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	495287	A. BUILDING _____ B. WING _____	C 08/05/2021

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HAMPTON HEALTH & REHAB CENTER, LLC	2230 EXECUTIVE DRIVE REVISED HAMPTON, VA 23666

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 8/3/21 through 8/5/21. One complaint was investigated during survey: VA00052436 was Substantiated with a related deficiencies. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 86 certified bed facility was 41 at the time of the survey. The survey sample consisted of 8 current resident reviews (Residents #201 through #208) and 7 closed record reviews (Resident #209 through #215).	F 000		
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 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		

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

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(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, facility document review, and clinical record review, it was determined that the facility staff failed to notify the physician of missed medication for one of 15 sampled residents, Resident #212.

The findings included:

Resident #212 was admitted to the facility on 6/30/21 with diagnoses that included but were not limited to chronic heart failure, closed fracture of

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the right tibia with healing, pain in right knee, and high blood pressure. Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain.

Review of Resident #212's medical record revealed that Resident #212 had an order for the following prn pain medication: "Tylenol Tablet 325 mg (milligrams) Give 3 tablets by mouth every 6 hours as needed for pain."

Review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that Resident #212 received Tylenol 325 mg 3 tablets on 7/1/21 through 7/11/21. Review of the Emar Administration notes revealed that the Tylenol was effective on these dates for pain relief.

Review of a therapy note dated 7/13/21 revealed that Resident #212 was having a pain of 8/10 during her therapy session. The following was documented in part,"...Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercies),

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however, pt continued to decline at this time...Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware."

Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: "She is being seen today for c/o(complaints) right knee pain. Pt is sitting up in her w/c (wheelchair), appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable... 1. Right knee pain: will give Tramadol (1) 50 mg 1 tab po (by mouth) Q (every) 12 x10 days."

Review of Resident #212's July 2021 POS (Physician Order Summary) revealed the following order: "Tramadol HCl Tablet 50 MG Give 1 tablet by mouth two times a day for Pain for 10 Days. Start Date: 7/13/21 2100 (9 p.m.)."

Further review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that her Tramadol was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p.m. dose of Tramadol on 7/13/21.

Review of Resident #212's July MAR revealed that nurses were signing off that they had administered the scheduled Tramadol on 7/14/21 at 9:00 a.m. and 9:00 p.m. Evidence (Narcotic sheets) could not be provided to show that the ordered Tramadol had made it to the facility from pharmacy. Evidence could not be shown that the

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nurses obtained the ordered Tramadol from the Omnicell (STAT box). Review of Resident #212's MAR also revealed that she missed her 9 a.m. dose of Tramadol on 7/15/21 (hours before her discharge home on 7/15/21).

Further review of Resident #212's clincial record revealed that she was discharged home on 7/15/21 at 1:40 p.m.

Review of the Omnicell list of STAT medications revealed that "Tramadol 50 mg" was a medication available in the Omnicell.

On 8/4/21 at 12:02 p.m., and 4 p.m., a telephone interview was attempted with Resident #212's representative. She could not be reached for an interview.

On 8/4/21 at 2:23 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked the process if she were to go administer a scheduled medication; more specifically a narcotic, and it was not in the medication cart, LPN #2 stated that she would check to see if the medication was available in the STAT Omnicell. LPN #2 stated that she would then pull the medication from the Omnicell. When asked if Tramadol 50 mg was in the Omnicell, LPN #2 stated, "Yes, I know that is in the STAT box." When asked if that is where she pulled Resident's #212's Tramadol on 7/14/21, LPN #2 stated, "Yes, I pulled from the STAT box."

On 8/4/21 at 2:30 p.m., an interview was conducted with LPN #3, the nurse who worked with Resident #212 on 7/13/21 evening shift. When asked why Resident #212 did not receive

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her ordered Tramadol on 7/13/21 at 9:00 p.m.; LPN #3 stated that the medication was not up from pharmacy. When asked the process if a medication such as a narcotic is not yet up from pharmacy and it is due to be administered, LPN #3 stated that she was new to the facility and did not have a code to get into the Omnicell system. When asked if she had asked for help regarding pulling the medication from the Omnicell system; LPN #3 stated that she told a nurse on the floor. LPN #3 stated that she wasn't sure what had happened after that.

On 8/4/21 at 2:59 p.m., an interview was conducted with RN (Registererd Nurse) #2, the nurse who did not administer the scheduled Tramadol on 7/15/21. When asked if residents are to receive all scheduled medications prior to their discharge that are due prior to discharge; RN #2 stated, "Yes." When asked if this included scheduled pain medications, RN #2 stated, "Yes." When asked why Resident #212 did not receive her scheduled Tramadol on 7/15/21 at 9:00 a.m. prior to her discharge; RN #2 stated, "She didn't have Tramadol." When asked what she had meant by that statement, RN #2 stated, "She didn't have a narcotic card at all." RN #2 then stated that she had told the nurse (LPN #1) that she had been shadowing that day that Resident #212 did not have Tramadol on the medication cart. RN #2 stated that she did not have a code to access the Omnicell to see if the medication was in there. RN #2 stated that she was not sure if Tramadol was in the Omnicell as she still did not have a code to access Omnicell. RN #2 stated that she believed her preceptor did not administer the tramadol because the resident was being sent home with a script for Tramadol anyway.When asked if it was acceptable for residents to not

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receive their ordered medications, RN #2 stated that it wasn't.

On 8/4/21 at 4:30 p.m., an interview was conducted with LPN #1, the nurse who was precepting RN #2. When asked what happened to Resident #212's tramadol on 7/15/21; why it was not administered, LPN #1 stated that it was not available in the medication cart. When asked the process if the medication is not in the medication cart, LPN #1 stated that she would call pharmacy to inquire about where the medication is, or what is needed to get the medication, such as a script. When asked if she recalled inquiring about Resident #212's Tramadol, LPN #1 stated that she did not. When asked if she attempted to pull the Tramadol from the Omnicell, LPN #1 stated that she did not have access to the Omnicell. LPN #1 stated that they have only had the Omnicell since June of 2021. When asked who she could ask to obtain a medication from the Omnicell, LPN #1 stated that she could ask LPN #2, who was also the unit manager. LPN #1 stated that she did not ask LPN #1 to obtain the Tramadol from the Omnicell. When asked if she should notify the MD (Medical Doctor) that a medication was missed, LPN #1 stated that the medical doctor should be aware of every missed dose of a medication. LPN #1 stated that she did not notify the MD at the time of the missed dose of Tramadol.

On 8/4/21 at 4:40 p.m., an interview was conducted with ASM (Administrative Staff Member) #4, the Nurse Practitioner. She could not recall being made aware that Resident #211 had missed all her doses of scheduled ordered Tramadol. ASM #4 stated that the physician may have been aware. ASM #4 stated that she

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expected the nursing staff to make her aware in order for her to give further direction.

On 8/5/21 at 5 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). When asked the process if a scheduled narcotic is not available in the medication cart, what nursing staff should do, ASM #2 stated that the nurses should be calling pharmacy to see the status of the medication and whether or not the medication needs a prescription. ASM #2 stated that she would expect nursing staff to obtain a script from the physician, if that is what was needed and send to pharmacy. ASM #2 stated that it takes sometime for pharmacy to verify the prescription so the nurse may not be able to get it from the Omnicell system immediately. ASM #2 stated she would then expect nursing staff to alert the physician if a medication cannot be administered for further direction. ASM #2 stated that she did expect staff to pull the medication from Omnicell if a script was available. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building who could assist. When asked if all nurses should have access to the Omnicell if they are adminisering medications, ASM #2 stated, "Yes." When asked who was responsible for ensuring all nurses had access to the Omnicell, ASM #2 stated that she was as the DON. When asked what had happened to Resident #212's Tramadol, ASM #2 stated that she didn't see where the Tramadol was ever delivered to the facility. ASM #2 stated that she remembered personally getting the script for the Tramadol has she recalled telling the NP (Nurse Practitioner) to assess Resident #212 for an increase in pain and yelling out. ASM #2 stated that she didn't personally hear the resident

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yell out, but that she recalled hearing a nurse tell her this information that day. ASM #2 could not recall the nurse. ASM #2 stated that she recalled putting the order into the electronic system and scheduling it for 9:00 p.m. because the medication would have had plenty of time to get to the facility by then. ASM #2 could not recall if she was the nurse who faxed the script to the pharmacy.

On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for the scheduled tramadol or a script (Prescription). OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell.

On 8/5/21 at 11:19 a.m., an interview was conducted with ASM #5, the physician. He could not recall being made aware that Resident #211 had missed all her scheduled doses of Tramadol.

On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Facility policy titled, "Medication Shortage/Unavailable Medications" documents in part, the following: "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. If the medication shortage is discovered at the time of medication administration facility staff should immediately

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F 580	Continued From page 9 take the action specified... 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery. 3. If the medication shortage is discovered after normal pharmacy hours: 3.1 A licensed nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency Delivery 3.2.2 Use of an emergency (back up) third party pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions." (1) Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p.	F 580		

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F 580	Continued From page 10 1197. COMPLAINT DEFICIENCY	F 580		
F 658 SS=E	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 representative interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to follow professional standards of practice by signing off medications were administered to two of 15 residents; Residents #212 and #211 that were not available. The findings included: 1. Resident #212 was admitted to the facility on 6/30/21 with diagnoses that included but were not limited to chronic heart failure, closed fracture of the right tibia with healing, pain in right knee, and high blood pressure. Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the	F 658		

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last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain.

Review of a therapy note dated 7/13/21 revealed that Resident #212 was having a pain of 8/10 during her therapy session. The following was documented in part,"...Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercies), however, pt continued to decline at this time...Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware."

Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: "She is being seen today for c/o(complaints) right knee pain. Pt is sitting up in her w/c, appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable... 1. Right knee pain: will give Tramadol (1) 50 mg 1 tab po (by mouth) Q (every) 12 (hours) x (for) 10 days."

Review of Resident #212's July 2021 POS (Physician Order Summary) revealed the following order: "Tramadol HCl Tablet 50 MG Give 1 tablet by mouth two times a day for Pain

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for 10 Days. Start Date: 7/13/21 2100 (9 p.m.)."

Further review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that her Tramadol was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p.m. dose of Tramadol on 7/13/21.

Review of Resident #212's July 2021 MAR revealed that nurses were signing off that they had administered the scheduled Tramadol on 7/14/21 at 9:00 a.m. and 9:00 p.m. Evidence (Narcotic sheets) could not be provided to show that the ordered Tramadol had made it to the facility from pharmacy. Evidence could not be shown that the nurses obtained the ordered Tramadol from the Omnicell (STAT box). Review of Resident #212's MAR also revealed that she missed her 9 a.m. dose of Tramadol on 7/15/21 (hours before her discharge home on 7/15/21).

Further review of Resident #212's clincial record revealed that she was discharged home on 7/15/21 at 1:40 p.m.

Review of the Omnicell list of medications revealed that "Tramadol 50 mg" was a medication available in the Omnicell.

On 8/4/21 at 2:23 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked the process if she were to go administer a scheduled medication; more specifically a narcotic, and it was not in the medication cart, LPN #2 stated that she would check to see if the medication was available in the STAT Omnicell. LPN #2 stated that she would then pull the medication from the Omnicell. When

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asked if Tramadol 50 mg was in the Omnicell, LPN #2 stated, "Yes, I know that is in the STAT box." When asked if that is where she pulled Resident's #212's Tramadol on 7/14/21, LPN #2 stated, "Yes, I pulled from the STAT box."

On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for the scheduled tramadol or a script (Prescription). OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell.

On 8/5/21 at 10:41 a.m., further interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked how she signed off that she had administered a 9 a.m. dose of Tramadol on 7/14/21 if the pharmacy had not yet recevied an order or a script for the medication; LPN #2 stated, "I don't remember why I signed that off." When asked if it was acceptable to sign off that medications were administered, if they were not in fact given to the resident, LPN #2 stated, "No ma'am." When asked what why the Tramadol had not made it to the facility, LPN #2 stated, "I don't know exactly the cause."

On 8/5/21 during a pre-exit meeting, ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility could not provide a policy or professional standard for the above concerns.

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(1) Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.

2. Resident #211 was admitted to the facility on 6/23/21 with diagnoses that included but were not limited to cerebral infarction (stroke), right sided hemiplegia (paralysis) following stroke, type two diabetes mellitus, and end stage renal disease requiring dialysis. Resident #211's most recent comprehensive MDS (minimum data set) assessment was an admission assessment dated 7/5/21. Resident #211 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #211 was coded in Section J0100. (Pain Management) as receiving scheduled pain medications in the last 5 days from the ARD date (7/5/21). Resident #211 was coded not receiving prn (as needed) pain medications in the last 5 days AND receiving non medication interventions for pain in the last 5 days. Resident #211 was coded as not having pain. Resident #211 was discharged from the facility on 8/3/21.

On 8/4/21 at 9:58 a.m., a telephone interview was conducted with Resident #211's emergency contact as a number was not listed for Resident #211. Resident #211's emergency contact was her son, and did not feel comfortable giving out his mother's telephone number. The son did have a concern regarding his mother's gabapentin (1) for her nerve pain. The son stated that there was quite some time where his mother was out and that nursing staff were not following up with obtaining the medication. The son stated that he

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eventually had to go to the facility to speak with the DON (Director of Nursing) who then took care of the issue. The son stated that his mother was not yet experiencing pain but was overall sick to her stomach and feeling "itchy" all over which was usually a withdrawal side effect for her. The son was upset that it took his involvement to finally get his mother's prescribed gabapentin.

Resident #211's care plan dated 6/24/21 documented the following for pain: "Resident is at risk for pain related to CVA (Stroke) with right hemiparesis...Administer analgesics/medications per physician's orders..."

Review of Resident #211's June, July and August 2021 POS (Physician Order Summary) revealed the following order: "Gabapentin 100 mg (milligrams) 100 mg capsule by mouth Three Times Daily." This order was initiated on 6/24/21.

Review of the June, July, and August 2021 MARS (Medication Administration Record) revealed that gabapentin was scheduled for 6:00 a.m., 2:00 p.m., and 9:00 p.m.

Review of the narcotic logs revealed on 6/24/21 the pharmacy had delivered 28 capsules of gabapentin. The first dose of gabapentin was given at 2100 (9:00 p.m.) on 6/24/21. Further review of the narcotic sheets revealed that Resident #211 had completed her gabapentin on 7/4/21 at 9:00 p.m.; where it was documented she had (zero) capsules left.

Review of the second narcotic sheet for gabapentin revealed that pharmacy had delivered 30 capsules of gabapentin on 7/9/21. Resident #211's first dose of gabapentin was on 7/9/21 at

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F 658	Continued From page 16 2100 (9:00 p.m.). There was no narcotic sheets/logs to account for days 7/5/21 through 7/9/21 at (2:00 p.m.) (13 administrations). Review of the facility STAT Omnicell list revealed that Gabapentin 100 mg was in the Omnicell STAT box. Further review of Resident #211's July 2021 MAR revealed that staff had not administered the gabapentin on the following dates: 7/5/21 at 2 p.m. and 9 p.m. 7/7/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m. 7/8/21 at 6:00 a.m. and 9:00 p.m. and 7/9/21 at 6:00 a.m. The following administration note was documented on 7/5/21 at 7:51 p.m.: "On hold until received per NP (Nurse Practitioner)." The following note was documented on 7/6/21 by the Nurse Practitioner: "...Denies pain and has no complaints, SOB (Shortness of breath), and (abdominal pain) or N/V (nausea/vomiting)...Neuropathy: Continue Neurontin (Gabapentin) 100 mg TID, script renewed." On 7/7/21 the following administration note was documented: "Gabapentin Capsule 100 mg- Give 1 mg by mouth three times a day for pain...pharmacy to send." On 7/8/21 the following administration note was documented: "Gabapentin Capsule 100 mg...needs hard script. MD (medical doctor)	F 658		

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aware."

On 7/9/21 at 10:29 a.m., the following administration note was documented: "Gabapentin 100 mg three times a day for pain...per MD, administrator, DON (Director of Nursing) ok to give now."

Further review of Resident #211's MAR revealed that gabapentin was documented as "administered" on the following dates; however there was no evidence that facility staff had pulled gabapentin from the facility STAT box:

7/5/21 at 6:00 a.m.,
7/6/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m.,
7/8/21 at 2:00 p.m."

On 8/4/21 at 3:45 p.m., during an interview with the pharmacist (OSM) Other Staff Member #2; it was determined that the pharmacy did not receive a script for the gabapentin until 7/9/21. OSM #2 stated that the only time nursing accessed the Omnicell to retrieve gabapentin for Resident #211 was on 7/9/21 at 10:24 a.m. OSM #2 stated that staff cannot pull gabapentin from the Omnicell unless a script is renewed so he could not explain why staff were documenting that they had administered the gabapentin on the above dates. OSM #2 stated that the pharmacy initially sent out 28 capsules of gabapentin on 6/24/21 which had run out on 7/4/21. OSM #2 stated that the second time they sent out gabapentin was on 7/9/21 and it was for 30 capsules. OSM #2 confirmed again that the only time Resident #211 received gabapentin in between dates 7/5/21 through 7/9/21 was on 7/9/21 at 10:24 a.m. OSM #2 stated that the request to retrieve the gabapentin was made

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from the DON (Director of Nursing).

On 8/4/21 at 5:00 p.m., an interview was conducted with the DON (Director of Nursing) (ASM (Administrative Staff Member) #2. When asked if there was has been issues obtaining scripts for narcotics or getting those scripts to the pharmacy; ASM #2 stated, "Yes." When asked what had happened with Resident #211's gabapentin as the NP had documented that she wrote a script on 7/6/21; ASM #2 stated that she was unaware that Resident #211's gabapentin prescription had run out until the son had come into the building on 7/9/21. ASM #2 stated that he was upset that his mom had missed her gabapentin for several days and wanted to know what was going on with it. ASM #2 stated that she had called the medical doctor to obtain a script that day. ASM #2 stated that she pulled the medication out of the Omnicell and the nurse administered the medication, but could not remember the time. ASM #2 stated that she realized the resident had been out sometime before she initiated getting the resident her gabapentin. When asked if the son really had initiated obtaining his mom's medication, ASM #2 stated, "Yes, it was in response to the son coming in." ASM #2 stated that she expected her nurses to follow up with gabapentin and not wait days later before obtaining the medication. ASM #2 stated that she was not sure what they did do, didn't do for the gabapentin. When asked if Resident #211 had an increase amount of pain related to missing 12 doses of gabapentin, ASM #2 stated that she didn't think so, that this information was never reported to her. When asked if nursing staff should be documenting that medications are being administered when they are not in fact given, ASM #2 stated, "Absolutely

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not." When asked if nursing staff should have pulled gabapentin from the Omnicell and administered the medication, ASM #2 stated that nursing staff could do that if there was a script for the medication. ASM #2 stated that she expected her staff to inquiring on why the gapabentin was not available and if it needed a script to call the physician, obtain a script and fax that to the pharmacy. ASM #2 stated that once the pharmacy has a script, the medication can be pulled from the Omnicell. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building with access. ASM #2 stated that she was not aware that not all nurses had access and didn't realize this was the responsibility of the DON to ensure their access. ASM #2 confirmed that all nurses should have access to the Omnicell if they are responsible for passing out medications, and that she was going to work on getting all nurses access.

The nurses who had documented that they had administered the gabapentin, when it was in fact, not administered could not be reached for an interview.

On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

(1) Gabapentin is commonly used to treat neuropathic pain (pain due to nerve damage). This information was obtained from the National Institutes of Health. https://pubmed.ncbi.nlm.nih.gov/28597471/.

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	COMPLAINT DEFICIENCY			
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		

§ 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 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, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to administer four doses of Scheduled IV narcotic pain medication, Tramadol per physician's orders and plan of care for one of 15 residents in the survey sample, Resident #212 .

The findings included:

Resident #212 was admitted to the facility on 6/30/21 with diagnoses that included but were not limited to chronic heart failure, closed fracture of the right tibia with healing, pain in right knee, and high blood pressure. Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview

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for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain.

Review of Resident #212's medical record revealed that Resident #212 had an order for the following prn pain medication: "Tylenol Tablet 325 mg (milligram) Give 3 tablets by mouth every 6 hours as needed for pain."

Review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that Resident #212 received Tylenol 325 mg 3 tablets on 7/1/21 through 7/11/21. Review of the Electronic Medication Administration Record (eMAR) Administration notes revealed that the Tylenol was effective on these dates for pain relief.

Review of a therapy note dated 7/13/21 revealed that Resident #212 was having increased pain on 8/10 during her therapy session. The following was documented in part,"...Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercises), however, pt continued to decline at this time...Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware."

Review of a note from the NP (Nurse Practitioner)

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dated 7/13/21 documented in part, the following: "She is being seen today for c/o (complaints) right knee pain. Pt is sitting up in her w/c, appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable... 1. Right knee pain: will give Tramadol (1) 50 mg 1 tab po (by mouth) Q (every) 12 (hours) x (for) 10 days."

Review of Resident #212's July 2021 POS (Physician Order Summary) revealed the following order: "Tramadol HCl Tablet 50 MG Give 1 tablet by mouth two times a day for Pain for 10 Days. Start Date: 7/13/21 2100 (9 p.m.)."

Further review of Resident #212's July 2021 MAR revealed that her Tramadol was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p.m. dose of Tramadol on 7/13/21.

Review of Resident #212's July MAR revealed that nurses were signing off that they had administered the scheduled Tramadol on 7/14/21 at 9:00 a.m. and 9:00 p.m. Evidence (Narcotic sheets) could not be provided to show that the ordered Tramadol had made it to the facility from pharmacy. Evidence could not be shown that the nurses obtained the ordered Tramadol from the Omnicell (narcotic STAT box). Review of Resident #212's MAR also revealed that she missed her 9 a.m. dose of Tramadol on 7/15/21 (hours before her discharge home on 7/15/21).

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Further review of Resident #212's clincial record revealed that she was discharged home on 7/15/21 at 1:40 p.m.

Review of the Omnicell list of medications revealed that "Tramadol 50 mg" was a medication available in the Omnicell.

On 8/4/21 at 12:02 p.m., and 4 p.m., a telephone interview was attempted with Resident #212's representative. She could not be reached for an interview.

On 8/4/21 at 2:23 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked the process if she were to go administer a scheduled medication; more specifically a narcotic, and it was not in the medication cart, LPN #2 stated that she would check to see if the medication was available in the STAT Omnicell. LPN #2 stated that she would then pull the medication from the Omnicell. When asked if Tramadol 50 mg was in the Omnicell, LPN #2 stated, "Yes, I know that is in the STAT box." When asked if that is where she pulled Resident's #212's Tramadol on 7/14/21, LPN #2 stated, "Yes, I pulled from the STAT box."

On 8/4/21 at 2:30 p.m., an interview was conducted with LPN #3, the nurse who worked with Resident #212 on 7/13/21 evening shift. When asked why Resident #212 did not receive her ordered Tramadol on 7/13/21 at 9:00 p.m.; LPN #3 stated that the medication was not up from pharmacy. When asked the process if a medication such as a narcotic is not yet up from pharmacy and it is due to be administered, LPN #3 stated that she was new to the facility and did

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not have a code to get into the Omnicell system. When asked if she had asked for help regarding pulling the medication from the Omnicell system; LPN #3 stated that she told a nurse on the floor. LPN #3 stated that she wasn't sure what had happened after that.

On 8/4/21 at 2:59 p.m., an interview was conducted with RN (Registererd Nurse) #2, the nurse who did not administer the scheduled Tramadol on 7/15/21. When asked if residents are to receive all scheduled medications prior to their discharge that are due prior to discharge; RN #2 stated, "Yes." When asked if this included scheduled pain medications, RN #2 stated, "Yes." When asked why Resident #212 did not receive her scheduled Tramadol on 7/15/21 at 9:00 a.m. prior to her discharge; RN #2 stated, "She didn't have Tramadol." When asked what she had meant by that statement, RN #2 stated, "She didn't have a narcotic card at all." RN #2 then stated that she had told the nurse (LPN #1) that she had been shadowing that day that Resident #212 did not have Tramadol on the medication cart. RN #2 stated that she did not have a code to access the Omnicell to see if the medication was in there. RN #2 stated that she was not sure if Tramadol was in the Omnicell as she still did not have a code to access Omnicell. RN #2 stated that she believed her preceptor did not administer the tramadol because the resident was being sent home with a script for Tramadol anyway.When asked if it was acceptable for residents to not receive their ordered medications, RN #2 stated that it wasn't.

On 8/4/21 at 4:30 p.m., an interview was conducted with LPN #1, the nurse who was precepting RN #2. When asked what happened

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to Resident #212's tramadol on 7/15/21; why it was not administered, LPN #1 stated that it was not available in the medication cart. When asked the process if the medication is not in the medication cart, LPN #1 stated that she would call pharmacy to inquire about where the medication is, or what is needed to get the medication, such as a script. When asked if she recalled inquiring about Resident #212's Tramadol, LPN #1 stated that she did not. When asked if she attempted to pull the Tramadol from the Omnicell, LPN #1 stated that she did not have access to the Omnicell. LPN #1 stated that they have only had the Omnicell since June of 2021. When asked who she could ask to obtain a medication from the Omnicell, LPN #1 stated that she could ask LPN #2, who was also the unit manager. LPN #1 stated that she did not ask LPN #1 to obtain the Tramadol from the Omnicell. When asked if she should notify the MD (Medical Doctor) that a medication was missed, LPN #1 stated that the medical doctor should be aware of every missed dose of a medication. LPN #1 stated that she did not notify the MD at the time of the missed dose of Tramadol.

On 8/5/21 at 5 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). When asked the process if a scheduled narcotic is not available in the medication cart, what nursing staff should do, ASM #2 stated that the nurses should be calling pharmacy to see the status of the medication and whether or not the medication needs a prescription. ASM #2 stated that she would expect nursing staff to obtain a script from the physician, if that is what was needed and send to pharmacy. ASM #2 stated that it takes sometime for pharmacy to verify the prescription so the

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nurse may not be able to get it from the Omnicell system immediately. ASM #2 stated she would then expect nursing staff to alert the physician if a medication cannot be administered for further direction. ASM #2 stated that she did expect staff to pull the medication from Omnicell if a script was available. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building who could assist. When asked if all nurses should have access to the Omnicell if they are adminisering medications, ASM #2 stated, "Yes." When asked who was responsible for ensuring all nurses had access to the Omnicell, ASM #2 stated that she was as the DON. When asked what had happened to Resident #212's Tramadol, ASM #2 stated that she didn't see where the Tramadol was ever delivered to the facility. ASM #2 stated that she remembered personally getting the script for the Tramadol has she recalled telling the NP (Nurse Practitioner) to assess Resident #212 for an increase in pain and yelling out. ASM #2 stated that she didn't personally hear the resident yell out, but that she recalled hearing a nurse tell her this information that day. ASM #2 could not recall the nurse. ASM #2 stated that she recalled putting the order into the electronic system and scheduling it for 9:00 p.m. because the medication would have had plenty of time to get to the facility by then. ASM #2 could not recall if she was the nurse who faxed the script to the pharmacy.

On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for the scheduled tramadol or a script (Prescription). OSM #3 stated

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that a script must also be in place for the nurse to access a STAT dose from the Omnicell.

On 8/5/21 at 10:41 a.m., further interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked how she signed off that she had administered a 9 a.m. dose of Tramadol on 7/14/21 if the pharmacy had not yet recevied an order or a script for the medication; LPN #2 stated, "I don't remember why I signed that off." When asked if it was acceptable to sign off that medications were administered, if they were not in fact given to the resident, LPN #2 stated, "No ma'am." When asked what why the Tramadol had not made it to the facility, LPN #2 stated, "I don't know exactly the cause."

On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Medication Shortage/Unavailable Medications" documents in part, the following: "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. If the medication shortage is discovered at the time of medication administration facility staff should immediately take the action specified...
2. If a medication shortage is discovered during normal pharmacy hours:
2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed

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facility nurse should place the order or reorder for the next scheduled delivery.
2.2 If the next available delivery causes delay or missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose.
2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery.
3. If the medication shortage is discovered after normal pharmacy hours:
3.1 A licensed nurse should obtain the ordered medication from the Emergency Medication Supply.
3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include:
3.2.1 Emergency Delivery
3.2.2 Use of an emergency (back up) third party pharmacy.
4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions."

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary."

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F 684	Continued From page 29 (1) Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.	F 684		
	COMPLAINT DEFICIENCY			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to ensure pain relief measures were provided to one of 15 residents in the survey sample, Resident #212 who requested pain medication on 7/13/21 and 7/14/21. The findings included: Resident #212 was admitted to the facility on 6/30/21 with diagnoses that included but were not limited to chronic heart failure, closed fracture of the right tibia with healing, pain in right knee, and high blood pressure. Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview	F 697		

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for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain.

Review of Resident #212's medical record revealed that Resident #212 had an order for the following prn pain medication: "Tylenol Tablet 325 mg (milligram) Give 3 tablets by mouth every 6 hours as needed for pain."

Review of Resident #212's July TAR (Treatment Administration Record) revealed that Resident #212 received Tylenol 325 mg 3 tablets on 7/1/21 through 7/11/21. Review of the Emar Administration notes revealed that the Tylenol was effective on these dates for pain relief.

Review of a therapy note dated 7/13/21 revealed that Resident #212 was having a pain of 8/10 during her therapy session. The following was documented in part,"...Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercies), however, pt continued to decline at this time...Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware."

There was no evidence on Resident #212's MAR (Medication Administration Record) that nursing administered prn (as needed) Tylenol to Resident

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#212 on 7/13/21. There was no evidence of any non-pharmacological pain relief measures provided to Resident #212 on 7/13/21.

Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: "She is being seen today for c/o (complaints) right knee pain. Pt is sitting up in her w/c, appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable... 1. Right knee pain: will give Tramadol (1) 50 mg 1 tab po (by mouth) Q (every) 12 (hours) x (for) 10 days."

Further review of Resident #212's MAR revealed that her Tramadol was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p.m. dose of Tramadol on 7/13/21.

Review of a therapy note dated 7/14/21 documented in part, the following: "...reported increased R knee pain...Pt left sitting up in wc (wheelchair) and NRSG (nursing) arriving to administer pain meds...Pt reported 7/10 p in R knee, NRSG made aware that pt requested pain meds."

Review of Resident #212's MAR revealed that there was no evidence that nursing administered administered prn (as needed) Tylenol to Resident #212 on 7/14/21. There was no evidence of any non-pharmacological pain relief measures provided to Resident #212 on 7/14/21.

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Further review of the July MAR revealed that a nurse had signed off that she had administered the scheduled Tramadol at 9:00 a.m. Evidence (Narcotic sheets) could not be provided to show that the ordered Tramadol had made it to the facility from pharmacy. Evidence could not be shown that the nurse obtained the ordered Tramadol from the Omnicell (STAT box).

Review of Resident #212's pain care plan dated 7/2/21 documented the following: "The resident has pain r/t (related to) Right knee pain AEB closed fracture of right tibial plateau, Osteroarthritis...Administer analgesics per orders, Anticipate the patient's need for pain relief and respond to any complaint of pain as needed. Assess/document for probable cause of each pain episode. Remove/limit causes where possible..."

On 8/4/21 at 12:02 p.m., and 4 p.m., a telephone interview was attempted with Resident #212's representative. She could not be reached for an interview.

On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for the scheduled tramadol or a script (Prescription). OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell.

On 8/5/21 at 10:41 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on both 7/13/21 and 7/14/21. When asked if she recalled therapy speaking to her about Resident #212's

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increased pain on both 7/13/21 and 7/14/21; LPN #2 stated that she didn't recall specific days but that they usually let her know. When asked if she provided any pain relief measures to Resident #212 on 7/13/21 and 7/14/21 after therapy had alerted her of Resident #212's pain; LPN #2 stated, "I don't remember." When asked if medications are usually signed off on the MAR after they are administered, LPN #2 stated that medications are to be signed off after they have been administered. This writer showed LPN #2 Resident #212's MAR and the lack of evidence that PRN medication was administered. LPN #2 stated, "I must not have given it then." When asked how she signed off that she had administered a 9 a.m. dose of Tramadol on 7/14/21 if the pharmacy had not yet recevied an order or a script for the medication; LPN #2 stated, "I don't remember why I signed that off." When asked if it was acceptable to sign off that medications were administered, if they were not in fact given to the resident, LPN #2 stated, "No ma'am." When asked if non-pharmacological interventions rendered for pain should be documented, LPN #2 stated that it should. LPN #2 stated again that she wasn't sure what happened, that sometimes therapy makes the pain sound bigger than it is and maybe she asked the resident and the resident was fine. LPN #2 could not provide evidence of a pain assessment conducted for Resident #212 on 7/13/21 and 7/14/21.

On 8/5/21 at 11:19 a.m., an interview was conducted with OSM #4, the PTA (Physical Therapy Assistant) who worked with Resident #212 on both 7/13/21 and 7/14/21. OSM #4 stated that the first day she had worked with the resident, the resident had declined her therapy

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F 697	Continued From page 34 due to pain. OSM #4 stated that the second day, Resident #212 was still having pain to that right knee but was able to participate some in therapy. OSM #4 stated that she had alerted the nurse on duty both times regarding her pain. OSM #4 stated that she could not specify who she had told. When asked if she had actually seen the nurse administer pain medication or provide non-pharmacolgical relief interventions; to Resident #212, OSM #4 stated that she did not witness that. On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility could not provide a policy or professional standard for the above concerns. (1) Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.	F 697		
F 755 SS=D	COMPLAINT DEFICIENCY 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	F 755		

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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 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 representative interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure medications were procured for two of 15 residents in the survey sample; Resident #212 and #211.

The findings included:

1. Resident #212 was admitted to the facility on 6/30/21 with diagnoses that included but were not limited to chronic heart failure, closed fracture of

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the right tibia with healing, pain in right knee, and high blood pressure. Resident #212's most recent comprehensive MDS (Minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 7/4/21. Resident #212 was coded as being cognitively intact in the ability to make daily decisions; scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #212 was coded in Section J0100. (Pain Management) as not receiving scheduled pain medications in the last 5 days from the ARD date (7/4/21). Resident #212 was coded as receiving prn (as needed) pain medications in the last 5 days AND recieved non medication interventions for pain in the last 5 days. Resident #212 was coded as not having pain.

Review of Resident #212's medical record revealed that Resident #212 had an order for the following prn pain medication: "Tylenol Tablet 325 mg (milligram) Give 3 tablets by mouth every 6 hours as needed for pain."

Review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that Resident #212 received Tylenol 325 mg 3 tablets on 7/1/21 through 7/11/21. Review of the Emar Administration notes revealed that the Tylenol was effective on these dates for pain relief.

Review of a therapy note dated 7/13/21 revealed that Resident #212 was having a pain of 8/10 during her therapy session. The following was documented in part,"...Pt (patient) declined participation in therapy 2/2 (two attempts) to increased pain and fatigue. PTA (Physicial Therapy Assistant) encouraged pt (patient) to engage in seated therex (therpapy exercies),

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however, pt continued to decline at this time...Pt reported 8/10p (pain) in R (right knee) and requested pain meds (medications), NRSG (Nursing) made aware."

Review of a note from the NP (Nurse Practitioner) dated 7/13/21 documented in part, the following: "She is being seen today for c/o(complaints) right knee pain. Pt is sitting up in her w/c, appears comfortable and in no acute distress. A&O x3 (Alert and Oriented x3), pleasant and responsive. She has a history of repeated falls where she has a displaced fracture of her right tibia. She is c/o right knee pain that is unrelieved by Tylenol. Right knee is currently stable in a right knee brace. She currently c/o (complaints) 3-4/10 right knee pain, but tolerable... 1. Right knee pain: will give Tramadol (1) 50 mg 1 tab po (by mouth) Q (every) 12 (hours) x (for) 10 days."

Review of Resident #212's July 2021 POS (Physician Order Summary) revealed the following order: "Tramadol HCl Tablet 50 MG Give 1 tablet by mouth two times a day for Pain for 10 Days. Start Date: 7/13/21 2100 (9 p.m.)."

Further review of Resident #212's July 2021 MAR (Medication Administration Record) revealed that her Tramadol was to be scheduled for 9 AM and 2100 (9:00 PM). Resident #212 did not receive her 9 p.m. dose of Tramadol on 7/13/21.

Review of Resident #212's July MAR revealed that nurses were signing off that they had administered the scheduled Tramadol on 7/14/21 at 9:00 a.m. and 9:00 p.m. Evidence (Narcotic sheets) could not be provided to show that the ordered Tramadol had made it to the facility from pharmacy. Evidence could not be shown that the

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nurses obtained the ordered Tramadol from the Omnicell (STAT box). Review of Resident #212's MAR also revealed that she missed her 9 a.m. dose of Tramadol on 7/15/21 (hours before her discharge home on 7/15/21).

Further review of Resident #212's clincial record revealed that she was discharged home on 7/15/21 at 1:40 p.m.

Review of the Omnicell list of medications revealed that "Tramadol 50 mg" was a medication available in the Omnicell.

On 8/4/21 at 12:02 p.m., and 4 p.m., a telephone interview was attempted with Resident #212's representative. She could not be reached for an interview.

On 8/4/21 at 2:23 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked the process if she were to go administer a scheduled medication; more specifically a narcotic, and it was not in the medication cart, LPN #2 stated that she would check to see if the medication was available in the STAT Omnicell. LPN #2 stated that she would then pull the medication from the Omnicell. When asked if Tramadol 50 mg was in the Omnicell, LPN #2 stated, "Yes, I know that is in the STAT box." When asked if that is where she pulled Resident's #212's Tramadol on 7/14/21, LPN #2 stated, "Yes, I pulled from the STAT box."

On 8/4/21 at 2:30 p.m., an interview was conducted with LPN #3, the nurse who worked with Resident #212 on 7/13/21 evening shift. When asked why Resident #212 did not receive

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her ordered Tramadol on 7/13/21 at 9:00 p.m.; LPN #3 stated that the medication was not up from pharmacy. When asked the process if a medication such as a narcotic is not yet up from pharmacy and it is due to be administered, LPN #3 stated that she was new to the facility and did not have a code to get into the Omnicell system. When asked if she had asked for help regarding pulling the medication from the Omnicell system; LPN #3 stated that she told a nurse on the floor. LPN #3 stated that she wasn't sure what had happened after that.

On 8/4/21 at 2:59 p.m., an interview was conducted with RN (Registererd Nurse) #2, the nurse who did not administer the scheduled Tramadol on 7/15/21. When asked if residents are to receive all scheduled medications prior to their discharge that are due prior to discharge; RN #2 stated, "Yes." When asked if this included scheduled pain medications, RN #2 stated, "Yes." When asked why Resident #212 did not receive her scheduled Tramadol on 7/15/21 at 9:00 a.m. prior to her discharge; RN #2 stated, "She didn't have Tramadol." When asked what she had meant by that statement, RN #2 stated, "She didn't have a narcotic card at all." RN #2 then stated that she had told the nurse (LPN #1) that she had been shadowing that day that Resident #212 did not have Tramadol on the medication cart. RN #2 stated that she did not have a code to access the Omnicell to see if the medication was in there. RN #2 stated that she was not sure if Tramadol was in the Omnicell as she still did not have a code to access Omnicell. RN #2 stated that she believed her preceptor did not administer the tramadol because the resident was being sent home with a script for Tramadol anyway.When asked if it was acceptable for residents to not

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receive their ordered medications, RN #2 stated that it wasn't.

On 8/4/21 at 4:30 p.m., an interview was conducted with LPN #1, the nurse who was precepting RN #2. When asked what happened to Resident #212's tramadol on 7/15/21; why it was not administered, LPN #1 stated that it was not available in the medication cart. When asked the process if the medication is not in the medication cart, LPN #1 stated that she would call pharmacy to inquire about where the medication is, or what is needed to get the medication, such as a script. When asked if she recalled inquiring about Resident #212's Tramadol, LPN #1 stated that she did not. When asked if she attempted to pull the Tramadol from the Omnicell, LPN #1 stated that she did not have access to the Omnicell. LPN #1 stated that they have only had the Omnicell since June of 2021. When asked who she could ask to obtain a medication from the Omnicell, LPN #1 stated that she could ask LPN #2, who was also the unit manager. LPN #1 stated that she did not ask LPN #1 to obtain the Tramadol from the Omnicell. When asked if she should notify the MD (Medical Doctor) that a medication was missed, LPN #1 stated that the medical doctor should be aware of every missed dose of a medication. LPN #1 stated that she did not notify the MD at the time of the missed dose of Tramadol.

On 8/5/21 at 5 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). When asked the process if a scheduled narcotic is not available in the medication cart, what nursing staff should do, ASM #2 stated that the nurses should be calling pharmacy to see the status of the medication and

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whether or not the medication needs a prescription. ASM #2 stated that she would expect nursing staff to obtain a script from the physician, if that is what was needed and send to pharmacy. ASM #2 stated that it takes sometime for pharmacy to verify the prescription so the nurse may not be able to get it from the Omnicell system immediately. ASM #2 stated she would then expect nursing staff to alert the physician if a medication cannot be administered for further direction. ASM #2 stated that she did expect staff to pull the medication from Omnicell if a script was available. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building who could assist. When asked if all nurses should have access to the Omnicell if they are adminisering medications, ASM #2 stated, "Yes." When asked who was responsible for ensuring all nurses had access to the Omnicell, ASM #2 stated that she was as the DON. When asked what had happened to Resident #212's Tramadol, ASM #2 stated that she didn't see where the Tramadol was ever delivered to the facility. ASM #2 stated that she remembered personally getting the script for the Tramadol has she recalled telling the NP (Nurse Practitioner) to assess Resident #212 for an increase in pain and yelling out. ASM #2 stated that she didn't personally hear the resident yell out, but that she recalled hearing a nurse tell her this information that day. ASM #2 could not recall the nurse. ASM #2 stated that she recalled putting the order into the electronic system and scheduling it for 9:00 p.m. because the medication would have had plenty of time to get to the facility by then. ASM #2 could not recall if she was the nurse who faxed the script to the pharmacy.

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On 8/5/21 at 10:25 a.m., an interview was conducted with the medical records personnel at the facility's pharmacy (OSM (Other Staff Member) #3). OSM #3 stated that the pharmacy had never received an order for the scheduled tramadol or a script (Prescription). OSM #3 stated that a script must also be in place for the nurse to access a STAT dose from the Omnicell.

On 8/5/21 at 10:41 a.m., further interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who worked day shift on 7/14/21. When asked how she signed off that she had administered a 9 a.m. dose of Tramadol on 7/14/21 if the pharmacy had not yet recevied an order or a script for the medication; LPN #2 stated, "I don't remember why I signed that off." When asked if it was acceptable to sign off that medications were administered, if they were not in fact given to the resident, LPN #2 stated, "No ma'am." When asked what why the Tramadol had not made it to the facility, LPN #2 stated, "I don't know exactly the cause."

On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Medication Shortage/Unavailable Medications" documents in part, the following: "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. If the medication shortage is discovered at the time of medication administration facility staff should immediately

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F 755	Continued From page 43 take the action specified... 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery. 3. If the medication shortage is discovered after normal pharmacy hours: 3.1 A licensed nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency Delivery 3.2.2 Use of an emergency (back up) third party pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions." (1) Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.	F 755		

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2. Resident #211 was admitted to the facility on 6/23/21 with diagnoses that included but were not limited to cerebral infarction (stroke), right sided hemiplegia (paralysis) following stroke, type two diabetes mellitus, and end stage renal disease requiring dialysis. Resident #211's most recent comprehensive MDS (minimum data set) assessment was an admission assessment dated 7/5/21. Resident #211 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #211 was coded in Section J0100. (Pain Management) as receiving scheduled pain medications in the last 5 days from the ARD date (7/5/21). Resident #211 was coded not receiving prn (as needed) pain medications in the last 5 days AND receiving non medication interventions for pain in the last 5 days. Resident #211 was coded as not having pain. Resident #211 was discharged from the facility on 8/3/21.

On 8/4/21 at 9:58 a.m., a telephone interview was conducted with Resident #211's emergency contact as a number was not listed for Resident #211. Resident #211's emergency contact was her son, and did not feel comfortable giving out his mother's telephone number. The son did have a concern regarding his mother's gabapentin (1) for her nerve pain. The son stated that there was quite some time where his mother was out and that nursing staff were not following up with obtaining the medication. The son stated that he eventually had to go to the facility to speak with the DON (Director of Nursing) who then took care of the issue. The son stated that his mother was not yet experiencing pain but was overall sick to

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her stomach and feeling "itchy" all over which was usually a withdrawal side effect for her. The son was upset that it took his involvement to finally get his mother's prescribed gabapentin.

Resident #211's care plan dated 6/24/21 documented the following for pain: "Resident is at risk for pain related to CVA (Stroke) with right hemiparesis...Administer analgesics/medications per physician's orders..."

Review of Resident #211's June, July and August 2021 POS (Physician Order Summary) revealed the following order: "Gabapentin 100 mg (milligrams) 100 mg capsule by mouth Three Times Daily." This order was initiated on 6/24/21.

Review of the June, July, and August 2021 MARS (Medication Administration Record) revealed that gabapentin was scheduled for 6:00 a.m., 2:00 p.m., and 9:00 p.m.

Review of the narcotic logs revealed on 6/24/21 the pharmacy had delivered 28 capsules of gabapentin. The first dose of gabapentin was given at 2100 (9:00 p.m.) on 6/24/21. Further review of the narcotic sheets revealed that Resident #211 had completed her gabapentin on 7/4/21 at 9:00 p.m; where it was documented she had (zero) capsules left.

Review of the second narcotic sheet for gabapentin revealed that pharmacy had delivered 30 capsules of gabapentin on 7/9/21. Resident #211's first dose of gabapentin was on 7/9/21 at 2100 (9:00 p.m.).

There was no narcotic sheets/logs to account for days 7/5/21 through 7/9/21 at (2:00 p.m.) (13

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administrations).

Review of the facility STAT Omnicell list revealed that Gabapentin 100 mg was in the Omnicell STAT box.

Further review of Resident #211's July 2021 MAR revealed that staff had not administered the gabapentin on the following dates:

7/5/21 at 2 p.m. and 9 p.m.
7/7/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m.
7/8/21 at 6:00 a.m. and 9:00 p.m.
and 7/9/21 at 6:00 a.m.

The following administration note was documented on 7/5/21 at 7:51 p.m.: "On hold until received per NP (Nurse Practitioner)."

The following note was documented on 7/6/21 by the Nurse Practitioner: "...Denies pain and has no complaints, SOB (Shortness of breath), and (abdominal pain) or N/V (nausea/vomiting)...Neuropathy: Continue Neurontin (Gabapentin) 100 mg TID, script renewed."

On 7/7/21 the following administration note was documented: "Gabapentin Capsule 100 mg- Give 1 mg by mouth three times a day for pain...pharmacy to send."

On 7/8/21 the following administration note was documented: "Gabapentin Capsule 100 mg...needs hard script. MD (medical doctor) aware."

On 7/9/21 at 10:29 a.m., the following administration note was documented:

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"Gabapentin 100 mg three times a day for pain...per MD, administrator, DON (Director of Nursing) ok to give now."

Further review of Resident #211's MAR revealed that gabapentin was documented as "administered" on the following dates; however there was no evidence that facility staff had pulled gabapentin from the facility STAT box:

7/5/21 at 6:00 a.m.,
7/6/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m.,
7/8/21 at 2:00 p.m."

On 8/4/21 at 2:45 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #6, the nurse who worked the 11-7 shifts with Resident #211 and who did not administer her scheduled gabapentin at 6:00 a.m. When asked the process if she were to administer a narcotic and it was not available on the medication cart, LPN #6 stated that she would check to see if the medication was already ordered. LPN #6 stated that if the medication says its "on order" she would wait for the next shift to follow up as she is night shift. When asked what happened with Resident #211's gabapentin, LPN #6 stated that she remembered the medication not being up from pharmacy for a couple of days. When asked what was going on with the gabapentin, LPN #6 stated, "No Idea." LPN #6 denied following up personally with the gapabentin to see why it had been missing for several days. LPN #6 denied Resident #211 having an increase in pain. She could not recall the resident complaining of nausea or an itchy feeling.

On 8/4/21 at 3:45 p.m., during an interview with the pharmacist (OSM) Other Staff Member #2; it

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was determined that the pharmacy did not receive a script for the gabapentin until 7/9/21. OSM #2 stated that the only time nursing accessed the Omnicell to retrieve gabapentin for Resident #211 was on 7/9/21 at 10:24 a.m. OSM #2 stated that staff cannot pull gabapentin from the Omnicell unless a script is renewed so he could not explain why staff were documenting that they had administered the gabapentin on the above dates. OSM #2 stated that the pharmacy initially sent out 28 capsules of gabapentin on 6/24/21 which had run out on 7/4/21. OSM #2 stated that the second time they sent out gabapentin was on 7/9/21 and it was for 30 capsules. OSM #2 confirmed again that the only time Resident #211 received gabapentin in between dates 7/5/21 through 7/9/21 was on 7/9/21 at 10:24 a.m. OSM #2 stated that the request to retrieve the gabapentin was made from the DON (Director of Nursing). When asked if there was any side effects or withdrawal effects to missing 12 doses of gabapentin, OSM #2 stated that there was not necessarily any withdrawal effects, that missing that many doses would lead to pain returning back. OSM #2 stated that he would expect pain to return by the second missed dose. When asked if missing 12 administrations was considered a significant error, OSM #2 stated that he wouldn't say significant but that the resident would be uncomfortable. When asked if missing 12 doses could make someone who uses it for pain feel nauseous or itchy all over; OSM #2 stated that he could imagine it would make someone feel anxious which could lead to an upset stomach. OSM #2 was not familiar with gabapentin withdrawals causing an "itchy" feeling unless it was the really the pins and needles feeling.

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Further review of Resident #211's clinical record revealed no evidence of an increase in pain or a decrease in appetite during the time of her missed doses of gabapentin. The following; however was documented in a physical therapy note dated 7/8/21: "Pt found supine in bed c/o (complaints) of not receiving her meds the last 3 days and says she is having withdrawal symptoms as she is itchy all over. PT attempts to consult nurse regarding this issue with PT unable to locate nurse."

The next therapy note dated 7/9/21, documented in part, the following: "Pt (Patient) found supine in bed, empathetic discussion had as pt reports she has not had her meds on the last 4 days. Nurse consulted regarding issue. Pt reports feeling itchy all over and nauseous."

On 8/4/21 at 5:00 p.m., an interview was conducted with the DON (Director of Nursing) (ASM (Administrative Staff Member) #2. When asked if there was has been issues obtaining scripts for narcotics or getting those scripts to the pharmacy; ASM #2 stated, "Yes." When asked what had happened with Resident #211's gabapentin as the NP had documented that she wrote a script on 7/6/21; ASM #2 stated that she was unaware that Resident #211's gabapentin prescription had run out until the son had come into the building on 7/9/21. ASM #2 stated that he was upset that his mom had missed her gabapentin for several days and wanted to know what was going on with it. ASM #2 stated that she had called the medical doctor to obtain a script that day. ASM #2 stated that she pulled the medication out of the Omnicell and the nurse administered the medication, but could not remember the time. ASM #2 stated that she

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realized the resident had been out sometime before she initiated getting the resident her gabapentin. When asked if the son really had initiated obtaining his mom's medication, ASM #2 stated, "Yes, it was in response to the son coming in." ASM #2 stated that she expected her nurses to follow up with gabapentin and not wait days later before obtaining the medication. ASM #2 stated that she was not sure what they did do, didn't do for the gabapentin. When asked if Resident #211 had an increase amount of pain related to missing 12 doses of gabapentin, ASM #2 stated that she didn't think so, that this information was never reported to her. When asked if nursing staff should be documenting that medications are being administered when they are not in fact given, ASM #2 stated, "Absolutely not." When asked if nursing staff should have pulled gabapentin from the Omnicell and administered the medication, ASM #2 stated that nursing staff could do that if there was a script for the medication. ASM #2 stated that she expected her staff to inquiring on why the gapabentin was not available and if it needed a script to call the physician, obtain a script and fax that to the pharmacy. ASM #2 stated that once the pharmacy has a script, the medication can be pulled from the Omnicell. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building with access. ASM #2 stated that she was not aware that not all nurses had access and didn't realize this was the responsibility of the DON to ensure their access. ASM #2 confirmed that all nurses should have access to the Omnicell if they are responsible for passing out medications, and that she was going to work on getting all nurses access.

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F 755	Continued From page 51 On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. (1) Gabapentin is commonly used to treat neuropathic pain (pain due to nerve damage). This information was obtained from the National Institutes of Health. https://pubmed.ncbi.nlm.nih.gov/28597471/.	F 755		
F 760 SS=E	COMPLAINT DEFICIENCY Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on representative interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that facility staff failed to ensure one of 15 residents, Resident #211 was free from a significant medication error. The findings included: Resident #211 was admitted to the facility on 6/23/21 with diagnoses that included but were not limited to cerebral infarction (stroke), right sided hemiplegia (paralysis) following stroke, type two diabetes mellitus, and end stage renal disease requiring dialysis. Resident #211's most recent comprehensive MDS (minimum data set) assessment was an admission assessment dated	F 760		

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7/5/21. Resident #211 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #211 was coded in Section J0100. (Pain Management) as receiving scheduled pain medications in the last 5 days from the ARD date (7/5/21). Resident #211 was coded not receiving prn (as needed) pain medications in the last 5 days AND receiving non medication interventions for pain in the last 5 days. Resident #211 was coded as not having pain. Resident #211 was discharged from the facility on 8/3/21.

On 8/4/21 at 9:58 a.m., a telephone interview was conducted with Resident #211's emergency contact as a number was not listed for Resident #211. Resident #211's emergency contact was her son, and did not feel comfortable giving out his mother's telephone number. The son did have a concern regarding his mother's gabapentin (1) for her nerve pain. The son stated that there was quite some time where his mother was out and that nursing staff were not following up with obtaining the medication. The son stated that he eventually had to go to the facility to speak with the DON (Director of Nursing) who then took care of the issue. The son stated that his mother was not yet experiencing pain but was overall sick to her stomach and feeling "itchy" all over which was usually a withdrawal side effect for her. The son was upset that it took his involvement to finally get his mother's prescribed gabapentin.

Resident #211's care plan dated 6/24/21 documented the following for pain: "Resident is at risk for pain related to CVA (Stroke) with right hemiparesis...Administer analgesics/medications per physician's orders..."

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Review of Resident #211's June, July and August 2021 POS (Physician Order Summary) revealed the following order: "Gabapentin 100 mg (milligrams) 100 mg capsule by mouth Three Times Daily." This order was initiated on 6/24/21.

Review of the June, July, and August 2021 MARS (Medication Administration Record) revealed that gabapentin was scheduled for 6:00 a.m., 2:00 p.m., and 9:00 p.m.

Review of the narcotic logs revealed on 6/24/21 the pharmacy had delivered 28 capsules of gabapentin. The first dose of gabapentin was given at 2100 (9:00 p.m.) on 6/24/21. Further review of the narcotic sheets revealed that Resident #211 had completed her gabapentin on 7/4/21 at 9:00 p.m.; where it was documented she had (zero) capsules left.

Review of the second narcotic sheet for gabapentin revealed that pharmacy had delivered 30 capsules of gabapentin on 7/9/21. Resident #211's first dose of gabapentin was on 7/9/21 at 2100 (9:00 p.m.).

There was no narcotic sheets/logs to account for days 7/5/21 through 7/9/21 at (2:00 p.m.) (13 administrations).

Review of the facility STAT Omnicell list revealed that Gabapentin 100 mg was in the Omnicell STAT box.

Further review of Resident #211's July 2021 MAR revealed that staff had not administered the gabapentin on the following dates:

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7/5/21 at 2 p.m. and 9 p.m.
7/7/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m.
7/8/21 at 6:00 a.m. and 9:00 p.m.
and 7/9/21 at 6:00 a.m.

The following administration note was documented on 7/5/21 at 7:51 p.m.: "On hold until received per NP (Nurse Practitioner)."

The following note was documented on 7/6/21 by the Nurse Practitioner: "...Denies pain and has no complaints, SOB (Shortness of breath), and (abdominal pain) or N/V (nausea/vomiting)...Neuropathy: Continue Neurontin (Gabapentin) 100 mg TID, script renewed."

On 7/7/21 the following administration note was documented: "Gabapentin Capsule 100 mg- Give 1 mg by mouth three times a day for pain...pharmacy to send."

On 7/8/21 the following administration note was documented: "Gabapentin Capsule 100 mg...needs hard script. MD (medical doctor) aware."

On 7/9/21 at 10:29 a.m., the following administration note was documented: "Gabapentin 100 mg three times a day for pain...per MD, administrator, DON (Director of Nursing) ok to give now."

Further review of Resident #211's MAR revealed that gabapentin was documented as "administered" on the following dates; however there was no evidence that facility staff had pulled gabapentin from the facility STAT box:

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7/5/21 at 6:00 a.m.,
7/6/21 at 6:00 a.m., 2:00 p.m., and 9:00 p.m.,
7/8/21 at 2:00 p.m."

On 8/4/21 at 2:45 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #6, the nurse who worked the 11-7 shifts with Resident #211 and who did not administer her scheduled gabapentin at 6:00 a.m. When asked the process if she were to administer a narcotic and it was not available on the medication cart, LPN #6 stated that she would check to see if the medication was already ordered. LPN #6 stated that if the medication says its "on order" she would wait for the next shift to follow up as she is night shift. When asked what happened with Resident #211's gabapentin, LPN #6 stated that she remembered the medication not being up from pharmacy for a couple of days. When asked what was going on with the gabapentin, LPN #6 stated, "No Idea." LPN #6 denied following up personally with the gapabentin to see why it had been missing for several days. LPN #6 denied Resident #211 having an increase in pain. She could not recall the resident complaining of nausea or an itchy feeling.

On 8/4/21 at 3:45 p.m., during an interview with the pharmacist (OSM) Other Staff Member #2; it was determined that the pharmacy did not receive a script for the gabapentin until 7/9/21. OSM #2 stated that the only time nursing accessed the Omnicell to retrieve gabapentin for Resident #211 was on 7/9/21 at 10:24 a.m. OSM #2 stated that staff cannot pull gabapentin from the Omnicell unless a script is renewed so he could not explain why staff were documenting that they had administered the gabapentin on the above dates. OSM #2 stated that the pharmacy

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initially sent out 28 capsules of gabapentin on 6/24/21 which had run out on 7/4/21. OSM #2 stated that the second time they sent out gabapentin was on 7/9/21 and it was for 30 capsules. OSM #2 confirmed again that the only time Resident #211 received gabapentin in between dates 7/5/21 through 7/9/21 was on 7/9/21 at 10:24 a.m. OSM #2 stated that the request to retrieve the gabapentin was made from the DON (Director of Nursing). When asked if there was any side effects or withdrawal effects to missing 12 doses of gabapentin, OSM #2 stated that there was not necessarily any withdrawal effects, that missing that many doses would lead to pain returning back. OSM #2 stated that he would expect pain to return by the second missed dose. When asked if missing 12 administrations was considered a significant error, OSM #2 stated that he wouldn't say significant but that the resident would be uncomfortable. When asked if missing 12 doses could make someone who uses it for pain feel nauseous or itchy all over; OSM #2 stated that he could imagine it would make someone feel anxious which could lead to an upset stomach. OSM #2 was not familiar with gabapentin withdrawals causing an "itchy" feeling unless it was the really the pins and needles feeling.

Further review of Resident #211's clinical record revealed no evidence of an increase in pain or a decrease in appetite during the time of her missed doses of gabapentin. The following; however was documented in a physical therapy note dated 7/8/21: "Pt found supine in bed c/o (complaints) of not receiving her meds the last 3 days and says she is having withdrawal symptoms as she is itchy all over. PT attempts to consult nurse regarding this issue with PT unable

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to locate nurse."

The next therapy note dated 7/9/21, documented in part, the following: "Pt (Patient) found supine in bed, empathetic discussion had as pt reports she has not had her meds on the last 4 days. Nurse consulted regarding issue. Pt reports feeling itchy all over and nauseous."

On 8/4/21 at 5:00 p.m., an interview was conducted with the DON (Director of Nursing) (ASM (Administrative Staff Member) #2. When asked if there was has been issues obtaining scripts for narcotics or getting those scripts to the pharmacy; ASM #2 stated, "Yes." When asked what had happened with Resident #211's gabapentin as the NP had documented that she wrote a script on 7/6/21; ASM #2 stated that she was unaware that Resident #211's gabapentin prescription had run out until the son had come into the building on 7/9/21. ASM #2 stated that he was upset that his mom had missed her gabapentin for several days and wanted to know what was going on with it. ASM #2 stated that she had called the medical doctor to obtain a script that day. ASM #2 stated that she pulled the medication out of the Omnicell and the nurse administered the medication, but could not remember the time. ASM #2 stated that she realized the resident had been out sometime before she initiated getting the resident her gabapentin. When asked if the son really had initiated obtaining his mom's medication, ASM #2 stated, "Yes, it was in response to the son coming in." ASM #2 stated that she expected her nurses to follow up with gabapentin and not wait days later before obtaining the medication. ASM #2 stated that she was not sure what they did do, didn't do for the gabapentin. When asked if

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Resident #211 had an increase amount of pain related to missing 12 doses of gabapentin, ASM #2 stated that she didn't think so, that this information was never reported to her. When asked if nursing staff should be documenting that medications are being administered when they are not in fact given, ASM #2 stated, "Absolutely not." When asked if nursing staff should have pulled gabapentin from the Omnicell and administered the medication, ASM #2 stated that nursing staff could do that if there was a script for the medication. ASM #2 stated that she expected her staff to inquiring on why the gapabentin was not available and if it needed a script to call the physician, obtain a script and fax that to the pharmacy. ASM #2 stated that once the pharmacy has a script, the medication can be pulled from the Omnicell. ASM #2 confirmed that not all nurses had access to the Omnicell but that there was always someone in the building with access. ASM #2 stated that she was not aware that not all nurses had access and didn't realize this was the responsibility of the DON to ensure their access. ASM #2 confirmed that all nurses should have access to the Omnicell if they are responsible for passing out medications, and that she was going to work on getting all nurses access.

On 8/5/21 during a pre-exit meeting at 12:30 p.m., ASM (Administrative Staff Member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Medication Shortage/Unavailable Medications" documents in part, the following: "Upon discovery that facility has an inadequate supply of a medication to

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administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration facility staff should immediately take the action specified...
2. If a medication shortage is discovered during normal pharmacy hours:
2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery.
2.2 If the next available delivery causes delay or missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose.
2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery.
3. If the medication shortage is discovered after normal pharmacy hours:
3.1 A licensed nurse should obtain the ordered medication from the Emergency Medication Supply.
3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include:
3.2.1 Emergency Delivery
3.2.2 Use of an emergency (back up) third party pharmacy.
4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions."

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HAMPTON HEALTH & REHAB CENTER, LLC	**2230 EXECUTIVE DRIVE REVISED HAMPTON, VA 23666**

(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 760	Continued From page 60 Review of the Omniview Drug Information documents in part, the following: "Gabapentin is used with other medications to prevent and control seizures. It is also used to relieve nerve pain following shingles...This drug may also be used for restless leg syndrome or other nerve pain conditions (such as diabetic neuropathy, peripheral neuropathy, trigeminal neuralgia...Do not stop taking this medication without consulting your doctor. Some conditions may become worse when the drug is suddenly stopped. Your dose may need to be gradually decreased...If you miss a dose, take it as soon as you remember." COMPLAINT DEFICIENCY	F 760		