STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING _____ B. WING _____	C 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

(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 COVID-19 Focused Survey was conducted on 08/10/2020 and 08/11/2020. The survey team returned to the facility to obtain additional information on 08/12/2020 with review of information off site on 08/13/2020. Therefore, the exit date was changed to 08/13/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 7ZR711.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 08/10/2020 and 08/11/2020. The survey team returned to the facility to obtain additional information on 08/12/2020 with review of information off site on 08/13/2020. Therefore, the exit date was changed to 08/13/2020. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. One of the 16 allegations was substantiated and resulted in deficiency. Event ID #7ZR711.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		9/6/20

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

Electronically Signed | 09/04/2020

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F 580	Continued From page 1 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

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F 580	Continued From page 2 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, and Nurse Practitioner (NP) interviews, the facility failed to notify the physician or the NP of a dialysis treatment that could not be rescheduled which resulted in 2 missed dialysis treatments for 1 of 2 residents (Resident #3) reviewed for notification. Findings included: Resident #3 was readmitted to the facility on 8/8/2020. Diagnoses included end-stage renal disease on dialysis. Resident #3's admission Minimum Data Set dated 6/11/2020 revealed he had intact cognition and had received dialysis services. Resident #3 had a plan of care in place dated 6/19/2020 related to dialysis. Interventions were inclusive of dialysis treatment as scheduled and medications as ordered. Resident #3's hospital discharge summary dated 8/8/2020 revealed he was hospitalized for treatment of hematuria with abdominal pain and had received dialysis treatments. Discharge medications included direction to administer lorazepam 0.5 milligrams (mg) every 12 hours for 14 days for anxiety. Review of Resident #3's August 2020 electronic physician orders and electronic medication administration record (eMAR) revealed no order for lorazepam.	F 580	Corrective Action for those residents found to have been affected by the deficient practice was achieved by: On 8/10/20 NP was notified of resident # 3 refusal to go to dialysis. NP and resident #3 were notified of appointment made for dialysis for Tuesday morning at 9:30 AM. Resident #3 refused to attend dialysis on Tuesday 8/11/20. NP Mara Keith was notified and verbal order given to send resident to ER related to dialysis. Resident #3 returned from ER with no new orders and not receiving dialysis. Resident #3 did go to dialysis on Wednesday 8/12/20 and was medicated per MAR prior to transport. All residents are identified as being at risk for deficient practice. Therefore, a 100% audit of all new orders for the last 30 days will be completed for MD/NP notification, as well as resident/family notification, by 9/6/2020. The following measures/systemic changes were put into place to ensure deficient practice does not recur: 100 % audit of all new orders for the last 30 days will be audited for MD/NP as well as resident/family notification by September 6, 2020. Education of all licensed nursing staff regarding physician communication of change in condition will be completed by 9/6/2020 and will be added to the facility orientation process thereafter. Monitoring of the corrected action includes: All new orders and change of conditions will be audited 5 x week x 4	

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F 580	Continued From page 3 Resident #3's August 2020 physician orders revealed an order for dialysis treatment every Monday, Wednesday and Friday. Review of the medical record for 8/08/2020 through 8/13/2020 revealed Resident #3 received dialysis treatment on 8/12/2020. An interview was completed with Nurse Aide (NA) #1 on 8/12/2020 at 8:46 AM. NA #1 explained Resident #3 had refused dialysis treatment on 8/10/2020 because he did not get his lorazepam and he always refused dialysis if he did not get it. She recalled the same thing happening on 8/11/2020 and was not certain if transport showed up. NA #1 indicated she informed the nurse on 8/10/2020 and 8/11/2020 of his refusal to go to dialysis because he had not received his lorazepam. An interview and observation was completed on 8/12/2020 at 8:51 AM of Resident #3. He was observed lying in his bed at the time. He expressed he was not going to his dialysis appointment if he did not receive his lorazepam. He explained he became extremely anxious on dialysis days and the medication allowed him to relax. Resident #3 continued to verbalize he was able to relax and tolerate his dialysis treatment once medicated. He did not understand why the nurses refused to administer the medication. He could not recall the last time he received dialysis treatment. He did not realize he had missed 2 dialysis treatments. A nursing note written by Nurse #2 dated 8/10/2020 documented Resident #3's transportation to dialysis did not arrive. Nurse #2 notified Unit Manager (UM) #2 and the NP. The	F 580	weeks, then 3 x weekly x 8 weeks to ensure proper notification. The Director of Nursing will present results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance. The administrator will oversee this process. Date of compliance: September 6th, 2020	

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F 580	Continued From page 4	F 580		

NP gave Nurse #2 verbal orders for Resident #3 to receive dialysis either at the dialysis center or send him to the hospital for dialysis treatment on 8/10/2020.

An interview was completed with Nurse #2 at 11:15 AM on 8/12/2020. Nurse #2 reported on 8/10/2020 the NA informed her that Resident #3's dialysis transportation did not arrive. Nurse #2 explained she did not realize Resident #3 required dialysis until the NA reported the transportation issue. Nurse #2 explained Resident #3 requested lorazepam which was not administered because it was not on the eMAR. Nurse #2 reported she was not aware Resident #3's refusal was linked to the medication. At the direction of UM #2, Nurse #2 notified the NP. Nurse #2 reported the NP gave verbal orders to send Resident #3 to the hospital for dialysis if the dialysis center could not accommodate Resident #3 that day (8/10/2020). Nurse #2 informed the UM #2 of the NP's verbal orders. Nurse #2 was not aware of any dialysis arrangements for Resident #3. Nurse #2 reported Resident #3 had not gone to dialysis when she left duty at 3:00 PM on 08/10/2020.

A nursing note written by Nurse #4 dated 8/11/2020 documented Resident #3 refused dialysis because he could not receive lorazepam. Nurse #4 documented Resident #3 did not have a lorazepam order. The NP received notification and ordered an emergency room evaluation. Nurse #4 prepared Resident #3 for ED transfer.

A telephone interview was completed on 8/13/2020 at 11:52 AM with Nurse #4. She explained she worked with Resident #3 on 8/11/2020. She stated the NA had informed her

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F 580	Continued From page 5	F 580		

Resident #3 refused dialysis treatment due to not receiving his lorazepam on 8/11/2020. She recalled there was no lorazepam ordered on the eMAR for Resident #3. Nurse #4 notified the NP of Resident #3's refusal of dialysis and inability to recall his last dialysis treatment date. Nurse #4 verbalized the NP gave verbal orders to send the resident to emergency room for evaluation. Nurse #4 verbalized she prepared Resident #4 for ED transfer.

A late entry nursing note written by UM #2 dated 8/12/2020 for 8/10/2020 documented UM #2 notified the NP of Resident #3's rescheduled dialysis appointment on 8/11/2020 at 9:30 AM.

An interview was completed on 8/12/2020 at 12:00 PM with Unit Manager (UM) #2. He stated Resident #3 was scheduled to go out to dialysis on 8/10/2020 but did not make his appointment. UM #2 expressed he was not notified of the missed appointment until the afternoon of 8/10/2020 by Nurse #3. UM #2 explained he contacted Resident #3's dialysis unit to determine if he could be seen the evening of 8/10/2020 but they could not accommodate this request but scheduled Resident #3 for dialysis at 9:30 AM on 8/11/2020. UM #2 explained he was not aware of any other orders given by the NP to send Resident #3 out to the hospital if dialysis could not be completed on 8/10/2020. UM #2 communicated when a resident refused dialysis treatment, nurse management should be notified immediately, physician or NP notification made and determination made for alternative arrangements and/ or further physician orders.

A telephone interview was completed on 8/12/2020 at 1:05 PM with the NP. She

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F 580	Continued From page 6 expressed she would have expected to have been notified of Resident #3's refusal of dialysis treatment scheduled for 8/10/2020. The NP does not recall being contacted by facility staff on 8/10/2020 regarding Resident #3 not being able to receive dialysis treatment that day. The NP verbalized she would not have agreed to a dialysis appointment on 8/11/2020 because she understood Resident #3 had not been dialyzed since 8/5/2020. The NP explained the facility should have followed the verbal orders given on 8/10/2020 which directed them to obtain a dialysis appointment for 8/10/2020 or send the resident to the ED for evaluation and treatment. An interview was completed on 8/12/2020 at 12:19 PM with the Interim Director of Nursing (DON) who revealed follow up notification should have been made to the physician or NP by nursing staff. Nurses should notify nurse management, in addition to, the physician or NP when residents refused dialysis treatment.	F 580		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview, and record review, the facility failed to	F 695	Corrective Action for those residents found to have been affected by the	9/6/20

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F 695	Continued From page 7	F 695		

provide oxygen therapy per physician order for 1 of 3 residents reviewed for respiratory care (Resident #3).

Findings included:

Resident #3 was readmitted to the facility on 8/8/2020. His diagnoses were inclusive of acute and chronic respiratory failure with hypoxia, acute pulmonary edema, and chronic obstructive pulmonary disease (COPD).

Resident #3 admission Minimum Data Set dated 6/11/2020 revealed he had intact cognition. Resident #3 was coded as receiving oxygen therapy.

Resident #3 had an alteration in respiratory status plan of care in place revised on 6/12/2019. Interventions were inclusive of monitoring oxygen flow rate and response.

Review of the August 2020 physician orders read: Oxygen Therapy at 2 liters per minute/via nasal cannula continuous.

An observation and interview was completed on 8/10/2020 at 8:11 AM with Resident #3. He was resting in bed watching television. His nasal cannula was applied to nares. A portable oxygen tank was observed which revealed the gauge in the "red" area which indicated the portable oxygen tank was empty. Resident #3 stated he was having difficulty breathing. The portable oxygen tank was set at 2 liters.

An observation and interview was completed on 8/10/2020 at 8:26 AM with Nurse #1. He stated he last checked on Resident #3 around 4:00 AM.

deficient practice was achieved by providing a full portable Oxygen tank for Resident #3 On 8/10/20. Nurse #1 was re-educated by the interim Director of Nursing on 8/10/20 regarding Oxygen tank usage and respiratory care.

Identify other residents who have the potential to be affected by same deficient practice: All residents currently on oxygen therapy are at risk for the deficient practice. On September 3rd, 2020, A 100% audit was completed by the Unit Manager and the Director of Nursing identifying residents currently on oxygen therapy per physician orders. For each resident identified, care plans were updated by the Minimum Data Set Nurse.

The following measures/systemic changes put into place to ensure deficient practice does not recur: On 9/4/20, a 100% audit was performed by the Unit Manager and the Director of Nursing identifying residents currently on oxygen therapy per physician orders. For each resident identified care plans were updated by the Minimum Data Set Nurse. All licensed nursing staff were re-educated by the Assistant Director of Nursing and Unit Managers to ensure all residents who require oxygen therapy are provided the necessary services needed to maintain the correct ordered settings, frequent checks of settings of oxygen concentrators/ portable 02 tanks q shift to ensure the correct setting is in place, and that only licensed Nursing staff are trained to make any changes to settings in

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F 695	Continued From page 8 He did not recall any concerns with Resident #3's portable oxygen tank. An oxygen saturation level was obtained which revealed a reading of 91% to 92%. Nurse #1 checked the portable oxygen tank and verbalized the portable oxygen tank was empty. Nurse #1 verbalized Resident #3 would need another portable oxygen tank that was full. He indicated there were no in-room oxygen concentrators available. Nurse #1 went to retrieve a full portable oxygen tank for Resident #3. An interview was completed on 8/10/2020 at 12:03 PM with Unit Manager (UM) #2. He stated residents that were in their rooms should be connected to an in-room oxygen concentrator versus a portable oxygen tank. Those residents on oxygen therapy should have their respiratory status checked throughout the shift by nursing. Nursing staff should ensure oxygen therapy was in place at the ordered liter and their equipment was functional. An additional observation was completed of an oxygen saturation level obtained on 8/10/2020 at 12:12 PM by the UM of Resident #3. The reading obtained was 96%. Resident #3 indicated he was breathing better. A telephone interview was completed on 8/11/2020 at 11:45 AM with the Administrator. She explained staff should ensure oxygen tanks were full and functional when applying to the residents. She further expressed staff should check to ensure the oxygen therapy was effective in increasing the oxygen saturation for the resident. The Administrator communicated for those resident's that remained in their rooms, the preference would be to utilize an in-room oxygen	F 695	accordance with the physician order. Monitoring: New hires will be educated on respiratory care during the orientation program. Unit Managers will audit all residents receiving oxygen 5 times a week for 4 weeks, then 3 times a week for 8 weeks. The results of audits will be discussed monthly in the Quality Assurance and Performance Improvement Meeting by the Director of Nursing for 3 months. Review and any changes will be made as necessary to ensure deficient practice does not recur. Date of compliance: September 6th, 2020	

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F 695	Continued From page 9 concentrator versus a portable oxygen tank. She voiced the facility had in-room concentrators available for resident use. She verbalized she also ordered an additional 15 in-room oxygen concentrators for resident use.	F 695		
F 760 SS=G	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 resident, staff, nurse practitioner, physician and Nephrologist interviews, and record review, the facility failed to administer anti-anxiety medication to 1 of 3 sampled residents who received psychoactive medications (Resident #3). The omissions of the anti-anxiety medication caused Resident #3 to refuse dialysis which resulted in emergency room treatment for elevated potassium, high blood pressure and anxiety. The findings included: Resident #3 was readmitted to the facility on 08/02/2020 with diagnoses which included end stage renal disease with dialysis, chronic respiratory failure, diabetes mellitus and cancer. Resident #3's admission Minimum Data Set (MDS) dated 06/11/2020 documented an assessment of intact cognition. The MDS indicated Resident #3 received dialysis treatments. The care plan for Resident #3 dated 06/19/2020	F 760	Corrective Action was accomplished for those residents found to have been affected by the alleged deficient practice. On 8/12/2020 an order was obtained from NP Mara Keith for Resident #3 for Ativan 1 mg tablet to be administered prior to dialysis on Monday, Wednesday and Friday. The Interim Director of Nursing re-educated the nurse who completed the admitting orders on Resident #3 regarding order transcription and the new admission process. Identify other residents who have the potential to be affected by same deficient practice. All residents are at risk for deficient practice therefore a 100% audit of all admission within the past 30 days will be completed by 9/6/2020. Also, a 100% MAR to Cart audit was completed on 9/3/2020. The following measures/systemic changes have been put into place to ensure alleged deficient practice does not reoccur: 100% audit of all admissions	9/6/20

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F 760	Continued From page 10 indicated interventions for dialysis care included scheduled dialysis treatment and administration of medications as ordered. The care plan indicated Resident #3 required encouragement to go for dialysis treatment. A Nurse Practitioner (NP) note dated 07/06/2020 documented Resident #3 experienced anxiety and required Ativan (an anti-anxiety medication) to aid in compliance with dialysis treatment. The NP continued the use of Ativan 0.5 milligrams (mg.) one tablet every 12 hours as needed for anxiety for 14 days. On 07/16/2020, the NP documented Resident #3 continued to experience anxiety. The NP increased the frequency of the Ativan 0.5 mg. to every 8 hours as needed for anxiety with reevaluation to occur in 14 days. A NP note dated 07/23/2020 documented Resident #3 requested an increase in dosage for continued anxiety. The NP increased the Ativan to 1 mg. every 8 hours as needed for anxiety for 14 days with reevaluation to occur in 14 days. A hospital discharge summary dated 08/08/2020 documented Resident #3 was hospitalized from 08/02/2020 to 08/08/2020 for treatment of hematuria with abdominal pain. Resident #3 received dialysis during his hospital stay. Discharge medications included Ativan 0.5 mg. every 12 hours for 14 days. Resident #3's August 2020 electronic medication administration record (eMAR) did not contain transcription of the Ativan order. A nursing note dated 08/12/2020 as late entry for	F 760	within the past 30 days by 9/6/20. One nurse will enter all orders into que and 2nd nurse will activate orders after verification of medication orders. All new admission medications will be reviewed with MD, NP or on call physician upon admission. Nurse management will review all admissions next day in clinical meeting for any discrepancies. In-service education will be provided to all nursing staff on admission process now, annually and all new hires. Effective 9/4/20, the Interim Director of Nursing re-educated the nurse who completed the admitting orders on Resident #3 regarding order transcription and the new admission process. Monitoring of the corrected action to ensure the deficient practice will not recur; All admissions will be reviewed in clinical meeting by the Director of Nursing/Assistant Director of Nursing 5 times week x 4 weeks, then 3 times week x 8 weeks. Will print off new orders daily for review in clinical meeting to ensure completion and receiving of medication 5 times week x 4 weeks, then 3 times week x 8 weeks. The Director of Nursing will present results of the audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance. The administrator will oversee this process. Date of compliance: September 6th, 2020	

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08/08/2020 documented the admitting nurse, Nurse #3, informed Unit Manger (UM) #1 of the change of frequency of the Ativan dose. UM #1 documented the NP gave verbal orders to discontinue the Ativan.

Resident #3's physician's orders did not contain an order to discontinue the Ativan.

Nurse #3 did not return telephone calls and was not able to be interviewed.

Interview with UM #1 on 08/12/2020 at 1:45 PM revealed the NP was contacted upon Resident #3's readmission on 08/08/2020 and discontinued the Ativan order. UM #1 could not provide a reason for the lack of a written order to discontinue the Ativan.

Telephone interview on 08/13/2020 at 9:46 AM with the NP specified in the readmission note of 08/08/2020 revealed the NP was not contacted by the facility on 08/08/2020. The NP explained she was not aware of Resident #3's 08/02/2020 hospitalization until 08/12/2020. The NP reported she did not discontinue the Ativan on 08/08/2020.

A nursing note dated 08/10/2020 written by Nurse #2 documented Resident #3's transportation to dialysis did not arrive. Nurse #2 informed Unit Manager (UM) #2 and notified the NP. The NP directed Resident #3 to receive dialysis either at the dialysis treatment center or the hospital.

A late entry nursing note dated 08/12/2020 for 08/10/2020 documented UM#2 notified the NP of Resident #3's rescheduled dialysis appointment on 08/11/2020 at 9:30 AM.

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	345201	A. BUILDING _____ B. WING _____	C 08/13/2020

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A nursing note dated 08/11/2020, written by Nurse #4, documented Resident #3 refused dialysis because he could not receive Ativan. Nurse #4 documented Resident #3 did not have an Ativan order. The NP received notification and ordered an emergency room evaluation.

The emergency room evaluation dated 08/11/2020 revealed Resident #3 received treatment for a hyperkalemia (high potassium), high blood pressure and acute anxiety. The physician documented hyperkalemia with a potassium level of 6.1 Millimoles per liter (mmol/L) with a normal reference range of 3.5 mmol/L to 5.1 mmol/L. Resident #3's EKG (electrocardiogram) had no significant changes. Resident #3's blood pressure measured 204/92 millimeters of mercury. (mmHg.). Resident # 3 received oral medications to lower the potassium level, blood pressure and anxiety. Resident #3 returned to the facility.

During an interview with Resident #3 on 08/12/2020 at 8:51 AM, Resident #3 explained he became extremely anxious on dialysis days. Resident #3 reported the Ativan enabled him to go to dialysis. Resident #3 explained he needed the Ativan and did not understand the refusal by nurses to administer the medication.

Interview with Nurse Aide (NA) #1 on 08/12/2020 at 8:46 AM revealed Resident #3 refused to go to dialysis if Ativan was not administered. NA #1 reported Resident #3's dialysis refusal due to lack of Ativan to Nurse #2 on 08/10/2020 and to Nurse #4 on 08/11/2020.

Interview with Nurse #2 on 08/12/2020 at 11:15 AM revealed Resident #3 requested Ativan the

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morning of 08/10/2020. Nurse #2 explained to Resident #3 that there was not an order for Ativan. Nurse #2 explained the Ativan was not on the eMAR which she used as guide for medication administration. Nurse #2 reported Resident #3 had Ativan available for administration but did not have an order.

Continued interview with Nurse #2 revealed NA #1 informed her at approximately 1:00 PM or 1:30 PM on 08/10/2020 that transportation did not arrive to take Resident #3 to dialysis. Nurse #2 reported she did not know Resident #3's refusal of dialysis was connected to the Ativan. At the direction of UM #2, Nurse #2 notified the NP. Nurse #2 reported the NP directed her to send Resident #3 to the hospital for dialysis if the dialysis center could not dialyze Resident #3 that day (08/10/2020). Nurse #2 informed UM #2 of the NP's order. Nurse #2 reported Resident #3 had not gone to dialysis when she left duty at 3:00 PM on 08/10/2020.

Telephone interview with Nurse #4 on 08/13/2020 at 11:52 AM revealed NA #1 informed her of Resident #3's refusal of dialysis transportation due to not receiving Ativan on 08/11/2020. Nurse #4 explained there was no Ativan ordered on the eMAR for Resident #3. Nurse #4 notified the NP of Resident #3's refusal of dialysis and Nurse #4's inability to determine the most recent date of dialysis treatment. The NP ordered emergency room evaluation.

A telephone interview with the NP on 08/12/2020 at 1:06 PM revealed Resident #3 should have received the Ativan as ordered on the discharge summary dated 08/08/2020. The NP explained she did not know Resident #3's refusal of dialysis

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was connected to the Ativan when notified on 08/10/2020. The NP explained she ordered an emergency room evaluation on 08/11/2020 when informed of Resident #3's missed dialysis sessions and request for Ativan. The NP reported the nurse (Nurse #4) could not be precise in the number of missed sessions so the NP did not want to order Ativan until after Resident #3 received the emergency room evaluation.

During an interview with UM #2 on 08/12/2020 at 11:59 AM, UM #2 explained he did not know Resident #3 refused dialysis because of Ativan omission until 08/11/2020. UM #2 did not know Resident #3's discharge summary contained an order for Ativan administration. UM #2 reported Resident #3 should have received Ativan and the facility will initiate a process to ensure medications are correctly transcribed from discharge summaries.

Interview with the interim Director of Nursing (DON) on 08/12/2020 at 12:17 PM revealed Resident #3 should have received the Ativan as ordered. The interim DON explained Resident #3 required the Ativan prior to dialysis treatments. The interim DON described Resident #3 as extremely anxious on dialysis days.

Telephone interview with Resident #3's physician on 08/12/2020 at 12:45 PM revealed Resident #3 should have received Ativan as ordered especially since the omissions caused dialysis refusal and emergency room evaluation.

A telephone interview was conducted with Resident #3's Nephrologist on 08/13/2020 at 2:32 PM. The Nephrologist explained omission of

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F 760	Continued From page 15 dialysis caused elevated potassium but could not be certain if Resident #3's elevated potassium was due to the omitted session on 08/10/2020. The Nephrologist reported Resident #3 should have received the Ativan as ordered.	F 760		