DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345000 | A. BUILDING ______ B. WING ______ | C 02/14/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUTUMN CARE OF BISCOE | 401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209 |

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| F 157 SS=E | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident, staff, physician and pharmacy consultant interview and record review; | F 157 | Preparation and submission of the plan of correction is in response to HCFA 2567 for the survey and does not constitute an agreement or admission by Autumn Care of Biscoe of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. Autumn Care of Biscoe contends that it was in substantial compliance with the requirements 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, Autumn Care of Biscoe submits this plan of correction to address the statement of deficiencies and to serve as its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully complete in all areas as of 3/11/13. | 3/11/13 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristine S Henson — TITLE: Administrator — (X6) DATE: 3/8/13

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

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| F 157 | Continued From page 1<br>the facility failed to notify the physician and obtain direction when medications were not available for 3 of 3 residents sampled for availability of medications (Resident #3, #4 and #5)<br><br>1. Resident #3 was admitted on 1/18/13 at 2:30 PM with diagnoses including: right total knee replacement on 1/15/13, fibromyalgia, osteoarthritis, migraine headaches, and history of Munchausen ' s syndrome. An Admission Minimum Data Set (MDS) was not due prior to her discharge and was not completed.<br><br>Review of the Hospital Discharge Medication Reconciliation dated 1/17/13 at 11:38 PM revealed that while in hospital the resident had an order for the following narcotic analgesics (pain medications):<br>a. Hydrocodone - Acetaminophen 10-500 mg (milligrams) 1 tablet every 4 hours as needed. There was no date or time noted under the column " Last Dose Taken. " The reconciliation indicated that this medication was to be discontinued at discharge.<br>b. Oxycodone - Acetaminophen 5 - 325 mg 2 tablets every 4 hours as needed. Under the column " Last Dose Taken " it read 1/17/13, 10:02 PM. The reconciliation indicated that this medication was to be continued after discharge from the hospital. There was also a hand written addition that changed the dosage to read 1 - 2 tablets every 4 - 6 hours as needed.<br><br>The FL2 Level of Care Screening Tool dated 1/18/13 indicated Resident #3 was cognitively intact.<br><br>Review of the Physician ' s Orders dated 1/18/13 | F 157 | **F157:** This facility has and will continue to inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). | 3/11/13 |

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| F 157 | Continued From page 2<br>and entered into the electronic medical record on 1/18/13 at 3:42 PM revealed an order for Percocet (a Brand name for Oxycodone - Acetaminophen) 5/325 mg 1 tablet every 4 hours as needed for pain.<br><br>The Admission Pain Assessment 1/18/13 revealed the resident had no pain at that time. No other information was documented.<br><br>On 1/18/13 the first entry in the nursing notes at 10:43 PM revealed " Resident complained of pain to right knee surgical site. No further information regarding the pain was documented.<br><br>Review of the electronic medical record and Nursing Notes for 1/18/13 revealed no admission note, no admission assessment or assessment of the Resident #3 ' s pain noted in the above Nursing Note and no documentation of pain management interventions, including pain medications.<br><br>Interview with Nurse # 1 on 2/13/13 at 2:42 PM revealed that Resident #3 arrived at 2:30 PM near the end of her shift (3 PM) on 1/18/13. She indicated that she stayed to input the medication orders and to clarify the Oxycodone - Acetominophen 5 - 325 mg 1 - 2 tablets as needed for pain medication order. Nurse #1 added that she needed to clarify the pain medication order to be for either just 1 tablet or for 2 tablets. She added that medications ordered from the pharmacy in the evening before 6 PM usually arrived on third shift around 11 PM.<br><br>In interview with Nurse #2 on 2/13/13 at 5:15 PM she recalled that Resident #3 had a lot of | F 157 | **Steps taken in regards to Resident # 3 & 4 found to have been cited in the survey findings**: The licensed nurse providing care to resident on the 7-3 and 3-11 shift received counseling and instruction regarding Admission/Pain documentation, Ordering/Re-Ordering of Medications and Medication Administration on 2/15/13 by D.O.N.<br>**Steps taken in regards to Resident #5 found to have been cited in the survey findings:** Exelon patch was applied on 1/13/13.<br>Steps taken in regards to residents having the potential to be affected by the survey findings: All licensed nurses received instruction by the D.O.N. or SDC regarding Admission/ Pain documentation, Ordering and Re-ordering of Medication and Medication Administration beginning on 2/15/13 and completed on 3/5/13.<br>**Systemic Changes:** Newly hired licensed nurses will receive instruction regarding Admission/Pain documentation, Ordering and Re-Ordering of Medication and Medication Administration during orientation by the SDC or Designee. | 3/11/13 |

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| F 157 | Continued From page 3<br>complaints and was very concerned that her pain medications may not arrive in the facility that evening. She added that she did everything she could to reassure Resident #3 her medications would arrive. When asked if she offered the resident pain medication Nurse #2 said that she was sure she would have (there was no documentation regarding pain assessment or pain management intervention including medication on 1/18/13) but that Resident #3 wanted 2 tablets like she had in the hospital " but I told her we don ' t do that " . When asked why she did not contact the physician to discuss Resident #3 ' s pain signs/symptoms and request for 2 tablets, Nurse #2 said that this was the responsibility of the first shift nurse.<br><br>Interview with the pharmacy consultant on 2/14/13 at 9:30 AM revealed that if medications were not ordered from pharmacy by 5 PM they would not be delivered that night and so would arrive the following day around 11 PM. He said that according to pharmacy records the pharmacy received the order for Resident #3 ' s medications on 1/18/13 at 4:03 PM and her medications including the Oxycodone - Acetaminophen 5 - 325 mg were delivered to the facility at 11:15 PM.<br><br>An interview with the Director of Nursing (DON) on 2/14/13 at 11:30 AM revealed that if Resident #3 was asking for 2 tablets of pain medication instead of 1, the physician should have been notified. She added that the pain assessment should have been communicated with the physician so appropriate interventions could be determined. The DON indicated that she expected pain medication to be given, when needed, and that not giving it because the | F 157 | **QA Monitoring to prevent reoccurrence**: All admissions will be audited by the D.O.N. or Designee for appropriate documentation x 4 weeks then weekly x 4 weeks then monthly x 3 months. All new admission charts will be reviewed x 4 weeks then weekly x 4 weeks then monthly x 3 months for timely administration of medications. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) will be addressed in Quality Assurance meeting for further action plans during morning meeting. | 3/11/13 |

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| F 157 | Continued From page 4<br>resident ' s medications had not arrived from pharmacy was not acceptable as there were back-up sources and options.<br><br>During telephone interview with Resident #3 on 2/14/13 at 2:45 PM she said that she repeatedly asked for pain medication on 1/18/13 and that she thought the facility should have been more prepared and had the medication available to her. Resident #3 indicated that she was " in so much pain " that day. She did not recall being asked to rate her pain on a scale of 0 - 10 but said that " I told them I was really hurting " .<br><br>Interview with the physician on 2/14/13 at 3 PM revealed he did not specifically recall if he had gotten any calls regarding Resident #3. He also indicated that if he had been informed of Resident #3 ' s concerns regarding pain management he would have expected the nurse to have completed a pain assessment on the resident with information regarding the characteristics and intensity of the pain so appropriate interventions could have been implemented.<br><br>2. Resident #4 was admitted 1/21/13 at 4:15 PM with diagnoses including: hypertension, sepsis, hyperlipidemia, atrial fibrilation and ottis media (ear infection).<br><br>The Admission Minimum Data Set dated 1/28/13 revealed Resident #4 was cognitively intact.<br><br>Review of the Physician ' s Orders dated 1/21/13 revealed medication orders including:<br><br>Atenolol 12.5 mg (milligrams) ordered for hypertension daily, | F 157 | | |

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| F 157 | Continued From page 5<br>Digoxin 125 mcg (micrograms) daily (Digoxin is used to treat atrial fibrillation),<br>Augmentin (antibiotic) 875 mg twice daily for 7 days, ordered for sepsis,<br>Cortisporin 4 gtts (drops) otic (ear) solution three times a day for otttis media (ear infection),<br>Lactobacillis 500 mg twice daily for 7 days, ordered for sepsis (Lactobacillis is used for general digestive problems such as diarrhea caused by antibiotic therapy)<br>Mirlax Powder 17 g (grams) daily ordered for constipation,<br>Protonix Enteric Coated 40 mg daily (Protonix is used to treat heartburn)<br><br>Review of the electronic medical record daily summary sheet for 1/22/13 revealed the following medications were not given as ordered on the morning of 1/22/13: atenolol, digoxin, augmentin, cortisporin, lactobacillis, mirilax powder and protonix. Review of the electronic medical record variance report associated with these missed medication doses revealed that in each case the reason the medications were missed was documented as " medication on order from pharmacy, pharmacy notified ". There was no documentation indicating that the physician had been notified.<br><br>Telephone Interview with Nurse #3 on 2/28/13 at 2:45 PM revealed that Resident #4 ' s medications were not available on the morning of 1/22/13. She stated because they had not arrived the night before she faxed the hospital discharge medications list to pharmacy that morning, and expected they would arrive around 11 PM that night. Nurse #3 said she did not think about notifying the physician that the medications were | F 157 | | |

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| F 157 | Continued From page 6<br>not given as ordered.<br><br>Review of the electronic medical record daily summary sheet for 1/23/13 and 1/24/13 revealed the following medication was not given as ordered on the morning of 1/23/13 and 1/24/13: lactobacillis. Review of the electronic medical record variance report associated with this missed medication revealed that in both cases the reason the medication was missed was documented as " medication on order from pharmacy, pharmacy notified " .<br><br>Interview with the Pharmacy Consultant on 2/14/13 at 9:30 AM revealed that medications ordered by 5 PM were usually delivered that same day by 11 PM. He added that if medications were ordered from pharmacy after that cut off time they would not be delivered to the facility until 11 PM the next day. The pharmacist also indicated that for most medications missing one dose was acceptable, so he did not think it was necessary for nursing staff to take any action to notify the physician or to obtain the medications from the back up pharmacy.<br><br>Interview with Resident #4 on 2/14/13 at 2:30 PM revealed that she recalled that she did not get her medications, including her antibiotic, as ordered on the morning of 1/22/13 as they had not yet arrived in the facility. She indicated that she thought the medications should have been available that morning.<br><br>An interview with the Director of Nursing (DON) on 2/14/13 at 11:30 AM revealed that Nursing staff were expected to inform the physician if medications were not being given because they | F 157 | | |

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| F 157 | Continued From page 7<br>were not available in the facility. She also said that for some non essential medications it would be acceptable to wait until they arrived from pharmacy.<br><br>Interview with the physician on 2/14/13 at 3 PM revealed he expected to be notified when medications were not being given because they were not available and that alternatives such as the back-up emergency kit and back-up pharmacy needed to be utilized, or an order to hold the medications until arrival from pharmacy could be written if appropriate.<br><br>3. Resident #5 was admitted on 3/21/11 with diagnoses including delirium, failure to thrive, alzheimers disease and depression.<br><br>Review of the Physician ' s Orders dated 10/22/12, revealed an order for Exelon 9.5 mg (milligram) patch, apply one patch daily (remove old patch before placing new one).<br><br>The Quarterly Minimum Data Set (MDS) dated 11/17/12 revealed the resident was moderately cognitively impaired.<br><br>Review of the electronic medical record daily summary sheet for 1/9/13 - 1/12/13 revealed the Exelon Patch was not given as ordered 1/9/13 through 1/12/13. Review of the electronic medical record variance report associated with these missed medication doses revealed that the reason the medication was missed was documented on each occasion as " medication on order from pharmacy, pharmacy notified " .<br><br>Review of the Grievance Report dated 1/12/13 | F 157 | | |

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| F 157 | Continued From page 8<br>revealed, in part, " This is the 3rd time that (Resident #5) has run out of her Exelon Patch. She ran out this time on 1/8/2013. Family notes that her mental status has changed and that is what prompted them to inquire about patch. Please note (name of nurse) promptly contacted pharmacy and it will be on tonight ' s tote " . Under action taken a hand written note indicated the Exelon Patch arrived on 1/12/13 and was applied at 8:20 AM. It also indicated that staff were inserviced on ordering of medications and contacting appropriate staff members.<br><br>Telephone Interview with Nurse #4 on 2/28/13 at 2:20 PM revealed that she worked with Resident #4 on the morning of 1/9/13 and 1/10/13, and that on both days the Exelon Patch was not given because it had not arrived from pharmacy. She stated that she did not contact pharmacy to reorder the medication on either 1/9/13 or 1/10/13, since she noticed the reorder sticker was missing and she therefore assumed that the medication had already been reordered. Nurse #4 said she did not notify the physician that this medication had not been given and that she typically had not been notifying the physician when other medications were not available, and therefore not given. She added that she did not observe any change in the resident.<br><br>Telephone Interview with Nurse #5 on 2/28/13 at 2 PM revealed that she worked with Resident #4 on the morning of 1/11/13, and that the Exelon Patch was not given that day because it had not arrived from pharmacy. She said that on 1/11/13 she was aware that the Exelon had been missed for the previous two days as well. Nurse #5 said another Nurse (Nurse #6) contacted pharmacy | F 157 | | |

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| F 157 | Continued From page 9<br>for her, to reorder the medication. Nurse #5 said that she did not notify the physician that the Exelon had not been given for 3 days. She also said that she did not notice any mental status changes in the resident.<br><br>Interview with the Pharmacy Consultant on 2/14/13 at 9:30 AM revealed that medications ordered by 5 PM were usually delivered that same day by 11 PM. He added that if medications were ordered from pharmacy after that cut off time they would not be delivered to the facility until 11 PM the next day.<br><br>An interview with the Director of Nursing (DON) on 2/14/13 at 11:30 AM revealed that Nursing staff should have contacted the physician when the Exelon Patch for Resident #5 was not available.<br><br>Interview with the physician on 2/14/13 at 3 PM revealed that he would have expected to be informed when the Exelon patch was not available from pharmacy. He did not recall if he had been contacted. He said however that he believed he was not contacted, as he would have ensured action was taken, such as ordering the medication from the back-up pharmacy if he had been aware. | F 157 | | |
| F 309 SS=E | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | F 309 | **F309**: This facility has and will continue to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | |

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| F 309 | Continued From page 10<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident, staff , physician and pharmacy consultant interview, record review and the facility failed to complete a nursing admission assessment for 1 of 3 residents sampled for nursing admission assessment completion (Resident #3), failed to assess pain and to provide pain management interventions for 1 of 3 residents sampled for pain management (Resident #3) and failed to assess or document pain characteristics pre and post pain management intervention for 2 of 3 residents sampled for pain management (Resident #3 and Resident #4).<br><br>Findings included:<br><br>1a. Resident #3 was admitted on 1/18/13 at 2:30 PM with diagnoses including: right total knee replacement on 1/15/13, fibromyalgia, osteoarthritis, migraine headaches, and history of Munchausen ' s syndrome (a disorder in which a person acts as if they have a physical of mental illness). An Admission Minimum Data Set (MDS) was not due prior to her discharge and was not completed.<br><br>The FL2 Level of Care Screening Tool dated 1/18/13 indicated Resident #3 was cognitively intact.<br><br>The Admission Pain Assessment 1/18/13 at 2:30 PM revealed the resident had no pain at that time. No other information was documented. | F 309 | **Steps taken in regards to Resident # 3 found to have been cited during the survey findings:** The licensed nurse providing care on the 3-11 shift for Resident # 3 received counseling and re-instruction regarding facility policy for Admission/Pain assessment and documentation on 2/15/13 by D.O.N.<br>**Steps taken in regards to resident having the potential to be affected by the survey findings:** All licensed nurses were re-in-serviced beginning on 2/15/13 and completed on 3/5/13 regarding facility policy on Admission/ Pain assessment and documentation by D.O.N. or SDC.<br>**Systemic Changes:** During orientation, all newly hired licensed nurses will receive instruction regarding Admission/Pain assessment and documentation by the SDC or Designee. | 3/11/13 |

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| F 309 | Continued From page 11<br><br>On 1/18/13 the first entry in the nursing notes at 10:43 PM revealed " Resident complained of pain to right knee surgical site. No further information regarding the pain was documented.<br><br>Review of the electronic medical record and Nursing Notes for 1/18/13 revealed no admission note, no admission assessment or assessment of the Resident #3 ' s pain noted in the above Nursing Note and no documentation of pain management interventions, including pain medications.<br><br>Further review of the medical record from 1/19/13 until the residents discharge on 1/21/13 revealed that an admission assessment was not documented.<br><br>Interview with Nurse # 1 on 2/13/13 at 2:42 PM revealed that Resident #3 arrived at 2:30 PM near the end of her shift (3 PM) on 1/18/13. She indicated that because the Resident had come so close to the end of the shift it was the responsibility of the oncoming nurse to complete the admission assessment.<br><br>In interview with Nurse #2 on 2/13/13 at 5:15 PM she stated that because the resident arrived on first shift it was the responsibility of the first shift nurse to complete the admission assessment.<br><br>An interview with the Director of Nursing (DON) on 2/14/13 at 11:30 AM revealed that it was the responsibility of the second shift nurse (Nurse #2) to complete the nursing admission assessment. She said it was her expectation that the Nursing Admission Assessment, including a thorough pain | F 309 | **QA Monitoring to prevent reoccurrence:** The D.O.N. or Designee will audit all new admissions for appropriate admission/ pain assessment and documentation daily x 4 weeks then weekly x 4 weeks then monthly x 3 months. All residents will be audited daily x 4 weeks then weekly x 4 weeks then monthly x 3 months for appropriate documentation regarding pain. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) will be addressed in Quality Assurance meeting for further action plans during morning meeting. | 3/11/13 |

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assessment could have been completed before the end of second shift (11 PM). She added that if a nursing admission assessment was not completed by the nurse who was responsible for it this information should have been passed on for the following day.

1b. The facility policy on Pain Management was from Lippincott ' s Nursing Procedures 4th Edition, 2004, pages 533 - 536. and read, in part, " To assess pain properly, you ' ll need to consider the patient ' s description and your observations of the patient ' s physical and behavioral responses. Start by asking the following series of questions (bearing in mind that the patient ' s responses will be shaped by his prior experiences, self-image, and beliefs about his condition):
- Where is the pain located? How long does it last? How often does it occur?
- Can you describe the pain?
- What brings the pain on?
- What relieves the pain or makes it worse?
Ask the patient to rank his pain on a scale of 0 - 10, with 10 denoting the worst pain. This helps the patient verbally evaluate pain therapies. Observe the patient ' s behavioral and physiologic responses to pain. Physiologic responses may be sympathetic or parasympathetic. "

Resident #3 was admitted on 1/18/13 at 2:30 PM with diagnoses including: right total knee replacement on 1/15/13, fibromyalgia, osteoarthritis, migraine headaches, and history of Munchausen ' s syndrome. An Admission Minimum Data Set (MDS) was not due prior to her discharge and was not completed.

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Review of the Hospital Discharge Summary dated 1/18/13 revealed, in part, that Resident #3 had medial calf tenderness and because of this a Doppler study (a test to evaluate blood flow) had been done. The results of this were still pending at the time of discharge.

The FL2 Level of Care Screening Tool dated 1/18/13 indicated Resident #3 was cognitively intact.

Review of the Hospital Discharge Medication Reconciliation dated 1/17/13 at 11:38 PM revealed that while in hospital the resident had an order for the following narcotic analgesics (pain medications):
a. Hydrocodone - Acetaminophen 10-500 mg (milligrams) 1 tablet every 4 hours as needed. There was no date or time noted under the column " Last Dose Taken. " The reconciliation indicated that this medication was to be discontinued at discharge.
b. Oxycodone - Acetaminophen 5 - 325 mg 2 tablets every 4 hours as needed. Under the column " Last Dose Taken " it read 1/17/13, 10:02 PM. The reconciliation indicated that this medication was to be continued after discharge from the hospital. There was also a hand written addition that changed the dosage to read 1 - 2 tablets every 4 - 6 hours as needed.

The Admission Pain Assessment 1/18/13 at 2:30 PM revealed the resident had no pain at that time. No other information was documented.

Review of the Interim Care Plan dated 1/18/13 revealed a Care Plan focus area for " Pain/Comfort Needs " . The interventions listed

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included: pain assessment to be completed on admitting shift, Oxycodone - Acetaminophen 5/325 mg 1 tablet every 4 hours as needed for pain and Percocet (a Brand name for Oxycodone - Acetaminophen) 5/325 mg 1 tablet every 4 hours as needed for pain.

Review of the Physician ' s Orders dated 1/18/13 and entered into the electronic medical record on 1/18/13 at 3:42 PM revealed an order for Percocet (a Brand name for Oxycodone - Acetaminophen) 5/325 mg 1 tablet every 4 hours as needed for pain.

Review of the Physician ' s Orders dated 1/18/13 and entered into the electronic medical record on 1/18/13 at 5:45 PM revealed an order Oxycodone - Acetaminophen 5/325 mg 1 tablet every 4 hours as needed for pain.

On 1/18/13 the first entry in the nursing notes at 10:43 PM revealed " Resident complained of pain to right knee surgical site. Area red and warm to touch. Requested to go to hospital for evaluation and requested family take her to hospital. (Name of Doctor) gave order to send to ER (Emergency Room) for evaluation. Family arrived at facility to take to (name of hospital) " .

Further review of the electronic medical record and Nursing Notes for 1/18/13 revealed no admission note, no admission assessment or assessment of the Resident #3 ' s pain noted in the above Nursing Note and no documentation of pain management interventions, including pain medications.

The Emergency Department Physician Record

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| F 309 | Continued From page 15<br>dated 1/18/13 with the " time seen " documented at 11:31 PM revealed that Resident #3 had right knee pain with an onset of the afternoon of 1/18/13. No vital signs were documented but her cardiovascular status was " normal ". Her right knee was noted to be swollen with limited range of motion and erythema (redness of the skin). There was no documentation in the section regarding pain severity and no indication of any treatment given. The diagnosis was listed as " ? (query) DVT ((Deep Vein Thrombosis) painful leg (leg was crossed out) knee ". Under the heading reevaluation " improved " was circled and under the heading for discharge condition " good " was circled.<br><br>The 1/19/13, 4:18 AM Nursing Note revealed, in part, " Resident reports that per hospital that her pain was just not controlled and that they gave her some of their medication ". " Called and spoke with (Name of hospital staff member) at (Name of Hospital) who reported that resident had dx (diagnosis) of DVT (deep vein thrombosis) and leg pain, received Dilaudid 2 mg (a narcotic pain medication) for pain while at hospital ".<br><br>Interview with Nurse # 1 on 2/13/13 at 2:42 PM revealed that Resident #3 arrived at 2:30 PM near the end of her shift (3 PM) on 1/18/13. She indicated that because the Resident had come so close to the end of the shift it was the responsibility of the oncoming nurse to complete the admission assessment. She acknowledged that she did stay to input the medication orders and to clarify the as needed pain medication order. Nurse #1 noted that the Hospital Discharge Summary indicated 1 - 2 tablets of | F 309 | | |

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hydrocodone - acetaminophen 5 - 325 mg could be given to Resident #3 as needed for pain every 4 - 6 hours. She stated that per facility policy, the order needed to be clarified to be specifically for 1 tablet, or for 2 tablets, and that an order for a range in the number of tablets and/or a range in the frequency was not an acceptable order at the facility. The order was clarified to for 1 tablet every 4 hours as needed. Nurse #1 also said that medications ordered from the pharmacy in the evening before 6 PM usually arrived on third shift around 11 PM.

In interview with Nurse #2 on 2/13/13 at 5:15 PM she recalled that Resident #3 had a lot of complaints and was very concerned that her pain medications may not arrive in the facility that evening. When asked if she offered the resident pain medication she Nurse #2 said that she was sure she would have but that Resident #3 wanted 2 tablets like she had in the hospital " but I told her we don ' t do that " . When asked to clarify this statement Nurse #2 stated that the order from the hospital was for 1 - 2 tablets of pain medication as needed every 4 - 6 hours but that the first shift nurse needed to have the order clarified (1 tablet only or 2 tablets only) as Nurse #1 was responsible for the admission and admission assessment.

During this interview, when asked why she did not contact the physician to discuss Resident #3 ' s pain signs/symptoms and request for 2 tablets, Nurse #2 reiterated that this was the responsibility of the first shift nurse. Nurse #2 also indicated that she was aware that hydrocodone - acetaminophen 5 - 325 was available in the emergency back-up kit within the facility but said

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| F 309 | Continued From page 17<br>that Resident #3 did not want the pain medication and just wanted to go back to the hospital because she did not want to be admitted to the facility.<br><br>Telephone interview with Resident #3 ' s Family Member #1 on 2/13/13 at 6:30 PM she said that Resident #3 was admitted around 3 PM and by 4 PM she was hurting and asked for pain medication. She stated that after she (Family Member #1) left she received a call from Resident #3 who said she was really hurting and still hadn ' t received any pain medications. Family Member #1 then said that she called Nurse #2 and Nurse #2 said she just gave Resident #1 something for pain around 9 PM that was borrowed from another resident. Family Member #1 said she asked when Resident #3 ' s medications would arrive and Nurse #2 said 11 PM. Family Member #1 stated that she then asked what would happen if the medication did not arrive and Nurse #2 said she will have to wait until the morning. Family Member #1 added that Nurse #2 called her back later and told her she had gone back to assess Resident #2 ' s knee and it was sore with red streeks running up her leg possibly related to a blood clot. She also said that Nurse #2 said Emergency Medical Services could be called to take Resident #3 to the hospital but that Resident #3 wanted family to take her. Family Member #1 said Resident #3 was crying and really hurting when she went with her to the hospital. (Review of the Oxycodone - Acetominophen Narcotic Count Sheets and corresponding Medication Administration Records for 1/18/13 revealed no borrowed medications and the Count Sheet for the Oxycodone - Acetominophen in the emergency kit revealed it | F 309 | | |

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| F 309 | Continued From page 18<br>was not used. Resident #3's MAR revelaed no Oxycodone - Acetominopent, Tylenol or other pain medication administered to Resident #3 on 1/18/13).<br><br>An interview with the Director of Nursing (DON) on 2/14/13 at 11:30 AM revealed that it was her expectation that the Nursing Admission Assessment, including a thorough pain assessment could have been completed before Resident #3 left for the ER on 1/18/13 (approximately 10:43 PM). She also said that if Resident #3 was asking for 2 tablets of pain medication instead of 1 the physician should have been notified and provided with information regarding Resident #3 ' s pain assessment, so appropriate interventions could be determined. The DON indicated that she expected pain medication to be given, when needed, and that not giving it because the resident ' s medications had not arrived from pharmacy was not acceptable as there were back-up sources and options.<br><br>During telephone interview with Resident #3 on 2/14/13 at 2:45 PM she said that she repeatedly asked for pain medication on 1/18/13 and that she thought the facility should have been more prepared and had the medication available to her. Resident #3 indicated that she was " in so much pain " that day. She did not recall being asked to rate her pain on a scale of 0 - 10 but said that " I told them I was really hurting " . Resident #3 also said that Nurse #2 finally gave her something for pain that she said was borrowed from another resident but it was too late and she needed to go to the hospital. (Review of the Oxycodone - Acetominophen Narcotic Count Sheets and | F 309 | | |

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| F 309 | Continued From page 19<br>corresponding Medication Administration Records for 1/18/13 revealed no borrowed medications and the Count Sheet for the Oxycodone - Acetominophen in the emergency kit revealed it was not used. Resident #3's MAR revelaed no Oxycodone - Acetominopent, Tylenol or other pain medication administered to Resident #3 on 1/18/13).<br><br>Interview with the physician on 2/14/13 at 3 PM revealed he did not specifically recall if he had gotten any calls regarding Resident #3. He also indicated that if he had been informed of Resident #3 ' s concerns regarding pain management he would have expected the nurse to have completed a pain assessment on the resident with information regarding the characteristics and intensity of the pain so appropriate interventions could have been implemented. The physician also confirmed that an order for 1 - 2 tablets of a pain medication was not an acceptable order at the facility and was to be clarified as either 1 or 2 tablets.<br><br>Telephone interview with Nurse #2 on 2/28/13 at 3:30 PM revealed that Resident #3 seemed fine while her family was visiting on the evening of 1/18/13 but after they left she talked about not wanting to be there and said her family could take care of her at home. Nurse #2 stated the resident indicated her pain was mild but also said the resident was worried about a blood clot. Nurse #2 said that she assessed the residents leg and found no signs of a deep vein thrombosis (blood clot) but said the resident ' s knee was a little red. She stated that she offered Resident #2 Tylenol as there are standing orders for Tylenol but did not give the oxycodone - acetaminophen | F 309 | | |

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| F 309 | Continued From page 20<br>because the order had not been clarified by Nurse #1 yet. Nurse #2 also said that Resident #3 did not show any non-verbal signs of pain only verbal signs. She said that she assessed Resident #2 ' s pain on a 0 - 10 scale but could not remember the result and did not document it. Nurse #2 said she did not give Resident #3 pain medication borrowed from another resident and did not recall receiving a call from Family Member #1. She stated Resident #3 had already called Family Member #1 to take her to the hospital before she (Nurse #2) was able to call her and let her know Resident #3 wanted to go to the hospital.<br><br>1c. Resident #3 was admitted on 1/18/13 at 2:30 PM with diagnoses including: right total knee replacement on 1/15/13, fibromyalgia, osteoarthritis, migraine headaches, and history of Munchausen ' s syndrome. An Admission Minimum Data Set (MDS) was not due prior to her discharge and was not completed.<br><br>The FL2 Level of Care Screening Tool dated 1/18/13 indicated Resident #3 was cognitively intact.<br><br>The Admission Pain Assessment 1/18/13 at 2:30 PM revealed the resident had no pain at that time. No other information was documented.<br><br>Review of the Physician ' s Orders dated 1/18/13 and entered into the electronic medical record on 1/18/13 at 3:42 PM revealed an order for Percocet (a Brand name for Oxycodone - Acetaminophen) 5/325 mg 1 tablet every 4 hours as needed for pain. | F 309 | | |

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| F 309 | Continued From page 21<br>Review of the Physician ' s Orders dated 1/18/13 and entered into the electronic medical record on 1/18/13 at 5:45 PM revealed an order Oxycodone - Acetaminophen 5/325 mg 1 tablet every 4 hours as needed for pain.<br><br>On 1/18/13 the first entry in the nursing notes at 10:43 PM revealed " Resident complained of pain to right knee surgical site. Area red and warm to touch. Requested to go to hospital for evaluation and requested family take her to hospital. (Name of Doctor) gave order to send to ER (Emergency Room) for evaluation. Family arrived at facility to take to (name of hospital) " .<br><br>Further review of the electronic medical record and Nursing Notes for 1/18/13 revealed no admission note, no admission assessment or assessment of the Resident #3 ' s pain noted in the above Nursing Note and no documentation of pain management interventions, including pain medications.<br><br>Review of the Nursing Notes, Pain Assessment Notes and Narcotic Count Sheet for 1/19/13 through 1/21/13 revealed:<br><br>1/19/13, 4:18 AM Nursing Note: " Resident reports that per hospital that her pain was just not controlled and that they gave her some of their medication " . " Called and spoke with (Name of hospital staff member) at (Name of Hospital) who reported that resident had dx (diagnosis) of DVT (deep vein thrombosis) and leg pain, received Dilaudid 2 mg (a narcotic pain medication) for pain while at hospital " .<br><br>1/19/13 4:30 AM Pain Assessment - " resident | F 309 | | |

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| F 309 | Continued From page 22<br>C/O (complains) some pain but received pain med (medication) at (name of hospital) while in the ER (emergency room) " . No further information regarding the pain was documented.<br><br>1/19/13, 5:44 AM Nursing Note: administration of pain medication as ordered was documented as given for right leg and knee pain. No other information regarding the pain was documented.<br><br>1/19/13, 8:45 AM (per Narcotic Count Sheet) - l tablet of hydrocodone - acetaminophen 5-325 mg given.<br><br>1/19/13, 10:32 AM Nursing Note: " No pain at present, PRN (as needed) pain med (medication) given this shift " .<br><br>1/19/13, 12:42 PM (per Narcotic Count Sheet) - l tablet of hydrocodone - acetaminophen 5-325 mg given.<br><br>1/19/13, 4:42 PM (per Narcotic Count Sheet) - 2 tablets of hydrocodone - acetaminophen 5-325 mg given. (Note: although the physician ' s order was clarified to be only for 1 tablet, the Narcotic Count Sheet indicated that the order was for 1 - 2 tablet every 4 - 6 hours).<br><br>1/19/13, 4:53 PM Nursing Note: administration of pain medication as ordered was documented as given. No other information regarding the pain was documented.<br><br>1/20/13, 1:20 AM (per Narcotic Count Sheet) - 2 tablets of hydrocodone - acetaminophen 5-325 mg given. | F 309 | | |

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| F 309 | Continued From page 23<br>1/20/13 1:42 AM: administration of pain medication as ordered was documented as given for right knee and leg pain. No other information regarding the pain was documented.<br><br>1/20/13, 2:44 AM Nursing Note: " Gave her pain medication at 0120 (1:20 AM) for right lower leg pain. Has edema to her right lower leg. Skin tight and red " .<br><br>1/20/13, 4:58 AM Nursing Note: administration of pain medication as ordered was documented. The note also read that the resident had no other complaints " at this time " .<br><br>1/20/12, 5:45 AM (per Narcotic Count Sheet) - 2 tablets of hydrocodone - acetaminophen 5-325 mg given.<br><br>1/20/13, 10:40 AM (per Narcotic Count Sheet) - 1 tablet of hydrocodone - acetaminophen 5-325 mg given.<br><br>1/20/13, 1:18 PM Pain Assessment: the assessment indicated " yes " for pain. No further information regarding the pain was documented.<br><br>1/20/13 4:03 PM Nursing Note: administration of pain medication as ordered was documented as given for complaints of pain. The note also read that effectiveness would be monitored. No other information regarding the pain was documented.<br><br>1/20/13, 5 PM (per Narcotic Count Sheet) - 1 tablet of hydrocodone - acetaminophen 5-325 mg given. | F 309 | | |

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| F 309 | Continued From page 24<br>1/20/13, 8:55 PM (per Narcotic Count Sheet) - 1 tablet of hydrocodone - acetaminophen 5-325 mg given.<br><br>1/20/13, 10 PM Pain Assessment: the assessment indicated " yes " for pain. No further information regarding the pain was documented.<br>1/21/13, 3:20 AM (per Narcotic Count Sheet) - 1 tablet of hydrocodone - acetaminophen 5-325 mg given.<br><br>1/21/13, 3:20 AM Nursing Note: administration of pain medication as ordered was documented as given for complaints of pain. No other information regarding the pain was documented.<br><br>1/21/13, 8:05 AM (per Narcotic Count Sheet) - 1 tablet of hydrocodone - acetaminophen 5-325 mg given.<br><br>1/21/13, 8:09 AM Nursing Note: administration of pain medication as ordered was documented the note also read " C/O (complains) pain with PRN (as needed) medication given. Pain 8 on scale of 1/10. Will monitor for effectivemness.<br><br>1/21/13, 12:20 PM (per Narcotic Count Sheet) - 1 tablet of hydrocodone - acetaminophen 5-325 mg given.<br><br>1/21/13, 2 PM Pain Assessment: the assessment indicated " yes " for pain. No further information regarding the pain was documented.<br><br>1/21/13, 2:42 PM Nursing Note: " C/O pain with medication given. No acute distress or discomfort noted " . | F 309 | | |

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| F 309 | Continued From page 25 | F 309 | | |

1/21/13, 5:15 PM (per Narcotic Count Sheet) - 1 tablet of hydrocodone - acetaminophen 5-325 mg given.

According to the medical record Resident #3 was discharged against medical advice on 1/21/13 at 6:35 PM.

Interview with Nurse # 1 on 2/13/13 at 2:42 PM revealed that when doing a pain assessment she would use a 0 - 10 scale to assess pain intensity or a faces scale to assess non-verbal indications of pain with cognitively impaired residents. She indicated that documentation of pain characteristics, including pain intensity is sometimes missed with the electronic system. Nurse #1 noted that with the paper system of charting it was easier to document pain assessment. She said with the paper system as there was a specific place to document pain characteristics and intensity and that effectiveness of pain medications could be documented on the back of the Medication Administration Record.

In interview with Nurse #2 on 2/13/13 at 5:15 PM she recalled that Resident #3 was concerned about her pain medication as soon as she came in the door. When asked if she assessed the reesident ' s pain and offered the resident pain medication, Nurse #2 said that she was sure she would have and that she would have documented this (there was no documentation regarding pain assessment or pain management intervention including medication on 1/18/13). Nurse #2 stated when doing a pain assessment she used a 0 - 10 to assess pain intensity. When asked why

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| F 309 | Continued From page 26<br>she did not contact the physician to discuss Resident #3 ' s pain signs/symptoms and request for 2 tablets, Nurse #2 reiterated that this was the responsibility of the first shift nurse.<br><br>Interview with the Staff Development Coordinator on 2/13/13 at 5:30 PM revealed that nurses were expected to use the alerts tab in the electronic medical record to find out when the last dose of as needed pain medication was given. She also stated that nurses should be documenting a more detailed pain assessment in their notes and should be reevaluating the effectiveness of pain medication. She acknowledged that this was not being done on a consistent basis.<br><br>An interview with the Director of Nursing (DON) on 2/14/13 at 11:30 AM revealed that it was her expectation that the Nursing Admission Assessment, including a thorough pain assessment could have been completed before Resident #3 left for the ER on 1/18/13 (approximately 10:43 PM). She also said that if Resident #3 was asking for 2 tablets of pain medication instead of 1 the physician should have been notified and provided with information regarding Resident #3 ' s pain assessment, so appropriate interventions could be determined.<br><br>During telephone interview with Resident #3 on 2/14/13 at 2:45 PM she indicated that she was " in so much pain " the day she was admitted (1/18/13). She did not recall being asked to rate her pain on a scale of 0 - 10 but said that " I told them I was really hurting " . Resident #3 also said that because she is used to taking pain medications for migraines she needs a higher dose (two tablets instead of one). She added that | F 309 | | |

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| F 309 | Continued From page 27<br>while at the facility, on most occasions, more than 4 hours had elapsed since her last dose of pain medication so she was always getting it late. Resident #3 felt that nursing staff should have known that she needed her pain medications every 4 hours and they should have brought her pain medication every 4 hours without her having to ask for it.<br><br>Interview with the physician on 2/14/13 at 3 PM revealed he did not specifically recall if he had gotten any calls regarding Resident #3. He also indicated that if he had been informed of Resident #3 ' s concerns regarding pain management he would have expected the nurse to have completed a pain assessment on the resident with information regarding the characteristics and intensity of the pain so appropriate interventions could have been implemented. The physician also confirmed that an order for 1 - 2 tablets of a pain medication was not an acceptable order at the facility and was to be clarified as either 1 or 2 tablets.<br><br>2. Resident #4 was admitted 1/21/13 at 4:15 PM with diagnoses including: hypertension, sepsis, atrial fibrilation and ottis media (ear infection).<br><br>The Admission Minimum Data Set dated 1/28/12 revealed Resident #4 was cognitively intact. The MDS indicated she had pain rarely, that it was moderate intensity and 7 on a scale of 0 (no pain) - 10 (worst pain) at its worst.<br><br>Review of the Physician Orders revealed an order dated 1/21/13 for hydrocodone - acetaminophen (narcotic analgesic pain medication) 7.5 - 650 mg 1 tablet every 8 hours as needed for pain | F 309 | | |

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| F 309 | Continued From page 28<br>(diagnosis: ottis media).<br><br>Review of the Nursing Notes and the Medication Administration Record (MAR) for 1/22/13 - 1/31/13 revealed:<br><br>On 1/22/13 Resident #4 received 2 doses of hydrocodone-acetominophen (Loracet) according to the MAR. The 4:27 AM Nursing note indicated this medication was " given per prn (as needed) order and resident request " ; no further information regarding the pain was documented. The 4:30 AM nursing note read, in part, " Resident questioned why she hasn ' t received her pain medication that was due. Explained to resident that pain medication was not scheduled and she had not c/o (complained) pain or asked for any pain medication this shift " . The 11:29 PM Nursing Note indicated Loracet was given per prn order and patient request; no further information regarding the pain was documented.<br><br>On 1/24/13 Resident #4 received 2 doses of Loracet according to the MAR. The 12:05 AM Nursing Note indicated Loracet was " given per prn order and resident request " ; no other information regarding the pain was documented. The 2:12 PM Nursing Note indicated " prn pain med (medication) was given " , no other information regarding the pain was documented. The 6:11 PM Nursing Note indicated " no c/o of pain at this time. No acute distress noted " .<br><br>On 1/25/13 Resident #4 received 2 doses of Loracet according to the MAR. The 12:30 AM Nursing Note indicated Loracet was given due to resident complaints of pain to the right leg and that the pain was 9 out of 10. The note also | F 309 | | |

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| F 309 | Continued From page 29<br>indicated the medication was tolerated well.<br><br>On 1/26/13 Resident #4 received 1 dose of Loracet according to the MAR. The 1:51 PM note indicated " prn pain med given " and the 11:53 PM note indicated " no c/o pain at this time ".<br><br>On 1/27/13 Resident #4 received 2 doses of Loracet according to the MAR. The 1:43 AM Nursing Note indicated the resident requested a pain pill earlier in the shift and it was given per prn order and resident request with no further signs or symptoms of pain.<br><br>On 1/28/13 Resident #4 received 2 doses of Loracet according to the MAR. The 8:24 AM Nursing Note indicated " prn pain med given, will continue to monitor effectiveness ". The 9:48 AM Nursing Note indicated " c/o back pain, prn pain med given will monitor for effectiveness ".<br><br>On 1/29/13 Resident #4 received 1 dose of Loracet according to the MAR. The 5:41 PM Nursing Note indicated " complained of pain with prn medication given " ; no further information regarding the pain was documented. The 8:04 PM Nursing Note indicated " c/o pain of 9 on 1/10 pain scale. Will monitor for effectiveness ".<br><br>On 1/30/13 Resident #4 received 1 dose of Loracet according to the MAR. The 7:58 PM Nursing Note indicated " c/o back/leg pain, prn pain med given, will monitor for effectiveness ".<br><br>On 1/30/13 Resident #4 received 1 dose of Loracet according to the MAR. The 11:04 AM Nursing Note indicated " pain med ' s requested for back/leg ". The 2:19 PM Nursing Note | F 309 | | |

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| F 309 | Continued From page 30<br>indicated " no c/o pain " .<br><br>Review of the Nursing Notes and MAR from 2/1/13 - 2/14/13 revealed no further documentation regarding complaints of pain and no further Loracet or other pain medication administered. The 2/14/13 2:29 PM Nursing Note indicated " no c/o pain or discomfort at this time " .<br><br>Interview with Nurse # 1 on 2/13/13 at 2:42 PM revealed that when doing a pain assessment she would use a 0 - 10 scale to assess pain intensity or a faces scale to assess non-verbal indications of pain with cognitively impaired residents. She indicated that documentation of pain characteristics, including pain intensity is sometimes missed with the electronic system. Nurse #1 noted that with the paper system of charting it was easier to document pain assessment. She said with the paper system as there was a specific place to document pain characteristics and intensity and that effectiveness of pain medications could be documented on the back of the Medication Administration Record.<br><br>Interview with the Staff Development Coordinator on 2/13/13 at 5:30 PM revealed that nurses were expected to use the alerts tab in the electronic medical record to find out when the last dose of as needed pain medication was given. She also stated that nurses should be documenting a more detailed pain assessment in their notes and should be reevaluating the effectiveness of pain medication. She acknowledged that this was not being done on a consistent basis. | F 309 | | |

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| F 309 | Continued From page 31<br>Interview with Resident #4 on 2/14/13 at 2:30 PM revealed that pain medications were given if she asked for them. She did not recall being asked specific questions regarding pain, like how intense her pain had been on a scale of 0 - 10. She also stated she had a sore throat for a few days and she did not think the medication she was taking for it was effective. Resident #4 said that she had told the nurses that it wasn ' t working but she didn ' t think anything was being done about it. She then said she was told the doctor would be in to see her today.<br><br>An interview with the Director of Nursing (DON) on 2/14/13 at 11:30 AM revealed that it was her expectation that pain assessment was done on admission and prior to pain management interventions. She added that effectiveness of pain management interventions was to be assessed and documented. The DON also indicated that she expected that concerns regarding pain management would be communicated to the physician, with a thorough pain assessment, so appropriate pain management interventions could be identified.<br><br>Interview with the physician on 2/14/13 at 3 PM revealed he expected to be notified when pain management interventions were needed or ineffective. He also indicated that he expected that a pain assessment, including characteristics of the pain and exacerbating or relieving factors was completed and communicated to him to aid in determining effective pain management interventions. | F 309 | | |
| F 333 SS=E | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS | F 333 | **F333:** This facility has and will continue to ensure that residents are free of any significant medication errors. | 3/11/13 |

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| F 333 | Continued From page 32<br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff, resident, physician and pharmacy consultant interview and record review the facility failed to administer Oxycodone-Acetaminophen (narcotic pain medication) as ordered and gave two tablets instead of one on 3 occasions, for 1 of 3 residents sampled for pain management (Resident #3); and failed to administer an Exelon patch (used in the treatment of Alzheimer ' s disease) for 4 days to 1 of 2 residents sampled for availability of medications after admission (Resident #5).<br><br>Findings included:<br><br>1. Resident #3 was admitted on 1/18/13 at 2:30 PM with diagnoses including: right total knee replacement on 1/15/13, fibromyalgia, osteoarthritis, migraine headaches, and history of Munchausen ' s syndrome. An Admission Minimum Data Set (MDS) was not due prior to her discharge and was not completed.<br><br>The FL2 Level of Care Screening Tool dated 1/18/13 indicated Resident #3 was cognitively intact.<br><br>Review of the Hospital Discharge Medication Reconciliation dated 1/17/13 at 11:38 PM revealed that while in hospital the resident had an order for the following narcotic analgesics (pain medications):<br>a. Hydrocodone - Acetaminophen 10/500 mg | F 333 | **Steps taken in regards to Resident # 3:** Labels were obtained by Pharmacy to be applied to blister packs to alert the nurse that a change had occurred with the order. Licensed nurses were instructed regarding the label on 2/18/13 by the SDC.<br>**Steps taken in regards to Resident # 5:** Exelon patch was applied on 1/13/13. Steps taken in regards to residents having the potential to be affected by the survey findings: All licensed nurses were re-instructed beginning on 2/15/13 and completed on 3/5/13 regarding Ordering/Re-Ordering Medications and Medication Administration by D.O.N. or SDC. All charts were reviewed during the months of January to present for current residents for medication errors with paperwork completed as indicated by D.O.N. or QA Nurse.<br>**Systemic Changes:** During orientation, all newly hired licensed nurses will receive instruction regarding Medication Administration and Order/Re-Ordering of Medications by the SDC or Designee. Annually an in-service will be held by the SDC or Designee on Medication Administration. | 3/11/13 |

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| F 333 | Continued From page 33<br>(milligrams) 1 tablet every 4 hours as needed. There was no date or time noted under the column " Last Dose Taken. " The reconciliation indicated that this medication was to be discontinued at discharge from the hospital.<br>b. Oxycodone - Acetaminophen 5/325 mg 2 tablets every 4 hours as needed. Under the column " Last Dose Taken " it read 1/17/13, 10:02 PM. The reconciliation indicated that this medication was to be continued after discharge from the hospital. There was also a hand written addition that changed the dosage to 1 - 2 tablets every 4 - 6 hours as needed.<br><br>Review of the Physician ' s Orders dated 1/18/13 and entered into the electronic medical record on 1/18/13 at 5:45 PM revealed an order for Oxycodone - Acetaminophen 5/325 mg 1 tablet every 4 hours as needed for pain.<br><br>Review of the Nursing Notes, Narcotic Count Sheet for 1/19/13 through 1/21/13 revealed:<br><br>1/19/13, 8:45 AM (per Narcotic Count Sheet) - 1 tablet of Oxycodone - Acetaminophen 5/325 mg given.<br><br>1/19/13, 12:42 PM (per Narcotic Count Sheet) - 1 tablet of Oxycodone - Acetaminophen 5/325 mg given.<br><br>1/19/13, 4:42 PM (per Narcotic Count Sheet) - 2 tablets of Oxycodone - Acetaminophen 5/325 mg given. (Note: although the physician ' s order was clarified to be only for 1 tablet, the Narcotic Count Sheet indicated that the order was for 1 - 2 tablets every 4 - 6 hours). | F 333 | **QA Monitoring to prevent reoccurrence:** A report will be generated from the E.H.R. system daily by D.O.N. or Designee on all charts related to medications charted as not done x 4 weeks then weekly x 4 weeks then monthly x 3 months for timely administration of medications. A Medication Pass will be conducted by the SDC or Designee on all licensed nurses annually. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) will be addressed in Quality Assurance meeting for further action plans during morning meeting. | 3/11/13 |

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| F 333 | Continued From page 34<br>1/20/13, 1:20 AM (per Narcotic Count Sheet) - 2 tablets of Oxycodone - Acetaminophen 5/325 mg given. (Note: although the physician ' s order was clarified to be only for 1 tablet, the Narcotic Count Sheet indicated that the order was for 1 - 2 tablets every 4 - 6 hours).<br><br>1/20/12, 5:45 AM (per Narcotic Count Sheet) - 2 tablets of Oxycodone - Acetaminophen 5/325 mg given. (Note: although the physician ' s order was clarified to be only for 1 tablet, the Narcotic Count Sheet indicated that the order was for 1 - 2 tablets every 4 - 6 hours).<br><br>1/20/13, 10:40 AM (per Narcotic Count Sheet) - 1 tablet of Oxycodone - Acetaminophen 5/325 mg given.<br><br>1/20/13, 5 PM (per Narcotic Count Sheet) - 1 tablet of Oxycodone - Acetaminophen 5/325 mg given.<br><br>1/20/13, 8:55 PM (per Narcotic Count Sheet) - 1 tablet of Oxycodone - Acetaminophen 5/325 mg given.<br><br>1/21/13, 8:05 AM (per Narcotic Count Sheet) - 1 tablet of Oxycodone - Acetaminophen 5/325 mg given.<br><br>1/21/13, 12:20 PM (per Narcotic Count Sheet) - 1 tablet of Oxycodone - Acetaminophen 5/325 mg given.<br><br>1/21/13, 5:15 PM (per Narcotic Count Sheet) - 1 tablet of Oxycodone - Acetaminophen 5/325 mg given. | F 333 | | |

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| F 333 | Continued From page 35<br>Interview with Nurse # 1 on 2/13/13 at 2:42 PM revealed that Resident #3 admitted at 2:30 PM near the end of her shift (3 PM) on 1/18/13. She said she stayed to input the medication orders and to clarify the as needed pain medication order. Nurse #1 noted that the Hospital Discharge Summary indicated 1 - 2 tablets of Oxycodone - Acetaminophen 5/325 mg could be given to Resident #3 as needed for pain every 4 - 6 hours. She stated that per facility policy, the order needed to be clarified to be specifically for 1 tablet, or for 2 tablets, and that an order for a range in the number of tablets and/or a range in the frequency was not an acceptable order at the facility. The order was clarified to 1 tablet every 4 hours as needed.<br><br>During a telephone interview with Resident #3 on 2/14/13 at 2:45 PM she indicated that she did not understand why she could not have two tablets of her pain medication like she did in the hospital. She added that she felt nursing staff were not taking into consideration that she suffered from migraine headaches and was therefore used to taking pain medication, so needed a stronger dose. Resident #3 indicated that one of the nurses told her she could have two tablets, according to the order, and did give her two. She said that on the following day she was told she could not have two tablets. She did not know why the change had occurred but she thought the nurse the next day was " mad " that the dosage had been increased and changed it back.<br><br>During an interview with the physician on 2/14/13 at 3 PM the narcotic count sheet for Resident#3 ' s Oxycodone - Acetaminophen was reviewed and he acknowledged that the 2 tablets given on | F 333 | | |

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| F 333 | Continued From page 36<br>1/19/13 (4:42 PM) and the 2 tablets given twice on 1/20/13 (1:20 AM and 5:45 AM) were medication errors. He added that checking the physician ' s medication order was one of the " rights " of medication administration that could have prevented the error. The physician also confirmed that an order for 1 - 2 tablets of a pain medication was not an acceptable order at the facility and was to be clarified as either 1 or 2 tablets. He added that the Narcotic Count Sheet and the Medication Punch Card should not have been used with the dosage written as 1 - 2 tablets and the new order for just 1 tablet should have been clarified with pharmacy. The physician indicated that the Narcotic Count Sheets were reviewed for accuracy monthly and but not necessarily against the physician ' s order.<br><br>A telephone interview on 2/28/13 at 3:15 PM with Nurse #7 revealed that she did not check the order as transcribed on the Medication Administration Record before giving 2 tablets of Oyxcodone - Acetaminophen 5/325 to Resident #3 on 1/19/13 at 4:42 PM. She stated that Resident #3 asked for 2 tablets and the resident knew that the punch card for her Oxycodone - Acetaminophen 5/325 indicated that the dose was 1 - 2 tablets. Nurse #7 said that when she documented that she had given 2 tablets in the medical record she still did not notice that she had given an extra tablet in error.<br><br>Interview with the Administrator on 2/14/13 at 4 PM revealed that the 2 tablets of Oxycodone - Acetaminophen given to Resident #3 on 1/19/13 (4:42 PM) and the 2 tablets given twice on 1/20/13 (1:20 AM and 5:45 AM) were medication errors staff at the facility had not been aware of | F 333 | | |

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| F 333 | Continued From page 37<br>prior to the survey. She indicated that medication error reports had not been done for these incidents but that they would be done now that the error was known,<br><br>2. Resident #5 was admitted on 3/21/11 with diagnoses including delirium, failure to thrive, Alzheimers disease and depression.<br><br>Review of the Physician ' s Orders dated 10/22/12, revealed an order for Exelon 9.5 mg (milligram) patch, apply one patch daily (remove old patch before placing new one).<br><br>The Quarterly Minimum Data Set (MDS) dated 11/17/12 revealed the resident was moderately cognitively impaired.<br><br>Review of the electronic medical record daily summary sheet for 1/9/13 - 1/12/13 revealed the Exelon Patch was not given as ordered 1/9/13 through 1/12/13. Review of the electronic medical record variance report associated with these missed medication doses revealed that the reason the medication was missed was documented on each occasion as " medication on order from pharmacy, pharmacy notified " .<br><br>Review of the Grievance Report dated 1/12/13 revealed, in part, " This is the 3rd time that (Resident #5) has run out of her Exelon Patch. She ran out this time on 1/8/2013. Family notes that her mental status has changed and that is what prompted them to inquire about patch. Please note (name of nurse) promptly contacted pharmacy and it will be on tonight ' s tote " . Under action taken, a hand written note indicated the Exelon Patch arrived on 1/12/13 and was | F 333 | | |

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| F 333 | Continued From page 38<br>applied at 8:20 AM.<br><br>Telephone Interview with Nurse #4 on 2/28/13 at 2:20 PM revealed that she worked with Resident #4 on the morning of 1/9/13 and 1/10/13, and that on both days the Exelon Patch was not given because it had not arrived from pharmacy. She stated that she did not contact pharmacy to reorder the medication on either 1/9/13 or 1/10/13, since she noticed the reorder sticker was missing and she therefore assumed that the medication had already been reordered. Nurse #4 also said that she did not verify if the Exelon had been reordered because it took a few days for reordered medications to arrive, so she expected it to come the night of 1/10/13. Nurse #4 added that because the medication was not given as ordered and because she did not take action to obtain the medication, or get a hold order; this was a medication error.<br><br>Telephone Interview with Nurse #5 on 2/28/13 at 2 PM revealed that she worked with Resident #4 on the morning of 1/11/13, and that the Exelon Patch was not given that day because it had not arrived from pharmacy. She said that on 1/11/13 she was aware that the Exelon had been missed for the previous two days as well. Nurse #5 said another Nurse (Nurse #6) contacted pharmacy for her, to reorder the medication. Nurse #5 stated that she did not think about asking pharmacy if the Exelon could be obtained from the back-up pharmacy because Nurse #6 told her the pharmacy said the Exelon would arrive that night (1/11/12). Nurse #5 indicated that when medications were obtained from the back-up pharmacy, it was the on-duty, or on call, pharmacist at the pharmacy that decided whether | F 333 | | |

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| F 333 | Continued From page 39<br>the back-up pharmacy would be used to supply the medication. She revealed that the pharmacist did not inquire about the status of the resident when determining whether to utilize the back-up pharmacy. Nurse #5 also said that she did not notice any mental status changes in the resident.<br><br>Interview with the Pharmacy Consultant on 2/14/13 at 9:30 AM revealed that medications ordered by 6 PM were usually delivered that same day by 11 PM. He added that if medications were ordered from pharmacy after that cut off time they would not be delivered to the facility until 11 PM the next day. The pharmacist also indicated that for most medications missing one dose was acceptable so he did not think it was necessary for nursing staff to take any action to notify the physician or to obtain the medications from the back up pharmacy.<br><br>An interview with the Director of Nursing (DON) on 2/14/13 at 11:30 AM revealed that Nursing staff should have contacted the physician when the Exelon Patch for Resident #5 was not available. She also stated that action could have been taken to obtain the medication from the back-up pharmacy.<br><br>During an interview with the physician on 2/14/13 at 3 PM, he acknowledged that the missed doses of Exelon constituted a medication error, at least after the first missed dose; since staff did not implement strategies to obtain the medication or inform him it was not being given. He also indicated that not giving the Exelon as ordered should have been identified as a medication once Administrative staff became aware this through the grievance that was filed. | F 333 | | |

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| F 425 SS=E | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>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.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff, physician and pharmacy consultant interview, record review and facility policy review; the facility failed to ensure medications were available for 1 of 3 newly admitted residents (Resident # 4) and failed to ensure medications were re-supplied for 1 of 2 residents sampled for availability of medications after admission (Resident #5).<br><br>The findings included:<br><br>1. Review of the facility policy titled Admissions | F 425 | **F425:** The facility has and will continue to provide routine and emergency drugs and biological to its residents, or obtain them under an agreement described in § 483.75(h) of this part.<br>**Steps taken in regards to Resident # 4 found to have been cited during the survey findings:** Licensed Nurses were re-instructed on policy regarding Order/Re-ordering and timely administration of Medications beginning on 2/15/13 and completed on 3/5/13 by D.O.N or SDC.<br>**Steps taken in regards to residents having the potential to be affected by the survey findings:** All new admission charts were reviewed by D.O.N. or QA Nurse for timely administration of medications and steps taken accordingly to obtain or physician notified and documentation placed in the resident's chart.<br>**Systemic Changes:** During orientation, newly hired licensed nurses will be instructed by the SDC or Designee regarding timely administration of medications, Order/ Re-Ordering of Medications and Documentation. | 3/11/13 |

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| F 425 | Continued From page 41<br>(undated) revealed, in part:<br>" Whenever a resident is admitted to the facility it is imperative that the information be sent to pharmacy as soon as possible " by fax.<br>" You must set the start date appropriately for all medications. If a resident is to be receiving a medication BID (twice a day) and the dose was administered at the hospital that morning, you must schedule the medication to begin that evening in the facility, tomorrow is to late " .<br>For after hours admissions " contact the on call pharmacist, explain the situation so medications can be obtained from the back up pharmacy. You must document your efforts in the nursing notes "<br>.<br><br>Review of the facility policy titled Procedure for Getting Medications for Weekend and Evening Admissions (undated) revealed, in part:<br>" If you know you have an evening admission coming in, the Admission dept (department) MUST notify the pharmacy via phone or fax as soon as you know. The may decide to wait for the faxed orders before leaving or before sending the courier " .<br>" The on-call pharmacist will decide whether to fill your meds (medications) from Legacy (pharmacy) or have a short supply filled by your back-up pharmacy and delivered " .<br><br>In contrast to the above policies, review of the facility ' s Pharmacy Services policy titled Medication Orders and dated June 2012 revealed, in part, under the heading Scheduling New Medication Orders:<br>" Non-emergency Medication Orders: The first dose is scheduled to be given after the next regularly scheduled pharmacy delivery to the | F 425 | **QA Monitoring to prevent the reoccurrence:** All new admission charts will be reviewed by D.O.N. or Designee x 4 weeks then weekly x 4 weeks then monthly x 3 months for timely administration of medications and Order/Re-Ordering of Medications. Ten different charts will be reviewed monthly x 4 months for timely administration of medications. Any area of identified concern will be addressed at the time as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.) will be addressed in Quality Assurance meeting for further action plans during morning meeting. | 3/11/13 |

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| F 425 | Continued From page 42<br>facility " .<br>" If greater than 24 hours before the next delivery, the medication is either pulled from the emergency kit (if applicable), or called into a back-up pharmacy " .<br>" Emergency/STAT Medication Order: Schedule the appropriate number of doses to be administered prior to the regularly scheduled pharmacy delivery. These doses will be obtained from a back-up pharmacy or the emergency kit (if applicable). Thereafter, doses are scheduled to be received from the regular pharmacy delivery " .<br><br>Resident #4 was admitted 1/21/13 at 4:15 PM with diagnoses including: hypertension, sepsis (a blood infection), hyperlipidemia, atrial fibrilation and ottis media (ear infection).<br><br>The Admission Minimum Data Set dated 1/28/13 revealed Resident #4 was cognitively intact.<br><br>Review of the Physician ' s Orders dated 1/21/13 revealed medication orders including:<br><br>Atenolol 12.5 mg (milligrams) ordered for hypertension daily,<br>Digoxin 125 mcg (micrograms) daily (Digoxin is used to treat atrial fibrillation),<br>Augmentin (antibiotic) 875 mg twice daily for 7 days, ordered for sepsis,<br>Cortisporin 4 gtts (drops) otic (ear) solution three times a day for otttis media (ear infection),<br>Lactobacillis 500 mg twice daily for 7 days, ordered for sepsis (Lactobacillis is used for general digestive problems such as diarrhea caused by antibiotic therapy)<br>Mirlax Powder 17 g (grams) daily ordered for constipation, | F 425 | | |

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| F 425 | Continued From page 43 | F 425 | | |

Protonix Enteric Coated 40 mg daily (Protonix is used to treat heartburn)

Review of the electronic medical record daily summary sheet for 1/22/13 revealed the following medications were not given as ordered on the morning of 1/22/13: atenolol, digoxin, augmentin, cortisporin, lactobacillis, mirilax powder and protonix. Review of the electronic medical record variance report associated with these missed medication doses revealed that in each case the reason the medications were missed was documented as " medication on order from pharmacy, pharmacy notified " . Review of the emergency kit list of medications (undated) revealed none of these medications were in the kit at the dosage ordered.

Telephone Interview with Nurse #3 on 2/28/13 at 2:45 PM revealed that Resident #4 ' s medications were not available on the morning of 1/22/13. She stated because they had not arrived the night before she faxed the hospital discharge medications list to pharmacy that morning, and expected they would arrive around 11 PM that night. Nurse #3 said she did not think about calling the pharmacy to see about getting medications from the back-up pharmacy.

Review of the electronic medical record daily summary sheet for 1/23/13 revealed the morning and evening doses of lactobacillis were not given. Review of the electronic medical record variance report associated with this missed medication revealed the reason the medication was missed was documented as " medication on order from pharmacy, pharmacy notified " .

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| F 425 | Continued From page 44<br>Telephone Interview with Nurse #1 on 2/28/13 at 11:20 AM revealed that on 1/23/12 she worked with the Resident #4 on first shift (7 - 3) and gave the resident her morning medications, except for the Lactobacillis . She stated she did not know why that one medication had not arrived from pharmacy with the resident ' s other medication. Nurse #1 added that she thought she must have been the one who called the pharmacy to ensure the Lactobacillis came in for Resident #4 as the medication was available the next morning. She indicated that when medications were not available in the morning the pharmacist should be notified and the medication could then be obtained from the back-up pharmacy if necessary, which opened at 9 AM. She further indicated this was not done for the Lactobacillis as she took steps to obtain it the next day.<br><br>Interview with the Pharmacy Consultant on 2/14/13 at 9:30 AM revealed that medications ordered by 6 PM were usually delivered that same day by 11 PM. He added that if medications were ordered from pharmacy after that cut off time they would not be delivered to the facility until 11 PM the next day. The pharmacist also indicated that for most medications missing one dose was acceptable so he did not think it was necessary for nursing staff to take any action to notify the physician or to obtain the medications from the back up pharmacy. He added that he did not think missing one dose of Digoxin was a concern but that nursing staff should have acted to obtain the morning dose of antibiotic.<br><br>Interview with Resident #4 on 2/14/13 at 2:30 PM revealed that she recalled that she did not get her | F 425 | | |

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| F 425 | Continued From page 45<br>medications, including her antibiotic, as ordered on the morning of 1/22/13 as they had not yet arrived in the facility. She indicated that she thought the medications should have been available that morning.<br><br>An interview with the Director of Nursing (DON) on 2/14/13 at 11:30 AM revealed that Resident #4 ' s, 1/23/13 missed morning medications could have been obtained from the back-up pharmacy if they were not in the emergency back-up kit. She also said that for some non essential medications it would be acceptable to wait until they arrived from pharmacy. The DON added that for planned evening admissions the Admissions Coordinator was expected to fax medication information to the pharmacy prior to admission.<br><br>Interview with the physician on 2/14/13 at 3 PM revealed when medications were not available, alternatives such as the back-up emergency kit and back-up pharmacy needed to be utilized.<br><br>Telephone Interview with the DON on 2/28/13 at 3:50 PM revealed that starting immediately the facility would be getting twice daily deliveries from the pharmacy instead of just once daily at 11 PM.<br><br>2. Review of the facility ' s Pharmacy Services policy titled Medication Ordering and Receiving from Pharmacy dated June 2012 revealed, in part:<br>" Medication refills are written on a medication order form/ordered by peeling the refill sticker portion off the label and placing it on the reorder sheet " . " Reorder medications 5 days in advance of need as indicated by the reorder sticker to assure an adequate supply is on hand " | F 425 | | |

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|---|---|---|---|
| | 345000 | A. BUILDING ______ B. WING ______ | C 02/14/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUTUMN CARE OF BISCOE | 401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209 |

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. The refill order is called in or faxed to the pharmacy.

Resident #5 was admitted on 3/21/11 with diagnoses including delirium, failure to thrive, alzheimers disease and depression.

Review of the Physician ' s Orders dated 10/22/12, revealed an order for Exelon 9.5 mg (milligram) patch, apply one patch daily (remove old patch before placing new one).

The Quarterly Minimum Data Set (MDS) dated 11/17/12 revealed the resident was moderately cognitively impaired.

Review of the electronic medical record daily summary sheet for 1/9/13 - 1/12/13 revealed the Exelon Patch was not given as ordered 1/9/13 through 1/12/13. Review of the electronic medical record variance report associated with these missed medication doses revealed that the reason the medication was missed was documented on each occasion as " medication on order from pharmacy, pharmacy notified " .

Review of the Grievance Report dated 1/12/13 revealed, in part, " This is the 3rd time that (Resident #5) has run out of her Exelon Patch. She ran out this time on 1/8/2013. Family notes that her mental status has changed and that is what prompted them to inquire about patch. Please note (name of nurse) promptly contacted pharmacy and it will be on tonight ' s tote " . Under action taken a hand written note indicated the Exelon Patch arrived on 1/12/13 and was applied at 8:20 AM.

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| F 425 | Continued From page 47<br>Telephone Interview with Nurse #4 on 2/28/13 at 2:20 PM revealed that she worked with Resident #4 on the morning of 1/9/13 and 1/10/13, and that on both days the Exelon Patch was not given because it had not arrived from pharmacy. She stated that she did not contact pharmacy to reorder the medication on either 1/9/13 or 1/10/13, since she noticed the reorder sticker was missing and she therefore assumed that the medication had already been reordered. Nurse #4 also said that she did not verify if the Exelon had been reordered because it took a few days for reordered medications to arrive, so she expected it to come the night of 1/10/13. When the Exelon didn ' t come, she assumed it would arrive on the night of 1/11/13. Nurse #4 said Exelon was not in the emergency back-up and she didn ' t think about calling to see if she could get it from the back-up pharmacy. She added that she did not observe any change in the resident.<br><br>Telephone Interview with Nurse #5 on 2/28/13 at 2 PM revealed that she worked with Resident #4 on the morning of 1/11/13, and that the Exelon Patch was not given that day because it had not arrived from pharmacy. She said that on 1/11/13 she was aware that the Exelon had been missed for the previous two days as well. Nurse #5 said another Nurse (Nurse #6) contacted pharmacy for her, to reorder the medication. Nurse #5 stated that she did not think about asking pharmacy if the Exelon could be obtained from the back-up pharmacy because Nurse #6 told her the pharmacy said the Exelon would arrive that night (1/11/12). Nurse #5 indicated that when medications were obtained from the back-up pharmacy, it was the on-duty, or on call, | F 425 | | |

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| F 425 | Continued From page 48<br>pharmacist at the pharmacy that decided whether the back-up pharmacy would be used to supply the medication. She revealed that the pharmacist did not inquire about the status of the resident when determining whether to utilize the back-up pharmacy. Nurse #5 also said that she did not notice any mental status changes in the resident.<br><br>Interview with the Pharmacy Consultant on 2/14/13 at 9:30 AM revealed that medications ordered by 6 PM were usually delivered that same day by 11 PM. He added that if medications were ordered from pharmacy after that cut off time they would not be delivered to the facility until 11 PM the next day. The pharmacist also indicated that for most medications missing one dose was acceptable so he did not think it was necessary for nursing staff to take any action to notify the physician or to obtain the medications from the back up pharmacy.<br><br>An interview with the Director of Nursing (DON) on 2/14/13 at 11:30 AM revealed that she expected staff to reorder medications according to facility procedures so medications were available and not missed. She also stated that staff should have contacted pharmacy in order to obtain the medication from the back-up pharmacy.<br><br>Telephone interview with the DON on 2/28/12 at 12:15 PM revealed that she had copies of the Exelon reorder requests that were faxed to pharmacy on 1/11/13 and 1/12/13. She stated she did not have documentation indicating that the Exelon had been re-ordered since it was last delivered to the facility on 12/3/12, although she did have one undated reorder request. | F 425 | | |

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| F 425 | Continued From page 49<br><br>During interview with the physician on 2/14/13 at 3 PM he indicated that steps should have been taken to obtain the Exelon for Resident #4 so she would not have missed 4 doses.<br><br>Telephone Interview with the DON on 2/28/13 at 3:50 PM revealed that starting immediately the facility would be getting twice daily deliveries from the pharmacy instead of just once daily at 11 PM. | F 425 | | |