

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

PRINTED: 01/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345551	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/12/2014
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-CAROLINA POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC 27705		
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F 000	INITIAL COMMENTS	F 000			
F 224 SS=G	<p>On 10/09/2015, tag F224 was amended. Scope and severity of tag F333 was changed from an E to a G. Tag F425 was also amended.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and physician interview the facility failed to provide and administer a medication ordered for pain (Elavil) for 10 days, failed to provide and administer ordered admission medications (Meropenum) for 8 days and (Tobramycin) for 3 days; and failed to provide assessments and treatments for a PICC (peripherally inserted central catheter) for 8 out of 10 days for 2 of 2 residents (Resident #181 and #128) missing 25 of 30 opportunities to provide care.</p> <p>1.Resident #181 was admitted on 10/8/14 with diagnoses that included a wound infection, ulcers on both lower legs and acute and chronic pain.</p> <p>The Nursing Home Admission History and Physical dated 10/9/14 indicated Resident #181 had a bilateral lower extremity chronic wound</p>	F 224	<p>This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law</p> <p>Corrective Action for the resident affected.</p> <p>Resident #128 and #181 medications were obtained from pharmacy and given as ordered. The Director or Health Services will counsel, and/or in-services the nursing staff involved in error.</p>	1/5/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/31/2014

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

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F 224	<p>Continued From page 1 infection and acute and chronic pain.</p> <p>The October 2014 signed admission Physician Orders included the following medications for pain: Gabapentin 300 milligrams (mg) three times a day. Ultram 50 mg every 6 hours as needed. Take 1 tablet for moderate pain, 2 for severe pain. Oxycodone 10 mg every 6 hrs as needed.</p> <p>The physician progress note dated 10/10/14 indicated Resident #181 was seen due to increased burning sensation in legs. The physician discontinued Gabapentin and started Lyrica for her nerve pain.</p> <p>The Physician Interim Orders dated 10/14/14 indicated: Morphine 4 mg [by mouth] 30 minutes before dressing change once daily.</p> <p>The Physician Interim Orders dated 10/15/14 indicated Oxycodone 10 mg [by mouth] x 1 dose now - extreme pain. Ultram 50 mg [by mouth every 6 hours as needed] mild pain. Ultram 100 mg [by mouth every 6 hours as needed] moderate pain. Oxycodone 10 mg [by mouth every 6 hours as needed] severe pain.</p> <p>The Minimum Data Set (MDS) dated 10/15/14 indicated Resident #181 was cognitively intact, had wounds, received scheduled and as-needed pain medication in the last 5 days, experienced pain frequently, the pain made it hard for her to sleep and her worst pain was a 10/10.</p>	F 224	<p>Corrective Action for Those with the Potential to be affected.</p> <p>Unit Managers and Supervisors have reviewed new Medication Admission Records and the medication in the Medication Carts, including IV medications and pain medications, to compare and assure new medication orders are in place and being followed. Director of Health Services or Clinical Competency Coordinator will select 10 patients weekly with new orders to ensure orders are being followed and correct by checking new orders to Medication Admission Record to medication cart.</p> <p>All resident with IV medications were reviewed by the Director of Health Services and Unit Manager for accuracy of orders to include flush orders, dressing changes and medication orders. Medication administration sheets reviewed for transcription of orders to include flushes, dressing changes, and medications.</p> <p>The Pharmacy Consultant, Director of Health Services, Clinical Competency Coordinator and interim Director of Health Services in-serviced the licensed staff on the provision of pharmacy services including following physician orders to include giving the medication ordered, including IV medications and pain medications. The Clinical Care Coordinator will include information on the provision of Pharmacy service including following physician orders to include</p>		

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F 224	<p>Continued From page 2</p> <p>The Physician Interim Orders dated 10/16/14 indicated: [Discontinue] Morphine 4 mg [by mouth 30 minutes before dressing change]. Start Morphine 5 mg [by mouth 30 minutes before dressing change] once daily. [Discontinue] Gabapentin. [Discontinue] Lyrica. Elavil 25 mg [by mouth every night at bedtime] - (pain). [Discontinue] Ultram. [Discontinue] Oxycodone. Oxycodone 10 mg [by mouth every 4 hours as needed] pain. Ultram 50 mg [by mouth every 4 hours as needed] pain.</p> <p>Review of the 24-hour Chart Check Form signed by Nurse #15 and dated 10/16/14 stated, "New orders" and indicated, by a checkmark, that the new orders were placed on the MAR.</p> <p>Review of the Medication Administration Record (MAR) indicated Elavil 25 mg for pain was ordered on 10/16/14 and was first signed off as being administered on 10/26/14.</p> <p>The physician progress note dated 10/20/14 indicated Resident #181 was seen due to continued complaint of severe pain in both of her legs. The physician added Morphine for pain management.</p> <p>The Physician Interim Orders dated 10/20/14 indicated: [Morphine] 15 mg [by mouth twice a day].</p> <p>The physician progress note dated 10/24/14 indicated Resident #181's pain was improved but</p>	F 224	<p>giving the dose ordered during orientation. The Director of Health Services or Clinical Competency Coordinator, will review orders on a weekly bases for 1 month then q2 weeks for 1 month then quarterly to assure medications are administered according to physician orders.</p> <p>Systemic Changes to Prevent Deficient Practice.</p> <p>New orders for medications, including IV medication, flush orders and pain medication will be checked by the unit manager/week-end supervisor daily to ensure medications were faxed to pharmacy, received, transcribed, and given.</p> <p>Education with licensed nurses began on Oct 27, 2014 by the Interim Director of Nursing and continued by the Clinical Competency Coordinator on use of the Emergency-Kit (E- Kit) for medications needed immediately, utilization of the back-up pharmacy for medications that are not available in the Emergency-kit (E-kit), and new medication administration. Education will be provided in orientation and licensed nursed on Leave and/or PRN will be educated prior to returning to work on use of emergency kit (E-kit) and back-up pharmacy.</p> <p>Education with licensed nurses began on Dec 24, 2014 by the Clinical Competency Coordinator and Director of Health Services on policy and procedure "Intermittent infusion device flushing and</p>		

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F 224	<p>Continued From page 3</p> <p>she was awakening at night with pain. The physician increased her Morphine at night.</p> <p>The Physician Interim Orders dated 10/24/14 indicated: [Discontinue Morphine] [Morphine] 15 mg [by mouth every morning]. [Morphine] 30 mg [by mouth at bedtime].</p> <p>The Physician Interim Orders dated 10/25/14 indicated: May hold Elavil 25 mg [by mouth at bedtime] until available from pharmacy.</p> <p>The October 2014 Medication Administration Record (MAR) revealed Resident #181 received 49 doses of as-needed pain medication between 10/8/14 and 10/31/14. The pain evaluation done every shift documented moderate to severe pain every day.</p> <p>The physician progress note dated 11/5/14 indicated Resident #181 was seen because of episodes of crying and that the resident stated "she was only crying [because] she continues to have pain in [both lower legs]." The physician increased her Elavil for her chronic nerve pain and bilateral leg ulcers.</p> <p>The Physician Interim Orders dated 11/5/14 indicated: [Discontinue Elavil]. Elavil 50 mg [by mouth at bedtime] for neuropathic pain.</p> <p>The Physician Interim Orders dated 11/11/14 indicated: [Discontinue Elavil]. Elavil 75 mg [by mouth at bedtime].</p>	F 224	<p>locking", and "Physician order for infusion therapy" Education will be added to license nursing orientation, and licensed nurses on Leave and/or PRN will be educated prior to returning to work.</p> <p>How will Corrective Action be monitored?</p> <p>The Director of Nursing will conduct a weekly review of the Unit Managers'/week- end supervisor's audit findings of new medications. Findings will be brought to the monthly Quality Assurance Performance Improvement Committee for review and revision as needed.</p>		

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F 224	<p>Continued From page 4</p> <p>During an interview on 12/10/14 at 3:26 pm with the acting Director of Nursing (DON) she stated, "Two nurses check the chart. The [night] nurse on the floor checks every new order that has come in [that 24-hour period]." She further indicated that there is no set time for the night (7 pm - 7 am) nurse to do the 24-hour chart check, but that the check for new orders should go all the way back to 7 pm the previous day so that no orders are missed. She also indicated that the Elavil is not a stock medication or available in the e-kit (emergency kit), should have been ordered from the pharmacy and should have been given to the resident as ordered.</p> <p>During an interview with Unit Coordinator #1 on 12/11/14 at 12:25 pm she stated, "The nurse will fax [the physician order] to the pharmacy no matter what time the order is written and then will write it on the MAR. The night supervisor does a chart check to ensure all orders are sent to the pharmacy and put on the MAR." After reviewing Resident #181's 10/16/14 Elavil order, she indicated a nurse did not sign off as receiving the order or faxing it to the pharmacy on 10/16/14, or any date since that time. She further stated, "If a written order does not arrive after it is sent to the pharmacy and is not in the e-kit, we write a hold order until it comes. I remember Nurse #2 mentioning the missed Elavil to me. I don't recall why it was not given. Elavil is not in the e-kit [and would have to come from the pharmacy]."</p> <p>During an interview with the DON on 12/11/14 at 4:15 pm she stated, "I would expect the order would have been caught by the night nurse doing the chart check."</p>	F 224			

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F 224	<p>Continued From page 5</p> <p>During an interview with Nurse #2 on 12/12/14 at 1:00 pm, regarding Resident #181's 10/16/14 Elavil order she stated, "I found [the missed order] when I was working on the hall on the 25th. A line was drawn on the MAR and [the medication was not] on the cart." She indicated the nurse working on the 16th must have written it on the MAR but never signed or faxed the order to the pharmacy and the resident never received the medication.</p> <p>Nurse #15 was unavailable for interview.</p> <p>2.Resident #128 was admitted to the facility from an acute hospital on 10/18/2014. His diagnoses included acute on chronic Bronchiectasis (a lung condition in which damage to the airways causes the air passages to widen and scar and lose their ability to move air in and out) exacerbation. The admission Minimum Data Set (MDS) dated 10/25/2014 revealed Resident #128 was cognitively intact but required extensive assistance from staff for his activities of daily living. Resident #128 was not coded in the MDS as receiving intravenous medication under special procedures nor was he care planned for a PICC line on admission.</p> <p>A hospital discharge summary dated 10/18/2014 included the discharge diagnosis of acute on chronic Bronchiectasis exacerbation, a history of Pulmonary Fibrosis, and previous admissions for Bronchiectasis exacerbation secondary to Pseudomonas (bacteria with antibiotic resistance). The sputum culture grew Pseudomonas and Resident #128 was treated at the hospital with Meropenem (antibiotic) every 12 hours 10/5/2014 through 10/18/2014 and</p>	F 224			

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F 224	<p>Continued From page 6</p> <p>Tobramycin (antibiotic) twice a day 10/2/2014 through 10/18/2014. The discharge medications included: Meropenem 500 mg (milligram) injections infuse 2 grams into venous catheter [e.g. PICC] every 12 hours for 10 days and Tobramycin 300 mg/ 5 ml (milliliters) nebulizer solution. Inhale 5 ml every 12 hours for 3 days.</p> <p>A medication list for Resident #128 provided by the hospital on 10/18/2014 included: [in part] the medications Meropenem and Tobramycin.</p> <p>A record review of the Medication list that was faxed to the pharmacy from the facility on 10/18/2014 attached to Resident #128 ' s FL2 (Level of Care Screening Tool) was the medication reconciliation list from the hospital dated 10/18/2014. Page 2 [not labeled] was not included: Insulin (Novolog), Ipratropium (Atrovent), Meropenem, Tobramycin, and Warfarin.</p> <p>A record review of Resident #128 ' s Physician ' s Orders dated 10/18/2014 transcribed by Nurse #4 and verified by Nurse #5 noted to be transcribed in two different hand writings included: Meropenem 500 mg injections infuse 2 grams into venous catheter every 12 hours for 10 days and Tobramycin 300 mg/5 ml nebulizer. Inhale 5 ml every 12 hours for 3 days. The Physician Order ' s did not include treatment for the PICC.</p> <p>A record review of Resident #128 ' s Medication Record dated 10/18/2014 included: Meropenem 500 mg injections infuse 2 grams into venous catheter every 12 hours for 10 days and Tobramycin 300 mg/5 ml nebulizer. Inhale 5 ml every 12 hours for 3 days.</p>	F 224			

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F 224	<p>Continued From page 7</p> <p>The designated boxes for nurse staff initials that indicated the medication was administered were blank from the PM of 10/18/2014 through the AM of 10/26/2014 for the Meropenem missing 16 of 20 opportunities. The boxes for the Tobramycin were blank or initialed with a circle around the initials that indicated not administered over a time span from 10/19/2014 to 10/24/2014 missing 6 out of 6 opportunities to administer the medication. The Medication Record was unclear as to what 3 days the nursing staff intended to administer the Tobramycin.</p> <p>A record review of the facility log for medication received from the pharmacy revealed that on 10/18/2014 fifteen medications were dispensed to the facility for resident #128. Meropenem and Tobramycin were not included. 10/19/2014 through 10/26/2014 was reviewed and Meropenem and Tobramycin were not dispensed. On 10/27/2014 Meropenem quantity of 4 was dispensed for Resident #128.</p> <p>A record review of Resident #128 ' s Admission/Nursing Observation Form dated 10/18/2014 included an IV (intravenous) /PICC under Devices/Special Treatments. In addition the assessment noted the PICC line in the left arm on the Body Audit section.</p> <p>A record review of a Body Audit Form dated 10/18/2014 signed by Nurse #4 did not include an assessment of the PICC.</p> <p>A record review of Resident #128 ' s admission nurse note dated 10/18/2014 written by Nurse #5 revealed all medications were verified by the Physician and faxed to the pharmacy. All medications were received from the back up</p>	F 224			

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F 224	<p>Continued From page 8</p> <p>pharmacy. Resident #128 was on multiple nebulizer treatments and inhalers. He was on antibiotic therapy Cipro (oral antibiotic). The admission nurse note did not include an assessment or treatment for Resident #128 ' s PICC.</p> <p>A record review of Resident #128 ' s 24 hour chart check form verifying that a second nurse checked all of Resident #128 ' s medications revealed Nurse #1 signature initialed on 10/18/2014, 10/19/2014, 10/23/2014 and 10/24/2014. Nurse # 12 signature initialed on 10/20/2014. Nurse # 7 signature initialed on 10/21/2014. Nurse # 9 signature initialed on 10/22/2014. The dates 10/25/2014 and 10/26/2014 were left blank.</p> <p>A record review of Resident #128 ' s nurse note dated 10/18/2014 written by Nurse # 1 did not include an assessment or treatment for Resident #128 ' s PICC. It included: tolerated all meds well; awaiting Tramadol delivery from pharmacy; resident (#128) on Coumadin; and nebulizer treatment given.</p> <p>A record review of Resident #128 ' s Skilled Daily Nurses Note dated 10/19/2014 included a full system assessment for each shift and was signed by Nurse #3 for day shift and Nurse #1 for night shift. It did not include assessment or treatment of Resident #128 ' s PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128. A narrative written by Nurse #3 included the use of multiple nebulizer treatments and Nurse #1 ' s notation included: tolerated medications well.</p>	F 224			

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F 224	<p>Continued From page 9</p> <p>A record review of Resident #128 ' s Physician Admission History and Physical dated 10/20/2014 included notation of the PICC.</p> <p>A record review of Resident #128 ' s Skilled Daily Nurses Note dated 10/20/2014 included a full system assessment for each shift and was signed by Nurse #6 for day shift. It did not include assessment or treatment of Resident #128 ' s PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128. A narrative from Nurse # 6 included breathing treatments x 4 today.</p> <p>A record review of Resident #128 ' s Skilled Daily Nurses Note dated 10/21/2014 included a full system assessment for each shift and was signed by Nurse #7 for night shift. It did not include assessment or treatment of Resident #128 ' s PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128. A narrative written from Nurse #7 included: tolerated medications well and scheduled breathing treatment given.</p> <p>A record review of Resident #128 ' s Skilled Daily Nurses Note dated 10/22/2014 included a full system assessment for each shift and was signed by Nurse #8 for day shift. It did not include assessment or treatment of Resident #128 ' s PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128. Addition nurse note narratives from Nurse #9 and Nurse #1 did not include assessment or treatment for Resident</p>	F 224			

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F 224	<p>Continued From page 10</p> <p>#128 ' s PICC. A narrative written by Nurse #8 included tolerated scheduled medications; Nurse # 9 as needed Albuterol administered; and Nurse #1 tolerated medications well and nebulizer treatment given.</p> <p>A record review of Resident #128 ' s Skilled Daily Nurses Note dated 10/23/2014 included a full system assessment for each shift and was signed by an unidentified nurse. It did not include assessment or treatment of Resident #128 ' s PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128.</p> <p>A record review of Resident #128 ' s Skilled Daily Nurses Note dated 10/24/2014 included a full system assessment for each shift and was signed by Nurse #3 for day shift and Nurse #1 for night shift. It did not include assessment or treatment of Resident #128 ' s PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128. A narrative written by Nurse #3 included tolerated medications and breathing treatments and Nurse #1 included tolerated all medications well and nebulizer treatment given.</p> <p>A record review of Resident #128 ' s Skilled Daily Nurses Note dated 10/25/2014 included a full system assessment for each shift and a nurse note narrative from Nurses #9 and #10. It did not include assessment or treatment of Resident #128 ' s PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128.</p>	F 224			

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F 224	<p>Continued From page 11</p> <p>A record review of Resident #128 ' s Skilled Daily Nurses Note dated 10/26/2014 included a full system assessment for each shift and was signed by Nurse #2. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128. A nurse note narrative written by Nurse #12 at 12:00 PM included the resident was alert and oriented and stated " I don ' t feel well " . Resident #128 ' d vital signs were assessed and orders ' were received from the Physician for blood work and radiology. A nurse note narrative written by Nurse #9 at 3:55 PM revealed his interpretation of the radiology report. Orders were received to start a peripheral intravenous access (PIV); start Meropenem as ordered at hospital; and to replace PICC line when possible.</p> <p>A record review of Resident #128 ' s Skilled Daily Nurses Note dated 10/27/2014 included a narrative by Nurse #11. The Physician ordered resident #128 to be sent to the hospital for an evaluation of the PICC and Resident #128 was transported at 1:15 PM.</p> <p>A record review of a facility communication tool (SBAR Communication Form) dated 10/27/2014 included Resident #128 ' s had no blood return from the PICC line and was transported to the hospital.</p> <p>A record review of the facility Nursing Home to Hospital Transfer Form dated 10/27/2014 included no blood return to PICC and the primary reason for transfer was de-clog/replace PICC.</p> <p>A record review of hospital emergency</p>	F 224			

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F 224	<p>Continued From page 12</p> <p>department discharge dated 10/27/2014 included a diagnosis of Occluded PICC line.</p> <p>Nurse #1 was Resident #128 ' s nurse on 10/18/2014, 10/19/2014 10/23/2014 and 10/24/2014. She was out of the country and unavailable for an interview during the survey.</p> <p>On 12/12/2014 at 1:48 PM an interview with Nurse #2 revealed she worked for 4 years as the admission nurse for a sister facility and was no longer employed. Nurse #2 reported she did not care for Resident #128 the week of 10/18/2014 through 10/26/2014 until the evening [10/26] when she found the error. She reported on 10/23/2014 a nurse in orientation worked the hall even though Nurse #2 ' s name remained on the schedule. The Meropenum on 10/26/2014 was delivered from a specialty pharmacy through the back up. The regular pharmacy delivered additional doses on 10/27/2014. Resident #128 was " oriented to person and place but he was sick. I am not sure he was able to understand that time had passed. I asked Resident #128 to show me his PICC line. The PICC dressing was nasty and it was not a facility dressing. "</p> <p>On 12/12/2014 at 1:18 PM an interview with Nurse #3 who cared for Resident #128 on 10/19/2014 and 10/24/2014 revealed she did not recall the Meropenum order nor does she recall Resident #128 having a PICC line.</p> <p>On 12/12/2014 at 11:22 PM an Interview with Nurse #4 revealed she was no longer employed at the facility. Nurse #4 was the treatment nurse on 10/18/2014 and helped Nurse #5 with Resident #128 ' s admission process. She recalled faxing the orders to the pharmacy, and</p>	F 224			

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F 224	<p>Continued From page 13</p> <p>transcribing orders to the telephone order sheet that were on formulary. She did not transcribe all of Resident #128 ' s Physician orders.</p> <p>Nurse #5 was Resident #128 ' s nurse on 10/18/2014 and was not available for an interview during the survey.</p> <p>Nurse #6 was Resident #128 ' s nurse on 10/20/2014 and was not available for interview during the survey.</p> <p>On 12/11/2014 at 1:29 PM an interview with Nurse #7 revealed she worked with Resident #128 on 10/21/2014 and 10/23/2014. She reported she ignored the order because the time said 9:00 AM. She looked at the administration time but not the order. Nurse #7 reported she did not check for a PICC line on Resident #128.</p> <p>Nurse #8 was Resident #128 ' s nurse on 10/22/2014 and was not available for interview during the survey.</p> <p>Nurse #9 was a supervising nurse who completed an assessment on Resident #128 Skilled Daily Nurses Note on 10/23/2014. He was not available for interview during the survey.</p> <p>Nurse #10 was Resident #128 ' s nurse on 10/25/2014 and was not available for interview during the survey.</p> <p>Nurse #11 was Resident #128 ' s nurse on 10/26/2014 and was not available for an interview during the survey.</p> <p>Nurse #12 was identified by the facility corporate administration team as one of the nurses that</p>	F 224			

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F 224	<p>Continued From page 14</p> <p>cared for Resident #128 the week of 10/18/2014 through 10/26/2014 based on the staff schedule. Nurse #12 ' s signature or initials were not identified and she was unavailable for an interview during the survey.</p> <p>Nurse #13 was identified by the facility corporate administration team as one of the nurses that cared for Resident #128 the week of 10/18/2014 through 10/26/2014.</p> <p>On 12/12/2014 at 2:28 PM an interview with Nurse #13 revealed she had not worked on Resident #128 ' s hall 10/18/2014 through 10/26/2014. She reported she returned to the hall on the first morning Resident #128 received his antibiotic through a PIV. Nurse #13 confirmed her signature initials on Resident #128 ' s Medication Record for 10/27/2014.</p> <p>Nurse #14 was identified by the facility corporate administration team as one of the nurses that cared for Resident #128 the week of 10/18/2014 through 10/26/2014 (10/21 and 10/22) based on the staff schedule. Nurse #12 ' s signature or initials were not identified and she was unavailable for an interview during the survey.</p> <p>On 12/10/2014 at 1:05 PM an interview with Unit Coordinator #1 revealed all nursing staff members were responsible for PICC line care that included: flush with the SASH (Saline/Antibiotic/Saline/Heparin) protocol, dressing changes and monitor site for redness. The nursing staff was responsible for transcribing the Physician order for PICC line care on the Medication Order form. It was Unit Coordinator #1 expectation that the responsibility of the nurses was to make sure the orders were transcribed</p>	F 224			

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F 224	<p>Continued From page 15</p> <p>and if the order was not written then the nurse was to call and get an order for the PICC line maintenance.</p> <p>She reported she did not look at Resident #128 ' s POF or Medication Record because she was not working on his admission date.</p> <p>On 12/10/2014 at 1:06 PM an interview with the Acting Director of Nursing (DON) revealed she agreed with Unit Coordinator #1 ' s statements and expectations. The facility policy was different than the nursing practice. The staff follows the Physician Orders which was to flush the PICC line every shift. Weekly body audits/skin assessments were done weekly and on a rotating staff schedule and the floor nurse was responsible for the PICC dressing changes. The Acting Director of Nursing (DON) revealed her expectation was the staff review the Medication Record and look at every page.</p> <p>An interview on 12/10/2014 at 4:54 PM with the Physician indicated the resident had a diagnosis of chronic and acute Bronchiectasis exacerbation and the Meropenem had been ordered due to his sputum culture results. The Physician received a call from Unit Coordinator #1 on 10/26/2014. She reported to the Physician that Resident #128 had not been receiving his antibiotic Meropenem. The Physician reported he ordered the Meropenem at that time and extended the end date for the medication. The PICC line was replaced because it was occluded from lack of use. It was not flushed but it should have been. " Do I wish [the nurses] had provided the antibiotic? Yes. It was important that he [Resident #128] received the antibiotic. I do not think his condition deteriorated during the time he did not receive the medication, but it was important for him to receive the</p>	F 224			

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F 224	<p>Continued From page 16</p> <p>medication, so we started a peripheral IV for him to get the medication when we realized it had not been given " . The Physician agreed there was a process issue.</p> <p>On 12/12/2014 at 3:40 PM an interview with the Acting DON revealed her expectation of the staff during the admission process was the nurse staff reviewed the admission discharge summary and verified the medications/treatments with the Physician and transfer the orders to the Physician Order Form. Another nurse was to verify the transcribed orders and then fax them to the pharmacy. If the pharmacy called for clarification then the nurse was to clarify the order with the Physician and resubmits an order on a telephone order sheet. The Acting DON reported that some staff will send both the discharge summary and the POF. The Pharmacy will disregard the discharge summary. The pharmacy will not send the medications or bill for medications based on receiving the discharge summary. When the medications are received the nursing staff would check against the POF and when they place the medications in the [medication cart] drawer they check the medications against the Medication Record. If something was missing the expectation was to call the Pharmacy or go to the back up pharmacy. Her expectation was for the nurse staff to view the orders during the routine medication pass and to know what medications they were giving. The nurse staff needed to read the medications listed on the Medication Record regardless of what the [designated] time said. The nursing staff was responsible for a 24 hour chart check [for order verification]. The night shift nurse staff does the 24 hour chart check. The nurse who transcribed the orders was not to be the nurse to sign off or complete order</p>	F 224			

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F 224	Continued From page 17 verification. It was not best practice for multiple nurses to be involved in the admission process/transcription of medications. It was the responsibility of the nurses to take care of Resident #128, keep him safe, and provide the care needed.	F 224			
F 328 SS=G	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide assessments and treatments for a PICC (peripherally inserted central catheter) for 8 out of 10 days for 1 of 1 residents (Resident #128) missing 15 of 20 opportunities to assess for infection and flush the line for patency which resulted in the PICC being occluded and required replacement. Findings included: Resident #128 was admitted to the facility from an acute hospital on 10/18/2014. His diagnoses included acute on chronic Bronchiectasis (a lung	F 328	Corrective Action for the resident affected. Resident #128 medications were obtained from pharmacy and given as ordered. The Director or Health Services will counsel, and/or in-services the nursing staff involved in error. Corrective Action for Those with the Potential to be affected. Unit Managers and Supervisors have reviewed new Medication Admission	1/5/15	

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F 328	<p>Continued From page 18</p> <p>condition in which damage to the airways causes the air passages to widen and scar and lose their ability to move air in and out) exacerbation. The admission Minimum Data Set (MDS) dated 10/25/2014 revealed Resident #128 was cognitively intact but required extensive assistance from staff for his activities of daily living. Resident #128 was not coded in the MDS as receiving intravenous medication under special procedures nor was he care planned for a PICC line on admission.</p> <p>A hospital discharge summary dated 10/18/2014 included the discharge diagnosis of acute on chronic Bronchlectasis exacerbation, a history of Pulmonary Fibrosis, and previous admissions for Bronchiectasis exacerbation secondary to Pseudomonas (bacteria with antibiotic resistance). The discharge medications included Meropenem (antibiotic) 500 mg injections infuse 2 grams into venous catheter [e.g. PICC] every 12 hours for 10 days.</p> <p>A record review of Resident #128 ' s Admission/Nursing Observation Form dated 10/18/2014 included an IV (intravenous) /PICC under Devices/Special Treatments. In addition the assessment noted the PICC line in the left arm on the Body Audit section.</p> <p>A record review of Resident #128's Physician ' s Orders dated 10/18/2014 transcribed by Nurse #4 and verified by Nurse #5 did not include treatment for the PICC. The physician orders dated 10/18/2014 were transcribed in two different hand writings.</p> <p>A record review of a Body Audit Form dated 10/18/2014 signed by Nurse #4 did not include an</p>	F 328	<p>Records and the medication in the Medication Carts, including IV medications and pain medications, to compare and assure new medication orders are in place and being followed. Director of Health Services or Clinical Competency Coordinator will select 10 patients weekly with new orders to ensure orders are being followed and correct by checking new orders to Medication Admission Record to medication cart.</p> <p>All resident with IV medications were reviewed by the Director of Health Services and Unit Manager for accuracy of orders to include flush orders, dressing changes and medication orders. Medication administration sheets reviewed for transcription of orders to include flushes, dressing changes, and medications.</p> <p>The Pharmacy Consultant, Director of Health Services, Clinical Competency Coordinator and interim Director of Health Services in-serviced the licensed staff on the provision of pharmacy services including following physician orders to include giving the medication ordered, including IV medications and pain medications. The Clinical Care Coordinator will include information on the provision of Pharmacy service including following physician orders to include giving the dose ordered during orientation. The Director of Health Services or Clinical Competency Coordinator, will review orders on a weekly bases for 1 month then q2 weeks for 1 month then quarterly</p>		

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F 328	<p>Continued From page 19 assessment of the PICC.</p> <p>A record review of Resident #128's admission nurse note dated 10/18/2014 written by Nurse #5 did not include an assessment or treatment for Resident #128's PICC.</p> <p>A record review of Resident #128's nurse note dated 10/18/2014 written by Nurse # 1 did not include an assessment or treatment for Resident #128's PICC.</p> <p>A record review of Resident #128's Skilled Daily Nurses Note dated 10/19/2014 included a full system assessment for each shift and was signed by Nurse #3 for day shift and Nurse #1 for night shift. It did not include assessment or treatment of Resident #128's PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128.</p> <p>A record review of Resident #128's Physician Admission History and Physical dated 10/20/2014 included notation of the PICC</p> <p>A record review of Resident #128's Skilled Daily Nurses Note dated 10/20/2014 included a full system assessment for each shift and was signed by Nurse #6 for day shift. It did not include assessment or treatment of Resident #128's PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128.</p> <p>A record review of Resident #128's Skilled Daily Nurses Note dated 10/21/2014 included a full system assessment for each shift and was signed</p>	F 328	<p>to assure medications are administered according to physician orders.</p> <p>Systemic Changes to Prevent Deficient Practice.</p> <p>New orders for medications, including IV medication, flush orders and pain medication will be checked by the unit manager/week-end supervisor daily to ensure medications were faxed to pharmacy, received, transcribed, and given.</p> <p>Education with licensed nurses began on Oct 27, 2014 by the Interim Director of Nursing and continued by the Clinical Competency Coordinator on use of the Emergency-Kit (E- Kit) for medications needed immediately, utilization of the back-up pharmacy for medications that are not available in the Emergency-kit (E-kit), and new medication administration. Education will be provided in orientation and licensed nursed on Leave and/or PRN will be educated prior to returning to work on use of emergency kit (E-kit) and back-up pharmacy.</p> <p>Education with licensed nurses began on Dec 24, 2014 by the Clinical Competency Coordinator and Director of Health Services on policy and procedure "Intermittent infusion device flushing and locking", and "Physician order for infusion therapy" Education will be added to license nursing orientation, and licensed nurses on Leave and/or PRN will be educated prior to returning to work.</p>		

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F 328	<p>Continued From page 20</p> <p>by Nurse #7 for night shift. It did not include assessment or treatment of Resident #128's PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128.</p> <p>A record review of Resident #128's Skilled Daily Nurses Note dated 10/22/2014 included a full system assessment for each shift and was signed by Nurse #8 for day shift. It did not include assessment or treatment of Resident #128's PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128. Addition nurse note narratives from Nurse #9 and Nurse #1 did not include assessment or treatment for Resident #128's PICC.</p> <p>A record review of Resident #128's Skilled Daily Nurses Note dated 10/23/2014 included a full system assessment for each shift and was signed by an unidentified nurse. It did not include assessment or treatment of Resident #128's PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128.</p> <p>A record review of Resident #128's Skilled Daily Nurses Note dated 10/24/2014 included a full system assessment for each shift and was signed by Nurse #3 for day shift and Nurse #1 for night shift. It did not include assessment or treatment of Resident #128's PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128.</p>	F 328	<p>How will Corrective Action be monitored?</p> <p>The Director of Nursing will conduct a weekly review of the Unit Managers'/week- end supervisor's audit findings of new medications. Findings will be brought to the monthly Quality Assurance Performance Improvement Committee for review and revision as needed.</p>		

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F 328	<p>Continued From page 21</p> <p>A record review of Resident #128's Skilled Daily Nurses Note dated 10/25/2014 included a full system assessment for each shift and a nurse note narrative from Nurses #9 and #10. It did not include assessment or treatment of Resident #128's PICC. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128.</p> <p>A record review of Resident #128's Skilled Daily Nurses Note dated 10/26/2014 included a full system assessment for each shift and was signed by Nurse #2. The boxes under services provided for central/peripheral IV therapy and teach/care IV catheter sites were not marked to indicate applicable for Resident #128. A nurse note narrative written by Nurse #12 at 12:00 PM included the resident was alert and oriented and stated " I don ' t feel well." Resident #128's vital signs were assessed and orders were received from the Physician for blood work and radiology. A nurse note narrative written by Nurse #9 at 3:55 PM revealed his interpretation of the radiology report. Orders were received to start a peripheral intravenous access (PIV); start Meropenem as ordered at hospital; and to replace PICC line when possible.</p> <p>A record review of Resident #128's Skilled Daily Nurses Note dated 10/27/2014 included a narrative by Nurse #11. The Physician ordered resident #128 to be sent to the hospital for an evaluation of the PICC and Resident #128 was transported at 1:15 PM.</p> <p>A record review of a facility communication tool (SBAR Communication Form) dated 10/27/2014</p>	F 328			

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F 328	<p>Continued From page 22 included Resident #128's had no blood return from the PICC line and was transported to the hospital.</p> <p>A record review of the facility Nursing Home to Hospital Transfer Form dated 10/27/2014 included no blood return to PICC and the primary reason for transfer was de-clog/replace PICC.</p> <p>A record review of hospital emergency department discharge dated 10/27/2014 included a diagnosis of Occluded PICC line.</p> <p>Nurse #1 was Resident #128's nurse on 10/18/2014, 10/19/2014 10/23/2014 and 10/24/2014. She was out of the country and unavailable for an interview during the survey.</p> <p>On 12/12/2014 at 1:48 PM an interview with Nurse #2 revealed she worked for 4 years as the admission nurse for a sister facility and was no longer employed. She reported she did not care for Resident #128 the week of 10/18/2014 through 10/26/2014 until the evening [10/26] when she found the error. She reported on 10/23/2014 a nurse in orientation worked the hall even though Nurse #2's name remained on the schedule. Resident #128 was "oriented to person and place but he was sick. I am not sure he was able to understand that time had passed. I asked Resident #128 to show me his PICC line. The PICC dressing was nasty and it was not a facility dressing."</p> <p>On 12/12/2014 at 11:22 PM an Interview with Nurse #4 revealed she was no longer employed at the facility. Nurse #4 was the treatment nurse on 10/18/2014 and helped Nurse #5 with Resident #128's admission process. She recalled</p>	F 328			

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F 328	<p>Continued From page 23</p> <p>faxing the orders to the pharmacy, and transcribing orders to the telephone order sheet that were on formulary. She did not transcribe all of Resident #128's Physician orders.</p> <p>Nurse #5 was Resident #128's nurse on 10/18/2014 and was not available for an interview during the survey.</p> <p>On 12/10/2014 at 1:05 PM an interview with Unit Coordinator #1 revealed all nursing staff members were responsible for PICC line care that includes: flush with the SASH (Saline/Antibiotic/Saline/Heparin) protocol, dressing changes and monitor site for redness. The nursing staff was responsible for transcribing the Physician order for PICC line care on the Medication Order form. It was Unit Coordinator #1 expectation that the responsibility of the nurses was to make sure the orders were transcribed and if the order was not written then the nurse was to call and get an order for the PICC line maintenance.</p> <p>On 12/10/2014 at 1:06 PM an interview with the Acting Director of Nursing (DON) revealed she agreed with Unit Coordinator #1's statements and expectations. The staff was supposed to follow the Physician Orders [not obtained until 10/26/2014] which was to flush the PICC line every shift. Weekly body audits/skin assessments were done weekly and on a rotating staff schedule and the floor nurse was responsible for the PICC dressing changes.</p> <p>An interview on 12/10/2014 at 4:54 PM with the Physician revealed the PICC line was replaced because it was occluded from lack of use. It was not flushed but it should have been.</p>	F 328			

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F 328	Continued From page 24 On 12/12/2014 at 3:40 PM an interview with the Acting DON revealed her expectation of staff during the admission process was the nurse staff reviewed the admission discharge summary and verified the medications/treatments with the Physician and transfer the orders to the Physician Order Form. Another nurse was to verify the transcribed orders and then fax them to the pharmacy. It was not best practice for multiple nurses to be involved in the admission process/transcription of medications. It was the responsibility of the nurses to take care of Resident #128, keep him safe, and provide the care needed.	F 328			
F 333 SS=G	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 record review, staff interview, physician interview the facility failed to administer admission medications (Meropenum) for 8 days and (Tobramycin) for 3 days; failed to obtain and administer a medication ordered for pain (Elavil) for 10 days; and failed to administer a stock medication ordered for supplement and wound healing (multivitamin) for 14 days for 3 of 3 residents (Resident #128, #181 and #75). Findings included: 1. Resident #128 was admitted to the facility from an acute hospital on 10/18/2014. His diagnoses	F 333	Corrective Action for the resident affected. Resident #128, #181, and #75 medications were obtained from pharmacy and given as ordered. The Director or Health Services will counsel, and/or in-services the nursing staff involved in error. Corrective Action for Those with the Potential to be affected. Unit Managers and Supervisors have reviewed new Medication Admission	1/5/15	

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F 333	<p>Continued From page 25</p> <p>included acute on chronic Bronchiectasis (a lung condition in which damage to the airways causes the air passages to widen and scar and lose their ability to move air in and out) exacerbation. The admission Minimum Data Set (MDS) dated 10/25/2014 revealed Resident #128 was cognitively intact but required extensive assistance from staff for his activities of daily living. Resident #128 was not coded in the MDS as receiving intravenous medication under special procedures.</p> <p>A hospital discharge summary dated 10/18/2014 included the discharge diagnosis of acute on chronic Bronchiectasis exacerbation, a history of Pulmonary Fibrosis, and previous admissions for Bronchiectasis exacerbation secondary to Pseudomonas (bacteria with antibiotic resistance). The sputum culture grew Pseudomonas and Resident #128 was treated at the hospital with Meropenem (antibiotic) every 12 hours 10/5/2014 through 10/18/2014 and Tobramycin (antibiotic) twice a day 10/2/2014 through 10/18/2014. The discharge medications included: Meropenem 500 mg (milligram) injections infuse 2 grams into venous catheter every 12 hours for 10 days and Tobramycin 300 mg/ 5 ml (milliliters) nebulizer solution. Inhale 5 ml every 12 hours for 3 days.</p> <p>A medication list for Resident #128 provided by the hospital on 10/18/2014 included: [in part] the medications Meropenem and Tobramycin.</p> <p>A record review of Resident #128 ' s Physician ' s Orders dated 10/18/2014 transcribed by Nurse #4 and verified by Nurse #5 noted to be transcribed in two different hand writings included:</p>	F 333	<p>Records and the medication in the Medication Carts, including IV medications and pain medications, to compare and assure new medication orders are in place and being followed. Director of Health Services or Clinical Competency Coordinator will select 10 patients weekly with new orders to ensure orders are being followed and correct by checking new orders to Medication Admission Record to medication cart.</p> <p>All resident with IV medications were reviewed by the Director of Health Services and Unit Manager for accuracy of orders to include flush orders, dressing changes and medication orders. Medication administration sheets reviewed for transcription of orders to include flushes, dressing changes, and medications.</p> <p>The Pharmacy Consultant, Director of Health Services, Clinical Competency Coordinator and interim Director of Health Services in-serviced the licensed staff on the provision of pharmacy services including following physician orders to include giving the medication ordered, including IV medications and pain medications. The Clinical Care Coordinator will include information on the provision of Pharmacy service including following physician orders to include giving the dose ordered during orientation. The Director of Health Services or Clinical Competency Coordinator, will review orders on a weekly bases for 1 month then q2 weeks for 1 month then quarterly</p>		

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F 333	<p>Continued From page 26</p> <p>Meropenem 500 mg injections infuse 2 grams into venous catheter every 12 hours for 10 days and Tobramycin 300 mg/5 ml nebulizer. Inhale 5 ml every 12 hours for 3 days.</p> <p>A record review of Resident #128 ' s Medication Record dated 10/18/2014 included: Meropenem 500 mg injections infuse 2 grams into venous catheter every 12 hours for 10 days and Tobramycin 300 mg/5 ml nebulizer. Inhale 5 ml every 12 hours for 3 days.</p> <p>The designated boxes for nurse staff initials that indicated the medication was administered were blank from the PM of 10/18/2014 through the AM of 10/26/2014 for the Meropenem missing 16 of 20 opportunities. The boxes for the Tobramycin were blank or initialed with a circle around the initials that indicated not administered over a time span from 10/19/2014 to 10/24/2014 missing 6 out of 6 opportunities to administer the medication. The Medication Record was unclear as to what 3 days the nursing staff intended to administer the Tobramycin.</p> <p>A record review of the facility log for medication received from the pharmacy revealed that on 10/18/2014 fifteen medications were dispensed to the facility for resident #128. Meropenem and Tobramycin were not included. 10/19/2014 through 10/26/2014 was reviewed and Meropenem and Tobramycin were not dispensed. On 10/27/2014 Meropenem quantity of 4 was dispensed for Resident #128.</p> <p>A record review of Resident #128 ' s admission nurse note dated 10/18/2014 written by Nurse #5 revealed all medications were verified by the Physician and faxed to the pharmacy. All medications were received from the back up</p>	F 333	<p>to assure medications are administered according to physician orders.</p> <p>Systemic Changes to Prevent Deficient Practice.</p> <p>New orders for medications, including IV medication, flush orders and pain medication will be checked by the unit manager/week-end supervisor daily to ensure medications were faxed to pharmacy, received, transcribed, and given.</p> <p>Education with licensed nurses began on Oct 27, 2014 by the Interim Director of Nursing and continued by the Clinical Competency Coordinator on use of the Emergency-Kit (E- Kit) for medications needed immediately, utilization of the back-up pharmacy for medications that are not available in the Emergency-kit (E-kit), and new medication administration. Education will be provided in orientation and licensed nursed on Leave and/or PRN will be educated prior to returning to work on use of emergency kit (E-kit) and back-up pharmacy.</p> <p>Education with licensed nurses began on Dec 24, 2014 by the Clinical Competency Coordinator and Director of Health Services on policy and procedure "Intermittent infusion device flushing and locking", and "Physician order for infusion therapy" Education will be added to license nursing orientation, and licensed nurses on Leave and/or PRN will be educated prior to returning to work.</p>		

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F 333	<p>Continued From page 27</p> <p>pharmacy. Resident #128 is on multiple nebulizer treatments and inhalers. He is on antibiotic therapy Cipro (oral antibiotic).</p> <p>Nurse #1 was Resident #128 ' s nurse on 10/18/2014, 10/19/2014 10/23/2014 and 10/24/2014. She also signature initialed the 24 hour chart check form for Resident #128 on admission 10/18/2014 verifying that she checked all of Resident #128 ' s admission medications. She was out of the country and unavailable for an interview during the survey.</p> <p>On 12/12/2014 at 1:48 PM an interview with Nurse #2 revealed she did not care for Resident #128 the week of 10/18/2014 through 10/26/2014 until the evening [10/26] when she found the error. She reported on 10/23/2014 a nurse in orientation worked the hall even though Nurse #2 ' s name remained on the schedule. The Meropenum on 10/26/2014 was delivered from a specialty pharmacy through the back up. The regular pharmacy delivered additional doses on 10/27/2014. The Tobramycin was not reordered.</p> <p>On 12/12/2014 at 1:18 PM an interview with Nurse #3 who cared for Resident #128 on 10/19/2014 and 10/24/2014 revealed she did not recall the Meropenum order.</p> <p>On 12/12/2014 at 11:22 PM an Interview with Nurse #4 revealed she was no longer employed at the facility. Nurse #4 was the treatment nurse on 10/18/2014 and helped Nurse #5 with Resident #128 ' s admission process. She recalled faxing the orders to the pharmacy, and transcribing orders to the telephone order sheet that were on formulary. She did not transcribe all of Resident #128 ' s Physician orders.</p>	F 333	<p>How will Corrective Action be monitored?</p> <p>The Director of Nursing will conduct a weekly review of the Unit Managers'/week- end supervisor's audit findings of new medications. Findings will be brought to the monthly Quality Assurance Performance Improvement Committee for review and revision as needed.</p>		

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

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F 333	<p>Continued From page 28</p> <p>Nurse #5 was Resident #128 ' s nurse on 10/18/2014 and was not available for an interview during the survey.</p> <p>Nurse #6 was Resident #128 ' s nurse on 10/20/2014 and was not available for interview during the survey.</p> <p>On 12/11/2014 at 1:29 PM an interview with Nurse #7 revealed she worked with Resident #128 on 10/21/2014 and 10/23/2014. She reported she ignored the order because the time said 9:00 AM. She looked at the administration time but not the order.</p> <p>Nurse #8 was Resident #128 ' s nurse on 10/22/2014 and was not available for interview during the survey.</p> <p>Nurse #10 was Resident #128 ' s nurse on 10/25/2014 and was not available for interview during the survey.</p> <p>Nurse #11 was Resident #128 ' s nurse on 10/26/2014 and was not available for an interview during the survey.</p> <p>Nurse #12 was identified by the facility corporate administration team as one of the nurses that cared for Resident #128 the week of 10/18/2014 through 10/26/2014 based on the staff schedule. Nurse #12 ' s signature or initials were not identified and she was unavailable for an interview during the survey.</p> <p>Nurse #13 was identified by the facility corporate administration team as one of the nurses that cared for Resident #128 the week of 10/18/2014</p>	F 333			

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F 333	<p>Continued From page 29 through 10/26/2014.</p> <p>On 12/12/2014 at 2:28 PM an interview with Nurse #13 revealed she had not worked on Resident #128 ' s hall 10/18/2014 through 10/26/2014. She reported she returned to the hall on the first morning Resident #128 received his antibiotic through a PIV. Nurse #13 confirmed her signature initials on Resident #128 ' s Medication Record for 10/27/2014.</p> <p>Nurse #14 was identified by the facility corporate administration team as one of the nurses that cared for Resident #128 the week of 10/18/2014 through 10/26/2014 (10/21 and 10/22) based on the staff schedule. Nurse #12 ' s signature or initials were not identified and she was unavailable for an interview during the survey.</p> <p>On 12/10/2014 at 1:05 PM an interview with Unit Coordinator #1 revealed all nursing staff members are responsible for transcribing the Physician order. She reported she did not look at Resident #128 ' s POF or Medication Record because she was not working on his admission date.</p> <p>On 12/10/2014 at 1:06 PM an interview with the Acting Director of Nursing (DON) revealed her expectation was the staff review the Medication Record and look at every page.</p> <p>An interview on 12/10/2014 at 4:54 PM with the Physician indicated the resident had a diagnosis of chronic and acute Bronchiectasis exacerbation and the Meropenem had been ordered due to his sputum culture results. The Physician received a call from Unit Coordinator #1 on 10/26/2014. She reported that Resident #128 had not been</p>	F 333			

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F 333	<p>Continued From page 30</p> <p>receiving his antibiotic Meropenem. The Physician reported he ordered the Meropenem at that time and extended the end date for the medication. " Do I wish [the nurses] had provided the antibiotic? Yes. It was important that he [Resident #128] received the antibiotic. I do not think his condition deteriorated during the time he did not receive the medication, but it was important for him to receive the medication, so we started a peripheral IV for him to get the medication when we realized it had not been given. " The Physician agreed there was a process issue.</p> <p>On 12/12/2014 at 3:40 PM an interview with the Acting DON revealed her expectation of staff was when the medications were received the nursing staff would check against the POF and when they place the medications in the [medication cart] drawer they are to check the medications against the Medication Record. If something was missing the expectation was to call the Pharmacy or go to the back up pharmacy. Her expectation was for the nurse staff to view the orders during the routine medication pass and to know what medications they were giving. The nurse staff needed to read the medications listed on the Medication Record regardless of what the [designated] time said. The nursing staff was responsible for a 24 hour chart check [for order verification]. The night shift nurse staff does the 24 hour chart check. The nurse who transcribed the orders was not to be the nurse to sign off or complete order verification. It was not best practice for multiple nurses to be involved in the admission process/transcription of medications. It was the responsibility of the nurses to take care of Resident #128, keep him safe, and provide the care needed.</p>	F 333			

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F 333	<p>Continued From page 31</p> <p>2. Resident #181 was admitted on 10/8/14 with diagnoses that included a wound infection, ulcers on both lower legs and acute and chronic pain.</p> <p>The Nursing Home Admission History and Physical dated 10/9/14 indicated Resident #181 had a bilateral lower extremity chronic wound infection and acute and chronic pain.</p> <p>The October 2014 signed admission Physician Orders included the following medications for pain: Gabapentin 300 milligrams (mg) three times a day. Ultram 50 mg every 6 hours as needed. Take 1 tablet for moderate pain, 2 for severe pain. Oxycodone 10 mg every 6 hrs as needed.</p> <p>The physician progress note dated 10/10/14 indicated Resident #181 was seen due to increased burning sensation in legs. The physician discontinued Gabapentin and started Lyrica for her nerve pain.</p> <p>The Physician Interim Orders dated 10/14/14 indicated: Morphine 4 mg [by mouth] 30 minutes before dressing change once daily.</p> <p>The Physician Interim Orders dated 10/15/14 indicated Oxycodone 10 mg [by mouth] x 1 dose now - extreme pain. Ultram 50 mg [by mouth every 6 hours as needed] mild pain. Ultram 100 mg [by mouth every 6 hours as needed] moderate pain. Oxycodone 10 mg [by mouth every 6 hours as needed] severe pain.</p>	F 333			

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F 333	<p>Continued From page 32</p> <p>The Minimum Data Set (MDS) dated 10/15/14 indicated Resident #181 was cognitively intact, had wounds, received scheduled and as-needed pain medication in the last 5 days, experienced pain frequently, the pain made it hard for her to sleep and her worst pain was a 10/10.</p> <p>The Physician Interim Orders dated 10/16/14 indicated: [Discontinue] Morphine 4 mg [by mouth 30 minutes before dressing change]. Start Morphine 5 mg [by mouth 30 minutes before dressing change] once daily. [Discontinue] Gabapentin. [Discontinue] Lyrica. Elavil 25 mg [by mouth every night at bedtime] - (pain). [Discontinue] Ultram. [Discontinue] Oxycodone. Oxycodone 10 mg [by mouth every 4 hours as needed] pain. Ultram 50 mg [by mouth every 4 hours as needed] pain.</p> <p>Review of the 24-hour Chart Check Form signed by Nurse #15 and dated 10/16/14 stated, "New orders" and indicated, by a checkmark, that the new orders were placed on the MAR.</p> <p>Review of the Medication Administration Record (MAR) indicated Elavil 25 mg for pain was ordered on 10/16/14 and was first signed off as being administered on 10/26/14.</p> <p>The physician progress note dated 10/20/14 indicated Resident #181 was seen due to continued complaint of severe pain in both of her legs. The physician added Morphine for pain</p>	F 333			

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F 333	<p>Continued From page 33 management.</p> <p>The Physician Interim Orders dated 10/20/14 indicated: [Morphine] 15 mg [by mouth twice a day].</p> <p>The physician progress note dated 10/24/14 indicated Resident #181's pain was improved but she was awakening at night with pain. The physician increased her Morphine at night.</p> <p>The Physician Interim Orders dated 10/24/14 indicated: [Discontinue Morphine] [Morphine] 15 mg [by mouth every morning]. [Morphine] 30 mg [by mouth at bedtime].</p> <p>The Physician Interim Orders dated 10/25/14 indicated: May hold Elavil 25 mg [by mouth at bedtime] until available from pharmacy.</p> <p>The October 2014 Medication Administration Record (MAR) revealed Resident #181 received 49 doses of as-needed pain medication between 10/8/14 and 10/31/14. The pain evaluation done every shift documented moderate to severe pain every day.</p> <p>The physician progress note dated 11/5/14 indicated Resident #181 was seen because of episodes of crying and that the resident stated "she was only crying [because] she continues to have pain in [both lower legs]." The physician increased her Elavil for her chronic nerve pain and bilateral leg ulcers.</p> <p>The Physician Interim Orders dated 11/5/14 indicated:</p>	F 333			

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F 333	<p>Continued From page 34 [Discontinue Elavil]. Elavil 50 mg [by mouth at bedtime] for neuropathic pain.</p> <p>The Physician Interim Orders dated 11/11/14 indicated: [Discontinue Elavil]. Elavil 75 mg [by mouth at bedtime].</p> <p>During an interview on 12/10/14 at 3:26 pm with the acting Director of Nursing (DON) she stated, "Two nurses check the chart. The [night] nurse on the floor checks every new order that has come in [that 24-hour period]." She further indicated that there is no set time for the night (7 pm - 7 am) nurse to do the 24-hour chart check, but that the check for new orders should go all the way back to 7 pm the previous day so that no orders are missed. She also indicated that the Elavil is not a stock medication or available in the e-kit (emergency kit), should have been ordered from the pharmacy and should have been given to the resident as ordered.</p> <p>During an interview with Unit Coordinator #1 on 12/11/14 at 12:25 pm she stated, "The nurse will fax [the physician order] to the pharmacy no matter what time the order is written and then will write it on the MAR. The night supervisor does a chart check to ensure all orders are sent to the pharmacy and put on the MAR." After reviewing Resident #181's 10/16/14 Elavil order, she indicated a nurse did not sign off as receiving the order or faxing it to the pharmacy on 10/16/14, or any date since that time. She further stated, "If a written order does not arrive after it is sent to the pharmacy and is not in the e-kit, we write a hold order until it comes. I remember Nurse #2 mentioning the missed Elavil to me. I don ' t</p>	F 333			

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F 333	<p>Continued From page 35 recall why it was not given. Elavil is not in the e-kit [and would have to come from the pharmacy]."</p> <p>During an interview with the DON on 12/11/14 at 4:15 pm she stated, "I would expect the order would have been caught by the night nurse doing the chart check."</p> <p>During an interview with Nurse #2 on 12/12/14 at 1:00 pm, regarding Resident #181's 10/16/14 Elavil order she stated, "I found [the missed order] when I was working on the hall on the 25th. A line was drawn on the MAR and [the medication was not] on the cart." She indicated the nurse working on the 16th must have written it on the MAR but never signed or faxed the order to the pharmacy and the resident never received the medication.</p> <p>Nurse #15 was unavailable for interview.</p> <p>3. Resident #75 was originally admitted on 9/19/14 and re-admitted on 10/3/14 with diagnoses that included sepsis, diabetes, hypertension, and methicillin-resistant staphylococcus aureus (MRSA).</p> <p>The Admission/Nursing Observation Form dated 10/3/14 indicated the resident had MRSA to the right knee and had a peripherally-inserted central catheter (PICC) in his right arm.</p> <p>The Minimum Data Set (MDS) dated 10/10/14 indicated the resident had a surgical wound, was on a therapeutic diet, received an antibiotic 7 of 7 look-back days, and was on intravenous (IV) medication.</p>	F 333			

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F 333	<p>Continued From page 36</p> <p>Review of the Resident's labwork dated 10/13/14 revealed a low Albumin level of 2.8 grams per deciliter (g/dL). The normal Albumin reference range noted on the labwork was 3.5-5.2 g/dL.</p> <p>The Physician Order dated 10/15/14 at 10:30 am stated, "Therapeutic [multivitamin (MVI) one tablet by mouth] daily - supplement/wound." The order was written as a telephone order from the physician by the dietician and was signed by the physician assistant on 10/15/14. The order did not have a signature of a "nurse receiving order."</p> <p>Review of the 24-hour Chart Check Form dated 10/15/14 indicated (by a circle with a diagonal slash through it) that there were no medications written within 24 hours, no medications transferred to the Medication Administration Record (MAR), and was initialed by Nurse #1.</p> <p>Review of the MAR indicated a daily multivitamin was ordered on 10/15/14 and was first signed off as being administered on 10/29/14.</p> <p>Review of the Resident's labwork dated 10/31/14 revealed a low Albumin level of 3.1 g/dL. The normal Albumin reference range noted on the labwork was 3.5-5.2 g/dL.</p> <p>During an interview on 12/10/14 at 3:26 pm with the acting Director of Nursing (DON) she stated, "Two nurses check the chart. The [night] nurse on the floor checks every new order that has come in [that 24-hour period]." She further indicated that there is no set time for the night (7 pm - 7 am) nurse to do the 24-hour chart check, but that the check for new orders should go all the way back to 7 pm the previous day so that no orders are missed. She also indicated that the MVI is a</p>	F 333			

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F 333	<p>Continued From page 37</p> <p>stock medication, available to nurses at all times in the facility and should have been given to the resident as ordered.</p> <p>During an interview with Physician #1 on 12/10/14 at 5:15 pm regarding Resident #75's MVI he stated, "The [MVI] is a nice adjunct and it is important for him. I would expect that it would have been given." The physician indicated the MVI would have been important for this resident due to multiple factors, including his infection and his low Albumin level.</p> <p>During an interview with Unit Coordinator #1 on 12/11/14 at 12:25 pm she stated, "The nurse will fax [the physician order] to the pharmacy no matter what time the order is written and then will write it on the MAR. The night supervisor does a chart check to ensure all orders are sent to the pharmacy and put on the MAR." After reviewing Resident #75's 10/15/14 MVI order, she indicated a nurse did not sign off as receiving the order on 10/15/14, or any date since that time, and Nurse #2 signed on 10/27/14 indicating she sent the order to the pharmacy.</p> <p>During an interview with the DON on 12/11/14 at 4:15 pm she stated, "I would expect the order would have been caught by the night nurse doing the chart check."</p> <p>During an interview on 12/12/14 at 12:32 pm with Nurse #3, the 7 am - 7pm nurse who was assigned to Resident #75 on 10/15/14, she stated, "We have had several reminders about looking at the orders, taking them off, and getting the orders double checked. I do not specifically remember this missed medication or anyone speaking to me about it."</p>	F 333			

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F 333	Continued From page 38	F 333			
F 425 SS=G	<p>During an interview on 12/12 12:44 pm with Nurse #2, regarding Resident #75's 10/15/14 MVI order, she stated, "When I was doing the MAR checks for November is when I caught the error. [The night nurse] is supposed to check every chart on the hall [every] night. [The 10/15/14 order] was a couple of pages back in the orders."</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, physician and pharmacist interview the facility failed to acquire by procedure, receive, and</p>	F 425	Corrective Action for the resident affected.	1/5/15	

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F 425	<p>Continued From page 39</p> <p>administer the admission medications (Meropenem) for 8 days and (Tobramycin) for 3 days as ordered; failed to obtain from the pharmacy and administer a medication ordered for pain (Elavil) for 10 days; and failed to administer a stock medication ordered for supplement and wound healing (multivitamin) for 14 days for 3 of 3 residents (Resident #128, #181 and #75).</p> <p>Findings included:</p> <p>1. Resident #128 was admitted to the facility from an acute hospital on 10/18/2014. His diagnoses included acute on chronic Bronchiectasis (a lung condition in which damage to the airways causes the air passages to widen and scar and lose their ability to move air in and out) exacerbation. The admission Minimum Data Set (MDS) dated 10/25/2014 revealed Resident #128 was cognitively intact but required extensive assistance from the staff for his activities of daily living. Resident #128 was not coded in the MDS as receiving intravenous medication under special procedures.</p> <p>A hospital discharge summary dated 10/18/2014 included the discharge diagnosis of acute on chronic Bronchiectasis exacerbation, a history of Pulmonary Fibrosis, and previous admissions for Bronchiectasis exacerbation secondary to Pseudomonas (bacteria with antibiotic resistance). The sputum culture grew Pseudomonas and Resident #128 was treated at the hospital with Meropenem (antibiotic) every 12 hours 10/5/2014 through 10/18/2014 and Tobramycin (antibiotic) twice a day 10/2/2014 through 10/18/2014). The discharge medications included: Meropenem 500 mg (milligram)</p>	F 425	<p>Resident #128, #181, and #75 medications were obtained from pharmacy and given as ordered. The Director or Health Services will counsel, and/or in-services the nursing staff involved in error.</p> <p>Corrective Action for Those with the Potential to be affected.</p> <p>Unit Managers and Supervisors have reviewed new Medication Admission Records and the medication in the Medication Carts, including IV medications and pain medications, to compare and assure new medication orders are in place and being followed. Director of Health Services or Clinical Competency Coordinator will select 10 patients weekly with new orders to ensure orders are being followed and correct by checking new orders to Medication Admission Record to medication cart.</p> <p>All resident with IV medications were reviewed by the Director of Health Services and Unit Manager for accuracy of orders to include flush orders, dressing changes and medication orders. Medication administration sheets reviewed for transcription of orders to include flushes, dressing changes, and medications.</p> <p>The Pharmacy Consultant, Director of Health Services, Clinical Competency Coordinator and interim Director of Health Services in-serviced the licensed staff on the provision of pharmacy services</p>		

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F 425	Continued From page 40 injections infuse 2 grams into venous catheter every 12 hours for 10 days and Tobramycin 300 mg/ 5 ml (milliliters) nebulizer solution. Inhale 5 ml every 12 hours for 3 days. Medication List: START: 1) Pulmicort 2) Performist 3) Novolog 4) Atrovent 5) Meropenem 6) Tobramycin 7) Warfarin CHANGE: 1) Albuterol Inhaler 2) Albuterol Nebulizer 3) Lasix 4) Lactulose 5) Sodium Polystrene CONTINUE: 1) Aspirin 2) Carvedilol 3) Ciprofloxacin 4) Creon 5) Hyper-Sal 6) Magnesium Oxide 7) Metformin 8) Nitrostat 9) Norvasc 10) Omeprazole 11) Tramadol 12) Trazadone STOP 1) Dulera 2) Spiriva A record review of Resident #128 ' s medication reconciliation from the hospital dated 10/18/2014 included:	F 425	including following physician orders to include giving the medication ordered, including IV medications and pain medications. The Clinical Care Coordinator will include information on the provision of Pharmacy service including following physician orders to include giving the dose ordered during orientation. The Director of Health Services or Clinical Competency Coordinator, will review orders on a weekly bases for 1 month then q2 weeks for 1 month then quarterly to assure medications are administered according to physician orders. Systemic Changes to Prevent Deficient Practice. New orders for medications, including IV medication, flush orders and pain medication will be checked by the unit manager/week-end supervisor daily to ensure medications were faxed to pharmacy, received, transcribed, and given. Education with licensed nurses began on Oct 27, 2014 by the Interim Director of Nursing and continued by the Clinical Competency Coordinator on use of the Emergency-Kit (E- Kit) for medications needed immediately, utilization of the back-up pharmacy for medications that are not available in the Emergency-kit (E-kit), and new medication administration. Education will be provided in orientation and licensed nursed on Leave and/or PRN will be educated prior to returning to work on use of emergency		

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F 425	Continued From page 41 STOP: 1) Dulera 2) Spiriva START: 1) Pulmicort 2) Performist 3) Novolog 4) Atrovent 5) Meropenem 6) Tobramycin 7) Warfarin CHANGE: 1) Albuterol Inhaler 2) Albuterol Nebulizer 3) Lasix 4) Lactulose 5) Sodium Polystrene CONTINUE: 1) Aspirin 2) Carvedilol 3) Ciprofloxacin 4) Creon 5) Hyper-Sal 6) Magnesium Oxide 7) Metformin 8) Nitrostat 9) Norvasc 10) Omeprazole 11) Tramadol 12) Trazadone A medication list for Resident #128 provided by the hospital on 10/18/2014 included: [in part] the medications Meropenem and Tobramycin. A record review of the Medication list that was faxed to the pharmacy from the facility on 10/18/2014 attached to Resident #128 's FL2	F 425	kit (E-kit) and back-up pharmacy. Education with licensed nurses began on Dec 24, 2014 by the Clinical Competency Coordinator and Director of Health Services on policy and procedure "Intermittent infusion device flushing and locking", and "Physician order for infusion therapy" Education will be added to license nursing orientation, and licensed nurses on Leave and/or PRN will be educated prior to returning to work. How will Corrective Action be monitored? The Director of Nursing will conduct a weekly review of the Unit Managers'/week- end supervisor's audit findings of new medications. Findings will be brought to the monthly Quality Assurance Performance Improvement Committee for review and revision as needed.		

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F 425	<p>Continued From page 42</p> <p>(Level of Care Screening Tool) was the medication reconciliation list from the hospital dated 10/18/2014. Page 2 [not labeled] was not included: Novolog, Atrovent, Meropenem, Tobramycin, and Warfarin.</p> <p>A record review of Resident #128 ' s Physician ' s Orders dated 10/18/2014 transcribed by Nurse #4 and verified by Nurse #5 noted to be transcribed in two different hand writings included: Meropenem 500 mg injections infuse 2 grams into venous catheter every 12 hours for 10 days and Tobramycin 300 mg/5 ml nebulizer. Inhale 5 ml every 12 hours for 3 days.</p> <p>A record review of Resident #128 ' s Medication Record dated 10/18/2014 included: Meropenem 500 mg injections infuse 2 grams into venous catheter every 12 hours for 10 days and Tobramycin 300 mg/5 ml nebulizer. Inhale 5 ml every 12 hours for 3 days.</p> <p>The designated boxes for nurse staff initials that indicated the medication was administered were blank from the PM of 10/18/2014 through the AM of 10/26/2014 for the Meropenem missing 16 of 20 opportunities. The boxes for the Tobramycin were blank or initialed with a circle around the initials that indicated not administered over a time span from 10/19/2014 to 10/24/2014 missing 6 out of 6 opportunities to administer the medication. The Medication Record was unclear as to what 3 days the nursing staff intended to administer the Tobramycin.</p> <p>A record review of the facility log for medication received from the pharmacy revealed that on 10/18/2014 fifteen medications were dispensed to the facility for resident #128. Meropenem and Tobramycin were not included. 10/19/2014</p>	F 425			

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

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F 425	<p>Continued From page 43 through 10/26/2014 was reviewed and Meropenem and Tobramycin were not dispensed. On 10/27/2014 Meropenem quantity of 4 was dispensed for Resident #128.</p> <p>A record review of Resident #128 ' s admission nurse note dated 10/18/2014 written by Nurse #5 revealed all medications were verified by the Physician and faxed to the pharmacy. All medications were received from the back up pharmacy. Resident #128 is on multiple nebulizer treatments and inhalers. He is on antibiotic therapy Cipro (oral antibiotic).</p> <p>Nurse #1 was Resident #128 ' s nurse on 10/18/2014, 10/19/2014 10/23/2014 and 10/24/2014. She also signature initialed the 24 hour chart check form for Resident #128 on admission 10/18/2014 verifying that she checked all of Resident #128 ' s admission medications. She was out of the country and unavailable for an interview during the survey.</p> <p>On 12/12/2014 at 1:48 PM an interview with Nurse #2 revealed she worked for 4 years as the admission nurse for a sister facility and was no longer employed. She reported having more knowledge about the admission process than the floor nurses at the facility. Nurse #2 reported during the admission process the medications are verified with the physician and then transcribed to the POF which carbon copies to the Medication Record. A second nurse checked the accuracy of the medications transcribed and then the POF was faxed to the pharmacy. If the pharmacy was closing the facility could fax the discharge summary as long as it included the resident room number, date of birth, allergies, and was verified by the Physician. The pharmacy delivered to the</p>	F 425			

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F 425	<p>Continued From page 44</p> <p>facility between 8 PM and 10 PM. The nurse was supposed to make sure all the medications were delivered. If not then the nurse was to call the back up pharmacy. The back up pharmacy only accepted POF. Nurse #2 reported she did not care for Resident #128 the week of 10/18/2014 through 10/26/2014 until the evening [10/26] when she found the error. She reported on 10/23/2014 a nurse in orientation worked the hall even though Nurse #2 ' s name remained on the schedule. The Meropenum on 10/26/2014 was delivered from a specialty pharmacy through the back up. The regular pharmacy delivered additional doses on 10/27/2014.</p> <p>On 12/12/2014 at 11:22 PM an Interview with Nurse #4 revealed she was no longer employed at the facility. Nurse #4 was the treatment nurse on 10/18/2014 and helped Nurse #5 with Resident #128 ' s admission process. She recalled faxing the orders to the pharmacy, and transcribing orders to the telephone order sheet that were on formulary. She did not transcribe all of Resident #128 ' s Physician orders.</p> <p>Nurse #5 was Resident #128 ' s nurse on 10/18/2014 and was not available for an interview during the survey.</p> <p>On 12/10/2014 at 1:05 PM an interview with Unit Coordinator #1 revealed all nursing staff members were responsible for transcribing the Physician order. She reported she did not look at Resident #128 ' s POF or Medication Record because she was not working on his admission date.</p> <p>On 12/10/2014 at 1:06 PM an interview with the Acting Director of Nursing (DON) revealed her</p>	F 425			

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F 425	<p>Continued From page 45 expectation was the staff review the Medication Record and look at every page.</p> <p>On 12/10/2014 at 3:45 PM an interview with Pharmacist #1 reveled Resident #128 ' s FL2/discharge summary was received at the Pharmacy on 10/18/2014 at 1:56 PM and the Physician Orders Form (POF) was received on 10/18/2014 at 4:15 PM. Resident #128 ' s medications were dispensed from the FL2.</p> <p>On 12/11/2014 at 2:05 PM an interview with Pharmacist #1 revealed the pharmacy closes on Saturday at 2 PM. If an order came in at 1:56 PM the pharmacy would fill the medication order and deliver it to the facility. If an order came in after 2 PM then the Pharmacy would review it on Monday morning. The facility was responsible for calling the back up pharmacy on the weekend. In regards to a second fax the pharmacy discourages the facility from sending the POF and encourages telephone order sheets. Only one full admission order would have been completed if a second was sent the pharmacy would only looked at the telephone order sheets. The pharmacy did receive Resident #128 ' s POF and " it did included the Meropenum and Tobramycin but we did not process the order because we already processed the admit orders off of the FL2/discharge summary " . In addition the pharmacy received 4 pages of telephone order sheets and the Meropenem or Tobramycin were not transcribed on those. Pharmacist #1 reported to her knowledge the facility knows the process.</p> <p>On 12/12/2014 at 10:34 AM an interview with the Pharmacy Director revealed the pharmacy will</p>	F 425			

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F 425	<p>Continued From page 46</p> <p>allow but discourage a faxed hospital discharge summary as orders. We will accept the hospital discharge summary as long as it included a written verification with a Physician or a verbal order from a Physician. The pharmacy has asked the facility to not send two sets of orders. The facility needed to choose either the discharge summary or the POF. Anything sent after needed to be a telephone order communication. If the pharmacy gets a second set of admission orders the pharmacy will call the facility but it was the facilities decision as to what set of admission orders was accurate.</p> <p>On 12/12/2014 at 3:40 PM an interview with the Acting DON revealed her expectation of staff during the admission process was the nurse staff reviewed the admission discharge summary and verified the medications/treatments with the Physician and transfer the orders to the Physician Order Form. Another nurse was to verify the transcribed orders and then fax them to the pharmacy. If the pharmacy called for clarification then the nurse was to clarify the order with the Physician and resubmits an order on a telephone order sheet. The Acting DON reported that some staff will send both the discharge summary and the POF. The Pharmacy will disregard the discharge summary. The pharmacy will not sent the medications or bill for medications based on receiving the discharge summary. When the medications are received the nursing staff would check against the POF and when they place the medications in the [medication cart] drawer they check the medications against the Medication Record. If something was missing the expectation was to call the Pharmacy or go to the back up pharmacy. Her expectation was for the nurse staff to view the orders during the routine</p>	F 425			

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F 425	<p>Continued From page 47</p> <p>medication pass and to know what medications they are giving. The nurse staff needed to read the medications listed on the Medication Record regardless of what the [designated] time said. The nursing staff was responsible for a 24 hour chart check [for order verification]. The night shift nurse staff does the 24 hour chart check. The nurse who transcribes the orders was not to be the nurse to sign off or complete order verification. It was not best practice for multiple nurses to be involved in the admission process/transcription of medications. It was the responsibility of the nurses to take care of Resident #128, keep him safe, and provide the care needed.</p> <p>2. Resident #181 was admitted on 10/8/14 with diagnoses that included a wound infection, ulcers on both lower legs and acute and chronic pain.</p> <p>The Nursing Home Admission History and Physical dated 10/9/14 indicated Resident #181 had a bilateral lower extremity chronic wound infection and acute and chronic pain.</p> <p>Review of the facility's pharmacy Ordering and Receiving information dated 10/7/14 provided the pharmacy address, phone number, fax number, hours of operations, and after-hours emergency service number and stated:</p> <ul style="list-style-type: none"> · New orders - faxed by 5 pm - delivered same day and by 2 pm on Saturdays. · All new orders must be written on the Interim Order form. Fill in name, date, time, and initials of person faxing on top of the Order form. · Fax to the pharmacy and keep the fax confirmation report. · All medication orders must be faxed to the pharmacy. 	F 425			

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F 425	<p>Continued From page 48</p> <p>The Physician Interim Orders dated 10/16/14 indicated: Elavil 25 mg [by mouth every night at bedtime] - (pain).</p> <p>Review of the 24-hour Chart Check Form signed by Nurse #15 and dated 10/16/14 stated, "New orders" and indicated, by a checkmark, that the new orders were placed on the MAR.</p> <p>Review of the Medication Administration Record (MAR) indicated Elavil 25 mg for pain was ordered on 10/16/14 and was first signed off as being administered on 10/26/14.</p> <p>The Physician Interim Orders dated 10/25/14 indicated: May hold Elavil 25 mg [by mouth at bedtime] until available from pharmacy.</p> <p>During an interview on 12/10/14 at 3:26 pm with the acting Director of Nursing (DON) she stated, "Two nurses check the chart. The [night] nurse on the floor checks every new order that has come in [that 24-hour period]." She further indicated that there is no set time for the night (7 pm - 7 am) nurse to do the 24-hour chart check, but that the check for new orders should go all the way back to 7 pm the previous day so that no orders are missed. She also indicated that the Elavil is not a stock medication or available in the e-kit (emergency kit), should have been ordered from the pharmacy and should have been given to the resident as ordered.</p> <p>During an interview with Unit Coordinator #1 on 12/11/14 at 12:25 pm she stated, "The nurse will fax [the physician order] to the pharmacy no</p>	F 425			

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F 425	<p>Continued From page 49</p> <p>matter what time the order is written and then will write it on the MAR. The night supervisor does a chart check to ensure all orders are sent to the pharmacy and put on the MAR." After reviewing Resident #181's 10/16/14 Elavil order, she indicated a nurse did not sign off as receiving the order or faxing it to the pharmacy on 10/16/14, or any date since that time. She further stated, "If a written order does not arrive after it is sent to the pharmacy and is not in the e-kit, we write a hold order until it comes. I remember Nurse #2 mentioning the missed Elavil to me. I don't recall why it was not given. Elavil is not in the e-kit [and would have to come from the pharmacy]."</p> <p>During an interview with the DON on 12/11/14 at 4:15 pm she stated, "I would expect the order would have been caught by the night nurse doing the chart check."</p> <p>During an interview with Nurse #2 on 12/12/14 at 1:00 pm, regarding Resident #181's 10/16/14 Elavil order she stated, "I found [the missed order] when I was working on the hall on the 25th. A line was drawn on the MAR and [the medication was not] on the cart." She indicated the nurse working on the 16th must have written it on the MAR but never signed or faxed the order to the pharmacy and the resident never received the medication.</p> <p>3. Resident #75 was originally admitted on 9/19/14 and re-admitted on 10/3/14 with diagnoses that included sepsis, diabetes, hypertension, and methicillin-resistant staphylococcus aureus (MRSA).</p> <p>Review if the facility's pharmacy Ordering and Receiving information dated 10/7/14 provided the</p>	F 425			

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F 425	<p>Continued From page 50</p> <p>pharmacy address, phone number, fax number, hours of operations, and after-hours emergency service number and stated:</p> <ul style="list-style-type: none"> · New orders - faxed by 5 pm - delivered same day and by 2 pm on Saturdays. · All new orders must be written on the Interim Order form. Fill in name, date, time, and initials of person faxing on top of the Order form. · Fax to the pharmacy and keep the fax confirmation report. · All medication orders must be faxed to the pharmacy. <p>The Physician Order dated 10/15/14 at 10:30 am stated, "Therapeutic [multivitamin (MVI) one tablet by mouth] daily - supplement/wound." The order was written as a telephone order from the physician by the dietician and was signed by the physician assistant on 10/15/14. The order did not have a signature of a "nurse receiving order."</p> <p>Review of the 24-hour Chart Check Form dated 10/15/14 indicated (by a circle with a diagonal slash through it) that there were no medications written within 24 hours, no medications transferred to the Medication Administration Record (MAR), and was initialed by Nurse #1.</p> <p>Review of the MAR indicated a daily multivitamin was ordered on 10/15/14 and was first signed off as being administered on 10/29/14.</p> <p>During an interview on 12/10/14 at 3:26 pm with the acting Director of Nursing (DON) she stated, "Two nurses check the chart. The [night] nurse on the floor checks every new order that has come in [that 24-hour period]." She further indicated that there is no set time for the night (7 pm - 7 am) nurse to do the 24-hour chart check, but that the</p>	F 425			

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F 425	<p>Continued From page 51</p> <p>check for new orders should go all the way back to 7 pm the previous day so that no orders are missed. She also indicated that the MVI is a stock medication, available to nurses at all times in the facility and should have been given to the resident as ordered.</p> <p>During an interview with Unit Coordinator #1 on 12/11/14 at 12:25 pm she stated, "The nurse will fax [the physician order] to the pharmacy no matter what time the order is written and then will write it on the MAR. The night supervisor does a chart check to ensure all orders are sent to the pharmacy and put on the MAR." After reviewing Resident #75's 10/15/14 MVI order, she indicated a nurse did not sign off as receiving the order on 10/15/14, or any date since that time, and Nurse #2 signed on 10/27/14 indicating she sent the order to the pharmacy.</p> <p>During an interview with the DON on 12/11/14 at 4:15 pm she stated, "I would expect the order would have been caught by the night nurse doing the chart check."</p> <p>During an interview on 12/12/14 at 12:32 pm with Nurse #3, the 7 am - 7pm nurse who was assigned to Resident #75 on 10/15/14, she stated, "We have had several reminders about looking at the orders, taking them off, and getting the orders double checked. I do not specifically remember this missed medication or anyone speaking to me about it."</p> <p>During an interview on 12/12 12:44 pm with Nurse #2, regarding Resident #75's 10/15/14 MVI order, she stated, "When I was doing the MAR checks for November is when I caught the error. [The night nurse] is supposed to check every</p>	F 425			

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F 425	Continued From page 52 chart on the hall [every] night. [The 10/15/14 order] was a couple of pages back in the orders."	F 425			