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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite from 4/14/2021 through 4/16/2021. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey and Focused Infection Control survey was conducted 4/14/2021 through 4/16/2021. Three complaints were investigated; VA00050155 and VA00050400 were substantiated with deficiencies. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements, 42 CFR Part 483.80 infection control regulations, and the CMS and Centers for Disease Control (CDC) recommended practices for COVID -19. The census in this 116 certified bed facility was 74 at the time of survey. There were no current positive cases of COVID-19 in the facility.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580	F580 F580 1. Resident #7 has been discharged from the facility. 2. Residents with change in condition have the ability to be affected by the deficient practice. A review of the 24 hour report for 72 hours was completed with follow up if indicated. 3. Licensed nurses have been educated on utilizing the SBAR for documentation of change in	

condition. Additionally they were educated on the requirements for notification of change in condition to include notification of the family and physician in a timely manner.

4. The 24 hour report will be reviewed during clinical meeting by the DON/designee to identify changes in condition with follow up as indicated. Findings of these audits will be submitted to the QAPI committee for 3 months for review/recommendations.
5. Date of Compliance 5/18/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 5/10/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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)(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 interviews and facility

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documentation, the facility staff failed to notify the physician and resident representative in a change of condition for 1 of 8 residents (Resident #7) in the survey sample.

The findings included:

Resident #7 was originally admitted to the nursing facility on 11/01/18. Diagnosis for Resident #7 included but not limited to COVID-19. The most recent Minimum Data Set (MDS - an assessment protocol) an annual assessment with an Assessment Reference Date (ARD) of 08/24/20 coded Resident #7 with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #7 total dependence of two with transfer, total dependence of one with bed mobility, dressing, toilet use, personal hygiene and bathing and set-up with supervision with eating for Activities of Daily Living (ADL) care.

Resident #7's person-centered comprehensive care plan created on 08/31/20 documented Resident #7 at risk for exposure and/or to transmission of COVID-19. The goal: will be monitored for signs/symptoms of COVID-19.

Review of the SBAR completed on 09/13/20 revealed the following documentation: The change in condition started on 09/13/20 at 7:00 a.m. Resident #7 was not easily awaken, increased lethargy, and decreased appetite. There were no evidence that Resident #7's responsible party (RP) or the physician were made aware of Resident #7's change in condition.

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During a review of Resident #7's nursing notes with an entry date of 09/13/20 at 5:02 p.m., read in part "Resident received in bed, eye closed, not easily aroused, several attempts made at trying to awaken Resident #7. Resident #7 would open her eyes then close them back. Resident #7 refused her medications, breakfast and lunch." A call was placed to Program of All-Inclusive Care for the Elderly (PACE) with a new order to send to Emergency Room (ER) for lethargy, decreased appetite and possible dehydration."

During the review of PACE documentation for September 13, 2020 at 3:30 p.m., and 4:00 p.m., read in part: (Name of facility) called to inform Resident #7's daughter was requesting for her to be sent out to the Emergency Department (ED.) LPN #1 stated' Resident #7's vital signs were stable and had no concerns. The PACE nurse informed LPN #1 that Resident #7's daughter had already called and spoken with the NP. The NP will be contacting the facility to send Resident #7 out to the hospital.

Review of the hospital discharge summary dated 09/26/20 read in part: admitted to (name of hospital) on 09/13/20 at approximately 5:32 p.m.
Resident #7 presented to the Emergency Room (ER) from the nursing home for evaluation of hypoxia (low oxygen in the blood.) Patient was found to be positive for COVID-19 on 09/09/20. Resident #7 will be admitted to the hospital for further management of acute hypoxic respiratory failure due to COVID-19 pneumonia and acute systolic Congestive Heart Failure (CHF) exacerbation. Resident #7 will be started on IV steroids, IV Lasix (diuretic) and Zosyn (antibiotic) for now.

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A phone interview was conducted with LPN #2 on 04/15/21 at approximately 10:06 a.m., who provided care to Resident #7 on 09/12/20 (7-3 shift.) She said Resident #7 was not alert/very drowsy; something about Resident #7 wasn't right. LPN #2, said she reached out to the Clinical Manager, Registered Nurse (RN #2) for further guidance/direction on how to proceed with assessing Resident #7. She stated, "The Clinical Manager told me to re-assess Resident #7 again, which I did. I rechecked her vital signs and obtained her blood sugar; all within range." The LPN was asked, if PACE was informed of Resident #7's change in condition, she replied, "No, that's why I asked the Clinical Manager for guidance." She said Resident #7's daughter did a window visit on the same day; voiced concerns related to a change in Resident #7's condition.

On 04/15/21 at approximately 9:52 a.m., a phone interview was conducted with Certified Nursing Assistant (CNA #1) who cared for Resident #7 on 09/13/20 (7-3 shift.) The CNA said Resident #7 was not herself. She said Resident #7 did not recognize or acknowledge me that morning, so I knew something wasn't right. She said Resident #7 would look at you but didn't speak and if she tried to speak, you were not able to understand her. The CNA said she notified License Practical Nurse (LPN #1) as soon as she realized there was a change with Resident #7. She said later that day (not sure of the time) Resident #7's daughter was banging on the window yelling for (LPN #1.)

A phone interview was conducted with LPN #1 on 04/15/21 at approximately 11:00 a.m. LPN #1 was Resident #7's nurse on 09/13/20 (7-3 shift.) When asked, "When did you first notice the

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change of condition with Resident #7," she replied, "On 09/13/20, during morning rounds; Resident #7 was hard to arouse." The LPN was asked if she notified the Clinical Manager or PACE of the change in condition , she replied, "I'm not sure if I notified the Clinical Manager but I did not notify PACE." The LPN said Resident #7's daughter called to check on her mom, an update was given related to the change in condition. She said Resident #7's (RP) later that day was banging on Resident #7's window yelling, "Send my mom to the hospital." PACE was called, spoke with the Nurse Practitioner (NP) who informed me she had already spoken to Resident #7's daughter. A new order was received to send to the (ER) for a change in condition.

A phone interview was conducted with the NP on 04/15/21 at approximately 1:25 p.m. Resident #7's clinical notes were reviewed with the NP from 09/09/20-09/13/20. After reviewing the clinical notes, the NP stated, "There was a significant change from 09/12/20 until the next morning on (09/13/20.) The NP stated, "Resident #7 was not easily aroused and more lethargic on 09/13/20 at 7:00 a.m. We (PACE) should have been notified on 09/13/20, that morning as soon as the nurse identified a change in condition.

On 04/15/21 at approximately 12:20 p.m., a phone interview was conducted with the RN #2 who was the Clinical Manager on duty (09/12/20)
7-3 shift. The Clinical Manager stated, "I remember Resident #7 but I don't remember LPN #2 reporting to me that Resident #7 had a change in condition."

A phone interview was conducted with the Director of Nursing (DON) on 04/15/21 at

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F 580	Continued From page 6 approximately 3:35 p.m. Resident #7's clinical notes from 09/09/20-09/13/20 were reviewed with the DON. After reviewing the clinical notes, the DON stated, "When LPN #1 completed her assessment on 09/13/20 at 7:00 a.m., she documented Resident #7 was not easily aroused, that should have triggered the nurse to inform the physician of the change in condition. The DON said, the nurse discovered a change in condition at 7:00 a.m., but she waited until 3:30 p.m., to notify the physician/NP. The DON stated, "That was a delay in treatment." The Administrator and Cooperate Nurse was informed during the debriefing on 04/16/21 at approximately 3:55 p.m. The facility did not present any further information about the findings. The facility policy titled: Resident Change in Condition Policy (last revision date: 11/10/20.) Policy: The license nurse will recognize and intervene in the event of a change in resident condition. The Physician/Provider and the Family/Responsible Party (RP) will be notified as soon as the nurse has identified the change in condition and the resident is stable. Complaint deficiency.	F 580	
F 697 SS=G	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	F 697	F697 1. Resident # 8 has been discharged from the facility. 2. Residents residing in the facility have the potential to be affected. MDS quarterly report for residents triggering for pain was reviewed. Short stay residents triggering no longer reside in the facility. No LTC residents triggered. An interview was conducted with residents receiving scheduled pain medication to determine if their pain management regime was effective. 3. The nursing staff have been educated on pain management, to include assessment, and alternatives for pain management.

4. The clinical managers will review the pain level scale of 10 residents per week to validate effectiveness of pain interventions for 12 weeks. Findings of these audits will be submitted to QAPI committee monthly for review and recommendations.
5. Date of Compliance 5/18/2021

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Based on observation, resident interview, staff interview, clinical record review, and a review of facility documents, the facility's staff failed to provide effective pain management for one resident diagnosed with post surgical foot repair for one of eight residents (Resident #8), in a closed record survey sample.

The findings included:

Resident #8 was admitted to the facility on 12/19/20 and discharged on 12/24/20. Diagnosis for Resident #8 included but not limited Post Traumatic Stress Disorder, Depression, Diabetes Mellitus and Other Orthopedic Conditions.

The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 12/24/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15 indicating resident is cognitively intact.

In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with locomotion on and off the unit, dressing, toilet use and personal hygiene. Requiring the supervision of one person with transfers and requires set-up help only with eating.

In section " M " (Skin Conditions) the resident was coded under Other Problems part (E) coded resident as having a surgical wound. M1200-Skin and Ulcer Treatments part (F) coded resident as needing Surgical Wound Care.

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In section " J " (Health Conditions) J0100-Pain Management (B) coded resident as receiving prn pain medications. (C) Receive non-medication intervention for pain. J0400- Pain frequency coded the resident as needing pain medication frequently.

A review of the careplan reads: Focus: The resident has pain r/t flat foot repair. Created on 12/24/2020. Goals: The resident will display a decrease in behaviors of inadequate pain control through the review date. The resident will not have discomfort related to side effects of analgesia through the review date. The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Created on 12/24/20.
Interventions:
Administer analgesia/medications per orders. assess/record/report to Nurse resident complaints of pain or requests for pain treatment. Identify and record previous pain history and management of that pain and impact on function per routine. Created on 12/24/20.

A review of Resident #8's physician order summary reads:

Percocet Tablet 10-325 MG (oxycodone-acetaminophen). Give 2 tablets by mouth every 4 hours as needed for pain. Order Date: 12/19/20. Start Date: 12/19/20.

Hydromorphone HCI tablet 2 MG give 0.5 by mouth every 3 hours as needed for pain. Order Date: 12/20/20. Start Date 12/20/20.

Ibuprofen Tablet 800 MG give 1 tablet by mouth every 6 hours as needed for pain.

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A review of the MAR (Medication Administration Record) reveals the following:
Resident #8 received Hydromorphone HCI tablet 2 mg give 0.5 tablet every 3 hours as needed for pain on the following dates/times: 12/20/20 at 6:46 AM. (pain level 7) (effective). 12/20/20 at 3:04 PM (Pain level 9) (Effective)., 12/23/20 at 1:20 PM (Pain level 7) (effective) and on 12/24/20 at 11:47 AM (Pain level is 9) (Ineffective).

Resident was administered Percocet tablets 10-325 mg 2 tabs as needed for pain on the following dates: 12/20/20 4:46 PM (Pain level 8) (Effective). 12/21/20 administered at 3:01 AM (Pain level 6) (Effective)., administered at 9:28 AM (pain level 8) (Effective) and administered at 6:14 PM (Pain level 8) (Effective). 12/22/20 administered at 9:07 AM (pain level 5) (Effective) and administered at 4:11 PM (Pain level 9) (Effective). 12/23/20 administered at 4:02 PM (Pain Level is 10) (Effective). 12/24/21 Administered medication at 9:30 AM (pain level 8) (Ineffective) Administered medication at 2:13 PM (Pain Level 8).

Ibuprofen 800 mg tablet was administered on 12/24/20 at 5:00 AM (Pain level 3) (Ineffective) and 11:48 AM (Pain level 9) (Drug refused).

A review of progress notes revealed the following:

According to the admissions note Resident #8 arrived to the facility via stretcher by medical transport on 12/19/20 at 18:41 (6:41 PM) from a local hospital. Reason for Admission: S/P (Status Post) Right foot surgery/Surgical incision to right lateral foot. The Resident's pain level was 7 on arrival to the facility.

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On 12/20/2020 at 00:59 (12:59 AM) Nursing Note Text: 10:30 This nurse (LPN #5, Licensed Practical Nurse) came to the patient's room, pt (patient) was agitated and complaining about her medication. This nurse explained to the pt that the pharmacy is already processing her narcotic medications and we are just waiting on the code to get her medications. Pt became more agitated and wanted to leave. This nurse explained the patient's rights and the discharge AMA. Pt refused to sign the AMA and left the facility at 2326 (11:26 PM). Pt came back at 2340 and wanted to get her discharge summary from the hospital. This nurse together with LPN #3, and CNA #2 came out the building and tried to calm the patient down and explained the facility protocol. At 0010 (12:10 AM) resident was back to her bed. Resident is now resting.

According to the progress notes Resident #8 had pain (pain level 7) issues on arrival to the facility on 12/19/20 at 6:41 PM until she received her as needed dilaudid/hydromorphone 2 mg 0.5 tablets on 12/20/20 at 6:43 AM.

An interview was conducted with Resident #8 on 4/14/21 at approximately, 12:40 PM concerning her pain issues while residing at the facility. She stated, I'm Forty-four years old and alert. I didn't get all of my medications until three days later. I was in a lot of pain when I got there. I didn't get my pain medication until the next morning. I kept trying to leave the facility because I was in pain and didn't feel right being in there.

An interview was conducted on 4/15/21 at 7:50 PM with LPN (Licensed Practical Nurse) #3 concerning Resident #8's medications. She

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stated, " When she came here she was not happy because we didn't come to her ASAP (as soon as possible) as she got here right at shift change. She wanted to go AMA (Against Medical Advice) on admission. We couldn't tend to her right away. She requested that nurse, LPN (Licensed Practical Nurse) #6 not help her. I didn't have any issues. She was very particular about her medications. She was knowledgeable about her medications. She was alert and oriented. I only had her that one time.

On 4/16/21 at approximately 12:22 PM an interview was conducted with LPN #5 concerning Resident #8's pain medications. She stated, "I admitted her. When I received a hospital report she was wanting her pain medications. The nurse at the hospital called and said. We asked if they had a prescription with them. The nurse said she was going to medicate her. I did her assessment. I asked her if she received pain med. She said yes. I saw a prescription in her folder. I faxed it three times. The pharmacy kept saying they didn't receive it. I needed to wait for the code in the STAT box. I got the code around 12 midnight before I left. I gave her dilaudid ½ tab at 12 midnight. She was angry. That was the only pill she had. The night nurse was there (LPN #3) She gave her the 6 am meds. We don't have Percocet anymore in the lock box. There's a problem with the fax. I was explaining to her about the meds. She (Resident #8) thought the pharmacy was located inside of here already. When she left the hospital she only had paper work. She was very agitated. Since she came around 7:00 PM it (medication) usually comes around 4:00 am (pharmacy). That's why we have to get medications from the stat box. I called the

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physician earlier to verify all of the meds. We cannot open the narcotic box until we get the pharmacy code. I called them and they gave me the code and it opened automatically. The resident received meds. The Omnicare issues are related to the fax. They will keep saying they didn't receive it (the fax). I made a copy of my fax and gave them to the former DON (Director of Nursing). When we had the other company we had no issues. She received medications at hospital around 5 PM before being sent here. Since the new company took over we have issues in delay of getting code to the narcotic box due to the fax."

A review of the Omnicare Request document for Removal of Schedule II-V (2-5) Medications from the Emergency Supply (ER lock box). Reads: Dilaudid 2 mg po (by mouth) 1 tablet. Quantity Requested: 0.5 mg. Time: 11:45 PM. Prescriber: Facility doctor. Faxed three times on 12/20/20 with the following times listed: 12:01 AM,
12:50:15 AM and 1:40:31 AM. The Pharmacy Response section on the authorization reads: Quantity: 1(one) Reads: (given at 0030). Dated 12/20/20. Time: illegible. Reads: code given to LPN #5 at 12:24 AM.

According to the Physician's order summary dated 12/19/20 Resident #8 was scheduled to receive as needed Percocet 10-325 mg (Oxycodone-Acetaminophen) 2 tablets every 4 hours for pain. LPN #5 stated that the emergency lock boxes no longer have percocets inside.

On 4/16/20 at 1:26 PM an interview was conducted with the Pharmacy Manager at Omnicare concerning the request for removal of scheduled medications and emergency locked

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box. She stated, the medication was given at 12:30 AM on 12/20/20. The dilaudid is kept in the box but not the Percocet. There was a pull from the STAT box at 12:30 Midnight. She got the code at Midnight and pulled the medication from the narcotic box. You really can't tell when she opened the box or gave it. The only paper trail is when they fax over the request and when we fax it back. So we usually call each other so no one will get hold of the four digit code. The Pharmacy system failed. There could be situations where their fax machines may not be working or our lines are down. They are required to fax all hard scripts and schedule IV (5) orders. The back-up pharmacy would have been the CVS Pharmacy. They were not opened. They (facility staff) could have called in or the doctor could have called if there were issues. The surveyor asked Pharmacist if she could explain how the ER (Emergency Box) code system works). She stated," There's an electronic pad that requires a code because the DEA (Drug Enforcement Administration) is very strict. They fax a hard script and removal form gives the facility permission to take morphine out for the resident. Giving her the code doesn't mean she went to the box right then. "

On 4/27/21 at 3:17 PM spoke to the Omnicare Pharmacy Account Manager concerning Pharmacy Response section on the Request for Removal of Schedule 2-5 medications from the Emergency Supply. The Pharmacy Account Manager verified under the Pharmacy Response section the authorization number was correct. The quantity 1 (one) was correct but stated that there are no hand written responses beside the quantity as listed on the copy the said surveyor received via email from the facility. (Reads: given

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at 0030 in manual print). The time was written as 12:18 AM per Pharmacy Account Manager.

The facility's policy on Pain Management and Pain Protocol Date Reviewed and Revised on May 21, 2015. Effective May 27, 2011. It is the policy of this facility to ensure any resident that is admitted to the facility is assessed for pain and or the potential for pain in order for the resident to obtain or maintain his or her highest practicable level of physical, mental and psychological well being in accordance with the comprehensive assessment and plan of care.
Procedure: A pain evaluation will occur on admission to the facility. The resident will be reassessed for pain at regular intervals.

On 04/16/21 at approximately 3:52 p.m., the above findings were shared with the Administrator and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.

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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 a licensed nurse.

§483.45(a) Procedures. A facility must provide

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1. Resident #8 has been discharged from the facility.
2. New admissions receiving pain management have the potential to be affected. An audit of resident admitted in the past 14 days was completed with follow up as indicated.
3. Licensed nurses have been educated on the process of obtaining pain medications from the E Stat box to include notification of physician, faxing the request form to pharmacy and obtaining the code to access the E box as well as the escalation process to secure medications.
4. New admissions/readmissions will be reviewed 5 X a week for 12 weeks by DON/designee to ensure pain medications are received and administered in a timely manner.

Results of the audits will be reported to QAPI for review and recommendations for 3 months.

5. Date of Compliance 5/18/2021

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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 record review and staff interviews, the facility staff failed to procure narcotics timely for one resident. (Resident # 8) a closed record resident in a survey sample of 8 residents.

For Resident #8, the facility staff failed to ensure as needed pain medications were available for administration per physician's order in a timely manner.

The findings included:

Resident #8 was admitted to the facility on 12/19/20 and discharged on 12/24/20. Diagnosis for Resident #8 included but not limited Post Traumatic Stress Disorder, Depression, Diabetes

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Mellitus and Other Orthopedic Conditions.

The current Minimum Data Set (MDS), a discharged assessment with an Assessment Reference Date (ARD) of 12/24/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15 indicating resident is cognitively intact.

In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with locomotion on and off the unit, dressing, toilet use and personal hygiene. Requiring the supervision of one person with transfers and requires set-up help only with eating.

In section " M " (Skin Conditions) the resident was coded under Other Problems part (E) coded resident as having a surgical wound. M1200-Skin and Ulcer Treatments part (F) coded resident as needing Surgical Wound Care.

In section " J " (Health Conditions) J0100-Pain Management (B) coded resident as receiving prn pain medications. (C) Receive non-medication intervention for pain. J0400- Pain frequency coded the resident as needing pain medication frequently.

A review of the careplan reads: Focus: The resident has pain r/t flat foot repair. Created on 12/24/2020. Goals: The resident will display a decrease in behaviors of inadequate pain control through the review date. The resident will not have discomfort related to side effects of analgesia through the review date. The resident will verbalize adequate relief of pain or ability to

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cope with incompletely relieved pain through the review date. Created on 12/24/20. Interventions: Administer analgesia/medications per orders. assess/record/report to Nurse resident complaints of pain or requests for pain treatment. Identify and record previous pain history and management of that pain and impact on function per routine. Created on 12/24/20.

A review of Resident #8's physician order summary reads:

Percocet Tablet 10-325 MG (oxycodone-acetaminophen). Give 2 tablets by mouth every 4 hours as needed for pain. Order Date: 12/19/20. Start Date: 12/19/20.

Hydromorphone HCI tablet 2 MG give 0.5 by mouth every 3 hours as needed for pain. Order Date: 12/20/20. Start Date 12/20/20.

Ibuprofen Tablet 800 MG give 1 tablet by mouth every 6 hours as needed for pain.

A review of the MAR (Medication Administration Record) reveals that
Resident #8 did not receive (dilaudid) Hydromorphone HCI tablet 2 mg ½ tablet (give 0.5 tablet every 3 hours as needed for pain) until 6:46 AM on 12/20/20.

According to Resident #8 she had not received any pain medication from the time of admission into the facility on 12/19/20 at 6:41 PM until 6:43 AM.

A review of progress notes reveal the following:

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According to the admissions note Resident #8 arrived to the facility via stretcher by medical transport on 12/19/20 at 18:41 (6:41 PM) from a local hospital. Reason for Admission: S/P (Status Post) Right foot surgery/Surgical incision to right lateral foot. The Resident's pain level was 7 on arrival to the facility.

On 12/20/2020 at 00:59 (12:59 AM) Nursing Note Text: 10:30 This nurse (LPN #5, Licensed Practical Nurse) came to the patient's room, pt (patient) was agitated and complaining about her medication. This nurses explained to the pt that the pharmacy is already processing her narcotic medications and we are just waiting on the code to get her medications. Pt became more agitated and wanted to leave. This nurses explained the patient's rights and the discharge AMA. Pt refused to sign the AMA and left the facility at 2326 (11:26 PM). Pt came back at 2340 and wanted to get her discharge summary from the hospital. This nurse together with LPN #3, and CNA #2 came out the building and tried to calm the patient down and explained the facility protocol. At 0010 (12:10 AM) resident was back to her bed. Resident is now resting.

An interview was conducted with Resident #8 on 4/14/21 at approximately, 12:40 PM concerning her pain issues while residing at the facility. She stated, I'm Forty-four years old and alert. I didn't get all of my medications until three days later. I was in a lot of pain when I got there. I didn't get my pain medication until the next morning. I kept trying to leave the facility because I was in pain and didn't feel right being in there.

An interview was conducted on 4/15/21 at 7:50

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PM with LPN (Licensed Practical Nurse) #3 concerning Resident #8's medications. She stated, " When she came here she was not happy because we didn't come to her ASAP (as soon as possible) as she got here right at shift change. She wanted to go AMA (Against Medical Advice) on admission. We couldn't tend to her right away. She requested that nurse, LPN (Licensed Practical Nurse) #6 not help her. I didn't have any issues. She was very particular about her medications. She was knowledgeable about her medications. She was alert and oriented. I only had her that one time.

On 4/16/21 at approximately 12:22 PM an interview was conducted with LPN #5 concerning Resident #8's pain medications. She stated, "I admitted her. When I received a hospital report she was wanting her pain medications. The nurse at the hospital called and said. We asked if they had a prescription with them. The nurse said she was going to medicate her. I did her assessment. I asked her if she received pain med. She said yes. I saw a prescription in her folder. I faxed it three times. The pharmacy kept saying they didn't receive it. I needed to wait for the code in the STAT box. I got the code around 12 midnight before I left. I gave her dilaudid ½ tab at 12 midnight. She was angry. That was the only pill she had. The night nurse was there (LPN #3) She gave her the 6 am meds. We don't have Percocet anymore in the lock box. There's a problem with the fax. I was explaining to her about the meds. She (Resident #8) thought the pharmacy was located inside of here already. When she left the hospital she only had paper work. She was very agitated. Since she came around 7:00 PM it (medication) usually comes around 4:00 am

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(pharmacy). That's why we have to get medications from the stat box. I called the physician earlier to verify all of the meds. We cannot open the narcotic box until we get the pharmacy code. I called them and they gave me the code and it opened automatically. The resident received meds. The Omnicare issues are related to the fax. They will keep saying they didn't receive it (the fax). I made a copy of my fax and gave them to the former DON (Director of Nursing). When we had the other company we had no issues. She received medications at hospital around 5 PM before being sent here. Since the new company took over we have issues in delay of getting code to the narcotic box due to the fax."

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