 9/24/20 and 5:00 PM on 9/28/20. A review of the nurse's notes revealed multiple notations of medication not available, linked to the EMAR for a medication that was not administered. No further information regarding the missed doses was documented. On 10/8/20 at 9:49 AM an interview was conducted with LPN (licensed practical nurse) #2. She stated that the Gabapentin required a hard script and that she did notify the doctor / nurse practitioner but did not document it. She could not recall what the doctor said. She stated the hospital did not send a hard script and it was a few days before the doctor / nurse practitioner came in to sign it. She stated that another nurse called the hospital to get it but that they did not send it. She stated that they were not given instructions of what to do in the meantime. LPN #2 stated the facility has struggles getting medication from this pharmacy and the doctor / nurse practitioner is not in every day. LPN #2 stated they try to get the hospital to send scripts	F 755	order and medication re-ordered from the pharmacy timely. 4. DON/Designee will conduct a quality review of 10 new orders for timely implementation/ medications available per MD orders weekly times 4 weeks then monthly x 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Date of compliance November 10, 2020	

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F 755	Continued From page 28 for meds that require them until the doctor comes in. LPN #2 stated she should have made a note that she notified them. On 10/9/20 at 10:47 AM, an interview was conducted with LPN #3, the unit manager. LPN #3 stated that "we had an issue with the pharmacy. One nurse practitioner does not have a prescription pad where she can write a script so we printed one out and had her fill it in and the pharmacy would not use it so we had to get another order and I don't know why it took that long to get it into the building. We have it in the stat box but we cannot pull it from the stat box until the pharmacy has a prescription. It would be procedure to notify the nurse practitioner or physician if meds are not available. It is procedure to document everything." On 10/8/20 at 4:10 PM ASM #2 (Administrative Staff Member - the Director of Nursing) was made aware of the concern Resident #5's medication Gabapentin not being available for administration as ordered by the physician. ASM #2 stated that she recalled the resident did not get the Gabapentin for 4 or 5 days. She stated she would look into the concern for additional information. In a follow up interview on 10/9/20 at 8:22 AM, ASM #2 stated that there was a prescription written on 9/28/20 or 9/29/20 but she had no proof it was faxed to the pharmacy. A copy of the prescription was provided and it was dated 9/27/20 and signed by the nurse practitioner. The medication still was not administered until 5:00 PM on 9/28/20 and was documented as unavailable. A review of the facility policy, "Medication Shortages/Unavailable Medications" documented,	F 755		

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F 755	Continued From page 29 "Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy....6. If the medication is unavailable from Pharmacy due to formulary coverage, contraindication, drug-drug interaction, drug-disease interaction, allergy or other clinical reason, Facility should collaborate with Pharmacy and Physician/Prescriber to determine a suitable therapeutic alternative....8. When a missed dose is unavoidable, Facility nurse should document the missed dose and the explanation for such missed dose on the MAR or TAR and in the nurse's notes per Facility policy. Such documentation should include the following information: 8.1 A description of the circumstances of the medication shortage; 8.2 A description of Pharmacy's response upon notification; and 8.3 Action(s) taken." On 10/9/20 at 11:45 AM, ASM #1(the Administrator) and ASM #2 were made aware of the findings. No further information was provided. References: 1. Gabapentin - is used to treat seizures and neuralgic pain. Information obtained from https://medlineplus.gov/druginfo/meds/a694007.html	F 755		