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

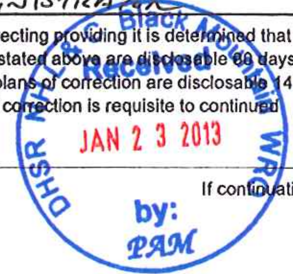
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345268	A. BUILDING ______ B. WING ______	C 12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER ST MARSHVILLE, NC 28103

(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 000	INITIAL COMMENTS Immediate Jeopardy began on 10/01/12 when Resident #1 did not receive scheduled seizure medications and subsequently exhibited grand mal seizures on 10/02/12. The Administrator was notified of immediate jeopardy on 12/19/12 at 4:02 PM. Immediate jeopardy was removed on 12/20/12 at 5:40 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity to complete education and to ensure monitoring systems put into place are effective.	F 000		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician interviews and record reviews the facility staff failed to administer medications related to resident's disease conditions for 5 of 5 newly admitted residents with physician's orders for significant medications that included seizure, blood pressure, pain, and respiratory medications. (Resident's #1, #2, #3, #4 and #5). Immediate Jeopardy began on 10/01/12 when Resident #1 did not receive scheduled seizure	F 309	This plan of correction will serve as the facility's allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to CMS 2567 for the 12-18-12 survey and does not constitute an agreement or admission of Autumn Care of Marshville of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	1/22/13

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



Original Signature Date: 1-15-13

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F 309	Continued From page 1 medications and subsequently exhibited grand mal seizures on 10/02/12. The Administrator was notified of immediate jeopardy on 12/19/12 at 4:02 PM. Immediate jeopardy was removed on 12/20/12 at 5:40 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective. The findings are: 1. Resident #1 was admitted on 10/01/12 at 3:00 PM with medical diagnoses which included malignant brain tumor with right sided paralysis, cerebral edema (swelling in the brain), history of seizures and deep vein thrombosis (blood clots). There was no Minimum Data Set (MDS) data available but the admission nursing assessment dated 10/01/12 but did not indicate the time is was completed revealed Resident #1 was alert and oriented to person, had impairment in short term memory and had modified independence with some difficulty in new situations only with cognition for daily decision making. The assessment further indicated Resident #1 required limited assistance with activities of daily living (ADL), had unclear speech, mumbled her words and was agitated. The assessment also revealed Resident #1's personal medications were not brought into facility when she was admitted.	F 309	because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, Autumn Care of Marshville submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 12/24/12. To address the alleged deficient practice for the residents allegedly affected, and to address the cited issues for all residents having potential to be affected, the facility has taken the following actions. All admissions from 12/1/2012-12/19/12 were audited on 12/19/12 for compliance. This audit was lead by the	

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F 309	Continued From page 2 A review of the hospital discharge summary dated 10/01/12 that was sent by the hospital to the facility indicated Resident #1's discharge medications included all of her home medications as follows: - Cipro 250 milligram (mg.) tablets by mouth every 12 hours for 5 days then stop (for urinary tract infection). - Dexamethasone 2 mg. by mouth 4 times a day (to decrease swelling in the brain). - Valium 5 mg. by mouth every 8 hours as needed (for anxiety). - Lovenox 100 mg./milliliter (ml) injectable solution 1.0 ml. subcutaneous every 12 hours (to prevent blood clots). - Labetalol 100 mg. by mouth 2 times a day (for blood pressure). - Vimpat 150 mg. by mouth 2 times a day (for seizure prevention). - Keppra 1000 mg. tablet by mouth 2 times a day (for seizure prevention). - Keppra 500 mg. tablet by mouth 2 times a day (for seizure prevention). - Levothyroxine 50 micrograms (mcg.) by mouth every day (for thyroid hormone replacement). - Lisinopril 10 mg. by mouth every day (for blood pressure). - Omeprazole 40 mg. by mouth every day (for esophageal reflux). - Trileptal 900 mg. by mouth 2 times a day (for seizure prevention). - K-Dur 20 millequivalents (mEq.) by mouth every day (for potassium supplement). A review of the Physician's admission orders for Resident #1 dated 10/01/12 indicated the following list of medications and the frequency of when they were to be given:	F 309	director of nursing and staff development coordinator and conducted by administrative nurses to insure all currently ordered medications were available for administration and were timely administered as ordered by the physician. The lack of available medication was not identified with any resident in this audit. Upon notification of admission from the transferring facility, the admissions coordinator will verbally request admission orders from the transferring staff. Clinical information and medication orders will be reviewed by a provider of Physicians Eldercare and approved or additional orders provided. This will be documented in the medical record by the nurse. Admission orders will be faxed to Legacy Pharmacy by the admission nurse or nurse	12/19/12

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F 309	Continued From page 3 - Dexamethasone 2 mg. by mouth QID (four times a day) for cerebral edema (swelling in the brain). - Keppra 1000 mg. by mouth BID (twice a day) for seizures. - Keppra 500 mg. by mouth BID (twice a day) for seizures. - Trileptal 300 mg. (3) tablets by mouth BID (twice a day) for seizure disorder. - Vimpat 150 mg. by mouth BID (twice a day) for seizures. - Cipro 250 mg. by mouth every 12 hours x 5 days for urinary tract infection. - Lovenox 100 mg./ml injectable solution 1.0 ml. subcutaneously every 12 hours for history of blood clots. - K-Dur 20 mEq. by mouth every day for low potassium. - Valium 5 mg. by mouth every 8 hours PRN (as needed) for anxiety. - Labetalol 100 mg. by mouth BID (twice daily) for high blood pressure. - Lisinopril 10 mg. by mouth every day for high blood pressure. - Omeprazole 40 mg. by mouth every day for esophageal reflux. - Levothyroxine 50 mcg. by mouth every day for thyroid disorder. A review of an electronic Medication Administration Record (MAR) dated 10/01/12 at 7:24 PM and completed by Nurse #2 indicated Cipro 250 mg. was given orally and Lovenox 100 mg/ml injectable solution 1.0 ml was given subcutaneously to Resident #1. There were no other medications listed on the MAR dated 10/01/12.	F 309	supervisor to begin dispensing process after the approval. The nurse responsible for processing the admission orders will contact the referring facility to obtain information regarding the last dose administered of each of the resident's prescribed medications. In the event this information is not available, the nurse will contact our physician or mid-level provider for directions on starting medications. The admitting nurse will enter all ordered medications into the Medication Administration Record and schedules per physician's orders. The steps outlined in this plan of correction will be reviewed by the Quality Assurance Committee at our next scheduled meeting and then as needed for the next six months to minimize opportunities for missed medications by maintaining	

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F 309	Continued From page 4 A review of a nurse's note dated 10/01/12 at 9:39 PM and written by Nurse #2 indicated a skilled narrative progress note that Resident #1 was admitted via emergency medical services (EMS) at 3:00 PM to the services of a facility physician and the physician, pharmacy and dietary were notified. The notes further indicated Resident #1 was alert but did not speak, sat in bed with her eyes mostly closed but would look at the nurse and had a history of seizures. A review of a facility document titled "packing slip" and dated 10/02/12 indicated the following medications were delivered to the facility from the pharmacy for Resident #1: Valium 5 mg. tablets; Cipro 250 mg. tablets; Dexamethasone 2 mg. tablets; Lovenox Injectable 100 mg./ml; Labetalol 100 mg. tablets; Keppra 1000 mg. tablets; Keppra 500 mg. tablets; Synthroid 50 mcg. tablets; Lisinopril 10 mg. tablets; Omeprazole 40 mg. capsules; Trileptal 300 mg. tablets and K-Dur 20 mEq. tablets. The medication Vimpat was not on the list of delivered medications. A review of a nurse's note dated 10/02/12 at 3:31 AM and written by Nurse #3 indicated Cipro 250 mg. had not caused any adverse side effects. A review of an electronic MAR dated 10/02/12 at 6:43 AM and completed by Nurse #3 indicated Levothyroxine 50 mcg. oral tablet every day with a note that indicated "not done" and Omeprazole 40 mg. oral tablet every day with a note that indicated "not done." A review of a nurse's note dated 10/02/12 at 9:00 AM and written by the day shift nursing supervisor indicated she was called to Resident #1's room	F 309	or further improving this system. Legacy Consultant Pharmacy has contracted for services with Marshville Pharmacy to ensure all new admissions' medications by the next scheduled dose and Marshville Pharmacy is available to our residents and potential residents as of 12/20/2012. This back-up service is in addition to our current back-up pharmacies and can respond quicker and deliver the medication as soon as it is ready during normal business hours. In addition, we are still contracted with CVS pharmacy and CMC-Union as part of our existing system. CMC-Union serves as our local 24-hour pharmacy and Legacy Consultant Pharmacy also has the ability to provide stat medications. The ability to rapidly obtain medications will be enhanced by the	12/20/12

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F 309	Continued From page 5 by a nurse aide and the resident was actively having a seizure. The notes revealed Resident #1 was moving her head back and forth and all of her extremities were jerking. The notes also revealed the seizure lasted 3 minutes, there was no respiratory distress and the physician was in facility and was called to the bedside of Resident #1. The notes indicated Resident #1 was non-verbal, did not follow any commands and looked at the physician then turned her eyes away. The notes revealed the blood pressure was 156/80; respirations 16; pulse 70 and the physician spoke to Resident #1's family about her medical history and condition and a decision was made to send the resident back to the hospital and emergency medical services (EMS) was notified. A review of a nurse's note dated 10/02/12 at 9:25 AM and written by the day shift nursing supervisor indicated Resident #1 was transported out of the facility via EMS. A review of an EMS patient care report dated 10/02/12 at 9:58 AM indicated EMS was dispatched to the facility and Resident #1 was in bed and conscious but would not speak to anyone. The report further indicated Resident #1 had 1 seizure prior to EMS arrival that lasted about 90 seconds and the resident was moved to a stretcher and taken to the EMS vehicle. The report revealed intravenous access was delayed because Resident #1 continuously pulled her arm away and she had another seizure that lasted about 90 seconds. The report further revealed intravenous access was obtained when the resident relaxed and she was transported to the emergency room and admitted to the hospital.	F 309	utilization of the services through Marshville Pharmacy. Given Marshville Pharmacy's size, close proximity to the facility and ability to deliver the medication as soon as it is filled, the facility will be able to provide the medication at the next scheduled medication administration. If there are orders for stat medications after hours, we will work with the pharmacist on call with Legacy to determine the optimal method of obtaining the medication. The medication orders will be sent to the back-up pharmacy via Legacy Consultant Pharmacy for a minimum of a 36 hour supply of medications to be delivered to the facility. If a medication cannot be obtained for any reason prior to the next scheduled medication administration, a call to our physician's group will be placed for direction.	

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F 309	Continued From page 6 During an interview on 12/18/12 at 1:25 PM the day shift nursing supervisor confirmed she worked on 10/02/12 and came on duty at approximately 8:00 AM. She explained she was called to Resident #1's room at 9:00 AM and the resident was having a seizure. She stated she did not know the resident because she had just been admitted the day before so she called for the doctor who was in the facility and he came to the resident's room and the resident was sent to the hospital emergency room. She explained she had not heard any concerns expressed about Resident #1 that morning and did not know anything about her refusal of medications before she was called into the room. During a phone interview on 12/18/12 at 1:40 PM Pharmacist #1 verified the physician orders for Resident #1 were faxed to the pharmacy at 3:15 PM on 10/01/12 and medications were delivered to the facility and a nurse signed for them on 10/02/12 at 12:03 AM. The pharmacist stated she did not see any notes or requests from the facility to call for back up medications. She explained the pharmacy had questioned the doses of several of the seizure medications since they were large doses but they went ahead and sent all of the medications except the Vimpat. She further explained Vimpat was a controlled drug and the facility could not answer questions the pharmacist had regarding the dosage Resident #1 was to receive. She stated the pharmacy called the facility the next day on 10/02/12 to follow up about the Vimpat and they were told Resident #1 had been sent to the hospital. The pharmacist stated it was the usual process for the pharmacy to take calls until 6:00	F 309	This direction will be documented in the resident's medical record. All nurses were retrained on this process of obtaining medications consist with physicians orders by 12/24/2012. Upon admission of each resident, the charge nurse will complete an admission assessment and document findings in the health record. Any acute findings will be communicated to the physician or mid-level provider for further direction. To ensure compliance, all nurses were inserviced by 12/24/2012 by the start of their next shift by the director of nursing or staff development coordinator on this process for administering medications for any new admission to the facility. The nurse responsible for the new admission will reconcile the medications delivered for the	12/24/12 12/24/12

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F 309	Continued From page 7 PM and deliveries of resident's medications were made between 10:00 PM and midnight. She stated the facility could also call the pharmacist on call or utilize the emergency kit/stat box available in the facility. She explained the facility's back up pharmacy closed at 9:00 PM but if medications were needed after 9:00 PM the pharmacist on call would call a pharmacy that was open 24 hours and they would get the medications for the facility. During a follow up interview on 12/18/12 at 4:12 PM the day shift nursing supervisor explained the hospital usually called a report to the facility before a resident was admitted and during this verbal report they were told the medications the resident had been taking and the times they were given. She further explained this information was not usually documented in the resident's medical record. She stated it was their usual process when the resident arrived at the facility for the admitting nurse to notify the pharmacy and send medication orders to them right away. She further stated when a resident was admitted from a hospital they usually documented the resident's medication list from the discharge or transfer summary form the hospital. She explained they then called the physician and reviewed the medication list with them and the physician ordered the medications, dosages and the frequency of the medications they wanted the resident to receive. She stated nursing staff then entered the medications, dosage and times the medications were to be administered into the computer system as physician orders and on the electronic MAR. She explained the pharmacy usually delivered medications between 10:00 PM and 12:00 AM each night and a nurse had to sign	F 309	specific resident to the medications orders. The nurse will also enter all ordered medications into the facility computer and place them on the MAR. Any variance will be discussed with a physician or physician extender for clarification and direction. On 12/19/2012, all full time nurses responsible for entering and scheduling admission orders were inserviced immediately on the proper method of scheduling medications to ensure all medications are administered timely. All nurses with the responsibility of entering admission orders have been inserviced on this process. This was completed on 12/19/2012. This new system is reflected by the facility updating its Policy for Medication Orders for New Admissions. It was	12/19/12

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F 309	Continued From page 8 for the medications when they were delivered. She stated they also had access to a back up pharmacy but they were not supposed to call them directly for medications because the facility pharmacy had protocols to follow so they called the back up pharmacy. She further stated they sometimes got a report from the hospital regarding which medications had been given to the resident before they were sent to the facility but more often they did not get this information and nursing staff in the facility had to figure it out. She stated she did not do Resident #1's admission paperwork on 10/01/12 and did not call the hospital to verify when Resident #1 received her medications prior to her admission to the facility. During an interview on 12/19/12 at 8:15 AM the Director of Nursing (DON) verified medications were delivered to the facility from the pharmacy between 10:00 PM and 12:00 AM. She explained it was their policy that routine medications were given after they were delivered from the pharmacy the next day during the next scheduled medication pass. She verified it was possible for residents to miss evening doses of medications when they were admitted late in the day since the pharmacy did not deliver medications until after 10:00 PM and they were not given until the next scheduled medication pass the next morning. During an interview on 12/19/12 at 9:40 a.m. Resident #1's physician stated the reason Resident #1 needed the seizure medications was because she was on triple therapy with 3 different types of anti seizure medications to prevent seizures. He stated if medications were not available then the physician should be alerted.	F 309	discussed by the Administrator and medical director who subsequently approved the policy revision 12/19/2012. To ensure on-going compliance, the director of nursing, staff development coordinator, or designee monitored these procedures by auditing every new admission to ensure compliance through 12/27/2012. This audit was designed to ensure the delivery of the medications as ordered by reconciling ordered medications to those delivered for administration. The director of nursing, or staff development coordinator will continue to audit at least 2 new admissions a week (as long as admissions are available) for 2 months until 3/1/2013. The results of these audits will be discussed at the department managers	12/19/12

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F 309	Continued From page 9 He further stated if Resident #1 did not have enough seizure medications in her system then she could have seizures. He explained that he would expect medications to be available in the facility and given as ordered. He further stated the process for waiting until next day on the next scheduled medication pass to give medications was not appropriate. He stated it was his expectation for nurses to follow physician's orders and administer medications as ordered. He further stated he was unaware Resident #1 missed her seizure medications and he had not been told the resident had refused medications on 10/02/12. During an interview on 12/19/12 at 10:05 AM Nurse #1 stated she usually worked the day shift from 8:00 AM to 4:30 PM. She further stated she took report from the hospital on 10/01/12 and Resident #1 was admitted to the facility around 3:00 PM. She explained the hospital reported to her that Resident #1 had a mild seizure earlier that morning in the hospital that lasted a couple of minutes. She stated after she got the physician's admission orders verified with a physician's assistant on 10/01/12 after 3:00 PM she entered medications in the computer system into Resident #1's MAR. She explained Resident #1's medication list was obtained from a list of medications on the discharge summary the hospital sent with the resident as part of her admission paperwork. She further stated she did not verify or document when Resident #1 received her last doses of medications at the hospital and she did not remember seeing a hospital MAR. Nurse #1 explained the nurses faxed any prescriptions or medication lists to the pharmacy and the medications were delivered to	F 309	meeting Monday through Friday, as scheduled, through 1/18/2013 in case immediate changes need to be discussed with the medical director and implemented. If no changes are needed, the daily discussion will end however, Director of Nursing can discuss any additional concerns as needed after 1/18/2013. If these audits identify an issue not consistent with this plan of correction, the director of nursing or staff development coordinator will re-inservice the staff member(s). The results of these audits are intended to ensure on-going compliance and will be discussed and monitored through our next quality assurance meeting or longer if the committee deems it necessary.	1/18/13 PER PHONE CONVERSATION WITH ADMINISTRATOR DL.

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F 309	Continued From page 10 the facility between 11:00 PM and 12:00 AM. She stated it was their usual practice to give medications to the resident on the next scheduled medication pass the next morning. She stated they had access to a back up pharmacy for after hours or if medications were unavailable they also had an emergency box that contained emergency medications. She further stated a resident admitted with seizures was not a common occurrence in the facility. During an interview on 12/19/12 at 10:53 AM Nurse #2 explained she was told Resident #1 had a history of seizures during the change of shift report on 10/01/12 on the 3:00 PM to 11:00 PM shift. She stated she was not told that Resident #1 had medications that needed to be given on her shift but she verified she documented on the electronic MAR that she gave Resident #1 Cipro 250 mg. by mouth and Lovenox 1.0 ml injection on 10/01/12 at 7:24 PM because those were the only medications she saw on Resident #1's MAR. She stated she did not remember where she got the medications but she might have gotten them out of the emergency box. She stated Resident #1's medications would not have been available in the medication cart because the pharmacy had not delivered them and they were usually delivered after 11:30 PM which was after her shift ended. She verified she did not give Resident #1 any seizure medications and she did not question the medications that were ordered for Resident #1 and did not request any medications from the backup pharmacy. She stated she was aware the back up pharmacy could provide medications if they needed to give them to a resident before the medications were delivered but she did not think she needed to call them because she	F 309		

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expected the pharmacy to deliver them later that night.

During an interview on 12/19/12 at 11:36 AM Nurse #3 explained she worked the 11:00 PM shift on 10/01/12 until 7:00 AM shift on 10/02/12 and was told in shift report Resident #1 had a history of seizures. She stated Resident #1 was a new admission and she checked on Resident #1 several times during the night. She verified she wrote the nurse's note on 10/02/12 at 3:31 AM to indicate the resident had not had any adverse reaction to the Cipro she was given during the 3:00 PM to 11:00 PM shift. She explained she thought Resident #1's medications were delivered by the pharmacy after midnight but she did not check the MAR until the next morning when she started her medication pass. She verified she documented on the electronic MAR on 10/02/12 at 6:43 AM that she did not give Resident #1 the Levothyroxine or Omeprazole because Resident #1 refused to open her mouth or take her medications so she documented them as not done. She explained she did not usually call the physician when a resident refused their medications but she thought she might have reported it to the nurse on the day shift before she left work that morning.

During an interview on 12/19/12 at 12:22 PM the Staff Development Coordinator (SDC) explained the nurses usually received medication lists for residents who were to be admitted prior to the resident arriving in the facility. She stated they verified the medications with the resident's physician and sent the resident's medication orders by fax to the pharmacy before the resident arrived but the resident had to be admitted and in

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the facility before they could requisition the medications from the pharmacy. The SDC explained mediations were delivered on second shift and nurses had access to emergency boxes that contained certain medications for staff to access if needed. She stated nursing staff were supposed to call the pharmacy anytime they needed medications and the pharmacy contacted the back up pharmacy for them after hours. She explained residents usually received their medications on the next scheduled medication pass but if they needed a medication right away such as an antibiotic it was given as soon as possible. She stated the nurses were expected to get the resident's medications from the pharmacy and to utilize the back up pharmacy as needed.

During a follow up interview on 12/19/12 at 3:25 PM the day shift Nursing Supervisor verified Resident #1 received Cipro 250 mg. by mouth and Lovenox 1.0 ml injection on 10/01/12 at 7:24 PM but no other medications were given. She explained the MAR only showed a limited list of medications when a resident was admitted late in the day because it only contained the medications that were actually given to the resident. She explained the complete listing of medications would not have appeared on the MAR until the next morning when the nurses gave the medications during the first med pass.

During an interview on 12/19/12 at 3:30 PM the facility Medical Director explained certain medications such as antibiotics, intravenous medications, medications for a bleed in the brain or for blood pressure should be given right away but it would depend on when the resident had the

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last dose of the medication. He stated residents should get the medication as ordered by the physician. He further stated if a resident refused medication the nurse should circle the medication on the MAR and determine why the resident refused the medication. He explained the facility had a communication book where they could leave notes for the physician, the physician group had 24 hour coverage in the facility and a physician or family nurse practitioner or physician's assistant was always available on call. He further stated it was his expectation for nurses to call the physician when they had questions about medications or dosages and they should get the medications from the pharmacy and give them according to the physician's orders.

The Administrator was informed of Immediate Jeopardy on 12/19/12 at 4:02 PM for Resident #1. The facility provided a credible allegation of compliance which included:

Autumn Care of Marshville
Allegation of Compliance
For the Provision of Care to Maintain the highest level of function for
Residents.

Resident #1 was admitted to the facility on 10/01/12. Resident #1 was transferred from the facility to the hospital on 10/02/12 after having a seizure and being assessed by her attending physician. The following audits were conducted by the staff development coordinator and the results are noted with each resident listed.
Resident #2 was admitted to the facility on 12/17/12 at 18:50 and his medical record was audited on 12/20/12 to ensure all current

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F 309	Continued From page 14 medications ordered were available for administration. On date of admission, the resident missed a dose of Colchicine at 20:00. No negative outcomes were noted. Resident #3 was admitted to the facility on 12/12/12 at 13:30 and his medical record was audited on 12/19/12 to ensure all current medications ordered were available for administration. On the date of admission, the Resident missed a dose of Hydralazine HCL at 1600, a dose of Labetalol at 20:00, and Pravastatin Sodium on at 20:00. No negative outcomes were noted. Resident #4 was admitted to the facility on 12/06/12 at 15:41 and her medical record was audited on 12/19/12 to ensure all current medications ordered were available for administration. On the date of admission, the resident missed a dose of Advair Diskus at 17:00, Nystatin mouth wash 1700 and 2100, Ferrous Fumarate at 17:00, Singulair at 17:00, and Neurontin at 1700. No negative outcomes were noted. Resident #5 was admitted to the facility on 12/17/12 at 18:30 and her medical record was audited on 12/19/12 to ensure all current medications ordered were available for administration. On the date of admission, the resident missed a dose of Ferrex at 2100. No negative outcomes were noted. All medications were administered following the delivery from the pharmacy as ordered by the physician. To ensure other residents are not affected in a similar manner, all admissions from 12/01/12-12/19/12 were audited on 12/19/12 for compliance. This audit was lead by the director of nursing and staff development coordinator and conducted by administrative nurses to insure all currently ordered medications were available for	F 309		

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F 309	Continued From page 15 administration. The lack of available medication was not identified with any resident in this audit. Upon notification of admission from the transferring facility, the admission coordinator will request admission orders from the transferring staff. Clinical information and medication orders will be reviewed by a provider of Physicians Eldercare and approved or additional orders provided. This will be documented in the medical record by the nurse. Admission orders will be faxed to Legacy Pharmacy by the admission nurse or nurse supervisor to begin dispensing process after the approval. The nurse responsible for processing the admission orders will contact the referring facility to obtain information regarding the last dose administered of each of the resident's prescribed medications. In the event this information is not available, the nurse will contact our physician or mid-level provider for directions on starting medications. The admitting nurse will enter all ordered medications into the Medication Administration Record and schedules per physician's orders. Efforts outlined in this plan of correction will be reviewed by the Quality Assurance Committee at our next two scheduled meetings and then as needed to minimize opportunities for missed medications by maintaining or further improving the new system. Legacy Consultant Pharmacy has contracted for services with Marshville Pharmacy to ensure all new admissions' medications by the next scheduled dose. This back-up service is in addition to our current back-up pharmacies and can respond quicker and deliver the medication as soon as it is ready during normal business	F 309		

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F 309	Continued From page 16 hours. In addition, we are still contracted with CVS pharmacy and CMC-Union as part of existing system. CMC-Union serves as our local 24-hour pharmacy and Legacy Consultant Pharmacy also has the ability to provide stat medications. The facility identified most of its concerns will be resolved by the utilization of the services through Marshville Pharmacy. Given their size, close proximity to the facility and ability to deliver the medication as soon as it is filled, the facility will be able to provide the medication at the next scheduled medication administration. If there are orders for stat medications after hours, we will work with the pharmacist on call with Legacy to determine the optimal method of obtaining the medication. The medication orders will be sent to the back-up pharmacy via Legacy Consultant Pharmacy for a minimum of a 36 hour supply of medications to be delivered to the facility. If a medication cannot be obtained for any reason prior to the next scheduled medication administration, a call to our physician's group will be placed for direction. This direction will be documented in the resident's medical record. Upon admission of each resident, the charge nurse will complete an admission assessment and document findings in the health record. Any acute findings will be communicated to the physician or mid-level provider for further direction. Legacy Consultant Pharmacy contracted with Marshville Pharmacy and it is available to our residents and potential residents on 12/20/12. To ensure compliance, all nurses will be inserviced starting 12/20/12 by the director of nursing or staff	F 309		

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F 309	Continued From page 17 development coordinator of this new process for administering medications for any new admission to the facility. Upon receipt of the new medications, a nurse will audit the medication orders as ordered by the physician to ensure each medication is available for administration. This audit will be a print out of the medication orders for the new admission. The nurse responsible for the new admission will reconcile the medications delivered for the specific resident to the medication list. Any variance will be discussed with a physician or physician extender for clarification and direction. On 12/19/12, all full time nurses responsible for entering and scheduling admission orders were inserviced immediately on the proper method of scheduling medications to ensure all medications are administered timely. All nurses with the responsibility of entering admission orders will be inserviced prior to their next shift. No nurse will be allowed to return to work without completing this training. This new system is reflected by the facility updating its Policy for Medication Orders for New Admissions. It has been approved by the Administrator and has been faxed to the medical director for his approval. To ensure on-going compliance, the director of nursing, staff development coordinator, or designee will audit every new admission on the day of admission to ensure compliance until 12/27/12. This audit will be completed upon the delivery of the medications by reconciling ordered medications to those delivered for administration. The director of nursing, or staff development	F 309		

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coordinator, will audit a minimum of 3 admissions a week (as long as admissions are available) until 01/03/12 and then will audit at least 2 charts a week for 2 months. The results of these audits will be discussed at the department managers meeting Monday through Friday, as scheduled, in case immediate changes need to be discussed and implemented. Audits as needed will be conducted to ensure the interventions are effective and on-going compliance is maintained.

The results of these audits intended to ensure on-going compliance will be discussed and monitored through our next quality assurance meeting for at least the next two meetings or longer if the committee deems it necessary.

Immediate jeopardy was removed on 12/20/12 at 5:20 PM when interviews of medication nurses and nursing supervisors confirmed they received inservice training on 12/19/12 and 12/20/12 prior to reporting for work regarding the policy changes for the new back up pharmacy and they were supposed to check medication orders when residents were admitted and were to ensure medications were given according to physician orders. They further explained they were expected to call the physician for clarification of medications and dosages when there were questions or discrepancies.

A review of the inservice training documents and sign in sheets on 12/20/12 confirmed the inservice training had been done on 12/19/12 and 12/20/12 and scheduled as ongoing to ensure all nurses received training prior to them working.

A review of the facility policy titled "Medication

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Ordering and Receiving from Pharmacy" indicated policy changes related to the new back up pharmacy.

2. Resident #2 was re-admitted to the facility on 12/17/12 at 6:50 PM with diagnoses including heart disease, high blood pressure, chronic obstructive lung disease, pleural effusion (excess fluid that accumulates between the two layers of space that surrounds the lungs), kidney disease and gout.

There was no Minimum Data Set (MDS) available but a review of a hospital discharge summary dated 12/17/12 indicated Resident #2 was alert and oriented.

A review of hospital discharge instructions dated 12/17/12 indicated the following medications were ordered for Resident #2:
- Atrovent HFA 2 puffs every 6 hours (for chronic obstructive lung disease).
- Amiodorarone 200 milligrams (mg.) by mouth daily (for irregular heart rate).
- Coreg 6.25 mg. by mouth twice daily (for high blood pressure).
- Colchicine 0.6 mg. by mouth daily (for gout).
- Pepcid 25 mg. by mouth daily (for esophageal reflux).
- Multivitamin 1 by mouth daily (for nutritional deficiency).
- Zocor 10 mg. by mouth at bedtime (for high fat levels in the blood).

A further review of the hospital discharge instructions did not specify if the resident had received his daily medications on 12/17/12.

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A review of the Medication Administration Record dated 12/17/12 specified the times in which Resident #2 was to receive his medications:
- Atrovent HFA 2 puffs every 6 hours at 12:00 AM; 6:00 AM; 12:00 PM; 6:00 PM
- Amiodorarone 200 milligrams (mg.) daily at 8:00 AM
- Coreg 6.25 mg. by mouth twice daily at 8:00 AM and 4:00 PM
- Colchicine 0.6 mg. by mouth daily at 8:00 PM
- Pepcid 25 mg. by mouth daily at 8:00 AM
- Multivitamin 1 by mouth daily at 8:00 AM
- Zocor 10 mg. by mouth at bedtime at 9:00 PM

A further review of the MAR revealed Resident #2 did not receive ordered medications on 12/17/12 that included:
- Colchicine 0.6 mg. by mouth at 8:00 PM

During an interview on 12/18/12 at 4:12 PM the day shift nursing supervisor reported that she, the Quality Assurance (QA) Nurse and the Staff Development Coordinator (SDC) usually were the nurses responsible for completing the admission process for a new resident entering the facility that included obtaining discharge instructions with medications. She stated they sometimes got a report from the hospital regarding which medications had been given to the resident before they were discharged but she explained sometimes they did not get any of this information and had to figure it out. She confirmed that in most cases residents were admitted to the facility and the nursing staff was unaware of what medications they had last received. She verified that Resident #2's medication list was obtained from the hospital discharge/transfer summary medication list and was called to the physician for

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approval the same day. She explained the pharmacy delivered medications usually between 10:00 PM and 12:00 AM and a nurse had to sign for them when they were delivered.

During an interview on 12/19/12 at 8:15 AM the Director of Nursing (DON) stated they didn't always get documentation when a resident last received medication in the hospital. She stated nurses should call the hospital if clarification was needed regarding physician orders and it was her expectation that anytime there was a discrepancy the nurses should call the physician for clarification.

During an interview on 12/19/12 at 9:40 AM Physician #1 stated the facility's practice of waiting to begin administering medications the day after admission was not appropriate. He added that he expected nurses to follow physician's orders and they should give the medications according to the physician's orders. He stated he was unaware that it was the facility's usual practice to wait until the next scheduled dose after the medication was delivered to the facility for administration. He further stated Resident #2 should have received all medications as ordered by his physician and he expected nursing staff to call the physician's group if they were unsure when a resident had last received their medications or needed clarification of medication orders.

During an interview on 12/19/12 at 10:41 AM the QA nurse stated the facility staff tried to get the information from the hospital when the next dosage of medication was due and sometimes the information was included with the hospital

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discharge summary. She was unable to recall if she attempted to speak with the hospital to determine what medications Resident #2 had last received.

During an interview on 12/20/12 at 10:45 AM Nurse #4 reported she was assigned to work 3:00 PM to 11:00 PM shift on 12/17/12 and she was Resident #2's assigned nurse. She added that she was not responsible for putting the Resident's medications into the computer system and she would not have administered medications to the resident unless they appeared "active" in the MAR. She verified Resident #2's MAR revealed the medications had not been made "active" until the next day on 12/18/12. She stated the medication ordered by the physician for evening administration was not given to Resident #2 because it had not been scheduled to be given on the MAR. She further stated she relied on the MAR to notify her of when the resident's medications were scheduled to be administered.

During a follow up interview on 12/20/12 at 12:15 PM the day shift supervisor stated it appeared to her that on Resident #2's admission orders and facility MAR the evening medication that was due on 12/17/12 had been omitted from the MAR. She further stated she was unaware this had happened and she was unable to recall if she was responsible for putting Resident #2's medications into the computer.

During an interview on 12/19/12 at 12:22 PM the Staff Development Coordinator (SDC) explained the nurses received medication lists for residents who were to be admitted prior to the resident arriving in the facility. She was unable to recall if

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she attempted to speak with the hospital to determine what medications Resident #2 had last received.

3. Resident #3 was admitted to the facility on 12/12/12 at 1:30 PM with diagnoses which included high blood pressure and a recent stroke. The most recent admission Minimum Data Set dated 12/21/12 indicated Resident #3 was cognitively intact.

A review of hospital discharge instructions dated 12/12/12 indicated the following medications were ordered for Resident #3:
- Folic Acid 1.0 milligrams (mg.) by mouth daily (for a nutritional deficiency).
- Thiamine 100 mg. by mouth daily (for a nutritional deficiency).
- Lisinopril 10 mg. by mouth daily (for high blood pressure).
- Labetalol 400 mg. by mouth twice daily (for high blood pressure).
- Prevastatin 40 mg. by mouth at bedtime (for high blood pressure).
- Aspirin 81 mg. by mouth daily (for stroke prevention).
- Nicotine patch transdermal 25 mg. daily x 4 weeks (for smoking prevention).
- Hydralazine 25 mg. by mouth every 8 hours (for high blood pressure).
- Multivitamin 1 by mouth daily (for nutritional deficiency).
- Colace 100 by mouth twice daily (for constipation).
- Valium 10 mg by mouth daily x 2 days, then 5 mg. by mouth x 2 days then 5 mg. by mouth every other day x 2 doses (for treatment of alcohol withdrawal).

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A further review of the hospital discharge instructions did not specify if the resident had received daily medications on 12/12/12.

A review of the Medication Administration Record dated 12/12/12 specified the times in which Resident #3 was to receive his medications:
- Folic Acid 1.0 milligrams (mg.) by mouth daily at 8:00 AM
- Thiamine 100 mg. by mouth daily at 8:00 AM
- Lisinopril 10 mg. by mouth daily at 8:00 AM
- Labetalol 400 mg. by mouth twice daily at 8:00 AM and 4:00 PM
- Prevastatin 40 mg. by mouth at bedtime at 9:00 PM
- Aspirin 81 mg. by mouth daily at 8:00 AM
- Nicotine patch transdermal 25 mg. daily x 4 weeks at 8:00 AM
- Hydralazine 25 mg. by mouth every 8 hours at 12:00 AM; 8:00 AM and 4:00 PM
- Multivitamin 1 by mouth daily at 8:00 AM
- Docusate 100 by mouth twice daily at 8:00 AM
- Valium 10 mg by mouth daily at 8:00 AM x 2 days, then 5 mg. by mouth x 2 days then 5 mg. by mouth every other day x 2 doses.

A further review of the MAR revealed Resident #3 did not receive ordered medications on 12/12/12 that included:
- Labetalol 400 mg. by mouth at 8:00 PM
- Prevastatin 40 mg. by mouth at bedtime at 8:00 PM
- Hydralazine 25 mg. by mouth every 8 hours at 4:00 PM

On 12/18/12 at 4:12 PM the day shift nursing supervisor was interviewed and reported that she,

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F 309	Continued From page 25 the Quality Assurance (QA) Nurse and the Staff Development Coordinator (SDC) usually were the nurses responsible for completing the admission process for a new resident entering the facility that included obtaining discharge instructions with medications. She stated they sometimes got a report from the hospital regarding which medications had been given to the resident before they were discharged but she explained sometimes they did not get any of this information and had to figure it out. She confirmed that in most cases residents were admitted to the facility and the nursing staff was unaware of what medications they had last received. She verified Resident #3's medication list was obtained form the hospital discharge/transfer summary medication list and was called to the physician for approval the same day. She explained the pharmacy delivered medications usually between 10:00 PM and 12:00 AM and a nurse had to sign for them when they were delivered. During an interview on 12/19/12 at 8:15 AM the Director of Nursing (DON) stated they didn't always get documentation when a resident last received medication in the hospital. She stated nurses should call the hospital if clarification was needed regarding physician orders and it was her expectation that anytime there was a discrepancy the nurses should call the physician for clarification. During an interview on 12/19/12 at 9:40 AM Physician #1 was interviewed and stated the facility's practice of waiting to begin administering medications the day after admission was not appropriate. He added that he expected nurses to follow physician's orders and they should give	F 309		

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the medication as ordered. He stated he was unaware that it was the facility's usual practice to wait until the next scheduled dose after the medication was delivered to the facility for administration. He further stated Resident #3 should have received all medications as ordered by his physician and he expected nursing staff to call the physician's group if they were unsure when a resident had last received their medications or needed clarification of medication orders.

During an interview on 12/19/12 at 10:41 AM the QA nurse stated the facility staff tried to get the information from the hospital when the next dosage of medication was due and sometimes the information was included with the hospital discharge summary. She was unable to recall if she attempted to speak with the hospital to determine what medications Resident #3 had last received.

During a follow up interview on 12/20/12 at 12:15 PM the day shift supervisor explained it appeared to her that on Resident #3's admission orders and facility MAR the evening medication that was due on 12/12/12 had been omitted from the MAR. She added she was unaware this had happened and stated it was important for the resident to receive his blood pressure medication. She stated she was unable to recall if she was responsible for putting Resident #3's medications into the computer.

During an interview on 12/19/12 at 12:22 PM the Staff Development Coordinator (SDC) explained the nurses received medication lists for residents who were to be admitted prior to the resident

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arriving in the facility. She was unable to recall if she attempted to speak with the hospital to determine what medications Resident #3 had last received.

4. Resident #4 was admitted to the facility on 12/06/12 at 3:41 PM with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), anemia, thrush and others. The most recent Minimum Data Set (MDS) dated 12/13/12 specified the resident had no impaired cognition.

Resident #4's hospital discharge instructions dated 12/06/12 were reviewed and specified the Resident was ordered by the physician to receive:
- Neurontin (pain medication) 100mg (milligrams) two times each day
- Advair Diskus (inhaler) 250mcg (micrograms) / 50mcg two times each day
- Theophylline (bronchodilator) 200mg every 12 hours
- Nystatin (antifungal) 100,000 units/mL (milliliters) 5 times each day
- Ferrous Fumarate (iron supplement) 150mg two times each day
- Levaquin 750 mg daily
- Prednisone (steroid) 10mg daily
- Carbidopa-levodopa (cardiac medication) 25mg/100mg daily
- Vitamin D3 (nutritional supplement) 2000 units daily
- Vitamin B12 (nutritional supplement) 500mcg daily
- Diltiazem (cardiovascular) 180mg daily
- Nexium (reflux) 40mg daily
- Lasix (diuretic) 40mg daily
- Lisinopril - hydroclorothiazide (cardiac) 10mg - 12.5mg daily

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F 309	Continued From page 28 - Methimazole (hyperthyroidism) 5mg daily - Singulair (inhaler)10mg daily - Daliresp (pulmonary) 500mcg daily - Crestor (cholesterol) 10mg daily - Sprivia (inhaler)18mcg daily Further review of the hospital discharge instructions did not specify if the resident had received her daily medications on 12/06/12. Review of Resident #4's "Medications Administration Record" (MAR) for 12/06/12 revealed there was no documentation to indicate the following medications were administered: - Advair Diskus at 5:00 PM - Singulair at 5:00 PM - Neurontin at 5:00 PM On 12/18/12 at 4:12 PM the day shift nursing supervisor was interviewed and reported that she, the Quality Assurance (QA) Nurse and the Staff Development Coordinator (SDC) usually were the nurses responsible for completing the admission process for a new resident entering the facility that included obtaining discharge instructions with medications. She stated they sometimes got a report from the hospital regarding which medications had been given to the resident before they were discharged but she explained sometimes they did not get any of this information and had to figure it out. She confirmed that in most cases residents were admitted to the facility and the nursing staff was unaware of what medications they had last received. She reviewed Resident #4's MAR for 12/06/12 and verified the resident did not receive the medications. She reported that the MAR reflected the medications were not scheduled to	F 309		

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be given until the following day on 12/07/12 because medications were not delivered until 10 PM.

During an interview on 12/19/12 at 8:15 AM the Director of Nursing (DON) stated they didn't always get documentation when a resident last received medication in the hospital. She stated nurses should call the hospital if clarification was needed regarding physician orders and it was her expectation that anytime there was a discrepancy the nurses should call the physician for clarification.

During an interview on 12/19/12 at 9:40 a.m. Physician #1 stated obtaining information concerning a new resident's medications received should be part of the admission process and that he would expect nurses to inquire and obtain such information from the hospital. He stated it was his expectation for nurses to follow physician's orders and give medications according to the physician's orders.

During an interview on 12/19/12 at 10:41 AM the QA nurse stated the facility staff tried to get the information from the hospital when the next dosage of medication was due and sometimes the information was included with the hospital discharge summary. She was unable to recall if she attempted to speak with the hospital to determine what medications Resident #4 had last received.

During an interview on 12/19/12 at 12:22 PM the Staff Development Coordinator (SDC) explained the nurses received medication lists for residents who were to be admitted prior to the resident

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F 309	Continued From page 30 arriving in the facility. She was unable to recall if she attempted to speak with the hospital to determine what medications Resident #4 had last received. On 12/20/12 at 10:45 AM Nurse #4 who worked 3-11 p.m. was interviewed and confirmed she was the first nurse assigned to care for Resident #4 after being admitted to the facility. She could not recall if she was made aware of what medications the resident had received in the hospital prior to admission. She stated she relied on the MAR to notify her of when the resident's medications were scheduled to be administered. 5. Resident #5 was admitted to the facility on 12/17/12 at 6:30 PM with diagnoses that included anticoagulant therapy and nutritional deficiency among others. No Minimum Data Set (MDS) information was available for the resident. Resident #5's hospital discharge instructions dated 12/17/12 were reviewed and specified the Resident was ordered by the physician to receive: - Aspirin 81mg daily - Sinemet (Parkinsonism) 25/100mg three times each day - Vitamin B12 (nutritional supplement) 2500mcg daily - Vitamin D (nutritional supplement) 2000units daily - Folic acid (nutritional supplement) 800mcg daily - Synthroid (thyroid disorder) 50mcg daily before breakfast - Multivitamin (nutritional supplement) 1 tablet daily - Tylenol (for pain) 650mg every eight hours	F 309		

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F 309	Continued From page 31 - Ferrex (iron)150mg daily at bedtime - Warfarin (anticoagulant) 4mg daily Further review of the hospital discharge instructions did not specify if the resident had received her daily medications on 12/17/12. Review of Resident #5's "Medications Administration Record" (MAR) for 12/17/12 specified the resident did not receive the following medication on 12/17/12 after being admitted to the facility: Ferrex 150 mg. at 9:00 PM. On 12/18/12 at 4:12 PM the day shift nursing supervisor was interviewed and reported that she, the Quality Assurance (QA) Nurse and the Staff Development Coordinator (SDC) usually were the nurses responsible for completing the admission process for a new resident entering the facility that included obtaining discharge instructions with medications. She stated they sometimes got a report from the hospital regarding which medications had been given to the resident before they were discharged but she explained sometimes they did not get any of this information and had to figure it out. She confirmed that in most cases residents were admitted to the facility and the nursing staff was unaware of what medications they had last received. She reviewed Resident #5's MAR for 12/17/12 and verified the resident did not receive the medications. She reported that the MAR reflected the medications were not scheduled to be given until the following day on 12/18/12 because medications were not delivered until 10 PM. During an interview on 12/19/12 at 8:15 AM the	F 309		

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F 309	Continued From page 32 Director of Nursing (DON) stated they didn't always get documentation when a resident last received medication in the hospital. She stated nurses should call the hospital if clarification was needed regarding physician orders and it was her expectation that anytime there was a discrepancy the nurses should call the physician for clarification. During an interview on 12/19/12 at 9:40 a.m. Physician #1 stated obtaining information concerning a new resident's medications received should be part of the admission process and that he would expect nurses to inquire and obtain such information from the hospital. He stated it was his expectation for nurses to follow physician's orders and give medications as ordered by the physician. During an interview on 12/19/12 at 10:41 AM the QA nurse stated the facility staff tried to get the information from the hospital when the next dosage of medication was due and sometimes the information was included with the hospital discharge summary. She was unable to recall if she attempted to speak with the hospital to determine what medications Resident #5 had last received. During an interview on 12/19/12 at 12:22 PM the Staff Development Coordinator (SDC) explained the nurses received medication lists for residents who were to be admitted prior to the resident arriving in the facility. She was unable to recall if she attempted to speak with the hospital to determine what medications Resident #5 had last received.	F 309		

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F 309	Continued From page 33 On 12/20/12 at 10:45 AM Nurse #4 was interviewed and confirmed she was the first nurse assigned to care for Resident #5 after being admitted to the facility. She could not recall if she was made aware of what medications the resident had received in the hospital prior to admission. She stated she relied on the MAR to notify her of when the resident's medications were scheduled to be administered.	F 309		
F 333 SS=J	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician interviews and record reviews the facility staff failed to administer significant medications which included seizure, blood pressure, pain and respiratory medications according to physician's orders for 3 of 5 sampled residents. (Resident's #1, #3, and #4). Immediate Jeopardy began on 10/01/12 when Resident #1 did not receive scheduled seizure medications and subsequently exhibited grand mal seizures on 10/02/12. The Administrator was notified of immediate jeopardy on 12/19/12 at 4:02 PM. Immediate jeopardy was removed on 12/20/12 at 5:40PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not	F 333	This plan of correction will serve as the facility's allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to CMS 2567 for the 12-18-12 survey and does not constitute an agreement or admission of Autumn Care of Marshville of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted	

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F 333	Continued From page 34 immediate jeopardy) to complete education and to ensure monitoring of systems put into place are effective. The findings are: A review of a facility document titled "Medication Orders" dated 06/12 under Procedures section D indicated the prescriber is contacted by nursing for direction when delivery of a medication will be delayed or the medication is not or will not be available. 1. Resident #1 was admitted on 10/01/12 at 3:00 PM with medical diagnoses which included malignant brain tumor with right sided paralysis, cerebral edema (swelling in the brain), a history of seizures and deep vein thrombosis. The admission nursing assessment dated 10/01/12 but did not include the time it was completed revealed Resident #1 was alert and oriented to person, had impairment in short term memory and had modified independence with some difficulty in new situations only with cognition for daily decision making. The assessment further indicated Resident #1 required limited assistance with activities of daily living (ADL), had unclear speech and mumbled her words and was agitated. The assessment also revealed Resident #1's personal medications were not brought into facility when she was admitted. A review of a hospital Medication Administration Record (MAR) dated 10/01/12 indicated the following seizure medications were given prior to Resident #1's discharge to the facility:	F 333	because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, Autumn Care of Marshville submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 12/24/12. To address the alleged deficient practice for the residents allegedly affected, and to address the cited issues for all residents having potential to be affected, the facility has taken the following actions. All admissions from 12/1/2012-12/19/12 were audited on 12/19/12 for compliance. This audit was lead by the	12/19/12

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F 333	Continued From page 35 10/01/12 at 9:06 AM Vimpat 150 mg. by mouth (for seizure prevention). 10/01/12 at 9:07 AM Keppra 1500 mg. by mouth (for seizure prevention). 10/01/12 at 9:08 AM Trileptal 300 mg. by mouth (for seizure prevention). The hospital MAR also indicated the following medication to control swelling in Resident #1's brain was given prior to her discharge to the facility as follows: 10/01/12 Dexamethasone 2 mg. by mouth at 9:08 AM and 2:28 PM. A review of Physician's admission orders dated 10/01/12 indicated the following list of seizure medications and the frequency of when they were to be given: Dexamethasone 2 mg. by mouth four times daily Keppra 1500 mg. by mouth twice daily Trileptal 900 mg. by mouth twice daily Vimpat 150 mg. by mouth twice daily A review of the facilty MAR for Resident #1 dated 10/01/12 revealed there were no seizure medications or the Dexamethasone listed to be given to the resident. A review of a facility document titled "packing slip" and dated 10/02/12 indicated the following medications were delivered to the facility from the pharmacy for Resident #1: Dexamethasone 2 mg. tablets; Keppra 1000 mg. tablets; Keppra 500 mg. tablets and Trileptal 300 mg. tablets. The medication Vimpat was not on the list of delivered medications. A review of an electronic MAR dated 10/01/12 at	F 333	director of nursing and staff development coordinator and conducted by administrative nurses to insure all currently ordered medications were available for administration and were timely administered as ordered by the physician. The lack of available medication was not identified with any resident in this audit. Upon notification of admission from the transferring facility, the admissions coordinator will verbally request admission orders from the transferring staff. Clinical information and medication orders will be reviewed by a provider of Physicians Eldercare and approved or additional orders provided. This will be documented in the medical record by the nurse. Admission orders will be faxed to Legacy Pharmacy by the admission nurse or nurse	

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F 333	Continued From page 36 7:24 PM indicated there were no medications given for seizures or to reduce swelling in Resident #1's brain. A review of an electronic MAR dated 10/02/12 at 6:43 AM indicated there were no medications given for seizures or to reduce swelling in Resident #1's brain. A review of a nurse's note dated 10/02/12 at 9:00 AM indicated a nurse was called to Resident #1's room by a nurse aide and the resident was actively having a seizure. The notes revealed Resident #1 was moving her head back and forth, all of her extremities were jerking. The notes also revealed the seizure lasted 3 minutes, there was no respiratory distress and the physician was in facility and called to the bedside of Resident #1. The notes indicated the physician spoke to Resident #1's family about her medical history and condition and a decision was made to send the resident back to the hospital and emergency medical services (EMS) was notified. A review of a nurse's note dated 10/02/12 at 9:25 AM indicated Resident #1 was transported to an emergency department via EMS. A review of a EMS patient care report dated 10/02/12 at 9:58 AM indicated EMS was dispatched to the facility and Resident #1 was in bed and conscious but would not speak to anyone. The report further indicated Resident #1 had a seizure that lasted about 90 seconds and the resident was transported to the emergency room and admitted to the hospital. During an interview on 12/18/12 at 1:25 PM the	F 333	supervisor to begin dispensing process after the approval. The nurse responsible for processing the admission orders will contact the referring facility to obtain information regarding the last dose administered of each of the resident's prescribed medications. In the event this information is not available, the nurse will contact our physician or mid-level provider for directions on starting medications. The admitting nurse will enter all ordered medications into the Medication Administration Record and schedules per physician's orders. The steps outlined in this plan of correction will be reviewed by the Quality Assurance Committee at our next scheduled meeting and then as needed for the next six months to minimize opportunities for missed medications by maintaining	

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F 333	Continued From page 37 day shift nursing supervisor confirmed she worked on 10/02/12 and came on duty at approximately 8:00 AM. She explained she was called to Resident #1's room at 9:00 AM and the resident was having a seizure. She stated she did not know the resident because she had just been admitted the day before so she called for the doctor who was in the facility and he came to the resident's room and the resident was sent to the hospital emergency room. She explained had not heard any concerns expressed about the resident that morning and was not aware Resident #1 had not received her seizure medications. The nursing supervisor verified on the electronic MAR that Resident #1 had not received any seizure medications or the medication to reduce swelling in her brain since she was admitted to the facility. During a phone interview on 12/18/12 at 1:40 PM Pharmacist #1 verified the physician orders for Resident #1 were faxed to the pharmacy at 3:15 PM on 10/01/12 and medications were delivered to the facility and a nurse signed for them at 12:03 AM on 10/02/12. The pharmacist stated she did not see any notes or requests from the facility to call for back up medications. She explained the pharmacy had questions about the doses of the seizure medications since they were large doses and they sent all of the medications except the Vimpat. She explained Vimpat was a controlled drug and the facility could not answer questions the pharmacist had regarding the dosage of the medication. She stated the pharmacy called the facility the next day on 10/02/12 to follow up about the Vimpat and they were told Resident #1 had been sent to the hospital. The pharmacist stated it was the usual	F 333	or further improving this system. Legacy Consultant Pharmacy has contracted for services with Marshville Pharmacy to ensure all new admissions' medications by the next scheduled dose and Marshville Pharmacy is available to our residents and potential residents as of 12/20/2012. This back-up service is in addition to our current back-up pharmacies and can respond quicker and deliver the medication as soon as it is ready during normal business hours. In addition, we are still contracted with CVS pharmacy and CMC-Union as part of our existing system. CMC-Union serves as our local 24-hour pharmacy and Legacy Consultant Pharmacy also has the ability to provide stat medications. The ability to rapidly obtain medications will be enhanced by the	12/20/12

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F 333	Continued From page 38 process for the pharmacy to take calls until 6:00 PM and deliveries of resident medications were made between 10:00 PM and midnight. She stated the facility could also call the pharmacist on call and they had an emergency kit/stat box available in the facility. She explained the facility's back up pharmacy closed at 9:00 PM but if medications were needed after 9:00 PM the pharmacy would call a pharmacy that was open 24 hours and they would get the medications for the facility. During a follow up interview on 12/18/12 at 4:12 PM the day shift nursing supervisor stated it was their usual process to notify the pharmacy and send medication orders to them right away when a resident was admitted to the facility. She verified that Resident #1's medication list was obtained from the hospital discharge/transfer summary medication list and was called to the physician assistant for verification and orders on 10/01/12 when Resident #1 was admitted at 3:00 PM. She explained the pharmacy delivered medications usually between 10:00 PM and 12:00 AM. and a nurse had to sign for them when they were delivered During an interview on 12/19/12 at 8:15 AM the Director of Nursing (DON) verified medications were delivered to the facility from the pharmacy between 10:00 PM and 12:00 AM. She explained it was their policy that routine medications were given after they were delivered from the pharmacy the next day during the next scheduled medication pass. She verified it was possible for residents to miss evening doses of medications when they were admitted late in the day since they were not delivered until after 10:00 PM and	F 333	utilization of the services through Marshville Pharmacy. Given Marshville Pharmacy's size, close proximity to the facility and ability to deliver the medication as soon as it is filled, the facility will be able to provide the medication at the next scheduled medication administration. If there are orders for stat medications after hours, we will work with the pharmacist on call with Legacy to determine the optimal method of obtaining the medication. The medication orders will be sent to the back-up pharmacy via Legacy Consultant Pharmacy for a minimum of a 36 hour supply of medications to be delivered to the facility. If a medication cannot be obtained for any reason prior to the next scheduled medication administration, a call to our physician's group will be placed for direction.	

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F 333	Continued From page 39 that was probably the reason Resident #1 did not get her seizure medications or the Dexamethasone. She stated nurses should call the hospital if clarification was needed regarding physician orders and it was her expectation that anytime there was a discrepancy the nurses should call the physician for clarification. During an interview on 12/19/12 at 9:40 a.m. Resident #1's physician stated the reason Resident #1 needed the seizure medications because she was on triple therapy with 3 different types of anti-seizure medications to prevent seizures. He stated if medications were not available then the physician should be alerted. He further stated if the resident did not have enough seizure medications in her system it could cause her to have seizures. He further stated he expected medications to be available in the facility and given as ordered. He further stated the process for waiting until next day on the next scheduled medication pass to give medications was not appropriate. He stated it was his expectation for nurses to follow physician's orders and to give medications as ordered. He further stated he was unaware Resident #1 missed dosages of her anti-seizure medications and he had not been told the resident refused medications on 10/02/12. During an interview on 12/19/12 at 10:05 AM Nurse #1 stated she took report from the hospital and Resident #1 was admitted around 3:00 PM on 10/01/12. She explained the hospital reported to her that Resident #1 had a mild seizure earlier that morning that lasted a couple of minutes. She stated she set up Resident #1's MAR and she put the medications into the computer system. She	F 333	This direction will be documented in the resident's medical record. All nurses were retrained on this process of obtaining medications consist with physicians orders by 12/24/2012. Upon admission of each resident, the charge nurse will complete an admission assessment and document findings in the health record. Any acute findings will be communicated to the physician or mid-level provider for further direction. To ensure compliance, all nurses were inserviced by 12/24/2012 by the start of their next shift by the director of nursing or staff development coordinator on this process for administering medications for any new admission to the facility. The nurse responsible for the new admission will reconcile the medications delivered for the	12/24/12 12/24/12

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F 333	Continued From page 40 further stated she did not verify or document when Resident #1 had her last doses of medications at the hospital. During an interview on 12/19/12 at 10:53 AM Nurse #2 explained she was told Resident #1 had a history of seizures when she got shift report on 10/01/12 on the 3:00 PM to 11:00 PM shift. She verified she gave Resident #1 Cipro 250 mg. by mouth and Lovenox 1.0 ml injection on 10/01/12 at 7:24 PM but she did not have seizure medications available during her shift for the resident. She stated Resident #1's medications would not have been available in the medication cart because the pharmacy usually delivered the medications nightly after 11:30 PM which was after her shift ended. She also stated she did not question the medications that were ordered for Resident #1 and did not request any medications from the backup pharmacy because she expected the pharmacy to deliver the medications later that night. During an interview on 12/19/12 at 11:36 AM with Nurse #3 she explained she worked the 11:00 PM shift on 10/01/12 until 7:00 AM shift on 10/02/12 and was told in shift report Resident #1 had a history of seizures. She stated she did not give seizure medications or the medication to reduce the swelling in Resident #1's brain during her shift because when she started her morning medication pass on 10/02/12 Resident #1 refused to open her mouth so she did not give Resident #1 any of her medications. She stated she did not usually call the physician when a resident refused their medications but she thought she reported it to the oncoming shift nurse.	F 333	specific resident to the medications orders. The nurse will also enter all ordered medications into the facility computer and place them on the MAR. Any variance will be discussed with a physician or physician extender for clarification and direction. On 12/19/2012, all full time nurses responsible for entering and scheduling admission orders were inserviced immediately on the proper method of scheduling medications to ensure all medications are administered timely. All nurses with the responsibility of entering admission orders have been inserviced on this process. This was completed on 12/19/2012. This new system is reflected by the facility updating its Policy for Medication Orders for New Admissions. It was	12/19/12

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F 333	Continued From page 41 During a follow up interview on 12/19/12 at 3:25 PM the day shift Nursing Supervisor verified Resident #1 did not receive any seizure medications or the medication to reduce the swelling in the resident's brain. She explained she would expect to see a limited list of medications on the MAR when a resident was admitted late in the day because it only contained any medications that were actually given. She explained the complete listing of medications would not have appeared on the MAR until the next morning when the nurse started giving the medications during their first medication pass. During an interview on 12/19/12 at 3:30 PM the facility Medical Director explained certain medications such as antibiotics, intravenous medications or medications for a bleed in the brain or for blood pressure should be given right away but it would depend on when the resident had the last dose of the medication. He stated residents should get the medication as ordered by the physician. He further stated if a resident refused medication the nurse should circle the medication on the MAR and determine why the resident refused the medication. He further stated the facility had a communication book where they could leave notes for the physician and the physician group had 24 hour coverage in the facility and a physician or family nurse practitioner or physician's assistant was always available on call. He further stated it was his expectation for nurses to call the physician when they had questions about medications or dosages and they should get it from the pharmacy and give the medication according to the physician's orders.	F 333	discussed by the Administrator and medical director who subsequently approved the policy revision 12/19/2012 by phone and again at our QA Meeting on 1/15/13. To ensure on-going compliance, the director of nursing, staff development coordinator, or designee monitored these procedures by auditing every new admission to ensure compliance through 12/27/2012. This audit was designed to ensure the delivery of the medications as ordered by reconciling ordered medications to those delivered for administration. The director of nursing, or staff development coordinator will continue to audit at least 2 new admissions a week (as long as admissions are available) for 2 months until 3/1/2013. The results of these audits	12/19/12

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

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F 333	Continued From page 42 The Administrator was informed of Immediate Jeopardy on 12/19/12 at 4:02 PM for Resident #1. The facility provided a credible allegation of compliance which included: Autumn Care of Marshville Allegation of Compliance For Significant Medication Error. Resident #1 was admitted to the facility on 10/01/12. Resident #1 was transferred from the facility to the hospital on 10/02/12 after having a seizure and being assessed by her attending physician. The following audits were conducted by the staff development coordinator and the results are noted with each resident listed. Resident #2 was admitted to the facility on 12/17/12 at 18:50 and his medical record was audited on 12/20/12 to ensure all current medications ordered were available for administration. On date of admission, the resident missed a dose of Colchicine at 20:00. No negative outcomes were noted. Resident #3 was admitted to the facility on 12/12/12 at 13:30 and his medical record was audited on 12/19/12 to ensure all current medications ordered were available for administration. On the date of admission, the Resident missed a dose of Hydralazine HCL at 1600, a dose of Labetalol at 20:00, and Pravastatin Sodium on at 20:00. No negative outcomes were noted. Resident #4 was admitted to the facility on 12/06/12 at 15:41 and her medical record was audited on 12/19/12 to ensure all current medications ordered were available for administration. On the date of admission, the resident missed a dose of Advair	F 333	will be discussed at the department managers meeting Monday through Friday, as scheduled, through 1/18/2013 in case immediate changes need to be discussed with the medical director and implemented. If no changes are needed, the daily discussion will end however, Director of Nursing can discuss any additional concerns as needed after 1/18/2013. If these audits identify an issue not consistent with this plan of correction, the director of nursing or staff development coordinator will re-inservice the staff member(s). The results of these audits are intended to ensure on-going compliance and will be discussed and monitored through our next quality assurance meeting or longer if the committee deems it necessary.	1/18/13 PER PHONE CONVERSATION WITH ADMINISTRATOR DL.

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Diskus at 17:00, Nystatin mouth wash 1700 and 2100, Ferrous Fumarate at 17:00, Singulair at 17:00, and Neurontin at 1700. No negative outcomes were noted. Resident #5 was admitted to the facility on 12/17/12 at 18:30 and her medical record was audited on 12/19/2012 to ensure all current medications ordered were available for administration. On the date of admission, the resident missed a dose of Ferrex at 2100. No negative outcomes were noted. All medications were administered following the delivery from the pharmacy as ordered by the physician.

To ensure other residents are not affected in a similar manner, all admissions from 12/1/12-12/19/12 have been audited for compliance. This audit was lead by the director of nursing and staff development coordinator and conducted by administrative nurses insure all currently ordered medications were given as ordered by the physician. In addition, the facility has agreed for services with Marshville Pharmacy to ensure all new admissions' medications arrive the same day as the admission. They are available Monday through Friday from 9:00 a.m. to 6:00 p.m and Saturdays from 9:00 a.m. to 12:00 p.m. In addition, we are contracted with CVS pharmacy and CMC-Union. CMC-Union serves as our local 24-hour pharmacy and Legacy Consultant Pharmacy also has the ability to provide stat medications. The medication orders will be sent to the back-up pharmacy via Legacy Consultant Pharmacy for a minimum of a 36 hour supply of medications to be delivered to the facility. If a medication cannot be obtained for any reason prior to the next scheduled medication administration, a call to our

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F 333	Continued From page 44 physician's group will be placed for direction. This direction will be documented in the resident's medical record. Marshville Pharmacy began offering this service on 12/20/12 and will be utilized on any new admissions beginning 12/20/12. To ensure compliance, all nurses will be inserviced by the director of nursing or staff development coordinator of this new service prior to processing any new admission to the facility. Upon receipt of the new medications, a nurse will audit the medication orders to ensure each medication is available for administration. This audit will be a print out of the medication orders for the new admission and these physician orders will be reconciled against what is in the E-MAR for administration and insure the medication was given as ordered unless otherwise noted by the nurse. The nurse responsible for the new admission will reconcile the medications delivered for the specific resident to the medication list. Any variance will be discussed with a physician or physician extender for clarification and direction. All full time nurses responsible for entering and scheduling admission orders were inserviced immediately on the proper method of scheduling medications to ensure all medications are administered timely. This was conducted on 12/19/12. All nurses with the responsibility of entering in the admission orders will be inserviced as soon as possible but no later than 12/28/12. No nurse will be allowed to return to work without completing this training. To ensure on-going compliance, the director of nursing, or staff development coordinator, will	F 333		

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F 333	Continued From page 45 audit every admission to ensure compliance until 12/27/12. This audit will be completed upon the delivery of the medications by reconciling ordered medications to those delivered for administration. The director of nursing, or staff development coordinator, will audit a minimum of 3 admissions a week (as long as admissions are available) until 1/3/12 and then will audit at least 2 charts a week for 2 months. The results of these audits will be discussed at the department managers meeting Monday through Friday, as scheduled, in case immediate changes need to be discussed and implemented. Audits as needed will be conducted to ensure the interventions are effective and on-going compliance is maintained. The results of theses audits intended to ensure on-going compliance will be discussed and monitored through our next quality assurance meeting for at least the next two meetings or longer if the committee deems it necessary. Immediate jeopardy was removed on 12/20/12 at 5:20 PM when interviews of medication nurses and nursing supervisors confirmed they received inservice training on 12/19/12 and 12/20/12 prior to reporting for work regarding the policy changes for the new back up pharmacy and they were supposed to check medication orders when residents were admitted and were to ensure medications were given according to physician orders. They further explained they were expected to call the physician for clarification of medications and dosages when there were questions or discrepancies. A review of the inservice training documents and sign in sheets on 12/20/12 confirmed the	F 333		

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inservice training had been done on 12/19/12 and 12/20/12 and scheduled to be ongoing to ensure all nurses received training prior to them working.

A review of the facility policy titled "Medication Ordering and Receiving from Pharmacy" indicated policy changes related to the new back up pharmacy.

2. Resident #3 was admitted to the facility on 12/12/12 at 1:30 PM with diagnoses which included high blood pressure and a recent stroke. The most recent admission Minimum Data Set dated 12/21/12 indicated Resident #3 was cognitively intact.

A review of hospital discharge instructions dated 12/12/12 indicated the following blood pressure medications were ordered for Resident #3:
- Labetalol 400 mg. by mouth twice daily
- Hydralazine 25 mg. by mouth every 8 hours

A review of the Medication Administration Record dated 12/12/12 specified the times in which Resident #3 was to receive his blood pressure medications:

- Labetalol 400 mg. by mouth twice daily at 8:00 AM and 4:00 PM
- Hydralazine 25 mg. by mouth every 8 hours at 12:00 AM; 8:00 AM and 4:00 PM

A further review of the MAR revealed Resident #3 did not receive ordered medications on 12/12/12 that included:
- Labetalol 400 mg. by mouth at 4:00 PM
- Hydralazine 25 mg. by mouth every 8 hours

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F 333	Continued From page 47 at 4:00 PM During an interview on 12/18/12 at 4:12 PM the day shift supervisor stated it was the facility's usual process to fax medication orders to the pharmacy right away when a resident was admitted to the facility. She verified Resident #3's medication list was obtained from the hospital transfer summary medication list and was called to the physician for approval the same day. She explained the pharmacy delivered medications usually between 10:00 PM and 12:00 AM and a nurse had to sign for them when they were delivered. During an interview on 12/19/12 at 8:15 AM the Director of Nursing (DON) verified medications were delivered to the facility from the pharmacy between 10:00 PM and 12:00 AM. She explained it was their policy that medications were given the next scheduled dose after they were delivered from the pharmacy and that was probably the reason Resident #3's medications were not given during the evening of 12/12/12. She verified it was possible for residents to miss evening doses of medications on the day of admission . During an interview on 12/19/12 at 9:40 AM Physician #1 was interviewed and stated the facility's practice of waiting to begin administering medications the day after admission was not appropriate. He added that he expected nurses to follow physician's orders and they should give the medication as ordered. He stated he was unaware that it was the facility's usual practice to wait until the next scheduled dose after the medication was delivered to the facility for administration. He further stated Resident #3	F 333		

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should have received all medications as ordered by his physician and he expected nursing staff to call the physician's group if they were unsure when a resident had last received their medications or needed clarification of medication orders.

During a follow up interview on 12/20/12 at 12:15 PM the day shift supervisor stated it appeared to her that on Resident #3's admission orders and facility MAR the evening medications that were due on 12/17/12 had been omitted from the MAR. She added she this had happened and Resident #3 required his blood pressure medication to control high blood pressure. The nurse was unable to recall if she was responsible for putting Resident #3's medications into the computer when he was admitted to the facility.

4. Resident #4 was admitted to the facility on 12/06/12 at 3:41 PM with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), anemia, thrush and others. The most recent Minimum Data Set (MDS) dated 12/13/12 specified the resident had no impaired cognition.

Resident #4's hospital discharge instructions dated 12/06/12 were reviewed and specified the Resident was ordered by the physician to receive:
- Neurontin 100mg (milligrams) two times each day
- Advair Diskus 250mcg (micrograms) / 50mcg two times each day
- Theophylline (bronchodilator) 200mg every 12 hours

Review of Resident #4's "Medications

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(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 333	Continued From page 49 Administration Record" (MAR) for 12/12 specified the times in which Resident #4 was to receive her medications: - Neurontin 100mg (milligrams) two times each day at 9:00 AM and 5:00 PM - Advair Diskus 250mcg (micrograms) / 50mcg two times each day at 6:30 AM and 5:00 PM - Theophylline (bronchodilator) 200mg every 12 hours at 9:00 AM and 9:00 PM Further review of Resident #4's MAR revealed the resident did not receive physician ordered medications on 12/06/12 that included: - Neurontin scheduled to be administered at 5:00 PM - Advair Diskus scheduled to be administered at 5:00 PM - Theophylline scheduled to be administered at 9:00 PM On 12/18/12 at 4:12 PM the day shift supervisor stated it was the facility's usual process to fax medication orders to the pharmacy right away when a resident was admitted to the facility. She verified that Resident #4's medication list was obtained from the hospital transfer summary medication list and was called to the physician for approval the same day. She explained the pharmacy delivered medications usually between 10:00 PM and 12:00 AM and a nurse had to sign for them when they were delivered. During an interview on 12/19/12 at 8:15 AM the Director of Nursing (DON) verified medications were delivered to the facility from the pharmacy between 10:00 PM and 12:00 AM. She explained it was their policy that medications were given the next scheduled dose after they were delivered	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345268	A. BUILDING ______ B. WING ______	C 12/20/2012

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F 333	Continued From page 50	F 333		

from the pharmacy and that was probably the reason Resident #4's medications were not given during the evening of 12/06/12. She verified it was possible for residents to miss evening doses of medications on the day of admission .

On 12/19/12 at 9:40 AM Physician #1 was interviewed and stated the facility's practice of waiting to begin administering multi dose medications the day after admission was not appropriate. He added that expected nurses to follow physician's orders and if a medication was to be given twice a day; three times a day or four times a day then the medicine should be given as ordered. He stated he was unaware that this was the facility's usual practice to wait until the next scheduled dose after the medication was delivered to the facility for administration. He further stated he was unaware of the missed medications for Resident #4 and he had not been told the resident refused medications.

12/20/12 at 10:45 AM Nurse #4 reported she was assigned to work 3:00 PM to 11:00 PM and that she cared for Resident #4 on 12/06/12. She added that she was not responsible for imputing the Resident's medications into the computer system. She stated that she would not have administered medications to the resident unless they appeared "active" in the MAR. Review of Resident #4's MAR revealed the medications had not been made "active" until 12/07/12. She verified that the medications ordered by the physician for evening administration were not given to Resident #4 because they had not been scheduled by the admitting nurse.

On 12/20/12 at 12:15 PM the day shift supervisor

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

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F 333	Continued From page 51 was interviewed again and stated that she usually entered residents' admission medications into the computer system. She stated that medications were scheduled to be administered starting the following day because the medications were not available to the facility until 10 PM or after. The nurse reviewed Resident #4's admission orders and facility MAR and stated it appeared the evening medications that were due on 12/06/12 had been omitted from the MAR. She added she was unaware of the potential problem. The nurse was unable to recall if she was responsible for putting Resident #4's medications into the computer.	F 333		