

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

PRINTED: 12/07/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/01/2017
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NAME OF PROVIDER OR SUPPLIER ASHTON HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301
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F 280 SS=D	<p>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)</p> <p>483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:</p> <p>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.</p> <p>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.</p> <p>(iv) The right to receive the services and/or items included in the plan of care.</p> <p>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.</p> <p>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and</p>	F 280		11/24/17
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/24/2017
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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 280	Continued From page 1 cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 280			

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F 280	<p>Continued From page 2 assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff and resident observations and observations, the facility failed to update the care plan and add interventions to prevent falls and fall related injury for 1 of 3 residents reviewed for falls. Resident # 6.</p> <p>Findings included:</p> <p>Resident # 6 was admitted to the facility on 08/25/2017 with diagnosis of post- surgical care, muscle weakness, lack of coordination, dyspnea (difficult breathing), depression, dementia, insomnia, constipation, pain and hypothyroidism.</p> <p>A Fall Risk Assessment dated 08/28/2017 revealed that Resident # 6 had a fall risk score of 9 and was at a high risk for falls.</p> <p>A physician (MD) progress note dated 08/28/2017 included in part that Resident # 6 had a right hip fracture post fall and had altered mental status. The resident had an unsteady gait and required physical and occupational therapy to regain strength and to restore function.</p> <p>A comprehensive Minimum Data Set (MDS) assessment dated 09/01/2017 revealed that Resident # 6 wore eye glasses, and was cognitively intact. Resident # 6 was coded as requiring staff of one staff member with transfers and locomotion and that Resident # 6 had unsteady balance when moving from a seated to a standing position, when walking with an assistive device, when turning around while walking, while moving on and off the toilet and had poor balance during surface to surface</p>	F 280	<p>F 280</p> <p>The care plan for resident 6 was updated with all interventions and measurable goals. (Completed by 11/1/17)</p> <p>The MDS nurse did not update the interventions/care plan in the falls meeting.</p> <p>The MDS nurse will update all falls care plans at the time of the interdisciplinary falls meeting.</p> <p>The DON will review all falls care plan the day after the interdisciplinary falls meeting to ensure accuracy. This will be done weekly for 90 days then monthly for 90 days. The results will be monitored in our monthly QAA meeting through May 2018.</p>		

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F 280	<p>Continued From page 3</p> <p>transfers. The MDS further indicated that Resident # 6 was frequently incontinent of bowel and bladder, received pain medication as needed and that Resident # 6 had had a fall prior to admission which had resulted in a fracture. Resident # 6 also received an antidepressant for 7 days of the assessment review period.</p> <p>The care plan initiated on 09/03/2017 indicated the resident was at risk for falls due to cognitive deficit, recent fall with fracture, required assist with mobility, had incontinent episodes and received an antidepressant and pain medication as needed. The goals were to be free from falls and not experience any injury related to falls. Interventions included to remind the resident to ask for assistance with all ambulation, monitor for changes in condition that may warrant increased assistance and to notify the physician, use of a wheelchair for long distance mobility and to keep the room free of clutter.</p> <p>A review of a Care Area Assessment (CAA) dated 09/04/2017 revealed that Resident # 6 was at risk for falls related to impaired balance, antidepressant use, incontinence of bowel and bladder, had difficulty changing position and used of pain medication as needed.</p> <p>A facility incident report dated 10/10/2017 at 12:30 PM revealed that Resident # 6 was ambulating in the dining room and had used a walker when she fell as she attempted to turn and sit in a chair. Resident # 6 had no complaint of dizziness or weakness and was continent of bowel and bladder. The room was free of clutter and nonskid shoes were in place. No first aid was administered and a referral was made to therapy.</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>A nurse progress note dated 10/10/2017 at 1:01 PM revealed that Resident # 6 was alert with confusion and had been noted lying on the floor on her left side. The Resident (# 6) had been ambulating with the walker in the dining room and fell when she attempted to turn and sit in the chair. Resident # 6 had range of motion to all four extremities, had no complaints and no visible injury was observed. Nonskid socks were noted on both of Resident # 6's feet and her vital signs were stable.</p> <p>A nurse progress note dated 10/10/2017 at 1:23 PM revealed that Resident # 6 was alert with confusion and had a fall on firs shift and had been monitored. Resident # 6 wore nonskid socks and was encouraged to wear shoes for safety. Resident # 6 walked with a walker, denied pain and no bruise was identified.</p> <p>A Falls Meeting was conducted on 10/11/2017 and revealed a therapy referral was made for transfers.</p> <p>A Therapy Referral dated 10/11/2017 revealed that Resident # 6 had a recent fall or changes in gait and stability and that Resident # 6 lost her balance when she turned and physical therapy was to screen for transfers. The Therapy Screen Form revealed that Resident # 6 was at functional baseline with no decline or concern reported. No skilled physical therapy was indicated.</p> <p>A facility incident report dated 10/20/2017 at 3:45 PM revealed that Resident # 6 had lost her balance when walking in the hallway with her walker and that Resident # 6 was alert and ambulating and had an unwitnessed fall with no complaint of pain, the floor was dry with no clutter</p>	F 280			

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F 280	<p>Continued From page 5</p> <p>and shoes had been worn. No first aid was administered and there was no head injury.</p> <p>A Therapy Referral form dated 10/25/2017 revealed a physical therapy referral was needed due to loss of balance when walking in the hall with her walker.</p> <p>A Falls Meeting form dated 10/26/2017 revealed that Resident # 6 had a fall on 10/20/2017 and the intervention was for therapy to screen.</p> <p>A Nurse Note dated 10/26/2017 at 4:11 PM revealed a late entry note for 10/20/2017 at 3:45 PM when the nurse was called to the hallway area by a visitor who stated that Resident # 6 was on the floor. Resident # 6 was observed by the nurse sitting on the floor with the walker in front of her. Resident # 6 was alert and oriented and stated she had lost her balance and sat down on the floor. Resident # 6 denied any pain or injury and that she had not hit her head and was able to move her extremities without difficulty or complaint of pain. Staff assisted Resident # 6 to the dining room.</p> <p>A nurse note dated 10/26/2017 at 4:58 PM revealed a post fall multidisciplinary fall meeting was held to discuss the fall on 10/20/2017 when Resident # 6 lost her balance while ambulating in the hallway. No injuries were noted and a therapy screen was completed.</p> <p>A Therapy referral dated 10/30/2017 revealed that Resident # 6 had a fall when she walked in the hallway with her walker and had lost her balance and fell to her knees.</p> <p>An interview and observation of Resident # 6 on</p>	F 280			

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F 280	<p>Continued From page 6</p> <p>10/30/2017 at 9:54 AM revealed Resident # 6 sitting in a chair in the dining area with a front wheeled walker in front of her. Resident # 6 had shoes on her feet and denied any concerns. Resident # 6 was wearing eye glasses.</p> <p>On 10/30/2017 at 2:43 PM an interview was conducted with nurse assistant (NA) # 4 which revealed that Resident # 6 had a fall trying to sit in a chair in the dining room and that Resident # 6 needed reminders to keep her walker closer to her body when she ambulated and that Resident # 6 needed to wear nonskid socks and shoes because Resident # 6 did not like to keep shoes on and took them off many times during the day.</p> <p>On 10/31/2017 at 8:25 AM an interview was conducted with MDS Nurse #1 which revealed that the interventions for Resident # 6 were for a post fall therapy screen. MDS Nurse # 1 revealed that she was unable to verify if the therapy screens were completed and that the day after each fall, the facility held a fall meeting which was attended by the Director of Nurses (DON), the MDS Nurses and the Rehab Manager to review falls and post fall interventions. MDS Nurse #1 revealed that she had no idea why the care plan was not updated for Resident # 6 after the fall on 10/10/2017 or the fall on 10/20/2017 and that it was the responsibility of the MDS Nurses to update care plans within a day or two after the fall meeting. MDS Nurse #1 revealed that the care plan goals for Resident # 6 were inappropriate and not measurable.</p> <p>On 10/31/2017 at 9:15 AM an interview and observation conducted with Resident # 6. Resident # 6 was lying in bed and revealed that she did not recall any recent falls and if she had a</p>	F 280			

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F 280	Continued From page 7 fall, she had not been hurt. On 10/31/2017 at 10:01 AM an interview was conducted with Physical Therapist (PT) # 1 which revealed that the therapist received therapy screens 1 to 2 days after a resident had a fall and PT # 1 revealed that Resident # 6 may have been screened on 10/26/2017 for the fall on 10/10/2017 and that it had been identified that Resident # 6 had no need for skilled PT services. On 10/31/2017 at 12:34 PM an interview was conducted with the Rehab manager which revealed that falls were reported to the therapy department by the DON and that the DON would schedule a fall meeting which the Rehab Manger attended. The Rehab Manager revealed that therapy screens were usually scheduled the day after the fall meeting which was also attended by the DON and the MDS nurses. On 10/31/2017 at 3:08 PM an interview was conducted with the DON. The DON revealed that the expectation was that care plans be updated by the MDS Nurse during the fall meeting which was held the first business day after a fall. The DON revealed that she was not certain why the care plan for Resident # 6 had not been updated after either the fall on 10/10/2017 or on 10/20/2017 and that the care plans had been expected to be updated during the fall meeting when post fall interventions had been discussed.	F 280			
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that	F 309		11/24/17	

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F 309	<p>Continued From page 8</p> <p>applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.</p> <p>483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:</p> <p>(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.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to provide pain medication when requested for one of four sampled residents reviewed for administration of medications as ordered. Resident #1.</p>	F 309	<p>F 309 Resident 1 has discharged from the facility. Resident 1 was provided with pain medication within 30 minutes of request until discharge except for one known</p>		

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F 309	<p>Continued From page 9</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 9/8/17 with diagnosis including status post knee replacement, insomnia and diabetes. Review of the admission Minimum Data Set (MDS) dated 9/14/17 indicated Resident #1 had no impairment with short or long-term memory, and was assessed as having pain.</p> <p>Review of the care plan dated 9/14/17 revealed a problem of pain associated with recent knee surgery with approaches that included administration of pain medication for relief of pain.</p> <p>Review of the admission orders on 9/8/17 revealed an order for Percocet 10/325 milligrams (mg) one tablet every six hours for pain. Review of the physician orders revealed an order for Percocet 5/325 mg, 2 tablets, to be given until the Percocet 10/325 mg arrived from the pharmacy.</p> <p>Review of the Medication Administration Record revealed Resident #1 received two tablets of the Percocet 5/325 mg at 3:15 PM on 9/8/17. The next dose of pain medication was documented as being administered on 9/9/17 at 1:25 AM. The documentation by the nurse indicated Resident #1 was assessed for pain, and his level was 8 out of 10 (with 10 being the most severe pain).</p> <p>Review of a concern form dated 9/11/17 revealed Resident #1 informed the administration he had not received pain medication. A written statement by Nurse #4 was attached to the concern form. Nurse #4 indicated she was aware Resident #1 had requested pain medication at the change of the shift. Nurse #4 gave the reason for the delay</p>	F 309	<p>instance.</p> <p>The nurse did not prioritize the administration of pain meds. All nurses were in serviced on the importance of administering pain medication within 30 minutes of request as well as treating pain management as a priority by 11/25/17. In addition, the use of medication aides to assist in timeliness of medication administration was initiated by 11/1/17.</p> <p>The DON (or designee) will monitor 10% of the administration of PRN medications weekly for 90 days then monthly for the next 90 days and she will report findings to the monthly QAA through May 2018. Monitoring will be through review of Medication Administration records, grievances and patient interview.</p>		

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F 309	Continued From page 10 in administering the pain medication was due to working on two nursing units that shift. She provided a written explanation indicating another resident had required care and she was not able to give the medication until 1:25 AM. The time the resident waited for the medication was 2 hours and 40 minutes. Interview with nurse #1 on 11/1/17 at 12:50 PM revealed that she didn ' t know the resident needed a pain pill. She stated she had asked him several times during the evening if he was ok and he stated he was. He had also slept off and on throughout the evening and did not seem to be in pain. Nurse #1e stated that she was making a round at 10:45pm and Resident #1 stated he needed a pain pill and asked why he hadn ' t gotten one and she explained to him that the med was prn and he had to ask for it. She stated that the 11p-7a nurse was taking over for her so she asked her to give him a pain pill and she stated she would. Attempts to contact Nurse #4, who worked 11-7 on 9/8/17 were made by phone. Nurse #4 was not available for interview. Interview with the Director of Nursing on 11/1/17 at 3:00 PM revealed she would expect nurses to administered pain medication as soon as possible and according to the physician ' s orders.	F 309			
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1) (f) Medication Errors. The facility must ensure that its-	F 332		11/24/17	

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F 332	<p>Continued From page 11</p> <p>(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review and staff and consultant pharmacist interviews the facility failed to ensure one resident (Resident #4) of four sampled residents for medication review received Lasix (fluid pill) every day as ordered for congestive heart failure.</p> <p>The findings included:</p> <p>Resident #4 was admitted to the facility on 2/22/17 with diagnoses including congestive heart failure (CHF) and diabetes. Review of the medical record revealed an order dated 6/7/17 for Lasix 20 milligrams (mg) one tablet every day for CHF.</p> <p>Review of the Medication Administration Records (MARs) for the months of June 2017 to October 2017 revealed Lasix had been administered every other day.</p> <p>Interview with the Director of Nursing on 10/31/17 at 7:30 PM revealed she was not aware the medication was not being given as ordered. During the interview, she explained there had been an error in transcription from the old electronic charting system and the new electronic system. The DON explained she would inform the nurse practitioner of the error.</p> <p>Interview with the consultant pharmacist on 11/1/17 at 1:38 PM revealed there had been ongoing issues with the new electronic MAR system. She explained she tried to catch them during her reviews, but the switch in computer</p>	F 332	<p>F332 Resident #4 was seen by a cardiologist who kept the resident on every other day dosage. (completed by 11/1/17) There was a transcription error when entering medications into the new data base A 100% audit was completed on all medication reviewed for correct order entry. (completed 11/6/17) All nurses will be in serviced on order entry (completed 11/25/17). A second check of all orders will be completed by the 11-7 shift daily. The DON (or designee) will check a minimum of 50% of all new orders daily for 2 weeks (completed 11/24/17) then 20% of new orders weekly for 90 days and then 10% monthly for 3 months. Results will be reported to the QAA each month through May, 2018.</p>		

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NAME OF PROVIDER OR SUPPLIER ASHTON HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301		
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F 332	Continued From page 12 programs had been an issue. Interview with the Director of Nursing on 11/1/17 at 1:48 PM revealed the nurse practitioner said to leave the medication as every other day due to he was stable on that dosage. She further explained Resident #4 had been seen by the cardiologist and was stable with no changes in any medications.	F 332			
F 333 SS=D	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and consultant pharmacist interview the facility had a significant medication error for a resident (Resident #7) who did not receive Keppra (anticonvulsant) twice a day on four days in October 2017. This was for one of four sampled residents for medication errors. The findings included: Resident #7 was admitted to the facility on 12/29/16 with diagnosis that included traumatic brain injury and seizure disorder. Review of the current physician orders for October 2017 included Keppra 500 milligrams mg) take one tablet by mouth every 12 hours for seizures. Take along with 1000 mg tablet for a	F 333	F 333 Resident #7's order was corrected in the medication administration system by Nov.1, 2017. There was a transcription error when entering medications into the new database. A 100% audit was completed on all medications for correct order entry. (Completed by 11/6/17) All nurses will be in-serviced on order entry (completed by 11/25/17). A second check of all orders will be completed by the 11-7 shift daily. The DON (or designee) will check a minimum of 50% of all new orders x 2 weeks (completed by 11/24/17) then 20%	11/24/17	

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F 333	<p>Continued From page 13 total dose of 1500 mg.</p> <p>Review of the October 2017 Medication Administration Record (MAR) for the documentation of the administration of Keppra revealed an asterisk was present for the morning and evening doses on 10/6, 10/13, 10/20 and 10/27/17. Review of the nurses ' notes section of the MAR revealed no explanation for the missed doses of Keppra. Review of the nurses ' progress notes in the electronic record revealed no explanation for the missed doses.</p> <p>Interview with Nurse #5 on 10/31/17 at 4:45 PM revealed she was not aware Resident #7 had not received the Keppra on day shift. She had worked on the morning of all four of the dates he had not received the medication. Nurse #5 explained the medication administration system was electronic. The computer brings up the medications that are ordered for the 9:00 AM doses. The Keppra was not showing as a medication he was supposed to have. She further explained, without a paper copy, she would not know the medication was ordered to be given on those dates. The explanation provided indicated there must have been a "glitch" in the computer system.</p> <p>Interview with the Director of Nursing (DON) on 11/1/17 at 1:15 PM revealed she was not aware a medication error had occurred for Resident #7, when he did not receive his Keppra. The electronic documentation system had changed from one company to another in June 2017. When the order was entered into the new system, it blocked out every Friday morning and evening dose. The DON further explained a review of the orders had been completed and a third check had</p>	F 333	<p>of new orders weekly for 90 days and then 10% monthly for 3 months. Results will be reported to the QAA each month through May 2018.</p>		

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F 333	Continued From page 14 been added, but this order had been missed. During the interview she indicate Resident #7 had not experienced any seizure activity and his blood level of the drug remained stable.	F 333			
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 514		11/24/17	

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F 514	<p>Continued From page 15</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to maintain accurate Medicine Administration Records for 3 of 4 residents. Resident #1's Medication Administration Record revealed inaccurate times that medications were given, Resident #7 's Medication Administration Record revealed inaccurate transcription of an order, missing dose administrations of insulin and finger stick blood sugars, and Resident #4's Medication administration Record revealed inaccurate transcription of an order.</p> <p>The findings included:</p> <p>1. Resident #1 was admitted to the facility on 9/8/17 with diagnosis of after care of joint replacement surgery right knee surgery, lack of coordination, hypertension, insomnia, and diabetes mellitus 2. Resident #1 was discharged in the care of a family member on 9/20/17. Review of the admission Minimum Data Set dated 9/14/17 revealed Resident #1 had a Brief Interview for Mental Status score indicating he was cognitively intact. The Admission Minimum Data Set also revealed Resident #1 required extensive assistance of two staff members for bed mobility; limited assistance of one staff member for transfers, dressing, toileting, personal</p>	F 514	<p>F 514</p> <p>Resident 1 has medications documented at the appropriate time. Resident's #4 and #7 medication</p> <p>Resident 1 has medications documented at the appropriate time. Resident's #4 and #7 medication dosing times were corrected by 10/31/17.</p> <p>For resident #1, the medication administration software allows the nurses to prepare and give medications and then come back later to sign that they were given, and this is the reason the time stamp appeared that the medication was given late. For residents #4 and #7, the interval codes were not entered correctly into the computer system resulting in missed doses.</p> <p>All nurses were in-serviced by the director of nurses on the need to sign medications as completed at the time given so as not to document them as appearing late. The staff was also in-serviced on correct order entry (completed by 11/25/17) including checking the back screens for each order (includes interval codes, time codes and special requirements). Any new nurses will be in serviced during</p>		

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F 514	Continued From page 16 hygiene and bathing; and could feed himself with set up of his meal tray by staff. Review of the Medication Administration Record and orders for Resident #1 for September 2017 revealed orders for Diltiazem ER 300 mg capsule every night before bed for hypertension (9 pm); Labetalol HCL 200 mg one tablet twice daily for hypertension (9 am and 9 pm); and Cozaar 100 mg one tablet daily for hypertension (9 am). On 9/8/17 the Medication Administration Record reflected Resident #1 received the 9:00 pm doses of hypertension medications at 10:46 pm. On 9/9/17 the Medication Administration Record reflected Resident #1 received the 9:00 am doses of hypertension medications at 10:51 am. On 9/9/17 the Medication Administration Record reflected Resident #1 received the 9:00 pm doses of hypertension medications at 10:51 pm. On 9/10/17 the Medication Administration Record revealed Resident #1 received the 9:00 pm dose of hypertension medication at 10:35 pm. On 9/12/17 the Medication Administration Record reflected Resident #1 received the 9:00 pm dose of hypertension medication was given at 10:10 pm. On 9/13/17 the Medication Administration Record revealed the 9:00 pm dose of hypertension medication was given at 11:11 pm. On 9/15/17 the 9:00 pm dose of hypertension medication was given at 1:06 am on 9/16/17. On 9/17/17 the 9:00 pm dose of hypertension medication was given at 11:38 pm. On 9/18/17 the Medication Administration Record revealed on 9/18/17 the 9:00 pm dose of hypertension medication was given at 11:09 pm. On 9/19/17 the Medication Administration Record revealed the 9:00 pm dose of hypertension medication was given at 10:43 pm.	F 514	orientation by the Staff Development Coordinator. A 100% audit was completed on all medications for correct order entry and completed by 11/6/17. The DON (or designee) will check 50% of new orders for 2 weeks (completed 11/24/17) then 20% weekly for 90 days and then monthly for 3 months. The facility is scheduled to stop using the current MAR software by February, 2018 and new computerized software (Point,Click, Care) to start that same month. Results will be reported to the QAA each month through May, 2018. on dosing times were corrected by 10/31/17. For resident #1, the medication administration software allows the nurses to prepare and give medications and then come back later to sign that they were given, and this is the reason the time stamp appeared that the medication was given late. For residents #4 and #7, the interval codes were not entered correctly into the computer system resulting in missed doses. All nurses were in-serviced on the need to sign medications as completed at the time given so as not to document them as appearing late. The staff was also in-serviced on correct order entry (completed by 11/25/17) including checking the back screens for each order (includes interval codes, time codes and special requirements). A 100% audit was completed on all medications for correct order entry and		

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F 514	<p>Continued From page 17</p> <p>Interview with Nurse #2 revealed she didn't recall Resident #1 ever getting his medications late for any reason. Nurse #2 stated she knew that medications must be given between one hour before and one hour after they are scheduled. Nurse #2 was assigned to Resident #1 on the 3:00 pm to 11:00 pm shift Monday through Friday. Nurse #2 stated that Resident #1 had received his blood pressure medication between 8:00 pm and 10:00 pm on each dose she had administered.</p> <p>Phone interview with Nurse #1 on 11/1/17 at 12:50 pm revealed she was the admitting nurse for Resident #1 on 9/8/17. She stated that she had given Resident #1 his hypertension medication between 8:00 pm and 8:30 pm but wasn't able to record it on the Medication Administration Record until his admission was completed in the computer. Nurse #1 stated she had checked Resident #1's orders and given him the medication that was ordered for hypertension.</p> <p>Interview with the Director of Nursing on 11/1/17 at 3:10 pm revealed the Medication Administration Soft Ware allowed the nurses to prepare and give medications and then come back later to sign that they were given, and this is the reason the time stamp appeared that the medication was given late. The Director of Nursing stated the medication should have been signed out when given to Resident #1.</p> <p>2. a. Resident #7 was admitted to the facility on 12/29/16 with diagnosis that included traumatic brain injury, seizure disorder and diabetes.</p>	F 514	<p>completed by 11/6/17.</p> <p>The DON (or designee) will check 50% of new orders for 2 weeks (completed 11/24/17) then 20% weekly for 90 days and then monthly for 3 months. The facility is scheduled to stop using the current MAR software by February, 2018 and new computerized software (Point,Click, Care) to start that same month.</p> <p>Results will be reported to the QAA each month through May, 2018.</p>		

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F 514	<p>Continued From page 18</p> <p>Review of the current physician orders for October 2017 included Keppra 500 milligrams mg) take one tablet by mouth every 12 hours for seizures. Take along with 1000 mg tablet for a total dose of 1500 mg.</p> <p>Review of the October 2017 Medication Administration Record (MAR) for the documentation of the administration of Keppra revealed an asterisk was present for the morning and evening doses on 10/6, 10/13, 10/20 and 10/27/17. Review of the nurses ' notes section of the MAR revealed no explanation for the missed doses of Keppra. Review of the nurses ' progress notes in the electronic record revealed no explanation for the missed doses.</p> <p>Interview with Nurse #5 on 10/31/17 at 4:45 PM revealed she was not aware Resident #7 had not received the Keppra on day shift. She had worked on the morning of all four of the dates he had not received the medication. Nurse #5 explained the medication administration system was electronic. The computer brings up the medications that are ordered for the 9:00 AM doses. The Keppra was not showing as a medication he was supposed to have. She further explained, without a paper copy, she would not know the medication was ordered to be given on those dates. The explanation provided indicated there must have been a "glitch" in the computer system.</p> <p>Interview with the Director of Nursing (DON) on 11/1/17 at 1:15 PM revealed she was not aware a medication error had occurred for Resident #7, when he did not receive his Keppra. The electronic documentation system had changed from one company to another in June 2017.</p>	F 514			

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F 514	<p>Continued From page 19</p> <p>When the order was entered into the new system, it blocked out every Friday morning and evening dose. The DON further explained a review of the orders had been completed and a third check had been added, but this order had been missed. During the interview she indicate Resident #7 had not experienced any seizure activity and his blood level of the drug remained stable.</p> <p>b. Review of the physician orders for the month of October revealed finger stick blood sugar checks were to be done three times a day at 7:30 AM, 11:30 AM and 4:30 PM. Sliding scale Humalog insulin dose was to be administered according to the blood sugar values.</p> <p>Review of the MAR for October 2017 revealed no blood sugar values were documented for the times/dates as follows: 7:30 AM on 10/25; 11:30 AM on 10/14, 10/22 and 10/24 and 4:30 PM on 10/22.</p> <p>Review of a blood sugar check on 10/16/17 at 11:30 AM revealed a value of 364. The order for sliding scale insulin instructed the nurse to call the physician if the blood sugar was greater than 350. Review of a physician's telephone order dated 10/16/17 revealed an order to administer Humalog insulin 10 units. Review of the MAR revealed the order was put in the computer, but there was no documentation the dose was administered.</p> <p>Interview with Nurse #5 on 10/31/17 at 4:45 PM revealed she had called the doctor, obtained the order and gave the medication. She explained the computer MAR would lock you out after a certain time if it was not documented immediately after administration. Nurse #5 explained she</p>	F 514			

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F 514	<p>Continued From page 20</p> <p>should have documented in the nurse's note the insulin was given.</p> <p>Interview with the Director of Nursing on 11/1/17 at 3:10 PM revealed the nurse should have documented the insulin was given after administration. The nurses had a paper copy of the MAR in a notebook at the nurses' desk. She explained the nurses could document hon the paper MAR the blood sugars and medications if there were problems with the computer.</p> <p>3. Resident #4 was admitted to the facility on 2/22/17 with diagnoses including congestive heart failure (CHF) and diabetes. Review of the medical record revealed an order dated 6/7/17 for Lasix 20 milligrams (mg) one tablet every day for CHF.</p> <p>Review of the Medication Administration Records (MARs) for the months of June 2017 to October 2017 revealed Lasix had been administered every other day.</p> <p>Interview with the Director of Nursing on 10/31/17 at 7:30 PM revealed she was not aware the medication was not being given as ordered. During the interview, she explained there had been an error in transcription from the old electronic charting system and the new electronic system. The DON explained she would inform the nurse practitioner of the error.</p> <p>Interview with the consultant pharmacist on 11/1/17 at 1:38 PM revealed there had been ongoing issues with the new electronic MAR system. She explained she tried to catch them during her reviews, but the switch in computer</p>	F 514			

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

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F 514	Continued From page 21 programs had been an issue.	F 514			