STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONV	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted 05/05/19 to 05/09/19. The facility was found in compliance with the requiremet CFR 483.73, Emergency Preparedness. Event ID# W7Q711.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# W7Q711.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of restraints (Residents #2, #22, #28, and #43) and diagnoses (Resident #43) for 4 of 7 residents reviewed for resident assessments. Findings included: 1. Resident #22 was admitted to the facility on 11/18/16 with multiple diagnoses that included hemiplegia (paralysis on one side of the body) following a cerebral infarction (stroke). Review of the quarterly MDS dated 01/31/19 coded Resident #22 with intact cognition and required extensive staff assistance with bed mobility and transfers. Section P0100 of the MDS was marked to indicated Resident #22 used a restraint daily and bed rail was marked as the	F 641	1. Residents identified as improper coding of section P of MDS, #22, #43,#2, #28 were reassessed with the use of side rails assessment. Side rails were determined not to be restraints and last MDS was modified and transmitted to state. 2. All residents have the potential to be affected. A complete audit was performed on all current residents, new side rail assessments were completed and consents were signed. This was completed on 5/22/2019 by Kim Cagle RN, MDS. 3. New side rail assessments will be performed and consents signed with every admit, readmit, significant change and quarterly assessment. This will be	5/31/19

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

Electronically Signed | 05/31/2019

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F 641	Continued From page 1 type of restraint utilized. During an interview on 05/08/19 at 12:30 PM, the MDS Coordinator confirmed the quarter bed rails used by Resident #22 were enablers for bed mobility and not restraints. The MDS Coordinator explained she was instructed by the corporate office to code side rails as a restraint due to Resident #22 not being able lower them down independently. She acknowledged bed rail use was incorrectly coded as a restraint for Resident #22. The MDS Coordinator added a modification would be submitted. During an interview on 05/08/19 at 2:49 PM, the Director of Nursing (DON) confirmed the MDS Coordinator was instructed by the corporate office to code bed rails as restraints. The DON added bed rails were never used as restraints, only to aid with bed mobility. She acknowledged the MDS assessment for Resident #22 was incorrectly coded and the MDS Coordinator would submit a modification. During an interview on 05/08/19 at 4:45 PM, the Administrator recalled the meeting with the corporate office regarding the coding of bed rail use and thought they had been coding the MDS assessments correctly based on the guidance received. 2. Resident #43 was admitted to the facility on 08/17/18 with multiple diagnoses that included Parkinson's disease, dementia and malignant neoplasm of the bladder. Review of the quarterly Minimum Data Set (MDS) dated 01/03/19 coded Resident #43 with severe impairment in cognition and required extensive	F 641	done by MDS nurses. Side rail assessments will be audited by MDS nurses weekly times 4 weeks, monthly times 2 months. First audit completed by Kim Cagle, MDS Coordinator, on 04/22/19. MDS nurses to complete Healthcare Academy, Section P, on Restraints Education, with passing scores completed by 05/31/19. 4. Plan of correction will be brought to QAPI for review monthly times three months by MDS nurse Kim Cagle, RN. 1. Resident #43, diagnosis for Foley catheter, was omitted on MDS. MDS was modified with correct diagnosis and modification was sent to OIES and accepted during the survey process. 2. All residents with Foley catheters have the potential to be affected. Residents with Foley catheters will be audited to ensure that correct diagnosis was present on 5/22/19 by Kim Cagle RN, MDS Coordinator. 3. Catheter justification forms will be completed by MDS nurses at residents admission, and re admission. MDS nurses will audit for appropriate catheter diagnosis on all MDS for residents with catheters weekly times four weeks, monthly times two months. First audit completed on 5/22/19 by Kim Cagle RN. 4. MDS nurses to complete section I of Health Care Academy with passing score by 6/05/19. MDS nurses will present to	

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F 641	Continued From page 2 staff assistance with bed mobility and transfers. Section P0100 of the MDS was marked to indicated Resident #43 used a restraint daily and bed rail was marked as the type of restraint utilized. Further review revealed Resident #43 had an indwelling catheter with no diagnosis indicated for its use. Review of the quarterly MDS dated 04/05/19 coded Resident #43 with severe impairment in cognition and required extensive staff assistance with bed mobility and transfers. Section P0100 of the MDS was marked to indicated Resident #43 used a restraint daily and bed rail was marked as the type of restraint utilized. Further review revealed Resident #43 had an indwelling catheter with no diagnosis indicated for its use. During an interview on 05/08/19 at 12:30 PM, the MDS Coordinator confirmed the quarter bed rails used by Resident #43 were enablers for bed mobility and not restraints. The MDS Coordinator explained she was instructed by the corporate office to code side rails as a restraint due to Resident #43 not being able lower them down independently. She acknowledged bed rail use was incorrectly coded as a restraint for Resident #43. The MDS indicated she overlooked the diagnosis of neurogenic bladder in Resident #43's medical record and missed coding it on the MDS. She added a modification would be submitted. During an interview on 05/08/19 at 2:49 PM, the Director of Nursing (DON) confirmed the MDS Coordinator was instructed by the corporate office to code bed rails as restraints. The DON added bed rails were never used as restraints, only to aid with bed mobility. She acknowledged the MDS assessments for Resident #43 were	F 641	QAPI times 3 months by Kim Cagle RN, MDS Coordinator.	

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F 641	Continued From page 3	F 641		

incorrectly coded for restraints and added she would also expect for the MDS assessments to accurately reflect his diagnoses for catheter use.

During an interview on 05/08/19 at 4:45 PM, the Administrator recalled the meeting with the corporate office regarding the coding of bed rail use and thought they had been coding the MDS assessments correctly based on the guidance received.

3. Resident #2 was admitted to the facility on 5/27/19 with diagnoses which included Non-Alzheimer's dementia and cerebral infarction.

The quarterly Minimum Data Set (MDS) dated 1/19/19 revealed that Resident #2 was moderately cognitively impaired and was coded for extensive two person assist with bed mobility and transfers. The MDS further revealed that Resident #2 was coded in Section P Restraints for daily use of bed rails as a restraint.

An interview with the MDS Coordinator on 5/9/19 at 10:28 AM indicated she coded Section P Restraints for daily bed rail use as a restraint. She further stated she had been instructed to code side rails as a restraint due to Resident #2 not being able to put them down independently. She confirmed the bed rails were quarter bed rails and were never used as a restraint. The MDS Coordinator also stated this was a coding error and she would correct it.

An interview with the Director of Nursing (DON) on 5/08/19 at 2:49 PM indicated the MDS Coordinator was instructed by their corporate office on how to code bed rails. She also

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F 641	Continued From page 4	F 641		

confirmed that bed rails were not used as a restraint for Resident #2. The DON indicated the MDS Coordinator would correct the coding for the bed rails.

An interview with the Administrator on 5/08/19 at 4:45 PM indicated he was aware the MDS Coordinator had been instructed to code the use of bed rails as a restraint and thought it was being coded correctly. He further stated the corporate office must have misunderstood the regulation and instructed them incorrectly and this would be corrected.

4. Resident #28 was admitted to the facility on 2/9/19 with diagnoses which included history of falling and right femur fracture.

The quarterly Minimum Data Set (MDS) dated 4/24/19 revealed that Resident #28 was cognitively intact and was coded for extensive assist with bed mobility and transfers. The MDS further revealed that Resident #28 was coded in Section P Restraints for daily use of bed rails as a restraint.

An interview with the MDS Coordinator on 5/9/19 at 10:28 AM indicated she coded Section P Restraints for daily bed rail use as a restraint. She further stated she had been instructed to code side rails as a restraint due to Resident #28 not being able to put them down independently. She confirmed the bed rails were quarter bed rails and were never used as a restraint. The MDS Coordinator also stated this was a coding error and she would correct it.

An interview with the Director of Nursing (DON) on 5/08/19 at 2:49 PM indicated the MDS

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F 641	Continued From page 5 Coordinator was instructed by their corporate office on how to code bed rails. She also confirmed that bed rails were not used as a restraint for Resident #28. The DON indicated the MDS Coordinator would correct the coding for the bed rails. An interview with the Administrator on 5/08/19 at 4:45 PM indicated he was aware the MDS Coordinator had been instructed to code the use of bed rails as a restraint and thought it was being coded correctly. He further stated the corporate office must have misunderstood the regulation and instructed them incorrectly and this would be corrected.	F 641		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		5/31/19

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F 758	Continued From page 6 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, Physician's interview, and staff interviews the facility failed to ensure physician's orders for a psychotropic medication, Lorazepam, were time limited in duration for 1 of 5 residents reviewed for unnecessary medication use (Resident #48). Findings included: Resident #48 was admitted to the facility on 12/13/18 with diagnoses which included	F 758	1. Resident #48 was found to have an order for Ativan with no stop date. Resident #48 was under services of Hospice and the Hospice MD. Immediate correction was completed by Hospice clinician/MD. New order received with stop date and documentation received for reasoning/continuation of Ativan. Immediate education was conducted by Hospice clinician to Hospice staff and then Hospice coordinated and shared	

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F 758	Continued From page 7 Parkinson's disease, depression, Post Traumatic Stress Disorder (PTSD), and adjustment disorder with mixed anxiety and depressed mood. The Hospice Physician's progress note dated 04/19/19 included the current Lorazepam orders for 1 mg (milligram) tab at 8:00 PM each evening and 0.5 mg every 2 hours prn (as needed) for acute episodes of agitation or anxiety without a duration date. Review of the Hospice Physician's order dated 04/19/19 revealed an order for Lorazepam 0.5 mg by mouth every 2 hours prn for anxiety. A review of Resident #48's Medication Administration Records (MARs) for April 19, 2019 to May 6, 2019 revealed per staff documentation on the MARs that Resident #48 had received 13 prn doses of Lorazepam in April and 5 prn doses in May 2019. Interview with the Hospice Nurse on 05/07/19 at 9:27 AM revealed she was aware of the Centers for Medicaid and Medicare Service (CMS) regulation for a duration date on prn psychotropic medications but stated this was something new for them to ensure was included on the physician's orders. Interview with the Physician on 05/08/19 at 12:47 PM revealed she was aware of the Lorazepam prn order for Resident #48 and was also aware of the CMS regulation for duration dates on prn psychotropic medications. She further revealed she was not sure why it was not being done, but stated it was just an oversight that there was no duration date on the prn Lorazepam.	F 758	education verification with Life Care Nursing Administration. 2. 100% of all residents have the potential to be affected. An audit was completed to determine those on PRN psychotropic medications to determine if any had orders without stop dates. If any were identified, new order was written with documentation supporting what and why medication needed to be continued. 3. 100% of licensed staff educated on guidelines of PRN psychotropic medications and the 14 day compliance of anti-psychotic medications. Education included that documentation by FNP or MD must support the continued need including benefits of the medication. All licensed staff was educated on this process by 5/31/19. All new hires will be educated during clinical orientation. DON, ADON or Designee will review PRN meds during clinical Grand Rounds and document results on an audit sheet 5 times weekly. Audits to begin Monday, June 3, 2019. Nursing to assure all psychotropic PRN meds have a stop date and supporting documentation. 4. DON, ADON or Designee will perform audits 5 times weekly for one month; 3 times weekly for one month; and one time weekly times one month. DON, ADON or Designee will present Audit results to QAPI committee monthly times 3 months to review and evaluate effectiveness of the system change.	

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F 758	Continued From page 8 Interview with the Director of Nursing (DON) on 05/07/19 at 10:44 AM revealed she was aware of the CMS regulation for a duration date on prn psychotropic medication orders but was unaware that the hospice physician was not writing duration dates for Resident #48's prn Lorazepam. She further revealed she would contact the Hospice Nurse to discuss plans for correction. Interview with the Administrator on 05/08/19 at 2:00 PM revealed he was unaware the physicians were not including a duration date for prn psychotropic medications when writing orders.	F 758		
F 842 SS=F	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(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 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842		5/31/19

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regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(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;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed

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F 842	Continued From page 10 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately document the administration of as needed (PRN) narcotic medication on the medication administration record for 5 of 5 residents reviewed for medical record accuracy (Resident #18, #20, #57, #58, and #116). Findings included: 1. Resident #18 was admitted to the facility on 07/06/15 with multiple diagnoses that included chronic pain. Review of Resident #18's medical record revealed the following physician orders: 05/15/18 read, "Norco (pain medication) 5 milligram (mg)-325mg one tablet twice daily at 8:00 AM and 8:00 PM for chronic pain. Do not exceed 3 grams of acetaminophen from all sources in 24 hours. Generic: Hydrocodone-acetaminophen." 06/04/18 read, "Norco 5mg-325mg one tablet every 6 hours PRN pain. Do not exceed 3 grams of acetaminophen from all sources in 24 hours. Generic: Hydrocodone-acetaminophen." Review of Resident #18's Controlled Medication Utilization Record (CMUR) dated 07/19/18 indicated in addition to the scheduled doses of hydrocodone-acetaminophen, she was also administered PRN doses on 08/06/18 at 11:30 AM and 5:30 PM, 08/10/18 at 1:00 PM, 08/21/18 at 10:00 AM, 08/22/18 at 3:00 PM, 08/23/18 at	F 842	1. Resident #116 is no longer in the facility. Resident #18, 20, 57 and 58 currently reside at Life Care. Due to policy of late documentation, this could not be corrected. 2. All residents with controlled medicines have the potential to be affected. 100% of resident MARs in controlled medication utilization records (CMUR) were audited to determine if nurses were documenting use of PRN narcotics and also if PRN narcotics were being signed out on the CMUR properly. 3. Systemic changes that occurred were 100% educated to licensed nurses on the Medication Administration Policy and documentation on MARS, CMURs and PRN Flow sheets. Education completed by DON, ADON and/or SDC on 10/15/18 with re-education of all licensed nurses completed by 5/31/19. All new licensed nurse associates will be educated upon hire. Paper MARs converted to Point Click Care (PCC) in November of 2018. Audit tool developed to monitor all med orders including narcotics to assure meds have been properly signed out in PCC. Follow up documentation concerning pain levels are also documented in PCC. Monitoring of CMUR to assure documentation is being completed properly. These audits will be conducted 5 times weekly by DON, ADON or Designee. The audits began 6/1/19. Master signature sheet was	

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F 842	Continued From page 11 9:00 AM, 1:15 PM and 6:00 PM, 08/24/18 at 9:30 AM, 1:00 PM and 6:00 PM, 08/27/18 at 6:00 AM, 12:00 PM and 5:45 PM, and 08/28/18 at 12:30 PM and 6:00 PM. Review of Resident #18's Medication Administration Record (MAR) for the month of August 2018 revealed hydrocodone-acetaminophen PRN was documented as being administered on 08/06/18. There was no documentation of hydrocodone-acetaminophen PRN being administered on 08/10/18, 08/21/18, 08/22/18, 08/23/18, 08/24/18, 08/27/18, or 08/28/18. Review of the significant change Minimum Data Set (MDS) dated 08/31/18 coded Resident #18 with intact cognition. The MDS indicated Resident #18 received scheduled pain medication daily during the MDS 7-day assessment period. Further review revealed she received no PRN pain medication. During an interview on 05/07/19 at 3:30 PM and follow-up interview on 05/08/19 at 2:49 PM, the Director of Nursing (DON) stated in September 2018 they audited all physician orders to "fine tune their processes" for monitoring narcotic medications and discovered there was an issue with nurse documentation. The DON explained they did not have a nursing staff signature sheet to confirm which nurse signed the CMUR when the narcotic medication was administered to Resident #18. She added they reviewed the staffing schedules to determine which nurse worked the medication cart on the hall Resident #18 resided for the dates and times the PRN narcotic medication was administered, and concluded Nurse #1 administered most of the	F 842	created for licensed nurses' signatures to be kept in each narcotic book and an additional one at each nurses' station. Signature sheet will be updated with each new hire and/or termination. 4. DON, ADON or Designee will monitor audit sheets 5 times weekly for one month, 3 times weekly for one month, and one time weekly for one month. The results of the monitoring will be taken to the QAPI committee times 3 months for review and evaluation.	

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doses. She further added Nurse #1 signed the CMUR for Resident #18 when the PRN doses of hydrocodone-acetaminophen were administered but did not document it on Resident #18's MAR. The DON stated she would expect for the administration of all narcotic medication to be signed out on the CMUR and documented on the MAR.

Nurse #1 was no longer employed by the facility. Telephone attempts to interview Nurse #1 were unsuccessful.

An interview with the Administrator on 05/08/19 at 4:45 PM revealed he expected for nursing staff to document on the MAR to accurately reflect when medication was administered per physician orders.

2. Resident #20 was admitted to the facility on 08/30/16 with multiple diagnoses that included diabetes, acquired absence of left leg below knee and chronic pain.

Review of Resident #20's medical record revealed the following physician orders:
12/05/17 read, "Norco 5mg-325mg one tablet every 8 hours PRN pain. Do not exceed 3 grams of acetaminophen from all sources in 24 hours. Generic: Hydrocodone-acetaminophen."
02/01/18 read, "Norco (pain medication) 5 milligram (mg)-325mg one tablet daily at 8:00 PM for chronic pain. Do not exceed 3 grams of acetaminophen from all sources in 24 hours. Generic: Hydrocodone-acetaminophen."

Review of Resident #20's Controlled Medication Utilization Record (CMUR) dated 07/31/18 indicated in addition to the scheduled doses of

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hydrocodone-acetaminophen, she was also administered PRN doses on 08/06/18 at 4:00 PM, 08/21/18 at 12:00 PM, 08/22/18 at 12:00 PM, 08/24/18 at 1:00 PM and 3:00 PM, 08/27/18 at 4:00 PM, 08/28/18 at 2:30 PM and 10:00 PM, and 08/30/18 at 7:30 AM.

Review of Resident #20's Medication Administration Record (MAR) for the month of August 2018 revealed hydrocodone-acetaminophen PRN was documented as being administered on 08/29/18. There was no documentation of hydrocodone-acetaminophen PRN being administered on 08/10/18, 08/21/18, 08/22/18, 08/23/18, 08/24/18, 08/27/18, 08/28/18, or 08/30/18.

Review of the annual Minimum Data Set (MDS) dated 09/02/18 coded Resident #20 with intact cognition. The MDS indicated Resident #20 received scheduled pain medication daily during the MDS 7-day assessment period. Further review revealed she received no PRN pain medication.

During an interview on 05/07/19 at 3:30 PM and follow-up interview on 05/08/19 at 2:49 PM, the Director of Nursing (DON) stated in September 2018 they audited all physician orders to "fine tune their processes" for monitoring narcotic medications and discovered there was an issue with nurse documentation. The DON explained they did not have a nursing staff signature sheet to confirm which nurse signed the CMUR when the narcotic medication was administered to Resident #20. She added they reviewed the staffing schedules to determine which nurse worked the medication cart on the hall Resident

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#20 resided for the dates and times the PRN narcotic medication was administered, and concluded Nurse #1 administered most of the doses. She further added Nurse #1 signed the CMUR for Resident #20 when PRN doses of hydrocodone-acetaminophen were administered but did not document it on Resident #20's MAR. The DON stated she would expect for the administration of all narcotic medication to be signed out on the CMUR and documented on the MAR.

Nurse #1 was no longer employed by the facility. Telephone attempts to interview Nurse #1 were unsuccessful.

An interview with the Administrator on 05/08/19 at 4:45 PM revealed he expected for nursing staff to document on the MAR to accurately reflect when medication was administered per physician orders.

3. Resident #57 was admitted to the facility on 06/30/17 with multiple diagnoses that included Alzheimer's, dementia and unspecified pain.

Review of Resident #57's medical record revealed the following physician orders:
06/30/17 read, "Hydrocodone 5 milligram (mg)-acetaminophen 325mg one tablet every 4 hours PRN chronic pain. Do not exceed 3 grams of acetaminophen from all sources in 24 hours."
07/03/17 read, "Norco 5mg-325mg one tablet every 8 hours for chronic pain at 6:00 AM, 2:00 PM and 10:00 PM. Do not exceed 3 grams of acetaminophen from all sources in 24 hours. Generic: Hydrocodone-acetaminophen."

Review of Resident #57's Controlled Medication

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Utilization Record (CMUR) dated 08/06/18 indicated in addition to the scheduled doses of hydrocodone-acetaminophen, she was also administered PRN doses on 08/17/18 at 1:30 AM, 08/19/18 at 2:00 AM, 08/21/18 at 9:00 AM, 4:00 PM and 8:15 PM, 08/23/18 at 7:20 AM, 11:00 AM and 4:00 PM, 08/24/18 at 8:00 AM, 11:45 AM and 3:45 PM, 08/27/18 at 8:00 AM, 11:30 AM, 1:00 PM, 6:00 PM and 9:00 PM, and 08/28/18 at 1:45 AM, 7:30 AM, 10:45 AM, 3:15 PM, 7:00 PM and 11:00 PM.

Review of Resident #57's Medication Administration Record (MAR) for the period 08/14/18 to 08/31/18 revealed hydrocodone-acetaminophen PRN was documented as being administered on 08/18/18, 08/19/18 and 08/28/18. There was no documentation of hydrocodone-acetaminophen PRN being administered on 08/21/18, 08/23/18, 08/24/18, or 08/27/18.

Review of the quarterly Minimum Data Set (MDS) dated 04/15/19 coded Resident #57 with moderate impairment in cognition. The MDS indicated Resident #57 received scheduled pain medication daily during the MDS 7-day assessment period. Further review revealed she received no PRN pain medication.

During an interview on 05/07/19 at 3:30 PM and follow-up interview on 05/08/19 at 2:49 PM, the Director of Nursing (DON) stated in September 2018 they audited all physician orders to "fine tune their processes" for monitoring narcotic medications and discovered there was an issue with nurse documentation. The DON explained they did not have a nursing staff signature sheet to confirm which nurse signed the CMUR when

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the narcotic medication was administered to Resident #57. She added they reviewed the staffing schedules to determine which nurse worked the medication cart on the hall Resident #57 resided for the dates and times the PRN narcotic medication was administered, and concluded Nurse #1 administered most doses. She further added Nurse #1 signed the CMUR for Resident #57 when PRN doses of hydrocodone-acetaminophen were administered but did not document it on Resident #57's MAR. The DON stated she would expect for the administration of all narcotic medication to be signed out on the CMUR and documented on the MAR.

Nurse #1 was no longer employed by the facility. Telephone attempts to interview Nurse #1 were unsuccessful.

An interview with the Administrator on 05/08/19 at 4:45 PM revealed he expected for nursing staff to document on the MAR to accurately reflect when medication was administered per physician orders.

4. Resident #58 was admitted to the facility on 04/07/18 with multiple diagnoses that included dementia, anxiety and chronic pain.

Review of Resident #58's medical record revealed a physician order dated 05/03/18 that read, "Oxycodone (pain medication) 5 milligram (mg) every 4 hours PRN pain." This order was discontinued on 09/14/18.

Review of Resident #58's Controlled Medication Utilization Record (CMUR) dated 04/17/18 indicated she was administered 27 PRN doses of

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Oxycodone on the following dates: 06/05/18 at 7:00 AM, 12:00 PM and 6:00 PM, 6/19/18 at 7:30 AM, 11:15 AM, 2:45 PM and 6:00 PM, 6/28/19 at 10:00 AM, 06/29/18 at 2:00 PM, 08/21/18 at 9:00 AM, 1:15 PM and 9:00 PM, 08/23/18 at 8:30 AM, 12:00 PM and 5:45 PM, 08/24/18 at 7:00 AM, 12:00 PM and 6:00 PM, 08/27/18 at 7:00 AM, 11:00 AM, 3:00 PM, 6:45 PM and 10:30 PM, and 08/28/18 at 7:00 AM, 11:00 AM, 3:00 PM and 7:00 PM.

Review of Resident #58's CMUR dated 05/04/18 indicated she was administered 5 doses of PRN Oxycodone on 08/28/18 at 7:15 AM, 10:45 AM, 2:30 PM, 6:00 PM and 9:45 PM.

Review of Resident #58's Medication Administration Records (MARs) for June 2018, July 2018 and August 2018 revealed the order for Oxycodone 5 mg every 4 hours PRN pain had not been transcribed to the MARs.

Review of the annual Minimum Data Set (MDS) dated 04/15/19 coded Resident #58 with severe impairment in cognition. The MDS indicated Resident #58 received scheduled pain medication daily during the MDS 7-day assessment period. Further review revealed she received no PRN pain medication.

During an interview on 05/07/19 at 3:30 PM and follow-up interview on 05/08/19 at 2:49 PM, the Director of Nursing (DON) stated they had discovered the physician's order for Resident #58's Oxycodone was accidentally left off the June 2018, July 2018 and August 2018 MARs and the narcotics had remained in the locked medication cart. The DON added in September 2018 they audited all physician orders to "fine

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tune their processes" for monitoring narcotic medications and discovered there was an issue with nurse documentation. The DON explained they did not have a nursing staff signature sheet to confirm which nurse signed the CMUR when the narcotic medication was administered to Resident #58. She added they reviewed the staffing schedules to determine which nurse worked the medication cart on the hall Resident #58 resided for the dates and times the PRN narcotic medication was administered and concluded it was Nurse #1. She further added Nurse #1 signed the CMUR for Resident #58 when the PRN doses of Oxycodone were administered but did not document them on the MAR since there was no order for the Oxycodone. The DON stated she would expect for the administration of all narcotic medication to be signed out on the CMUR, have a corresponding physician's order and documented on the MAR.

Nurse #1 was no longer employed by the facility. Telephone attempts to interview Nurse #1 were unsuccessful.

An interview with the Administrator on 05/08/19 at 4:45 PM revealed he expected for nursing staff to document on the MAR to accurately reflect when medication was administered per physician orders.

5. Resident #116 was admitted to the facility on 06/11/18 with multiple diagnoses of emphysema, pain in left arm and cancer.

Review of Resident #116's medical record revealed a physician order dated 08/09/18 that read in part, "Oxycodone (pain medication) 5

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milligram (mg) every 4 hours PRN pain."

Review of Resident #116's Controlled Medication Utilization Record (CMUR) dated 08/10/18 indicated she was administered 28 PRN doses of Oxycodone for the month of August 2018 on the following dates: 08/12/18 at 6:00 PM, 08/15/18 at 9:10 PM, 08/21/18 at 7:15 AM, 08/22/18 at 11:00 AM, 5:30 PM and 9:45 PM, 08/23/18 at 8:00 AM, 12:00 PM, 6:00 PM and 10:00 PM, 08/24/18 at 7:00 AM, 11:00 AM, 2:45 PM and 6:30 PM, 08/27/18 at 6:45 AM, 10:00 AM, 2:00 PM, 5:45 PM and 9:30 PM, 08/28/18 at 7:00 AM, 10:15 AM, 2:15 AM, 5:30 PM and 9:00 PM, 08/30/18 at 5:00 PM and 10:00 PM, and 08/31/18 at 3:30 PM and 8:00 PM.

Review of Resident #116's Medication Administration Record (MAR) for August 2018 revealed PRN doses of Oxycodone were documented as administered on 08/09/18, 08/12/18, 08/15/18, 08/21/18, 08/30/18, and 08/31/18. There was no documentation noted for the doses administered on 08/22/18, 08/23/18, 08/24/18, 08/27/18, or 08/28/18.

Review of the significant change Minimum Data Set (MDS) dated 09/22/18 coded Resident #116 with moderate impairment in cognition. The MDS indicated Resident #116 received no scheduled pain medication but did received PRN pain medication daily during the 7-day MDS assessment period.

During an interview on 05/07/19 at 3:30 PM and follow-up interview on 05/08/19 at 2:49 PM, the Director of Nursing (DON) stated on 09/21/18 they audited all physician orders to "fine tune their processes" for monitoring narcotic medications

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and discovered there was an issue with nurse documentation. The DON explained they did not have a nursing staff signature sheet to confirm which nurse signed the CMUR when the narcotic medication was administered to Resident #116. She added they reviewed the staffing schedules to determine which nurse worked the medication cart on the hall Resident #116 resided for the dates and times the PRN narcotic medication was administered and concluded it was Nurse #1 who had administered most of the doses. She further added Nurse #1 signed the CMUR for Resident #116 when the PRN doses of oxycodone were administered but did not document it on Resident #116's MAR. The DON stated she would expect for the administration of all narcotic medication to be signed out on the CMUR and documented on the MAR.

Nurse #1 was no longer employed by the facility. Telephone attempts to interview Nurse #1 were unsuccessful.

An interview with the Administrator on 05/08/19 at 4:45 PM revealed he expected for nursing staff to document on the MAR to accurately reflect when medication was administered per physician orders.