STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. BUILDING _____ B. WING _____	C 11/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews the facility failed to prevent medication errors when medications were not administered as ordered between 7:00 AM and 3:00 PM on 10/26/19 and/or on 10/27/19 for 4 of 27 sampled residents reviewed for medication errors (Residents #5, 8, 21 and 22). Findings included: 1. Resident #5 was admitted to the facility on 10/9/11 with diagnoses including hypertension and diabetes. Review of the 5-day Minimum Data Set (MDS) assessment dated 10/16/19 revealed Resident #5 was able to make his own decisions about activities of daily living. Review of the physician orders revealed an order for Lisinopril 10mg daily for blood pressure. Review of the Medication Administration Record (MAR) revealed Lisinopril 10 mg, scheduled for 9:00 AM, was not documented as given on 10/26/19 and 10/27/19. No blood pressure readings were noted on the MAR. An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1	F 658	University Place Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction as required by Federal and State regulations and statutes applicable to long term care providers. This plan does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute an agreement by the facility that the surveyor□s findings or conclusions are accurate, that the findings constitute a deficiency, or the scope or severity regarding any of the deficiencies cited are correctly applied. F658 The plan of correcting the specific deficiency By 11/1/19 resident # 5 was assessed by facility licensed nurse with no negative effects related to the medication documentation error, failure to follow care plan. By 11/1/19 resident # 8 was assessed by facility licensed nurse with no negative	11/21/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/20/2019

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F 658	Continued From page 1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #5 on 10/26/19 and 10/27/19. An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications. An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19 on 1000 hall after the scheduled nursed refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she heard nothing from the nurses. The DON stated she did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed she was made aware of the staffing issue on Sunday 10/27/19 in the afternoon and contacted the DON. She confirmed there was a misunderstanding between the DON and Nurse #1 on duty during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant	F 658	effects related to the medication documentation error, failure to follow care plan. By 11/1/19 resident # 21 was assessed by facility licensed nurse with no negative effects related to the medication documentation error, failure to follow care plan. By 11/1/19 resident # 22 was assessed by facility licensed nurse with no negative effects related to the medication documentation error, failure to follow care plan. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 11/1/19 the director of nursing and assistant director of nursing audited the medication administration records for residents on affected assignment 1000 hall for medication documentation errors. Audit revealed no negative resident outcomes, based on facility nurse assessment of affected residents. Systemic change On 10/30/19 the director of nursing completed an in-service with licensed nurses on medication administration including adherence to medication administration times, and documenting medications as ordered, included in the care plan, to prevent the medication errors. On 11/1/19 the director of nursing started an in-service with licensed nurses on acceptance and completion of assignments, including communicating	

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F 658	Continued From page 2 the DON worked the hall, so that medications would be administered as ordered by the physician. 2. Resident #8 was admitted to the facility on 4/28/16 with diagnoses including hypertension. Review of the quarterly MDS dated 9/26/19 revealed Resident #8 had short term and long-term memory loss and was unable to make decisions about activities of daily living. Review of the physician orders revealed an order dated 4/28/16 for Lisinopril 20 mg one tablet daily. Review of the MAR revealed Lisinopril 20 mg scheduled at 8:30 AM was not documented as given on Saturday 10/26/19 and Sunday 10/27/19. Resident's blood pressure was checked weekly on Tuesdays. An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #8 on 10/26/19 and 10/27/19. An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.	F 658	concerns or inability to complete with nurse management. Both in-services were completed by 11/1/19. These in-services were added to the orientation for newly hired licensed nurses. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, assistant director of nursing, unit manager, and/or staff facilitator will audit medication administration records, including 1000 hall, weekly x 12 weeks to ensure medications are administered and documented according to the order and care plan. This audit will be documented on the MAR audit tool. The monthly quality improvement (QAPI) committee will review the results of the MAR audit tools for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QAPI committee to the quarterly executive quality improvement performance improvement (QAPI) committee for further recommendations and oversight.	

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An interview, conducted with the DON and ADON on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19 on 1000 hall after the scheduled nursed refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she heard nothing from the nurses. The DON stated she did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed she was made aware of the staffing issue on Sunday 10/27/19 in the afternoon and contacted the DON. She confirmed there was a misunderstanding between the DON and Nurse #1 on duty during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

3. Resident #21 was admitted to the facility on 7/13/18 with diagnoses including hypertension. Review of the quarterly MDS dated 9/12/19 revealed Resident #21 had short term and long-term memory loss and was unable to make decisions about his activities of daily living.

Review of the physician orders revealed an order dated 1/25/19 for Lisinopril 2.5 mg one tablet daily for high blood pressure.

Review of the MAR revealed Lisinopril 2.5 mg,

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F 658	Continued From page 4	F 658		

scheduled at 8:00 AM, was not documented as given on 10/27/19. On 10/25/19, resident's blood pressure (BP) was 130/78, on 10/26/19 BP was 133/69, on 10/28/19 BP was 139/88 and on 10/29/19 BP was 128/74.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #21 on 10/26/19 and 10/27/19.

An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the DON and ADON on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19 on 1000 hall after the scheduled nursed refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she heard nothing from the nurses. The DON stated she did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment.

An interview, conducted with the Administrator on

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11/1/19 at 12:45 PM, revealed she was made aware of the staffing issue on Sunday 10/27/19 in the afternoon and contacted the DON. She confirmed there was a misunderstanding between the DON and Nurse #1 on duty during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

4. Resident #22 was admitted to the facility on 7/27/13 with diagnoses including hypertension. Review of the quarterly MDS dated 8/9/19 revealed Resident #22 had short term and long-term memory loss and was not able to make decisions about his activities of daily living.

Review of the physician orders dated 4/3/19 for Lasix 40 mg one tablet every morning for excess fluid; and an order dated 2/26/18 for Hydralazine 50 mg one tablet twice daily for blood pressure (BP).

Review of the MAR revealed Hydralazine 50 mg, scheduled at 8:30am, and Lasix 40 mg, scheduled at 9:30am, were not documented as given on 10/26/19 and 10/27/19. On 10/24/19 resident's blood pressure (BP) was 126/72, on 10/25/19 BP was 130/78, on 10/28/19 BP was 132/72, and on 10/29/19 BP was 134/80.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed

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F 658	Continued From page 6	F 658		

to take the facility's 1000 hall, so she did not administer any medications to Resident #22 on 10/26/19 and 10/27/19.

An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00pm, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the DON and ADON on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19 on 1000 hall after the scheduled nursed refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she heard nothing from the nurses. The DON stated she did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed she was made aware of the staffing issue on Sunday 10/27/19 in the afternoon and contacted the DON. She confirmed there was a misunderstanding between the DON and Nurse #1 on duty during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the

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F 658	Continued From page 7 physician.	F 658		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to maintain sufficient nursing staff to ensure residents received medications during first shift on 10/26/19 and 10/27/19. This affected 18 of 27 residents whose	F 725	University Place Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction as required by Federal and State regulations	11/21/19

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F 725	Continued From page 8 medications were reviewed (Residents #1, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21 and 22). Findings included: This tag is cross-referenced to: F-760: Based on record review, resident, staff, Nurse Practitioner (NP) and physician interviews the facility failed to prevent significant medication errors when medications were not administered as ordered between 7:00 AM and 3:00 PM on 10/26/19 and/or on 10/27/19 for 14 of 27 sampled residents whose medications were reviewed (Residents #1, 4, 6, 7, 9, 11, 12, 13, 14, 15, 16, 17, 18, and 20). F-658: Based on record review, staff and physician interviews the facility failed to prevent medication errors when medications were not administered as ordered between 7:00 AM and 3:00 PM on 10/26/19 and/or on 10/27/19 for 4 of 27 sampled residents whose medications were reviewed (Residents #5, 8, 21 and 22). An interview, conducted with Resident #1 on 10/31/19 at 9:30 AM, revealed he did not get his medications during first shift (7:00 AM to 3:00 PM) on 10/26/19 and 10/27/19. An interview, conducted with Nurse #1 and the Administrator on 11/1/19 at 8:15 AM, revealed she worked 7:00 AM to 3:00 PM and her assignment has been 600, 700 and 900 halls. The Administrator stated Nurse #1 did not understand that on 10/26/19, after the nurse assigned to 1000 hall walked out, she became Person 1 and was supposed to change her	F 725	and statutes applicable to long term care providers. This plan does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute an agreement by the facility that the surveyor□s findings or conclusions are accurate, that the findings constitute a deficiency, or the scope or severity regarding any of the deficiencies cited are correctly applied. F725 The plan of correcting the specific deficiency By 11/1/19 resident # 5 was assessed by facility licensed nurse with no negative effects related to the medication documentation error, failure to follow care plan. By 11/1/19 resident # 8 was assessed by facility licensed nurse with no negative effects related to the medication documentation error, failure to follow care plan. By 11/1/19 resident # 21 was assessed by facility licensed nurse with no negative effects related to the medication documentation error, failure to follow care plan. By 11/1/19 resident # 22 was assessed by facility licensed nurse with no negative effects related to the medication documentation error, failure to follow care plan. By 11/1/19 resident #1 was assessed by facility nurse with no negative findings	

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F 725	Continued From page 9 assignment to 1000 hall and Rooms 601 to 604 on 10/26/19 and 10/27/19. An interview, conducted with the Clinical Social Worker (CSW) on 11/1/19 at 9:00 AM, revealed she was the Manager on Duty on Sunday 10/27/19. CSW stated she arrived at the facility around 7:00 AM on Sunday morning. When she was making rounds, she noticed there was no nurse for the 1000 hall. Nurse #1 told CSW there was no nurse for 1000 hall. CSW #1 stated she notified the Assistant Director of Nursing (ADON) that the facility was short one nurse for first shift. The ADON stated she would take care of it. After about an hour, she heard nothing from the ADON so she notified the Director of Nursing (DON), who instructed CSW #1 to tell the five nurses in the building to split the carts. CSW #1 notified the DON that all the nurses were upset about splitting the carts. The DON responded that the nurses had to split the carts. CSW #1 stated she then notified the Administrator who stated she would contact the DON. Unable to reach the Manager on Duty for Saturday 10/26/19. An interview, conducted with the Scheduler on 11/1/19 at 9:15 AM, revealed on Saturday 10/26/19, Nurse #2 clocked in at 7:00 AM. She went to the Memory Care unit, which was not her assigned unit for the shift. The night shift supervisor advised her she was assigned to Arboretum, which included 1000 hall. She refused the assignment, clocked out and left the facility. The night shift supervisor notified the Scheduler to find coverage for first shift on 10/26/19 and 10/27/19. The Scheduler stated she sent a text message to the five nurses, who were working	F 725	related to medication administration error. By 11/1/19 resident # 4 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 6 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 7 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 9 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 11 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 12 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident #13 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 14 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident #15 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 16 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 17 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 18 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 20 was assessed by facility nurse with no negative findings	

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F 725	Continued From page 10 first shift, to split the carts based on the staffing model used for third shift as follows: Person 1 would take 1000 hall and Rooms 601 to 604; Person 2 would take 300 hall and Rooms 100-114 B; Person 3 would take Room 600, 900 hall, 700 hall, 800 hall and Rooms 115 A to 118 B . There should have been a nurse in Rehab, 400 hall and 200 hall and a nurse in the Memory Care unit. The Scheduler stated she explained to the nurses that they had to shift up which meant that the nurse listed second on the schedule would become Person 1. Person 1 was Nurse #1 and she should have taken 1000 hall and rooms 601 to 604. On Sunday 10/27/19, the Scheduler stated she talked to the DON around 7:00 AM after she had talked to the staff about splitting the carts. The DON sent a text message to the nurses telling them to split the carts. An interview, conducted with Unit Manager #1 (UM) on 11/1/19 at 9:30 AM, revealed Resident #1 complained to the treatment nurse on Saturday about not getting his medications. She gave Resident #1 the medications that were due while she was in the building on Saturday. On the following Monday, UM contacted the Nurse Practitioner and the Medical Director about the residents on 1000 hall not getting their medications during first shift on Saturday 10/26/19 and Sunday 10/27/19. An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed the nurse who was scheduled to work 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19 on 1000 hall refused to accept the assignment. She clocked out and left the building. The night shift supervisor notified the Scheduler. The scheduler notified the	F 725	related to medication administration error. On 11/1/19 the facility administration and director of nursing met to discuss alternative communication methods with licensed nurses regarding their assignments. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 11/1/19 the director of nursing and assistant director of nursing audited the medication administration records for residents on affected assignment 1000 hall for medication documentation errors. Audit revealed no negative resident outcomes, based on facility nurse assessment of affected residents. Systemic change On 10/30/19 the director of nursing completed an in-service with licensed nurses on medication administration including adherence to medication administration times, and documenting medications as ordered, included in the care plan, to prevent the medication errors. On 11/1/19 the director of nursing started an in-service with licensed nurses on acceptance and completion of assignments, including communicating concerns or inability to complete with nurse management. Both in-services were completed by 11/1/19. These in-services were added to the orientation for newly hired licensed nurses. On 11/1/19 as an outcome of the meeting between the facility administrator and director of nursing staffing sheets for	

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F 725	Continued From page 11 DON and ADON on 10/26/19 at 8:18am by text that she instructed the five nurses who were left in the building to split the assignments according to the paper they had access to. The paper the scheduler referenced indicated that Person 1 would take 1000 hall. Person 1 was Nurse #1. Both the DON and ADON stated they thought all was good because they did not hear from any of the nurses. On 10/26/19 at 12:58pm, the scheduler sent a text message to both the DON and ADON that Nurse #1 was upset about her assignment. The DON told the scheduler that the nurses needed to split the carts. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses. She stated she saw a missed call from Nurse #1 later in the day, time unknown. She called Nurse #1 back but did not get an answer. The DON stated that she did not realize there was a problem with the first shift staff assignment on Saturday 10/26/19. On Sunday 10/27/19 at 7:14am the DON and ADON received a text message from the scheduler stating that all the nursing carts were covered for first shift (7:00am - 3:00 pm). The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work the 1000 hall because they thought Nurse #1 had taken the assignment. An interview, conducted with the Administrator on 11/1/19 at 12:30pm, revealed Nurse #1 had not understood the change in her assignment on 10/26/19 and 10/27/19. There were text messages sent from the DON with the assignments, stating "Person 1 assigned to 1000 hall." Nurse #1 did not understand that she was Person 1. The Administrator stated she was notified on Sunday 10/27/19 by the Manager on	F 725	licensed nurses will include the nurse name instead of nurse 1, 2, and so on. This will improve communication of assignment and allow the license nurse to fulfil their duty. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, assistant director of nursing, unit manager, and/or staff facilitator will audit medication administration records, including 1000 hall, weekly x 12 weeks to ensure medications are administered and documented according to the order to ensure sufficient staff present to provide care. This audit will be documented on the MAR audit tool. Beginning 11/5/19 a staffing meeting will be held 5 x per week x 12 weeks to review the upcoming staffing and any needs. This will ensure staffing is sufficient to provide care according to the residents care plan, including medication administration. This meeting is documented in the Cardinal meeting minutes. The monthly quality improvement (QAPI) committee will review the results of the MAR audit tools for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for	

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F 725	Continued From page 12 Duty that there was some confusion among the nurses about resident assignments. The Administrator contacted the DON on Sunday 10/27/19 about the missed assignments on first shift on Saturday 10/26/19 and Sunday 10/27/19. The Administrator stated she expected the DON to make sure staffing is adequate during all shifts to assure medications are administered per physician orders.	F 725	continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QAPI committee to the quarterly executive quality improvement performance improvement (QAPI) committee for further recommendations and oversight	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, Nurse Practitioner (NP) and physician interviews the facility failed to prevent significant medication errors when medications were not administered as ordered for 14 of 27 sampled residents whose medications were reviewed (Residents #1, 4, 6, 7, 9, 11, 12, 13, 14, 15, 16, 17, 18, and 20). The findings included: 1. Resident #1 was admitted to the facility on 6/29/19 with diagnoses including hypertension (high blood pressure) and diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated 10/16/19 revealed Resident #1 could make his own decisions about his activities of daily living. Resident #1's October 2019 physician orders revealed an order, dated 6/29/19, for Coreg 25 milligrams (mg) one tablet two times a day for	F 760	University Place Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction as required by Federal and State regulations and statutes applicable to long term care providers. This plan does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute an agreement by the facility that the surveyor□s findings or conclusions are accurate, that the findings constitute a deficiency, or the scope or severity regarding any of the deficiencies cited are correctly applied. F760 The plan of correcting the specific deficiency	11/21/19

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F 760	Continued From page 13 blood pressure and Glucotrol XL 2.5mg one tablet once daily for blood sugar. Resident #1's October 2019 Medication Administration Record (MAR) revealed the Coreg 25 mg and Glucotrol XL 2.5 mg, scheduled daily at 9:30 AM, were not documented as given on 10/26/19 and 10/27/19. An interview, conducted with Resident #1 on 10/31/19 at 4:30 PM revealed he did not get his scheduled medications during first shift on Saturday 10/26/19 and Sunday 10/27/19. He stated he had no side effects from not receiving the medications. An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #1 on 10/26/19 and 10/27/19. An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The	F 760	By 11/1/19 resident #1 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 4 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 6 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 7 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 9 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 11 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 12 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident #13 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 14 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident #15 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 16 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 17 was assessed by facility nurse with no negative findings related to medication administration error. By 11/1/19 resident # 18 was assessed by facility nurse with no negative findings	

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F 760	Continued From page 14 DON and ADON stated they were unaware the residents on the 1000 hall did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19. An interview, conducted with the Nurse Practitioner (NP) on 11/1/19 at 10:00 AM, revealed she was made aware on Monday 10/28/19 that Resident #1 had not been given his scheduled medications at 9:30 AM on 10/26/19 and 10/27/19. She evaluated Resident #1 on 10/28/19 and determined there was no negative outcome from the resident not receiving prescribed medications including Coreg and Glucotrol XL during the first shift on 10/26/19 and 10/27/19. An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications. An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to	F 760	related to medication administration error. By 11/1/19 resident # 20 was assessed by facility nurse with no negative findings related to medication administration error. The procedure for implementing the acceptable plan of correction for the specific deficiency cited By 11/1/19 the director of nursing and assistant director of nursing audited the medication administration records for residents on affected assignment 1000 hall for medication documentation errors. Audit revealed no negative resident outcomes, based on facility nurse assessment of affected residents. Systemic change On 10/30/19 the director of nursing completed an in-service with licensed nurses on medication administration including adherence to medication administration times, and documenting medication administration as ordered to prevent the medication errors. On 11/1/19 the director of nursing started an in-service with licensed nurses on acceptance and completion of assignments, including communicating concerns or inability to complete with nurse management. Both in-services were completed by 11/1/19. These in-services were added to the orientation for newly hired licensed nurses. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

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F 760	Continued From page 15 assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician. 2. Resident #4 was admitted to the facility on 10/18/14 with diagnoses including diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated 10/8/19 revealed Resident #4 had short term and long-term memory loss and was unable to make her own decisions about activities of daily living. Resident #4's October 2019 physician orders revealed an order dated 5/23/15 for Linagliptin 5 milligrams (mg) once daily for diabetes and an order dated 10/5/15 for Novolog insulin 8 units subcutaneously (under the skin) before meals for diabetes. Resident #4's October 2019 Medication Administration Record (MAR) revealed Linagliptin 5 milligrams (mg), scheduled at 9:30 AM, and Novolog insulin 8 units, scheduled at 11:30 AM was not documented as given on 10/26 19 and 10/27/19. An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #4 on 10/26/19 and 10/27/19. An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse	F 760	The director of nursing, assistant director of nursing, unit manager, and/or staff facilitator will audit medication administration records, including 1000 hall, weekly x 12 weeks to ensure medications are administered and documented according to the order and care plan. This audit will be documented on the MAR audit tool. The monthly quality improvement (QAPI) committee will review the results of the MAR audit tools for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QAPI committee to the quarterly executive quality improvement performance improvement (QAPI) committee for further recommendations and oversight.	

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#1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the residents on the 1000 hall did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19.

An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if

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it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

3. Resident #6 was admitted to the facility on 6/18/18 with diagnoses including hypertension and diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated 8/21/19 revealed Resident #6 had short term and long-term memory loss and was unable to make his own decisions about the activities of daily living.

Resident #6's October 2019 physician orders revealed orders dated 6/18/18 for Plavix 75 milligrams (mg) one tablet daily (prevent blood clots), Lisinopril 20 mg one tablet daily for blood pressure, Coreg 25 mg one tablet twice a day for blood pressure, Hydralazine 100 mg one tablet three times a day for blood pressure; an order dated 7/6/18 for Humalog insulin sliding scale per blood sugar results three times a day.

Resident #6's October 2019 Medication Administration Record (MAR) revealed Lisinopril 2 20 mg, scheduled at 8:30 AM was not documented as given on 10/26/19 and 10/27/19. Plavix 75 mg and Coreg 25 mg, scheduled at 9:30am, were not documented as given on 10/26/19 and 10/27/19. Hydralazine 100 mg, scheduled at 9:30am and 1:30pm, were not documented as given on 10/26/19 and 10/27/19. On 10/26/19 at 11:30 AM the blood sugar was not documented as checked and no insulin was documented as given, at 4:30 PM the blood sugar was 131 and required no insulin. On 10/27/19 at 11:30 AM the blood sugar was not documented as checked and no insulin was documented as given, at 4:30 PM the blood sugar was 102 and

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no insulin was required.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #6 on 10/26/19 and 10/27/19.

An interview, conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the resident's on the 1000 hall did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19.

An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed

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medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

4. Resident #7 was admitted to the facility on 9/4/18 with diagnoses including hypertension and seizure disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated 9/22/19 revealed Resident #7 had short term and long-term memory loss and was unable to make decisions about the activities of daily living.

Resident #7's October 2019 physician orders revealed orders dated 9/4/19 for Losartan 50 milligrams (mg) one tab daily for blood pressure, Lamictal 25 mg one tablet twice a day along with 200 mg to equal 225 mg for seizures, Lamictal 200 mg one table along with 25 mg twice a day to equal 225 mg for seizures, Keppra 750 mg 2 tablets twice a day for seizures and Tegretol 200 mg one and one-half tabs to equal 300 mg three times a day for seizures.

Resident #7's October 2019 Medication Administration Record (MAR) revealed Losartan

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50 mg, Lamictal 25 mg, Lamictal 200 mg and Keppra 1500 mg, scheduled at 9:00am were not documented as given on 10/26/19 and 10/27/19. Tegretol 300 mg, scheduled for 9:00am and 2:00pm, were not documented as given on 10/26/19 and 10/27/19.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #7 on 10/26/19 and 10/27/19.

An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the residents on the 1000 hall did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19.

An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the

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1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

5. Resident #9 was admitted to the facility on 4/29/19 with diagnoses including diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated 10/19/19 revealed Resident #9 had short term and long-term memory loss and unable to make decisions about activities of daily living.

Resident #9's October 2019 physician orders revealed an order dated 4/29/19 for Humalog insulin three times a day before meals per sliding scale based on resident's blood sugar.

Resident #9's October 2019 Medication Administration Record (MAR) revealed on 10/26/19 at 6:30 AM, his blood sugar was 66 and

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required no insulin. At 11:30 AM, the blood sugar was not documented as checked and no insulin was documented as given per sliding scale. At 4:30 PM, his blood sugar was 118 and required no insulin. On 10/27/19, at 11:30 AM the blood sugar was not documented as checked and no insulin was documented as given, at 4:30 PM his blood sugar was 172 and required no insulin.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #9 on 10/26/19 and 10/27/19 during first shift.

An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the residents on the 1000 hall did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19.

An interview, conducted with the Medical Director

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(MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

6. Resident #11 was admitted to the facility on 4/3/19 with diagnoses including hypertension, myocardial infarction (heart attack) and CVA (stroke). Review of the quarterly Minimum Data Set (MDS) assessment dated 8/9/19 revealed Resident #11 had short term and long-term memory loss and was unable to make decisions about his activities of daily living.

Resident #11's October 2019 physician orders revealed orders dated 4/3/19 for Plavix 75 milligrams (mg) one tablet daily for blood clots, Lopressor 50 mg one tablet twice daily, Catapres 0.2 mg one tab twice daily for blood pressure and

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Hydralazine 100 mg one tablet three times a day for blood pressure.

Resident #11's October 2019 Medication Administration Record (MAR) revealed Plavix 75 milligrams (mg), Catapres 0.2 mg, and Lopressor 50 mg scheduled at 8:30 AM were not documented as given on 10/26/19 and 10/27/19. Hydralazine 100 mg, scheduled at 8:30 AM and 2:30 PM, was not documented as given on 10/26/19 and 10/27/19.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #11 on 10/26/19 and 10/27/19.

An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON)) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the resident's on the 1000 hallway did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until

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Monday 10/28/19.

An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

7. Resident #12 was admitted to the facility on 6/8/18 with diagnoses including hypertension and seizure disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated 8/15/19 revealed Resident #12 was able to make his own decisions about the activities of daily living.

Resident #12's October 2019 physician orders revealed orders dated 6/8/18 revealed Losartan 100 milligrams (mg) one tablet daily for blood

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pressure, Metoprolol 100 mg daily for blood pressure and Tegretol 200 mg three times a day for seizures.

Resident #12's October 2019 Medication Administration Record (MAR) revealed Losartan 100mg scheduled at 9:00am, Metoprolol 100 mg scheduled at 8:30am and Tegretol 200 mg scheduled at 2:00pm were not documented as given on 10/26/19 and 10/27/19.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #12 on 10/26/19 and 10/27/19.

An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the residents on the 1000 hall did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19.

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An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

8. Resident #13 was admitted to the facility on 5/27/19 with diagnoses including hypertension and seizure disorder. Review of the annual Minimum Data Set (MDS) assessment dated 10/16/19 revealed Resident #13 had short term and long-term memory loss and was unable to make decisions about his activities of daily living.

Resident #13's October 2019 physician orders revealed orders dated 5/27/19 for Trileptal 150 milligrams (mg) every morning for seizures and Lopressor 25 mg one tablet every 12 hours for

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blood pressure.

Resident #13's October 2019 Medication Administration Record (MAR) revealed Trileptal 150 mg and Lopressor 25 mg, both scheduled at 9:30am, were not documented as given on 10/26/19 and 10/27/19.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #13 on 10/26/19 and 10/27/19.

An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the residents on the 1000 hallway did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19.

An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was

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notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

9. Resident #14 was admitted to the facility on 12/21/16 with diagnoses including hypertension and seizure disorder. Review of the annual Minimum Data Set (MDS) assessment dated 9/25/19 revealed Resident #14 had short term and long-term memory loss and was unable to make decisions about his activities of daily living.

Resident #14's October 2019 physician orders revealed orders dated 12/21/16 for Losartan 100 milligrams (mg) one tab daily for blood pressure, Tegretol 200 mg one tablet twice a day for seizures, Keppra 750 mg one tablet twice daily for seizures and Depakote 250 mg one tablet twice daily for seizures.

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Resident #14's October 2019 Medication Administration Record (MAR) revealed Depakote 250mg scheduled at 8:30 am, Losartan 100 mg, Tegretol 200 mg, Keppra 750 mg all scheduled at 9:30 am were not documented as given on 10/26/19 and 10/27/19.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #14 on 10/26/19 and 10/27/19.

An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the residents on the 1000 hall did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19.

An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was

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notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

10. Resident #15 was admitted to the facility on 11/21/11 with diagnoses including hypertension and seizure disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated 7/25/19 revealed Resident #15 had short term and long-term memory loss and was not able to make decisions about his activities of daily living.

Resident #15's October 2019 physician orders revealed an order dated 9/23/14 for Keppra 750 milligrams (mg) one tablet twice daily for seizures and on 12/27/12 an order for Hydralazine 50mg one tablet three times a day for high blood pressure.

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Resident #15's October 2019 Medication Administration Record (MAR) revealed Keppra 750mg, scheduled at 9:30 am, and Hydralazine 50mg, scheduled at 9:30 am and 1:30 pm, were not documented as given on 10/26/19 and 10/27/19.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #15 on 10/26/19 and 10/27/19.

An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the residents on the 1000 hall did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19.

An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the

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1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

11. Resident #16 was admitted to the facility on 11/28/16 with diagnoses including hypertension and seizure disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated 8/27/19 revealed Resident #16 had short term and long-term memory loss and was unable to make decisions about her activities of daily living.

Resident #16's October 2019 physician orders revealed orders dated 11/28/16 for Lisinopril and HCTZ 20/12.5 milligrams (mg) one tablet daily for blood pressure, Lamictal XR 250 mg once daily for seizures, and Coreg 6.25 mg one twice a day for blood pressure.

Resident #16's October 2019 Medication

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Administration Record (MAR) revealed Lisinopril/HCTZ, Lamictal, and Coreg, scheduled at 12:00 pm, were not documented as given on 10/27/19.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #16 on 10/27/19.

An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the resident's on the 1000 hall did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19.

An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD

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stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

12. Resident #17 was admitted to the facility on 9/23/19 with diagnoses including hypertension, diabetes and seizure disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated 9/24/19 revealed Resident #17 was able to make his own decisions about activities of daily living.

Resident #17's October 2019 physician orders revealed orders dated 9/23/19 for Losartan 100 milligrams (mg) one tablet daily for blood pressure, Depakote 250 mg three tablets twice a day for seizures, Humalog insulin sliding scale before meals and bedtime based on blood sugars, Humalog insulin 10 units three times a day with meals for diabetes.
Resident #17's October 2019 Medication Administration Record (MAR) revealed on

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10/26/19 Depakote 750 mg, scheduled at 8:30 AM, Losartan 100 mg scheduled at 9:30 AM, Humalog insulin 10 units scheduled at 12:00 PM were not documented as given. On 10/27/19 Humalog sliding scale insulin with blood sugar scheduled at 11:30 AM and Humalog 10 units scheduled at 8:30 AM and 12:00 PM were not documented as given. The resident's blood sugar at 4:30 PM was 176 and required no insulin.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #17 on 10/27/19.

An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the residents on the 1000 hall did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19.

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An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

13. Resident #18 was admitted to the facility on 3/6/18 with diagnoses including hypertension and seizure disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated 9/5/19 revealed Resident #18 was able to make his own decisions about activities of daily living.

Resident #18's October 2019 physician orders revealed orders dated 3/16/18 for Dilantin 300 milligrams (mg) every morning for seizures, Zonegran 100 mg one daily for seizures, Keppra 750 mg one tablet twice daily for seizures,

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Catapres 0.1 mg one tablet twice daily for blood pressure, Lopressor 75 mg twice daily for blood pressure and Hydralazine 100 mg three times a day for blood pressure.

Resident #18's October 2019 Medication Administration Record (MAR) revealed Dilantin 300 mg, Zonegran 100 mg, Catapres 0.1 mg, Keppra 750 mg and Lopressor 75 mg, all scheduled at 9:30 AM were not documented as given on 10/26/19 and 10/27/19. Hydralazine 100 mg scheduled at 9:30 AM and 1:30 PM were not documented as given on 10/26/19 and 10/27/19.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #18 on 10/27/19.

An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the residents on the 1000 hall did not receive their

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medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19.

An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.

14. Resident #20 was admitted to the facility on 1/6/16 with diagnoses including diabetes and hypertension. Review of the annual Minimum Data Set (MDS) assessment dated 8/28/19 revealed Resident #20 had short term and long-term memory loss and was not able to make decisions regarding his activities of daily living.

Resident #20's October 2019 physician orders

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revealed an order dated 2/6/19 for Lisinopril 2.5 milligrams (mg) one tablet daily for blood pressure; an order dated 10/28/16 for Humalog sliding scale insulin three times a day based on blood sugar; and an order dated 12/24/16 for Glucophage 1000 mg one tablet twice daily for diabetes; and an order dated 7/7/16 for Humalog insulin 14 units subcutaneously before meals three times a day.

Review of Resident #20's October 2019 Medication Administration Record (MAR) revealed on 10/27/19 Lisinopril 2.5 mg and Glucophage 1000 mg, both scheduled at 9:30 AM, were not documented as given. On 10/27/19, Humalog insulin 14 units and Humalog insulin per sliding scale, both scheduled at 11:30 AM, were not documented as given. On 10/27/19 at 4:30 PM his blood sugar was 109 and required no insulin.

An interview, conducted with Nurse #1 on 11/1/19 at 8:15 AM, revealed she was assigned to 30 clients on 600, 700 and 900 halls from 7:00 AM to 3:00 PM on 10/26/19 and 10/27/19. Nurse #1 stated she did not understand she was supposed to take the facility's 1000 hall, so she did not administer any medications to Resident #20 on 10/27/19.

An interview, conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/1/19 at 11:43 AM revealed Nurse #1 was assigned to work on the 1000 hallway on 10/26/19 and 10/27/19 during the 7:00 AM to 3:00 PM shift after the scheduled nurse refused to accept the assignment. The DON stated she felt there was no problem and all residents had been taken care of because she had not heard

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anything from the nurses on 10/26/19 and 10/27/19. The DON and ADON stated they did not go into the facility on Saturday 10/26/19 or Sunday 10/27/19 to work 1000 hall because they thought Nurse #1 had taken the assignment. The DON and ADON stated they were unaware the residents on the 1000 hall did not receive their medications as ordered during the 7:00 AM to 3:00 PM shift on 10/26/19 or 10/27/19 until Monday 10/28/19.

An interview, conducted with the Medical Director (MD) on 11/1/19 at 12:00 PM, revealed he was notified by staff on 10/28/19 that residents on the 1000 hall did not receive their medications during first shift on 10/26/19 and 10/27/19. The MD stated there was no negative outcomes, no reported incidents and no residents were sent to the hospital as a result of the missed medications.

An interview, conducted with the Administrator on 11/1/19 at 12:45 PM, revealed during the afternoon of 10/27/19 she was made aware that residents, who resided on the facility's 1000 hall, did not receive their ordered medications during the first shift on 10/26/19 ad 10/27/19 and she contacted the DON. The administrator stated there was a misunderstanding between the DON and Nurse #1 during the first shift on 10/26 and 10/27/19 and medications were not administered as ordered. She stated she expected the DON to assure the facility was staffed adequately, even if it meant the DON worked the hall, so that medications would be administered as ordered by the physician.