STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 07/06/2018

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 7/5/18-7/6/18. Immediate jeopardy was identified at: CFR 483.45 at tag F757 at a scope and severity (J) The tag F757 constituted substandard quality of care Immediate jeopardy began on 3/13/18 and was removed on 7/6/18. An extended survey was conducted. Upon review of the 2567 by CMS, tag F 757 was changed to tag F760 and the 2567 was reposted.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		7/6/18

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

Electronically Signed | 07/31/2018

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F 580	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner (NP) and Physician interview, the facility failed to notify the attending physician regarding a significant change in the resident's condition in relation to a potential adverse consequences of Ibuprofen (a nonsteroidal anti-inflammatory drug). The resident required	F 580	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has take nor will take the actions set forth in this Plan of	

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F 580	Continued From page 2 hospitalization due to hemoglobin of 4.2 and received 6 units of blood. This was evident for 1 of 3 sampled residents reviewed (Resident #1). Findings included: Resident #1 was originally admitted to the facility on 6/24/15 with multiple diagnoses including anemia and gastroesophageal reflux disease (GERD). The quarterly Minimum Data Set (MDS) assessment dated 3/30/18 indicated that Resident 1's cognition was intact. Resident #1 had a doctor's order dated 3/13/18 for Ibuprofen 200 milligrams (mgs) 3 tablets by mouth with meals for arthritis and was discontinued on 4/23/18 due to black stools. The nurse's and NP notes for Resident #1 were reviewed. The notes dated 4/7/18 at 6:22 PM indicated that the resident complained of sore stomach and she was noted to have a small amount of brown liquid emesis (vomitus). The notes dated 4/8/18 at 7:54 AM, the resident was given Prilosec due to indigestion and at 11:59 AM, the notes revealed that the resident had loose stools and was eating small amount. On 4/19/18 at 11:41 PM, the resident was yelling out loudly and wanted to know where she was and "who put her here". On 4/23/18 5:47 PM, the resident had emesis and diarrhea. The NP was informed and assessed the resident with no new orders and at 7:36 PM, the notes revealed that the resident was vomiting. The NP notes dated 4/23/18 (entered on 4/25/18 at 2:28 PM) revealed that that she was called to check on Resident #1. The resident had vomited some burgundy looking fluid and she had black tarry stools. Her stool was positive for blood. She stopped the	F 580	Correction. The Plan of Correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F580 Notify of Changes (Injury/Decline/Room, etc.) Based on record review and staff, Nurse Practitioner and Physician interview, the facility failed to notify the attending physician regarding a significant change in the resident's condition in relation to a potential adverse consequences of Ibuprofen (a non-steroidal anti-inflammatory drug). The resident required hospitalization due to hemoglobin of 4.2 and received 6 units of blood. This was evident for 1 of 3 sampled residents reviewed (Resident #1). The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: Resident #1 had an allergy to Ibuprofen noted. Physician ordered Ibuprofen for the resident for Arthritis on 3/13 /18. Staff and the physician failed to identify the resident□s allergy to Ibuprofen. On 4/7/18 Resident #1 complained of stomach discomfort and brown colored emesis. Interviews by the Director of Nurses with assigned nursing assistants revealed that they had notified the facility nurses about a change in patient condition for several days prior to the nurses notifying the physician. The patient was noted by the	

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F 580	Continued From page 3 Ibuprofen and she ordered complete blood count (CBC) on 4/25/18 and to monitor the resident. On 4/24/18 at 11:11 AM, the notes indicated that the Physician had assessed the resident and he ordered Rocephin (an antibiotic) for urinary tract infection (UTI) and intravenous fluid (IVF) for dehydration. On 4/25/18 at 11:28 AM, the notes indicated that the resident was alert with confusion. On 4/25/18 at 4:11 AM, the notes indicated that the resident was alert with confusion. The nurse received a call from the laboratory that the resident had a critical hemoglobin of 4.2. The Physician was informed and requested to call the family if they wanted the resident to be sent out to the hospital. The family requested to send the resident to the hospital. Resident #1 was sent to the hospital at 2:10 AM. The physician and NP progress notes for Resident #1 were reviewed. The notes revealed that Resident #1 was seen by the Physician on 4/3/18 and by the NP on 4/16/18 but the notes did not address the resident's GI symptoms of sore stomach, brown emesis, indigestion and loose stools. The physician's notes dated 4/24/18 indicated that the resident had 2 episodes of emesis and diarrhea. The stool was positive for blood but the hem occult card was expired. The resident was more lethargic and confused than usual but arousable. There was mild generalized tenderness to the abdomen on palpation. The NP notes dated 4/25/18 revealed that Rocephin was started for UTI and IVF for nausea and vomiting. The resident stated that she still didn't feel good and she appeared weak and tired. She appeared very pale. The notes further indicated that the resident had black tarry stool and was positive for blood. The plan was "CBC was ordered to check for the extent of bleeding since	F 580	nursing assistants to have black stools. Interview by the Director of Nurses with facility nurses revealed that they contributed the black stool to the resident□s receiving iron supplementation. On 4/23/18 the nurse notified the physician of the change in condition and the Nurse Practitioner ordered a CBC to be drawn on 4/25/18. Results of the CBC received on 4/26/18 revealed a HGB of 4.2. The physician was notified and the resident was transferred to the hospital for further evaluation. The resident was admitted and received six liters of blood. The resident returned to the facility on 5/7/18 and remains a resident of the facility. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 7/06/18 Resident #1 was assessed by the floor nurse for any change in condition and allergies related to current orders. No identified change in condition identified or medication vs. allergies were identified. On 7/06/18 the Director of Nurses, Support Nurse and staff nurses assessed all residents for change in condition by utilizing the 24 hr. report, change in condition report and observation and assessment of each resident. 5 residents were identified with a change in condition using the Situation, Background, Assessment, and Recommendation Change in Condition Form. Corrective Action: The physician has been notified of	

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F 580	Continued From page 4 patient did have black tarry stool on the same day that she started to have symptoms of nausea and vomiting. Stopped her daily Ibuprofen that day as well. She has been on Omeprazole (used to treat GERD) 20 mgs daily while on Ibuprofen. Result still pending". The hospital discharge summary dated 5/7/18 was reviewed. The admitting diagnosis was gastrointestinal (GI) bleed and anemia. The discharge diagnosis was acute GI bleeding secondary to duodenal ulcer, status post esophagogastroduodenoscopy (EGD), a procedure that visualized the upper tract of the GI tract down to the duodenum and received 6 units of blood transfusion. On 7/6/18 at 11:38 AM, Nursing Assistant (NA) #1 was interviewed. She stated that she was assigned to Resident #1. She stated that the resident was having black and loose stools days before she was discharged to the hospital. NA #1 stated that the nurses especially Nurse #2 were aware that the resident was having black stool. On 7/5/18 at 4:34 PM, NA #2 was interviewed. She stated that she was assigned to Resident #1. She stated the resident was passing cranberry colored stool couple of days before she was discharged to the hospital. NA #2 indicated that the nurses were aware of the cranberry colored stool and they stated that it was from the iron pill the resident was taking. The NA also revealed that Resident #1 was alert and oriented but became more confused during the time she was passing cranberry colored stool. On 7/6/18 at 9:10 AM, NA #3 was interviewed. The NA stated that he was assigned to Resident	F 580	the identified changes in condition by the staff nurse n 7/6/18. On 7/6/18 all resident allergies were audited by the Support Nurse and Director of Nurses to ensure that they are not receiving medications that they are allergic to or have documented side effects of. Results showed that no further allergies versus ordered medications or side effects were identified. On 7/6/18 The Director of Nurses and Nurse Consultant educated all FT, PT and PRN Nurses, Nursing Assistants and the Physician and Nurse Practitioner on: Verification of allergies with new orders prior to administration of meds/treatments/tests. Location of identified allergies for each resident under their name in the electronic health record. Notification of Physician for any identified allergies or side effects related to ordered medications. Change in Condition identification which includes identification of medication side effects. Change in Condition Reporting and Follow Through to the Physician. Follow Through by Nurses on Reported Change in Condition by Nursing Assistants. Reporting to the Director of Nurses and or Administrator by Nursing Assistants if nurses do not respond to a reported change in condition. This training has been incorporated into the new hire orientation process for all licensed nurses and nursing assistants. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 580	Continued From page 5 #1. NA #3 indicated that the resident was having dark, black and loose stools several days before she was sent to the hospital. He revealed that the resident's stool was not normal and she was more confused. NA #3 stated that the nurses were aware of the black stools especially Nurse #2. On 7/5/18 at 10:50 AM, Nurse #1 (author of nurse's notes dated 4/7/18) was interviewed. She stated that she remembered Resident #1 had complained of sore stomach and had brown emesis. Nurse #1 stated that she didn't call the physician nor the NP to inform them of the resident's complaint of sore stomach and the brown emesis but she had left a note in the communication book for the physician and NP. On 7/6/18 at 11:05 AM, Nurse #2 (author of nurse's notes dated 4/23/18) was interviewed. She stated that she had informed the NP on 4/23/18 of resident's having black stools. The NP ordered to discontinue the Ibuprofen and to check the CBC on 4/25/18. Nurse #2 further indicated that the resident was having loose stools and was vomiting. She further stated that she didn't know that the resident was having black stools until 4/23/18. On 7/5/18 at 12:50 PM, the NP was interviewed. She stated that she was not informed that Resident #1 had complained of sore stomach and was noted to have brown emesis on 4/7/18. She indicated that she had assessed the resident on 4/23/18 when she was informed that the resident was passing black stools. She had discontinued the Ibuprofen and ordered CBC that Monday. The NP further indicated that the CBC was not drawn on Monday because the laboratory was	F 580	and/or in compliance with the regulatory requirements: The Director of Nurses/Support Nurse will monitor change in condition daily Monday-Friday x 4 weeks and monthly for 2 months. All changes in condition will be reviewed for reporting, notification and timely implementation and follow through. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing 07/06/18	

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F 580	Continued From page 6 scheduled to come every Monday, Wednesday and Friday. She had seen the resident on 4/25/18 but the CBC was still pending. On 7/6/18 at 9:35 AM, the Physician was interviewed. He indicated that he came to assess the resident on 4/24/18 and nobody had informed him that the resident was having black stools. The Physician also stated that if he had known the resident was having black stools, he would have sent the resident to the hospital sooner or checked the CBC stat. The physician further indicated that he was made aware that the resident was having black stools after reading the hospital records. On 7/5/18 at 4:34 PM, the Director of Nursing (DON) was interviewed. She stated that she could not find a note in the communication book dated 4/7/18 and some notes were already shredded. The DON further stated that she expected the nurse to call the physician or the NP for symptoms like brown colored emesis and stomach pain.	F 580		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		7/20/18

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F 727	Continued From page 7 §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 24 of the past 90 days reviewed (4/2/18, 4/3/18, 4/7/18, 4/8/18, 4/11/18, 4/16/18, 4/17/18, 4/30/18, 5/1/18, 5/3/18, 5/9/18, 5/14/18, 5/23/18, 5/28/18, 5/29/18, 6/6/18, 6/7/18, 6/11/18, 6/12/18, 6/20/18, 6/29/18, 7/2/18, 7/3/18 and 7/4/18). The findings included: A review of the facility's Daily Schedules and the Daily Nursing staff posting for the past 90 days was conducted on 7/6/18. The Daily Schedules and the Nursing Staff posting indicated a Registered Nurse (RN) was not scheduled for at least 8 consecutive hours a day on the following dates: 4/2/18, 4/3/18, 4/7/18, 4/8/18, 4/11/18, 4/16/18, 4/17/18, 4/30/18, 5/1/18, 5/3/18, 5/9/18, 5/14/18, 5/23/18, 5/28/18, 5/29/18, 6/6/18, 6/7/18, 6/11/18, 6/12/18, 6/20/18, 6/29/18, 7/2/18, 7/3/18 and 7/4/18. An interview was conducted on 7/6/18 at 12:02 PM with NA #4. NA #4 stated that she was the scheduler and was responsible for completing the daily staffing posting. She stated that she didn't know that an RN should be scheduled at least 8 hours a day seven days a week. An interview was conducted on 7/6/18 at 12:10 PM with the Director of Nursing (DON). During the interview, the DON stated that she didn't know that the regulation was to have at least 8	F 727	Tag 0727 - 483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON (LONG TERM CARE FACILITIES) Based on record review and staff interview, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 24 of the past 90 days reviewed (4/2/18, 4/3/18, 4/7/18, 4/8/18, 4/11/18, 4/16/18, 4/17/18, 4/30/18, 5/1/18, 5/3/18, 5/9/18, 5/14/18, 5/23/18, 5/28/18, 5/29/18, 6/6/18, 6/7/18, 6/11/18, 6/12/18, 6/20/18, 6/29/18, 7/2/18, 7/3/18 and 7/4/18). The process leading to the deficiency was a lack of education for the new Director of Nursing, Scheduler, Support Nurse and the Minimum Data Set Coordinator. On 7/20/18 the Director of Nursing, Support Nurse, MDS Coordinator and Scheduler were educated on 483.35 Nursing Services (b) Registered Nurse: (2)Except when waived under paragraph(c)or(d)of this section, the facility must use the services of a registered nurse for at least 8 conservative hours a day, 7 days a week. The procedure for implementing the acceptable plan of correction is education on 483.35 Nursing Services provided by the Administrator.	

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F 727	Continued From page 8 consecutive hours of RN coverage 7 days a week.	F 727	All residents would have the potential to be affected by the alleged deficient practice.On 7/20/18 the Director of Nursing, Support Nurse, MDS Coordinator and Scheduler were educated on 483.35 Nursing Services (b) Registered Nurse: (2)Except when waived under paragraph(c)or(d)of this section, the facility must use the services of a registered nurse for at least 8 conservative hours a day, 7 days a week. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: On 07/20/18, the Director of Nurses and Scheduler along with our full-time night shift Registered Nurse who works 9 days a pay-period and our weekend Registered Nurse Supervisor who works every weekend 12 hour shifts have completed a schedule where the Registered Nurse Supervisor will cover 3-11 shift when the night shift Registered Nurse is off to ensure Registered Nurse coverage 8 hours a day for 7 days a week. The Director of Nursing and the Scheduler will meet daily to review the schedule for the next day to ensure continuation of daily Registered Nurse coverage. The Director of Nursing or the Scheduler will notify the Administrator immediately of changes in the schedule affecting the regulation for Registered Nurse coverage daily for 8 consecutive hours a day. The Support	

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F 727	Continued From page 9	F 727	Nurse will fill in the absence of either the Director of Nursing or the Scheduler. The Director of Nursing and Scheduler will bring to the Quality Assurance Performance Improvement meeting held monthly the staffing sheets for the month to be reviewed by the Quality Assurance Performance Improvement members which consists of the Administrator, Director of Nursing, Support Nurse, Scheduler, Maintenance, Activities Director, Admissions Director, the Minimum Data Set Coordinator, the Director of Health Information Management, the Nurse Practitioner, Dietary Manager, Housekeeping Supervisor, Pharmacy, and Medical Director quarterly, to ensure compliance with 483.35. The person responsible for implementing the plan of correction for scheduling will be the Director of Nursing.	
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner (NP) and Physician interview, the facility administered Ibuprofen, a nonsteroidal anti-inflammatory drug (NSAID) to a resident and failed to recognize that the resident was allergic to the drug. In the presence of initial	F 760	F760 Drug Regimen is Free from Unnecessary Drugs: Based on record review and staff, Nurse Practitioner (NP) and Physician interview, the facility administered Ibuprofen, a	7/24/18

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F 760	Continued From page 10 gastrointestinal (GI) symptoms, the facility failed to recognize the use of the Ibuprofen as potentially causing or contributing to the GI symptoms, resulting in the continued administration of the Ibuprofen. The resident required hospitalization due to hemoglobin (protein molecules in red blood cells that carries oxygen to the body's tissues) of 4.2 (normal value 11.7-15.5) and received 6 units of blood. This was evident for 1 of 3 sampled residents reviewed (Resident #1). Immediate jeopardy began on 3/13/18 when Resident #1 started to receive the Ibuprofen and was removed on 7/6/18 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective. Findings included: Resident #1 was originally admitted to the facility on 6/24/15 with multiple diagnoses including anemia and gastroesophageal reflux disease (GERD). The quarterly Minimum Data Set (MDS) assessment dated 3/30/18 indicated that Resident 1's cognition was intact and she was always incontinent of bowel and bladder. The assessment further indicated that Resident #1 needed extensive assistance with toileting. Resident #1's care plan dated 3/30/18 was reviewed. There was no care plan to address the use of the NSAID.	F 760	nonsteroidal anti-inflammatory drug (NSAID) to a resident and failed to recognize that the resident was allergic to the drug. In the presence of initial gastrointestinal (GI) symptoms, the facility failed to recognize the use of the Ibuprofen as potentially causing or contributing to the GI symptoms, resulting in the continued administration of the Ibuprofen. The resident required hospitalization due to hemoglobin (protein molecules in red blood cells that carries oxygen to the body's tissues) of 4.2 (normal value 11.7-15.5) and received 6 units of blood. This was evident for one of three sampled residents reviewed (Resident #1). The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: Resident #1 had an allergy to Ibuprofen noted. Physician ordered Ibuprofen for the resident for Arthritis on 3/13 /18. Staff and the physician failed to identify the resident□s allergy to Ibuprofen. On 4/7/18 Resident #1 complained of stomach discomfort and brown colored emesis. Interviews by the Director of Nurses with assigned nursing assistants revealed that they had notified the facility nurses about a change in patient condition for several days prior to the nurses notifying the physician. The patient was noted by the nursing assistants to have black stools. Interview by the Director of Nurses with facility nurses revealed that they contributed the black stool to the	

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F 760	Continued From page 11 The electronic and hard copy medical records were reviewed. The monthly Medication Administration Records (MARs) and the nurse's and NP's progress notes from January through March 2018 were reviewed and listed the resident's allergy to Ibuprofen. The MARs and the notes did not indicate what allergic reaction the resident had to the Ibuprofen. The doctor's progress notes dated 3/12/18 also indicated that the resident was allergic to Ibuprofen and the reaction was hives. The physician's orders for Resident #1 revealed that her medications included Aspirin (used to reduce risk of heart attack) 81 milligrams (mgs) by mouth daily for atherosclerotic heart disease (ASHD) since 5/15/16 and Ferrous Sulfate (an iron supplement) 325 mgs by mouth twice a day for chronic anemia since 2/22/17. . Resident #1 had a doctor's order dated 3/13/18 for Ibuprofen 200 milligrams (mgs) 3 tablets by mouth with meals for arthritis and was discontinued on 4/23/18 due to black stools. Resident #1's laboratory report dated 3/14/18 revealed that her hemoglobin level was 11.8 The nurse's and NP notes for Resident #1 were reviewed. The notes dated 4/7/18 at 6:22 PM indicated that the resident complained of sore stomach and she was noted to have a small amount of brown liquid emesis(vomitus). The notes dated 4/8/18 at 7:54 AM, the resident was given Prilosec due to indigestion and at 11:59 AM, the notes revealed that the resident had loose stools and was eating small amount. On 4/19/18 at 11:41 PM, the resident was yelling out loudly and wanted to know where she was and	F 760	resident□s receiving iron supplementation. On 4/23/18 the nurse notified the physician of the change in condition and the Nurse Practitioner ordered a CBC to be drawn on 4/25/18. Results of the CBC received on 4/26/18 revealed a HGB of 4.2. The physician was notified and the resident was transferred to the hospital for further evaluation. The resident was admitted and received six liters of blood. The resident returned to the facility on 5/7/18 and remains a resident of the facility. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 7/06/18 Resident #1 medical record and physician orders were reviewed by the Director of Nurses for any allergies related to current orders. No medication vs. allergies were identified. On 7/06/18 the Director of Nurses and Nurse Consultant reviewed all residents for allergy to Ibuprofen and Ibuprofen orders. No further occurrences were found. On 7/6/18 all resident allergies were audited by the Director of Nurses and Support Nurse to ensure that they are not receiving medications that they are allergic to or have documented side effects of. Results showed no further allergies versus ordered medications or side effects identified in the residents□ electronic health record.	

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F 760	Continued From page 12 "who put her here". On 4/23/18 5:47 PM, the resident had emesis and diarrhea. The NP was informed and assessed the resident with no new order and at 7:36 PM, the notes revealed that the resident was vomiting. The NP notes dated 4/23/18 (entered on 4/25/18 at 2:28 PM) revealed that she was called to check on Resident #1. The resident had vomited some burgundy looking fluid and she had black tarry stools. Her stool was positive for blood. She stopped the Ibuprofen and she ordered complete blood count (CBC) on 4/25/18 and to monitor the resident. On 4/24/18 at 11:11 AM, the notes indicated that the Physician had assessed the resident and he ordered Rocephin (an antibiotic) for urinary tract infection (UTI) and intravenous fluid (IVF) for dehydration. On 4/25/18 at 11:28 AM, the notes indicated that the resident was alert with confusion. On 4/26/18 at 4:11 AM, the notes indicated that the resident was alert with confusion. The notes further indicated that the nurse received a call from the laboratory at 1:30 AM that the resident had a critical hemoglobin of 4.2. The Physician was informed and requested to call the family if they wanted the resident to be sent out to the hospital. The family requested to send the resident to the hospital. Resident #1 was sent to the hospital at 2:10 AM on 4/26/18. The physician and NP progress notes for Resident #1 were reviewed. The notes revealed that Resident #1 was seen by the Physician on 4/3/18 and by the NP on 4/16/18 but the notes did not address the resident's GI symptoms of sore stomach, brown emesis, indigestion and loose stools. The physician's notes dated 4/24/18 indicated that the resident had 2 episodes of emesis and diarrhea. The stool was positive for blood but "the hem occult card (a card used to	F 760	On 7/6/18, the Director of Nurses and Nurse Consultant educated all FT, PT, PRN Nurses, the Physician and Nurse Practitioner on verification of allergies with orders prior to administration of meds/treatments/tests. Location of identified allergies for each resident under their name in the electronic health record. Notification of the Physician for any identified allergies or side effects related to ordered medications. This training has been incorporated into the new hire orientation process for all licensed nurses and nursing assistants. The pharmacy consultant completed an audit on 7/23/18 of all resident allergies to compare pharmacy-listed allergies versus allergies noted in each resident□s electronic health record and an allergy versus medication order audit. Seven percent of residents had a discrepancy between the pharmacy system documented allergies and allergies documented in the resident electronic health record. The Director of Nurses verified and corrected the allergy discrepancies with the Medical Director in the resident□s electronic health record and with the pharmacy on 7/24/18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses/Support Nurse will	

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check for the presence of blood in the stool) was expired". The resident was more lethargic and confused than usual but arousable. There was mild generalized tenderness to the abdomen on palpation. The NP notes dated 4/25/18 revealed that Rocephin was started for UTI and IVF for nausea and vomiting. The resident stated that she still didn't feel good and she appeared weak and tired. She appeared very pale. The notes further indicated that the resident had black tarry stool and was positive for blood. The plan was "CBC was ordered to check for the extent of bleeding since patient did have black tarry stool on the same day that she started to have symptoms of nausea and vomiting. Stopped her daily Ibuprofen that day as well. She has been on Prilosec 20 mgs daily while on Ibuprofen. Result still pending".

The hospital discharge summary dated 5/7/18 was reviewed. The discharge summary listed the resident's allergy to Ibuprofen. The admitting diagnosis was gastrointestinal (GI) bleed and anemia. The discharge diagnosis was acute GI bleeding secondary to duodenal ulcer, status post esophagogastroduodenoscopy (EGD), a procedure that visualized the upper tract of the GI tract down to the duodenum. Resident #1 had received 6 units of blood transfusion.

On 7/5/18 at 3:10 PM, a family member of Resident #1 was interviewed. The family member stated that she had discussed her concerns with Nurse #2 regarding Resident #1 having black stools and had been throwing up several days before the hospitalization. Nurse #2 informed the family member that the black stool was from the iron medication.

monitor 4 residents x 4 weeks and monthly x2, who have been admitted, readmitted or received new orders for identified allergies versus medication orders, as well as a comparison of allergies entered into the resident electronic health record vs. pharmacy system recorded allergies Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process.

The title of the person responsible for implementing the acceptable plan of correction:

The Director of Nursing

07/24 /18

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On 7/6/18 at 11:38 AM, Nursing Assistant (NA) #1 was interviewed. She stated that she was assigned to Resident #1. She stated that the resident was having black and loose stools days before she was discharged to the hospital. NA #1 stated that the nurses especially Nurse #2 were aware that the resident was having black stool.

On 7/5/18 at 4:34 PM, NA #2 was interviewed. She stated that she was assigned to Resident #1. NA #2 stated that Resident #1 was always incontinent of bowel and bladder and she needed assistance with toileting. She had described the resident's stool as cranberry color. She stated the resident was passing cranberry colored stool couple of days before she was discharged to the hospital. NA #2 indicated that the nurses were aware of the cranberry colored stool and they stated that it was from the iron pill the resident was taking. The NA also revealed that Resident #1 was alert and oriented but became more confused during the time she was passing cranberry colored stool.

On 7/6/18 at 9:10 AM, NA #3 was interviewed. The NA stated that he was assigned to Resident #1. NA #3 indicated that the resident was having dark, black and loose stools several days before she was sent to the hospital. He revealed that the resident's stool was not normal and she was more confused. NA #3 stated that the nurses were aware of the black stools especially Nurse #2.

On 7/5/18 at 10:50 AM, Nurse #1 (author of nurse's notes dated 4/7/18) was interviewed. She stated that she remembered Resident #1 had complained of sore stomach and had brown emesis. Nurse #1 stated that she didn't call the

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physician nor the NP to inform them of the resident's complaint of sore stomach and the brown emesis but she had left a note in the communication book for the physician and NP. Nurse #1 didn't know that the resident was allergic to Ibuprofen.

On 7/6/18 at 11:05 AM, Nurse #2 (author of nurse's notes dated 4/23/18) was interviewed. She stated that she had informed the NP on 4/23/18 of resident's having black stools. The NP ordered to discontinue the Ibuprofen and to check the CBC on 4/25/18. Nurse #2 further indicated that the resident was having loose stools and was vomiting. The Nurse didn't know that Resident #1 was allergic to Ibuprofen. Nurse #2 stated that she didn't know that the resident was having black stools until 4/23/18 but the resident was receiving iron pill.

On 7/5/18 at 12:50 PM, the NP was interviewed. She stated that she was aware that Resident #1 was placed on Ibuprofen but she had missed that she was allergic to it. She stated that she was not informed that Resident #1 had complained of sore stomach and was noted to have brown emesis on 4/7/18. She indicated that she had assessed the resident on 4/23/18 when she was informed that the resident was passing black stools. She had discontinued the Ibuprofen and ordered CBC that Monday (4/23/18). The NP further indicated that the CBC was not drawn on Monday because the laboratory was scheduled to come every Monday, Wednesday and Friday. She had seen the resident on 4/25/18 but the CBC was still pending.

On 7/6/18 at 9:35 AM, the Physician was interviewed. He stated that he ordered the

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Ibuprofen not knowing that Resident #1 was allergic to it. He stated that the pharmacy should have caught the allergy and alerted the facility. He also indicated that he came to assess the resident on 4/24/18 and nobody had informed him that the resident was having black stools. He treated the resident with antibiotic for UTI and IVF for dehydration. The Physician also stated that if he had known the resident was having black stools, he should have done differently, send the resident to the hospital or check the CBC stat. The physician further indicated that he was made aware that the resident was having black stools after reading the hospital records.

On 7/5/18 at 4:34 PM, the Director of Nursing (DON) was interviewed. She stated that she could not find a note in the communication book dated 4/7/18 and some notes were already shredded. The DON further stated that she expected the nurse to call the physician or the NP for symptoms like brown colored emesis and stomach pain.

On 7/6/18 at 8:30 AM, the DON was again interviewed. She stated that the facility had a schedule for routine blood draw every Monday, Wednesday and Friday. If the laboratory work was ordered "stat", she had to draw the blood and sent it to the hospital and usually the result was available in 2-3 hours. The DON stated that when Resident #1 was noted to have black stools, the CBC should have been ordered stat.

The Nurse Consultant and the DON were informed of the Immediate jeopardy on 7/6/18 at 9:30 AM.

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F 760	Continued From page 17 On 7/6/18 at 3:41 PM, the facility provided the following Credible Allegation of Compliance: The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #1 had an allergy to Ibuprofen noted. Physician ordered Ibuprofen for the resident for Arthritis on 3/13 /18. Staff and the physician failed to identify the resident's allergy to Ibuprofen. On 4/7/18 Resident #1 complained of stomach discomfort and brown colored emesis. Interviews by the Director of Nurses with assigned nursing assistants revealed that they had notified the facility nurses about a change in patient condition for several days prior to the nurses notifying the physician. The patient was noted by the nursing assistants to have black stools. Interview by the Director of Nurses with facility nurses revealed that they contributed the black stool to the resident's receiving iron supplementation. On 4/23/18 the nurse notified the physician of the change in condition and the Nurse Practitioner ordered a CBC to be drawn on 4/25/18. Results of the CBC received on 4/26/18 revealed a HGB of 4.2. The physician was notified and the resident was transferred to the hospital for further evaluation. The resident was admitted and received six liters of blood. The resident returned to the facility on 5/7/18 and remains a resident of the facility. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Audits: On 7/06/18 the resident D.M. was assessed by the floor nurse for any change in condition and	F 760		

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allergies related to current orders.
Results: No identified change in condition identified or medication vs. allergies were identified.
On 7/06/18 the Director of Nurses, Support Nurse and staff nurses assessed all residents for change in condition by utilizing the 24 hr. report, change in condition report and observation and assessment of each resident.
Results: 5 residents were identified with a change in condition using the Situation, Background, Assessment, and Recommendation (SBAR) Change in Condition Form
Corrective Action: The physician has been notified of the identified changes in condition by the staff nurse.
On 7/6/18 all resident allergies were audited by the Support Nurse and Director of Nurses to ensure that they are not receiving medications that they are allergic to or have documented side effects of medications.
Results: None were identified.

Education:
Nursing Education:
Employees to receive education: All Full time, Part time and as needed (PRN) Nurses, Nursing Assistants and Medication Aides, Physician and Nurse Practitioner.

Topics discussed:
Verification of Allergies with new orders prior to administration of meds/treatments/tests.
Location of identified allergies for each resident under their name in the electronic health record.
Notification of Physician for any identified allergies or side effects related to ordered medications.
Change in Condition identification which includes

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identification of medication side effects.
Change in Condition Reporting.
Follow Through by Nurses on Reported Change in Condition by Nursing Assistants.
Reporting to Director of Nurses and or Administrator by Nursing Assistants if nurses do not respond to their reports of a change in condition.
Change in Condition Follow Through.
When was it started: 7-06-18 all staff have received the required education.
The Director of Nurses will ensure that any employee who has not received this education by 7/6/18 will not be allowed to work until the education is provided. The Director of Nursing will ensure that all staff should receive this education. This training will be incorporated into the new hire orientation process for all licensed nursing, medication aides and nursing assistant

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

The Director of Nurses/Support Nurse will monitor change in condition daily Monday- Friday x 4 weeks and monthly for 2 months. All changes in condition will be reviewed for reporting, notification and timely implementation and follow through. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager.

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F 760	Continued From page 20 Any issues identified will be reported to the Administrator for appropriate action. The title of the person responsible for implementing the Quality Improvement Plan. The Administrator. Compliance Date: 7/6/18 The credible allegation was verified on 7/6/18 at 3:50 PM as evidenced by staff interview and review of the in-service records. Nurses were interviewed and they verified that they had received training on verification and notification of MD of allergies and identification and notification of MD of resident's change in condition. Nursing Assistants were interviewed and they verified that they had received training on notification of nurses, DON and Administrator of resident's change in condition. The sign in sheets for the in-service were reviewed.	F 760		