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	345391	A. BUILDING _____ B. WING _____	C 02/16/2019

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HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

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F 000	INITIAL COMMENTS A complaint survey was conducted from 2/11/19 through 2/16/19. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity K CFR 483.25 at tag F689 at a scope and severity J CFR 483.45 at F760 at a scope and severity K The tags F600, F689, and F760 constituted Substandard Quality of Care. Three additional citations were identified during the complaint survey. One citation at CFR 483.12 for F602 had a scope and severity of D; and two citations at CFR 483.70 for Tags F835 and F842 had a scope and severity of E. Immediate Jeopardy for F600 and F760 began on 11/5/18 and was removed on 2/15/19. Immediate Jeopardy for F689 began on 2/7/19 and was removed on 2/14/19. A partial extended survey was conducted. 3/19/19, the 2567 was amended to remove the disclaimers in the credible allegation of immediate jeopardy removal in tags F600, F689 and F760.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		3/12/19

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

Electronically Signed | 03/11/2019

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F 600	Continued From page 1 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, resident ' s family, staff and physician interviews, and oncologist and facility record reviews, the facility neglected to meet a resident ' s care needs by failing to initiate and administer an antineoplastic medication used to treat cancer (lenalidomide) as prescribed for 1 of 3 residents (Resident #4) whose medications were reviewed. Resident #4 ' s Oncologist noted on 10/12/18 that her lab results reflected a progression of her multiple myeloma. Lenalidomide was ordered by the oncologist on 10/30/18 from a specialty pharmacy, and brought to the facility by Resident #4 ' s family on 11/5/18. The medication was stored on the hall medication cart (unopened) and not administered until 1/10/19. A count of the lenalidomide capsules conducted on 2/14/19 revealed only 6 capsules had been administered to Resident #4 to date. Failure to administer the medication as prescribed to treat the progression of myeloma may have delayed the resident ' s response to the treatment. Immediate Jeopardy began on 11/5/18 when lenalidomide was available at the facility for administration to Resident #4 as prescribed by her oncologist, but the facility neglected to administer the medication until 1/10/19. Immediate Jeopardy was removed as of 2/15/19 when the facility implemented an acceptable	F 600	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice The resident identified as Resident #4 was seen by the oncologist on 10/12/2018 and Revlimid (Lenolidomide) 5 milligrams (mg) -take one tab by mouth daily was added to the medication list. On 1/10/19, it was discovered that resident had not received Revlimid (Lenolidomide) was initially ordered at the 10/12/18 appointment. The DNS verified that the medication was on the cart on 1/10/19 and the medication aides documented medication as given from 1/10/19-1/31/19 and 2/7/19 to 2/14/19; however, 22 pills were in the cart on the morning of 2/14/19 when the surveyor counted the medication with the medication aide. The oncologist has been notified by the DNS on 2/15/19 of the discovery of 22 pills and through verbal communication with the oncologist office (2/15/19) at 12:45pm the order has been rewritten to the following, begin a 21-day cycle today at 1PM, and finish this cycle. After the 7-day rest period, begin the next 28-day cycle with nurse	

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F 600	Continued From page 2 allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education and ensure monitoring systems put into place are effective. The findings included: Resident #4 was admitted to the facility on 8/28/17 with re-entry to the facility on 2/21/18. Her cumulative diagnosis included multiple myeloma (a cancer that forms in a type of white blood cell called a plasma cell) not having achieve remission; malignant neoplasm (tumor) of unspecified site of right female breast; and secondary malignant neoplasm of the bone. A review of the facility ' s October 2018 Physician Order Summary for Resident #4 revealed her medications included 2.5 milligrams (mg) letrozole to be given as one tablet by mouth daily for breast cancer (initiated on 2/21/18). A review of the resident ' s medical record included an Oncology Consult Progress Note dated 10/12/18. The note indicated Resident #4 was seen at the oncology office by the Nurse Practitioner (NP) on 10/12/18. The following issues were addressed: multiple myeloma in relapse and malignant neoplasm of breast, Stage 4. The notes read, in part: "(Resident #4) is here today with her (family member) to discuss her myeloma progression and starting her on lenalidomide (brand name of Revlimid). She is receiving bortezomib (an antineoplastic agent used to treat multiple myeloma that is administered either subcutaneously or	F 600	administration verifying daily dose given The ordered dose was given today at 1PM and will continue daily at 1PM X 20 days (ending on 3/7/19) The oncologist further stated that there was no physical harm done in missing the ordered doses. The morning of 2/15/19, the facility suspended both medication aides who had access to the medication cart from 2/14/19 to 2/15/19. The Executive Director has also completed an initial report to the Department of Health and Human Service for misappropriation of property as of 2/15/19 and police were notified this AM (2/15/19). On 2/15/19 two licensed pharmacists reviewed every prescription, compared each against the MAR to ensure the prescription was available and medications were given. No discrepancies were noted. Address how the facility will identify other residents having the potential to be affected by the same deficient practice 100% of all alert and residents able to be interviewed were interviewed on 2/14/19 by the Social Worker and/or designee to ensure their rights are being honored and the resident is free from abuse and neglect. Findings were documented on the Resident Rights Audit Tool. On 2/15/19 two licensed pharmacists reviewed every prescription, compared	

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F 600	Continued From page 3	F 600		

intravenously) every 2 weeks and is tolerating that well." Lenalidomide is an antineoplastic medication used to treat multiple myeloma in patients by multiple mechanisms, including inhibiting the growth of myeloma cells. The plan of treatment noted in the Oncology Consult Note for Resident #4 read, "(Resident #4) will start on lenalidomide 5 mg daily. (Name of oncologist) has prescribed this ....She will receive bortezomib today. She is tolerating that well. I reviewed with (name of family member) the labs that we drew that indicated a slow progression of her myeloma. I also gave him detailed info about the lenalidomide in (resident ' s) after visit summary."

An addendum was made to the 10/12/18 Oncology Consult Progress Note by the oncologist which indicated he met with Resident #4 and a family member. At that time, her lab work indicating the progression of the multiple myeloma was discussed, along with the need to intensify her treatment. The oncologist noted, "There are many ways of doing this, but I think the simplest one would be to add lenalidomide..." The oncologist also indicated he had discussed the medication with their oral chemotherapy pharmacy specialist to help obtain the medication for Resident #4.

A review of Resident #4 ' s electronic medical record (EMR) revealed the oncology consult report dated 10/12/18 was scanned into the resident ' s EMR at the facility on 10/16/18.

Review of Resident #4s October 2018 Physician Order Summary revealed there was no order for lenalidomide. A review of the resident ' s October 2018 Medication Administration Record (MAR) reflected lenalidomide was not included on the

each against the MAR to ensure the prescription was available and medications were given. No discrepancies were noted.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

All licensed nursing staff and medication aides was in-serviced 2/14/19 on abuse, neglect, and resident rights and the implications for resident□s missing scheduled medications without physician notification. Any staff not in-serviced by 2/14/19 will be in-serviced by the Staff Development Coordinator/Designee before the next scheduled shift.

All new hires will be in-serviced on abuse, neglect, and resident rights. All new licensed nursing staff and medication aides will be made aware of the implications for resident□s missing scheduled medications without physician notification.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained

As a monitoring tool, the Random Resident Rights Audit Tool will be completed on 10% of the resident census weekly x4 and monthly x6 by the Social Services Director/ designee. Findings will be brought to ED (Executive Director) and negative findings will be addressed by the

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F 600	Continued From page 4 record of medications administered to Resident #4. A review of the resident ' s medical record included another Oncology Consult Progress Note dated 10/30/18. The note indicated Resident #4 was seen at the oncology office on 10/30/18 with the following issues addressed: multiple myeloma not having achieved remission; lytic bone lesions on x-ray (areas of bone damage that result from cancerous plasma cells building up in the bone marrow); and malignant neoplasm of breast, Stage 4. The resident ' s medication list from the oncology notes included 5 mg lenalidomide to be given as one capsule by mouth once daily. A review of Resident #4 ' s electronic medical record (EMR) revealed the oncology consult report dated 10/30/18 was scanned into the resident ' s EMR at the facility on 11/2/18. Review of the resident ' s medical record included a Progress Note authored by the facility ' s NP and dated 11/2/18. A review of the resident ' s medications indicated 5 mg lenalidomide was being initiated. Review of Resident #4s November 2018 Physician Order Summary revealed there was no order for lenalidomide. A review of the resident ' s November 2018 Medication Administration Record (MAR) reflected lenalidomide was not included on the record of medications administered to Resident #4. Review of the resident ' s medical record included a Physician ' s Progress Note dated 12/20/18. The note indicated Resident #4 was seen for a	F 600	ED. The Medication Carts (at one cart a day) will be audited by the DNS/designee weekly x4 weeks, and as needed, then monthly thereafter x 6 months, and as needed to ensure compliance with the medication administration protocol. The audit will be monitoring residents medication orders compared to the medication in the cart and if any medications are not present. Should a medication not be present it will be obtained as soon as possible, either through the facility Omnicell, pharmacy, or back-up pharmacy. The DNS/designee will review the resident□s MAR for any miss doses, and if found a medication error report will be completed and the nurse/med aide will receive one-on-one counseling by DNS/designee regarding notification to charge nurse and pharmacy of any missing medication. Audit Compliance (Medication Carts) will be discussed weekly by the DNS/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. The DNS/designee will bring results of Medication Cart audit the facility monthly QA meetings for committee review and input monthly X 7 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require	

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F 600	Continued From page 5 nursing facility follow up of chronic medical diagnoses. Her history of present illness (HPI) included the following notation, in part: "She was receiving infusion therapy for IgG kappa (a classification) multiple myeloma which is progressing slowly. She was last seen by oncology 10/12/18; that assessment was reviewed ...At the last visit lenalidomide was initiated ..." Review of Resident #4s December 2018 Physician Order Summary revealed there was no order for lenalidomide. A review of the resident ' s December 2018 Medication Administration Record (MAR) reflected lenalidomide was not included on the record of medications administered to Resident #4. A review of Resident #4 ' s most recent quarterly Minimum Data Set (MDS) dated 1/9/19 revealed the resident was assessed by staff to have severely impaired cognitive skills for daily decision making. She required extensive assistance by staff for all of her Activities of Daily Living (ADLs). Further review of Resident #4 ' s medical record included an Oncology Consult Progress Note dated 1/10/19. This note read, in part: "(Resident #4) returns today for follow-up and treatment of her estrogen receptor positive breast cancer as well as her history of multiple myeloma accompanied by her two (family members). As far as the breast cancer is concerned, she continues on letrozole, with good tolerance. She receives bortezomib every 2 weeks. She takes this with good tolerance. Also on 10/30/18 we prescribed lenalidomide at 5 mg daily. Receipt of this by the patient was confirmed 11/5/18 by our	F 600	re-inservicing by the DNS/designee and monitoring to begin again at the weekly audits until compliance is met. Audit Compliance (Resident Rights Audit Tool) will be discussed weekly by the ED/designee X 4 weeks, and as needed during morning administrative meeting followed by monthly X 7 months, and as needed during facility monthly QA meetings. Any non-compliance will be noted and corrective actions taken. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-inservicing by the DNS/designee and monitoring to begin again at the weekly audits until compliance is met. The Executive Director is the person responsible for initiating and monitoring the stated plan. In the event the ED is not available, the Director of Nursing Services will continue the plan in ED□s absence The completion date for corrective action will be 3/12/19	

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oral chemotherapy pharmacists." The oncologist noted, however, that lenalidomide was not included on the patient's list of medications from the facility. The plan of treatment noted in the Oncology Consult Note for Resident #4 read, "(Resident #4) looks clinically very stable and has no complaints. However her numbers (referring to lab work showing progression of the multiple myeloma) have been going up. She was supposed to have started lenalidomide certainly by the first week in November, but I do not find it in her MAR. I have written a request to Heartland Living to let us know whether the patient has been receiving the medication, how much medication she has been receiving, whether she has missed any doses, and whether they have noticed any side effects." The oncologist also noted he provided the direct line to his nurse to document the facility ' s response and asked her family members to inquire at the facility as to what happened to the medication they delivered in early November. The oncologist noted, "If she has been receiving lenalidomide and the labs today show further progression, we will need to intensify the bortezomib and move to weekly, or we can consider switching to carfilzomib (another antineoplastic medication indicated to treat multiple myeloma). Of course that she has not been receiving lenalidomide and that is what we need to do and then follow-up."

On 1/10/19 at 3:27 PM, a physician ' s order was received in accordance with the oncologist ' s recommendations to initiate the administration of lenalidomide. The medication order instructed 5 mg lenalidomide to be administered to Resident #4 as one capsule once daily for 21 days, stop for 7 days; then restart the same cycle.

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A Med Error Report dated 1/31/19 revealed one extra daily dose (22 days versus 21 days) of lenalidomide was administered to Resident #4 due to a transcription error. The resident ' s physician was notified; no clinical harm was noted.

On 2/13/19 at 1:00 PM, a telephone interview was conducted with the oncologist ' s nurse. The nurse reported after Resident #4 ' s September appointment, additional lab results were received by the oncologist which indicated progression of her multiple myeloma. When the resident came in for her 10/12/18 appointment, it was decided lenalidomide would be initiated. The nurse reported while her condition was not curable, it was treatable and controllable. She stated lenalidomide was a medication that was dispensed from a specialty pharmacy and the process of acquiring it took some time. Upon review of Resident #4 ' s records, she stated the oncology office was still trying to obtain insurance authorization for the medication as of 10/17/18. Upon further review, the nurse reported their records indicated the medication was sent to the resident ' s family member on 11/3/18. The nurse recalled speaking with someone at the facility on 1/10/19 about Resident #4 ' s lenalidomide and the delay in getting her started on the medication. She reported there was a "huge communication problem."

A telephone interview was conducted with Resident #4 ' s oncologist on 2/13/19 at 1:21 PM. During the interview, the oncologist was asked how the delay in receiving lenalidomide would potentially affect Resident #4. He stated the lenalidomide was prescribed due to the resident ' s progression of the myeloma. Although the

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resident was reported to have a chronic condition that was not curable, the oncologist stated, "I would have preferred she had been started (on the medication) 2-3 months earlier." He stated, "It ' s been very difficult for us to understand what the problem was."

A telephone interview was conducted on 2/14/19 at 10:20 AM with a representative from the specialty pharmacy which dispensed Resident #4 ' s lenalidomide. During the interview, the representative reported 1 bottle of lenalidomide was shipped to the resident ' s family member on 11/3/19; and, a second bottle was shipped to the family member on 2/5/19. Each bottle of lenalidomide contained 28 capsules.

A telephone interview was conducted on 2/14/18 at 8:20 PM with Resident #4 ' s family member. During the interview, the family member reported he attended the oncology consultation with Resident #4 on 10/12/18. He recalled being told by the oncologist ' s office that the resident ' s new medication (lenalidomide) could not be obtained through the facility. The family member reported the oncologist ' s office set up everything with the specialty pharmacy; he did not receive a printed prescription for the medication. Upon further inquiry, the family member stated he received the medication at his home and brought it to the facility within "a day or so" after it was delivered to him in early November. He stated he gave the medication bottle to the nurse and she put it in the medication cart. The family member was asked if he could recall who he gave the medication to. He stated, "Yes," but he declined to identify the staff member. When asked what he told the staff member when he handed her the medication bottle, he reported he explained what

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F 600	Continued From page 9	F 600		

the medication was and that it was coming from the doctor. The family member reported that when he later went back to see the oncologist with Resident #4, "He (the doctor) was fussing at me" thinking he had not brought the medication in to the facility. The family member reported he went to the facility right after that appointment (1/10/19) and talked with the DNS. He stated the facility said they did not have an order for the medication, but they did find the medication bottle on the med cart. The family member stated, "It had been two months, that ' s crazy." When asked how he needed to obtain refills for the medication, he reported the specialty pharmacy called him about a week before they sent the second bottle of medication (lenalidomide) out to him. He reported he received the second bottle of medication a few days ago, but had not yet brought it into the facility.

During an interview conducted on 2/16/19 at 10:15 AM with the DNS, it was reported Med Aide #2 had indicated she was the staff member who received the first bottle of lenalidomide from Resident #4 ' s family member. The DNS reported that based on the family member ' s recollection, it had been determined the first bottle of the lenalidomide was brought in to the facility on 11/5/18.

An interview was conducted on 2/15/19 at 11:05 AM with the NP who helped care for Resident #4. Upon request, the NP reviewed the notation she wrote on 11/2/18. The NP reported the lenalidomide was listed on the resident ' s medication list with an authorization number. When asked, the NP stated the authorization number showed, "They are asking for (insurance) authorization." She further explained that once a

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medication was put on the list (even by another provider such as oncology), it would automatically go over to the med list for her note. The NP reported the next time she saw the resident was on 1/14/19. Lenalidomide was included as one of the current meds on the resident ' s medication list at that time.

An interview was conducted on 2/12/18 at 11:30 AM with the facility ' s Medical Director (who was also the resident ' s physician). During the interview, the Medical Director reported his records showed a NP facility note on 11/2/18 which included lenalidomide on Resident #4 ' s medication list. The physician also reported he could see a progress note he himself authored on 12/20/18 which included lenalidomide on the resident ' s medication list (he was unsure why this was because the resident was not receiving it and did not have it ordered for administration at the facility). The physician reported the facility could not enter a new order unless he or the NP signed the order; he did not recall doing so until after the delay in the med administration for lenalidomide was identified on 1/10/19. The physician questioned whether the delay in receiving this medication would have made a difference for Resident #4.

An interview was conducted on 2/12/19 at 9:15 AM with the facility ' s Director of Nursing Services (DNS) in the presence of the Executive Director. During the interview, the nurse was asked to describe the facility ' s process of communication with outside consultants. The DNS reported a face sheet and current medication list (either the physician ' s orders or MAR) was sent with the transportation staff member when she took a resident to an outside

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consultation. Upon return from the consult appointment, a packet of information would come back with the resident. The DNS reported there may be a note written at the bottom of the consult form brought back to the facility. Whether or not there was a new order for the resident, the consultation information was supposed to be put in the provider box for the facility ' s NP or physician to review. She reported that if there was a new medication order, the nurse would fax the order to the facility ' s contracted pharmacy. When asked who would initiate a new medication order recommended by an outside consultation, the DNS stated the nurse receiving the consult back would usually do so.

A follow-up interview was conducted on 2/12/19 at 5:21 PM with the facility ' s DNS. The DNS reported she was first informed of a problem with the delay in Resident #4 receiving lenalidomide on 1/10/19. The resident ' s family member came directly from the oncologist ' s office visit on that date over to the facility. He was concerned because the oncologist ' s office made him aware the resident was supposed to be taking some medication that they noticed was not included on the med list sent to them by the facility. The DNS stated she understood the family member had obtained a prescription for the lenalidomide from the oncologist because the medication would only be covered by insurance through another pharmacy. Around the first part of November, 2018, the prescription for lenalidomide was filled and the family member brought the medication in to the facility. She reported the family member could not recall who he gave the medication to. The DNS stated after she checked the resident ' s physician ' s orders and her MAR, she confirmed the medication was not given. When

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she went to the med cart, she discovered an unopened bottle of lenalidomide labeled for Resident #4 was stored on the cart. When asked if anyone had questioned why the medication was on the med cart, she stated, "No." The DNS reported she called the oncologist ' s office and talked with his nurse on 1/10/19. The DNS received a verbal order for the administration of the lenalidomide and a fax with the order. The DNS was uncertain at that time why the facility had not been aware of the need to initiate lenalidomide for Resident #4.

A second follow-up interview was conducted on 2/15/19 at 4:20 PM with the DNS. The DNS reported upon investigation, they discovered the resident ' s oncology consults did come to the facility. She reported consultation reports were sent from the oncologist to the attending physician, in addition to paperwork being sent to the facility via the transport driver. She stated the facility has identified a problem with the consult reports getting scanned into the electronic medical records before they were reviewed by a nurse, the NP, or the physician.

A telephone interview was conducted on 2/16/19 at 12:54 PM with the facility ' s transportation staff member. During the interview, the staff member reported when she previously transported Resident #4 back from an outside consult, she would typically put the consult packet (containing information from the outside consult) on the desk at the nursing station. She reported this process has recently been changed and she has been instructed to now place this packet of information directly in the hands of the nurse on duty to ensure the consult was reviewed.

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The resident ' s February 2019 MAR indicated 5 mg lenalidomide was administered to Resident #4 once daily at 5:00 PM on 2/7/19 through 2/13/19 (representing 7 capsules for a total of 29 capsules administered to date). According to the MARs, a total of 29 lenalidomide capsules were documented as administered to the resident by the following staff members: Med Aide #1 administered 2 capsules; Med Aide #2 administered 20 capsules; Med Aide #3 administered 2 capsules; and Med Aide #4 administered 4 capsules; and Med Aide #5 administered 1 capsule.

An observation and interview was conducted on 2/14/19 at 10:10 AM with Med Aide #1. Med Aide #1 was assigned to Resident #4 ' s hall medication cart. At that time, one bottle of lenalidomide labeled for Resident #4 was observed to be stored on the med cart. Labeling on the medication bottle also included an original prescription date of 10/30/18 and the date dispensed by the pharmacy (11/2/18). Upon request, Med Aide #1 counted the lenalidomide capsules remaining in the medication bottle. The Med Aide was observed as she poured the capsules out of the original container one at a time (while counting) into two medication cups. One medication cup was counted and contained 9 capsules. The second medication cup was counted and contained 11 capsules. After the capsules had been poured into the two medication cups for counting, two additional capsules were observed to be left at the bottom of the original container and were added to the total count. The Med Aide confirmed the counts. It was determined a total of 22 capsules remained in the medication bottle originally containing 28 capsules. After counting the

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capsules, Med Aide #1 was observed as she returned all capsules back to the original medication bottle, secured the cap on the bottle, and returned the lenalidomide medication bottle to a drawer on the medication cart.

An observation and interview was again conducted on 2/15/19 at 8:35 AM with Med Aide #1. Med Aide #1 was assigned to Resident #4 ' s hall medication cart. At that time, the resident ' s bottle of lenalidomide stored on the med cart was observed. Upon opening the bottle of lenalidomide, only 7 capsules were seen lying on the bottom of the bottle. The 7 capsules were clearly visible and easily counted without removing them from the container. The labeling on the medication bottle was confirmed to be the same as that observed on 2/14/19, and included the resident ' s name, an original prescription date of 10/30/18, and the date dispensed by the pharmacy (11/2/18). When asked, the Med Aide reported she did not recall the exact number of capsules that were counted from Resident #4 ' s lenalidomide bottle the previous morning (2/14/19). Upon further inquiry, however, Med Aide #1 stated, "It was more." A thorough inspection of all drawers and compartments in the medication cart conducted by Med Aide #1 revealed there were no other bottles of lenalidomide stored on the med cart.

An interview on 2/15/19 at 9:10 AM with the DNS and facility ' s Executive Director (ED). During the interview, the count discrepancy of Resident #4 ' s lenalidomide medication from 2/14/19 (22 capsules) to 2/15/19 (7 capsules) was discussed. At the time 22 capsules of lenalidomide were counted (10:10 AM on 2/14/19), Resident #4 ' s MAR documented the resident had received 29

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capsules. However, the lenalidomide bottle originally contained 28 capsules, which indicated the resident could have only received a total of 6 lenalidomide capsules. The DNS and ED stated they had not been informed of the 2/14/19 count of lenalidomide. However, the DNS reported a medication audit was conducted the evening of 2/14/19. The DNS reported she observed 7 capsules of lenalidomide were remaining in the bottle at approximately 9:30 PM on 2/14/19. Based on the MAR documentation for this medication, the DNS indicated that she, too, had identified a concern because there should not have been any capsules remaining in the bottle of lenalidomide. The DNS reported the MAR documented that Med Aide #1, Med Aide #2, Med Aide #3 and Med Aide #4 had administered this medication to Resident #4. During the interview, the DNS confirmed only one bottle of lenalidomide was on the medication cart. She reported Resident #4 ' s family member brought in the second bottle of lenalidomide earlier that morning (on 2/15/19), which the DNS still had in her possession. The second bottle of lenalidomide was observed to be sealed (unopened). This medication was labeled with Resident #4 ' s name and a pharmacy dispensed date of 2/4/19.

A telephone interview was conducted on 2/16/19 at 10:30 AM with Med Aide #1 in presence of the DNS and ED. During the interview, the med aide was asked to describe the process used to count Resident #4 ' s lenalidomide on 2/14/19. Med Aide #1 reported the lenalidomide capsules were poured into two different medication cups on top of the med cart as the capsules were counted. When asked if she recalled how many capsules were in the bottle of lenalidomide when they were

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counted on the morning of 2/14/19, the med aide reported she could not remember. However she added, "But I know it was more than 7."

Med Aide #1 was also asked to describe the process she used to administer medications to a resident. The med aide reported she would first pull up the resident ' s profile on the computer, make sure she had the right resident, the right med, right dose, and right route of administration. She would then pull the med from the cart and hold it up against the electronic MAR to ensure the resident ' s name and medication was correct. After she administered the medication to the resident, the med aide reported she would sign off that the resident received the med on the electronic MAR.

A telephone interview was conducted on 2/16/19 at 10:41 AM with Med Aide #2. During the interview, the med aide was asked if Resident #4 ' s family member had given her a bottle of medication (lenalidomide) for the resident in November 2018. She stated, "No he didn ' t hand me a bottle ....the (family member) had just mentioned about (Resident #4) not receiving it." Although she was not sure of the date, she thought this probably occurred in December. The med aide stated since the resident was receiving another chemotherapy medication, she assumed that was the medication he was talking about. Med Aide #2 stated the family member told her he had a bottle of medication at home and she told him he could bring it in. The med aide stated she thought it might have been the next weekend when she saw the medication bottle (lenalidomide) on the med cart. Med Aide #2 reported sometime later (maybe in January), she looked at the medication bottle and saw this med

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was different from the one the resident had been receiving. The med aide reported she looked for this medication order in the computer and didn ' t see one, "but didn ' t think anything about it" and did not follow-up on this. During the interview, Med Aide #2 was asked to describe the process she used to administer medications to a resident. The med aide reported she would log into the computer, look at the medication and the person receiving it. After she double checked that it was the right medication, she would pop the med and put check on the "prepped" button in the electronic MAR. After she administered the med to the resident, she would record the med was administered on the electronic MAR. If the resident refused the medication, she would record the med as "refused" on the MAR. When asked, Med Aide #2 reported if her initials were on the MAR to indicate a medication was administered, the resident did receive the medication.

A telephone interview was conducted on 2/16/19 at 10:58 AM with Med Aide #3. During the interview, Med Aide #3 was asked to describe the process he used to administer medications to a resident. The med aide reported he would pull up the electronic MAR for the resident; pull the medication from the med cart; double check the name of the resident, the name of the medication and the dose; and then administer the medication to the resident. Once he administered the medication, he would then come back to the cart and record the medication administration on the electronic MAR.

An attempt to conduct a telephone interview with Med Aide #4 was unsuccessful.

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An interview was conducted on 2/15/19 at 4:20 PM with the DNS. During the interview, the DNS was asked what her expectation was in regards to Resident #4 ' s lenalidomide. She responded by stating the facility determined the oncology consult reports were scanned into the electronic medical record before being reviewed by nursing staff, the NP, or the physician. The DNS indicated she would have expected the facility to have reviewed this information and known lenalidomide was initiated for the resident. If she would have been aware of the need for the medication, she could have followed up on it. When asked, the DNS also reported that once Resident #4 ' s lenalidomide was initiated, she would have expected the documentation on the MARs to be accurate and for the medication to have been administered to the resident as ordered.

An interview was conducted on 2/16/19 at 1:18 PM with the facility ' s Executive Director, in presence of the Corporate Director of Clinical Quality and Education, and the Director of Clinical Operations and Corporate Compliance Officer. Upon inquiry, the Executive Director reported the facility last conducted training on Abuse for staff during their all-staff meeting on 1/31/19. The training covered the topics of abuse, neglect and misappropriation. It also included the required reporting for these issues.

On 2/14/19 at 2:11 PM, the facility ' s ED and the Director of Operations and Compliance Officer were informed of the immediate jeopardy. The facility provided the following acceptable credible allegation of Immediate Jeopardy removal on 2/16/19 at 9:03 AM:

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1. The resident identified as Resident #4 was seen by the oncologist on 10/12/2018 and Revlimid (Lenolidomide) 5 milligrams (mg) -take one tab by mouth daily was added to the medication list.
On 1/10/19, it was discovered that resident had not received Revlimid (Lenolidomide) was initially ordered at the 10/12/18 appointment. The DNS verified that the medication was on the cart on 1/10/19 and the medication aides documented medication as given from 1/10/19-1/31/19 and 2/7/19 to 2/14/19; however, 22 pills were in the cart on the morning of 2/14/19 when the surveyor counted the medication with the medication aide.
The oncologist has been notified by the DNS on 2/15/19 of the discovery of 22 pills and through verbal communication with the oncologist office (2/15/19) at 12:45pm the order has been rewritten to the following, "begin a 21-day cycle today at 1PM", and finish this cycle. After the 7-day rest period, begin the next 28-day cycle with nurse administration verifying daily dose given" The ordered dose was given today at 1PM and will continue daily at 1PM X 20 days (ending on 3/7/19)
The oncologist further stated that there was no physical harm done in missing the ordered doses

The morning of 2/15/19, the facility suspended both medication aides who had access to the medication cart from 2/14/19 to 2/15/19. The Executive Director has also completed an initial report to the Department of Health and Human Service for misappropriation of property as of 2/15/19 and police were notified this AM (2/15/19).

On 2/15/19 two licensed pharmacists reviewed every prescription, compared each against the

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MAR to ensure the prescription was available and medications were given. No discrepancies were noted.

2. As all residents have the potential to be affected by neglect and dose omissions, therefore, the follow actions will be implemented:
· 100% of all alert and residents able to be interviewed were interviewed on 2/14/19 by the Social Worker and/or designee to ensure their rights are being honored and the resident is free from abuse and neglect. Findings were documented on the Resident Rights Audit Tool.

· On 2/15/19 two licensed pharmacists reviewed every prescription, compared each against the MAR to ensure the prescription was available and medications were given. No discrepancies were noted.

3. All licensed nursing staff and medication aides was in-serviced 2/14/19 on abuse, neglect, and resident rights and the implications for resident ' s missing scheduled medications without physician notification. Any staff not in-serviced by 2/14/19 will be in-serviced by the Staff Development Coordinator/Designee before the next scheduled shift.

All new hires will be in-serviced on abuse, neglect, and resident rights. All new licensed nursing staff and medication aides will be made aware of the implications for resident ' s missing scheduled medications without physician notification.

4. As a monitoring tool, the Random Resident Rights Audit Tool will be completed on 10% of the resident census weekly x4 and monthly x6 by the

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Social Services Director/ designee. This audit observes/monitors the following:

a. Observation of staff/resident interaction

b. Is the facility meeting the resident ' s need for privacy

c. Is the resident being treated with dignity and respect by staff

d. Is the resident being informed of changes in their plan of care

e. Determine if resident and/or family attend plan of care meetings

f. Has the resident or does the resident perceive they have been verbally, sexually, or physically abused

g. Are any grievances being addressed by the staff

h. Has the resident seen any other resident being abused or mistreated

i. Is the resident receiving their ordered medications

j. Does the resident feel the staff is neglecting any of their needs

Findings will be brought to ED (Executive Director) and negative findings will be addressed by the ED.

The Medication Carts (at one cart a day) will be audited by the DNS/designee weekly x4 weeks, and as needed, then monthly thereafter x 6 months, and as needed to ensure compliance with the medication administration protocol. The audit will be monitoring residents medication orders compared to the medication in the cart and if any medications are not present. Should a medication not be present it will be obtained as soon as possible, either through the facility Omnicell, pharmacy, or back-up pharmacy. The DNS/designee will review the resident ' s MAR for

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any miss doses, and if found a medication error report will be completed and the nurse/med aide will receive one-on-one counseling by DNS/designee regarding notification to charge nurse and pharmacy of any missing medication.

Audit Compliance (Medication Carts) will be discussed weekly by the DNS/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. The DNS/designee will bring results of Medication Cart audit the facility monthly QA meetings for committee review and input monthly X 7 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-inservicing by the DNS/designee and monitoring to begin again at the weekly audits until compliance is met.

Audit Compliance (Resident Rights Audit Tool) will be discussed weekly by the ED/designee X 4 weeks, and as needed during morning administrative meeting followed by monthly X 7 months, and as needed during facility monthly QA meetings. Any non-compliance will be noted and corrective actions taken. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-inservicing by the DNS/designee and monitoring to begin again at the weekly audits until compliance is met.

The Executive Director is the person responsible for initiating and monitoring the stated plan. In the event the ED is not available, the Director of

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HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

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F 600	Continued From page 23 Nursing Services will continue the plan in ED ' s absence Effective of IJ removal: February 15, 2019 The facility ' s credible allegation of Immediate Jeopardy removal was validated on 2/16/19 at 1:20 PM. The validation was evidenced by interviews with both licensed nursing staff and Med Aides on the 6 rights of medication administration and the facility process expected when a resident returned form an outside consultation. Review of on-going in-service records revealed licensed and unlicensed staff were in-serviced prior to working on the floor. A review of the pharmacy cart audit report and Daily Appointment Tracking Log was also was also conducted as part of the validation process.	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility record reviews, the facility failed to prevent the misappropriation of a resident ' s antineoplastic medication used to treat cancer (lenalidomide) for 1 of 1 resident reviewed for misappropriation of property (Resident #4). The findings included:	F 602	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice The resident identified as Resident #4 was seen by the oncologist on 10/12/2018 and Revlimid (Lenolidomide) 5 milligrams	3/12/19

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F 602	Continued From page 24 Resident #4 was admitted to the facility on 8/28/17 with re-entry to the facility on 2/21/18. Her cumulative diagnosis included multiple myeloma not having achieve remission; malignant neoplasm (tumor) of unspecified site of right female breast; and secondary malignant neoplasm of the bone. Review of the resident ' s medical record revealed a physician ' s order was written at the facility on 1/10/19 at 3:27 PM to initiate 5 milligrams (mg) lenalidomide to be administered as one capsule once daily for 21 days, stop for 7 days; then restart the same cycle. A review of Resident #4 ' s January 2019 MAR indicated 5 mg lenalidomide was administered to the resident as scheduled at 5:00 PM on 1/10/19 to 1/31/19 (representing 22 capsules administered). The resident ' s February 2019 MAR indicated 5 mg lenalidomide was administered to Resident #4 once daily at 5:00 PM on 2/7/19 through 2/13/19 (representing 7 capsules, for a total of 29 capsules documented as administered to date). An observation and interview was conducted on 2/14/19 at 10:10 AM with Med Aide #1. Med Aide #1 was assigned to Resident #4 ' s hall medication cart. At that time, one bottle of lenalidomide labeled for Resident #4 was observed to be stored on the med cart. Labeling on the medication bottle also included an original prescription date of 10/30/18 and the date dispensed by the pharmacy (11/2/18). Upon request, Med Aide #1 counted the lenalidomide capsules remaining in the medication bottle. The Med Aide was observed as she poured the	F 602	(mg) -take one tab by mouth daily was added to the medication list. On 1/10/19, it was discovered that resident had not received Revlimid (Lenolidomide) was initially ordered at the 10/12/18 appointment. The DNS verified that the medication was on the cart on 1/10/19 and the medication aides documented medication as given from 1/10/19-1/31/19 and 2/7/19 to 2/14/19; however, 22 pills were in the cart on the morning of 2/14/19 when the surveyor counted the medication with the medication aide. The oncologist has been notified by the DNS on 2/15/19 of the discovery of 22 pills and through verbal communication with the oncologist office (2/15/19) at 12:45pm the order has been rewritten to the following, begin a 21-day cycle today at 1PM, and finish this cycle. After the 7-day rest period, begin the next 28-day cycle with nurse administration verifying daily dose given The ordered dose was given today at 1PM and will continue daily at 1PM X 20 days (ending on 3/7/19) The oncologist further stated that there was no physical harm done in missing the ordered doses. The morning of 2/15/19, the facility suspended both medication aides who had access to the medication cart from 2/14/19 to 2/15/19. The Executive Director has also completed an initial report to the Department of Health and Human Service for misappropriation of property as of 2/15/19 and police were notified this AM (2/15/19).	

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F 602	Continued From page 25 capsules out of the original container one at a time (while counting) into two medication cups. One medication cup was counted and contained 9 capsules. The second medication cup was counted and contained 11 capsules. After the capsules had been poured into the two medication cups for counting, two additional capsules were observed to be left at the bottom of the original container and were added to the total count. The Med Aide confirmed the counts. It was determined a total of 22 capsules remained in the medication bottle originally containing 28 capsules. After counting the capsules, Med Aide #1 was observed as she returned all capsules back to the original medication bottle, secured the cap on the bottle, and returned the lenalidomide medication bottle to a drawer on the medication cart. An observation and interview was again conducted on 2/15/19 at 8:35 AM with Med Aide #1. Med Aide #1 was assigned to Resident #4 ' s hall medication cart. At that time, the resident ' s bottle of lenalidomide stored on the med cart was observed. Upon opening the bottle of lenalidomide, only 7 capsules were seen lying on the bottom of the bottle. The 7 capsules were clearly visible and easily counted without removing them from the container. The labeling on the medication bottle was confirmed to be the same as that observed on 2/14/19, and included the resident ' s name, an original prescription date of 10/30/18, and the date dispensed by the pharmacy (11/2/18). When asked, the Med Aide reported she did not recall the exact number of capsules that were counted from Resident #4 ' s lenalidomide bottle the previous morning (2/14/19). Upon further inquiry, however, Med Aide #1 stated, "It was more." A thorough	F 602	On 2/15/19 two licensed pharmacists reviewed every prescription, compared each against the MAR to ensure the prescription was available and medications were given. No discrepancies were noted. Address how the facility will identify other residents having the potential to be affected by the same deficient practice 100% of all alert and residents able to be interviewed were interviewed on 2/14/19 by the Social Worker and/or designee to ensure their rights are being honored and the resident is free from abuse and neglect. Findings were documented on the Resident Rights Audit Tool. On 2/15/19 two licensed pharmacists reviewed every prescription, compared each against the MAR to ensure the prescription was available and medications were given. No discrepancies were noted. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur All licensed nursing staff and medication aides was in-serviced 2/14/19 on abuse, neglect, and resident rights and the implications for resident□s missing scheduled medications without physician notification. Any staff not in-serviced by 2/14/19 will be in-serviced by the Staff	

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F 602	Continued From page 26	F 602		

inspection of all drawers and compartments in the medication cart conducted by Med Aide #1 revealed there were no other bottles of lenalidomide stored on the med cart.

An interview on 2/15/19 at 9:10 AM with the facility ' s Director of Nursing Services (DNS) and Executive Director (ED). During the interview, the count discrepancy of Resident #4 ' s lenalidomide medication from 2/14/19 (22 capsules) to 2/15/19 (7 capsules) was discussed. The DNS and ED stated they had not been informed of the 2/14/19 count of lenalidomide. However, the DNS reported a medication audit was conducted the evening of 2/14/19. The DNS reported she observed 7 capsules of lenalidomide were remaining in the bottle at approximately 9:30 PM on 2/14/19. Based on the MAR documentation for this medication, the DNS indicated that she, too, had identified a concern because there should not have been any capsules remaining in the bottle of lenalidomide. During the interview, the DNS confirmed only one bottle of lenalidomide was on the medication cart. She reported Resident #4 ' s family member brought in the second bottle of lenalidomide earlier that morning (on 2/15/19), which the DNS still had in her possession. The second bottle of lenalidomide was observed to be sealed (unopened). This medication was labeled with Resident #4 ' s name and a pharmacy dispensed date of 2/4/19.

A 24-hour Initial Allegation Report faxed to the State Agency on 2/15/19 at 11:17 AM was reviewed. The ED submitted the report which indicated an allegation of misappropriation of resident property was being investigated. The date of the incident was 2/14/19. The description

Development Coordinator/Designee before the next scheduled shift.

All new hires will be in-serviced on abuse, neglect, and resident rights. All new licensed nursing staff and medication aides will be made aware of the implications for resident□s missing scheduled medications without physician notification.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained

As a monitoring tool, the Random Resident Rights Audit Tool will be completed on 10% of the resident census weekly x4 and monthly x6 by the Social Services Director/ designee. Findings will be brought to ED (Executive Director) and negative findings will be addressed by the ED.

The Medication Carts (at one cart a day) will be audited by the DNS/designee weekly x4 weeks, and as needed, then monthly thereafter x 6 months, and as needed to ensure compliance with the medication administration protocol. The audit will be monitoring residents medication orders compared to the medication in the cart and if any medications are not present. Should a medication not be present it will be obtained as soon as possible, either through the facility Omnicell, pharmacy, or back-up pharmacy. The DNS/designee will review the resident□s MAR for any

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F 602	Continued From page 27 of the allegation read, "Resident medication was counted on 2/14/19 and initially 22 pills were accounted for. As of 2/15/19, 7 pills were remaining in resident ' s medication bottle." A notation made on the report revealed the incident was currently pending with the local police department. An incident/investigation report dated 2/15/19 at 12:37 PM from the police department confirmed a report of larceny was made by the facility related to the missing medication. A follow-up interview was conducted on 2/15/19 at 4:20 PM with the DNS. During the interview, the DNS reported only Med Aide #1 and Med Aide #2 had keys to Resident #4 ' s hall medication cart on 2/14/19 between 10:10 AM (when 22 capsules of lenalidomide were counted on the med cart) and 9:30 PM (when she counted 7 capsules of lenalidomide left on the med cart). Both medication aides were suspended pended the results of the facility ' s investigation. The DNS also indicated she would expect the medication count to be correct when reconciled with the MAR. A telephone interview was conducted on 2/16/19 at 10:30 AM with Med Aide #1 in presence of the DNS and ED. During the interview, the med aide was asked to describe the process used to count Resident #4 ' s lenalidomide on 2/14/19. Med Aide #1 reported the lenalidomide capsules were poured into two different medication cups on top of the med cart as the capsules were counted. When asked if she recalled how many capsules were in the bottle of lenalidomide when they were counted on the morning of 2/14/19, the med aide reported she could not remember. However she	F 602	miss doses, and if found a medication error report will be completed and the nurse/med aide will receive one-on-one counseling by DNS/designee regarding notification to charge nurse and pharmacy of any missing medication. Audit Compliance (Medication Carts) will be discussed weekly by the DNS/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. The DNS/designee will bring results of Medication Cart audit the facility monthly QA meetings for committee review and input monthly X 7 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-inservicing by the DNS/designee and monitoring to begin again at the weekly audits until compliance is met. Audit Compliance (Resident Rights Audit Tool) will be discussed weekly by the ED/designee X 4 weeks, and as needed during morning administrative meeting followed by monthly X 7 months, and as needed during facility monthly QA meetings. Any non-compliance will be noted and corrective actions taken. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-inservicing by the DNS/designee and	

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F 602	Continued From page 28 added, "But I know it was more than 7."	F 602	monitoring to begin again at the weekly audits until compliance is met. The Executive Director is the person responsible for initiating and monitoring the stated plan. In the event the ED is not available, the Director of Nursing Services will continue the plan in ED□s absence. The date the corrective action will be completed is 3/12/19.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, facility staff interviews, and record reviews, the facility failed to ensure the required safety precautions were taken for 2 of 3 sampled residents reviewed for accidents (Resident #6 and Resident #8). Resident #6 experienced a fall from his bed while he was being given a bed bath by a nursing assistant on 1/13/19, resulting in a laceration of the forehead and a closed displaced fracture of the proximal phalanx (the bone closest to the palm of the hand) of the right little finger. After the 1/13/19 fall, the facility determined the resident required two person assistance while in bed when receiving ADL care. On 2/7/19, the resident was being provided incontinence care by one nursing	F 689	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #6 experienced a fall from bed on 1/13/19 during the 7-3am shift while Activities of Daily Living (ADL) care was being provided by CNA. The resident□s initial plan of care related to ADL bed mobility stipulated assistance needed with bed mobility. The plan of care was not clear if the assistance needed required one-person or two-person assistance.	3/12/19

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F 689	Continued From page 29 assistant when the resident experienced another fall from the bed and sustained a laceration above his left eyebrow and a skin tear on his right middle finger. The facility failed to follow the manufacturer's instruction to safely transfer Resident #8 out of bed with a mechanical lift. Immediate Jeopardy began on 2/7/19 when Resident #6 experienced his second fall from the bed as he was being provided incontinence care with staff assist of one. This fall occurred after the facility had determined the resident required the assistance of two staff members to provide ADL care. Immediate Jeopardy was removed as of 2/14/19 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance with this tag at a lower scope and severity level of "D" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) for example number 2 where a plan of correction is required. The findings included: 1) Resident #6 was admitted to the facility on 1/11/19 with a cumulative diagnoses which included recent surgical repair of a right hip fracture. A review of Resident #6 ' s baseline care plan dated 1/11/19 indicated the resident required staff assist of one for bathing/hygiene, dressing/grooming, eating, and toileting. The baseline care plan noted this resident required the assistance of two staff members for ambulation and transfers. A review of the resident ' s most recent	F 689	Resident Representative (RR) and attending physician notified and resident transported to Emergency Department (ED) for evaluation on 1/13/19 and returned same day with a report sustaining a closed displaced fracture of the proximal phalanx of right little finger. Report was given to the RR following resident□s return from ED. Upon return to the facility, Resident #6 was re-assessed for care needs that were addressed through care planning and KARDEX. Interventions initiated were as follows: Resident to be a 2 person assist with ADLs added to resident plan of care and KARDEX Intervention was communicated to line-staff by the Staff Development Coordinator (SDC) through the facility□s Communication Log on 1/13/19 Resident #6 experienced a subsequent fall from bed on 2/7/19 during the 11pm-7am (12:58AM) shift while CNA was providing peri-care. Nurse was notified by CNA prior to moving resident for proper assessment and determined to have sustained a skin tear to left eyebrow and right middle finger. Physician notified and resident sent to ED for evaluation. RR notified of fall with transport on 2/7/19 to the ED for further evaluation Resident returned from ED to the facility on 2/7/19 6:55AM with a report of laceration to left eye. Resident discharged home on 2/8/19. The facility administrator interviewed the CNA involved in the incident of 2/7/19 regarding care delivery. When asked if	

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F 689	Continued From page 30 individualized care plan included the following areas of focus, in part: --1/12/19 (Resident) is at risk for bleeding related to aspirin use. --1/12/19 (Resident) requires assistance with activities of daily living (ADLs). The care plan interventions included: "Provide assistance with adequate staff support for all safety compromising activities ...transfers, toileting, etc." --(Not dated) (Resident) is at risk for falls related to multiple factors. The care plan interventions included, in part: "Provide assistance with adequate staff support for all safety compromising activities ...check for needs often ...encourage resident to summon assistance for all safety compromising activities;" and, "Ensure adequate staff support for safety compromising activities and ensure safe positioning, safe parameters and proper body alignment to maximize safety." Review of an Incident Report dated 1/13/19 at 11:20 AM revealed Resident #6 experienced a fall in his room while bathing. A Nurse ' s Note written on this report (authored by Nurse #1) described the incident and indicated the nursing assistant (NA) called the nurse into Resident #6 ' s room after the resident experienced a fall. A laceration was noted above the resident ' s right eyebrow and a pressure dressing was applied for the bleeding to stop. A Witness Statement of what happened (authored by NA #1) read, in part: "As I was finishing my bed bath with (the resident) he was on his side turned and steady. I turned to get a towel and the (resident) leaned/turned further in the bed and falling hitting his right side and head on the A/C unit (heating/air conditioning unit). Further falling off the unit hitting his face and left side on the floor ..." The resident was	F 689	the CNA had reviewed the resident□s KARDEX prior to delivering care, the CNA responded that he did not review it prior to care, but did review it after the incident. When further questioned as to knowledge that reviewing the resident KARDEX prior to delivery of care is protocol, he responded he did, but did not review the KARDEX. The CNA's employment was terminated. Resident #8 remains in the facility and has not experienced any falls related to transfers with the mechanical lift. Address how the facility will identify other residents having the potential to be affected by the same deficient practice The facility□s interdisciplinary team re-assessed 100% of all residents with regards to bed mobility and positioning on 2/13/19 to ensure the individual needs of residents are met without compromising safety. Identified needs, including the required assistance (one-person/two-person) were documented and updated on the resident□s Kardex and Care Plan on 2/14/19. Any resident identified through the re-assessment by the IDT team as needing assistance with bed mobility and positioning will be referred to therapy for screen/evaluation to assure the amount of assistance is accurate. In addition to the audit of bed	

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F 689	Continued From page 31 transported to the Emergency Department (ED) for evaluation and treatment. A telephone interview was conducted with NA #1 on 2/13/19 at 9:10 AM. During the interview, the NA was asked to describe the incident that occurred with Resident #6 on 1/13/19. The NA reported he went into the resident ' s room to help him get washed up and dressed; the resident was lying in bed at the time. When the NA had finished giving the resident the 1st part of his full bath, he was going to work on his lower body and provide perineal care on the resident ' s backside. The NA used a draw sheet to turn the resident away from him so that he was lying on his left side. The NA reported he himself was standing on the right side of the bed (towards the door). At that time, the resident was lying on his side and reportedly, "not wobbly at all." The NA reported the resident was "not on the edge of the bed and I was right by him and within reach." The NA stated he took his hand to grab a washcloth which had been placed within reach. As he turned to the right to grab the cloth, the resident rolled out of bed. When he rolled, his upper body hit the heating/air conditioning unit, then he hit the bed, then hit the floor face down after that. NA #1 added, "It literally happened when I turned my body to grab the rag. I wasn ' t away from him ...I had all my water, soaps, and towels all within reach ... When I turned back towards him I saw him hit the floor." The NA reported the resident ' s bed was in a high position at the time of the fall because he was providing a bath. When asked if the NA touched the resident as he rolled off the bed, the NA stated he dropped the towel and reached for him, but at that point he was already falling and out of reach. The NA reported after the fall, he literally pulled the call light cord out of	F 689	mobility/KARDEX/CNA, all lifts, and accompanying lift pads were examined by the DNS/designee on/before 3/6/19 for operating order, condition of lift pads and correct lift pads. Any equipment determined to be faulty or not compatible will be taken out of operation by the DNS/designee until repaired or the ordered lift pads arrive. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur All CNAs (direct care) will be audited for referring to resident KARDEX before conducting bed mobility/positioning as identified in the resident□s KARDEX. This audit will be conducted by the Director of Nursing Service(DNS), and designees on 2/13/19-2/14/19. The audit will monitor CNAs□ ability to check KARDEX for resident□s care guides, positioning resident, the use of lifts and lift pads if applicable. Any staff not observed on/before 2/14/19 will be observed/audited by nursing administrative staff prior to the start of the employees□ next scheduled shift Any staff not observed on/before 3/11/19 with regards to properly using lifts/lift pads/ care guides will be audited prior to the beginning of their next scheduled shift by the DNS/ designee. Staff education will be given to all CNAs	

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F 689	Continued From page 32 the wall to request help. Upon inquiry, NA #1 reported he was alone in the room when the fall occurred. When the nurse came, he assisted her by getting the resident ' s vital signs. Then when the Emergency Medical Technicians (EMTs) arrived, he helped them transfer the resident onto the stretcher. During the interview with NA #1, the NA was asked how he knew what needed to be done to keep a resident safe while providing ADL care. The NA reported he sometimes asked questions of the resident and/or the nurse if he was not familiar with the resident. He also reported electronic information from the Kardex typically included some notes listed in regards to providing ADL care. At the time of Resident #6 ' s fall from the bed on 1/13/19, however, the facility had not been determined the resident required 2-person assistance with his ADL care. An interview was conducted on 2/14/19 at 3:27 PM with Nurse #1. Nurse #1 was the 1st shift nurse who was assigned to Resident #6 ' s hall on 1/13/19 when the resident fell. The nurse reported upon entering the room, the resident was bleeding above his right eye brow with blood all over his face. When asked if she identified any other injuries at that time, she stated she did not. Nurse #1 reported she assessed the resident, had vital signs taken, and tried to stop the bleeding. Upon inquiry, the nurse reported there would have been additional staff to assist with the resident ' s ADL care, if needed. After the fall on 1/13/19, the nurse reported seeing NAs get a second person to help provide care to the resident. However, she was uncertain if 2-person assistance was always used to provide ADL care to Resident #6 after this incident. Hospital Emergency Department (ED) records	F 689	by the DNS/designee on/before 2/14/19 regarding the following: Staff (CNA) to review each resident□s KARDEX prior to care. The importance and necessity to monitor staff under their supervision for following protocol in referencing the resident KARDEX for guidelines of care. Staff education will be provided to the CNAs by the DNS/designee on/before 3/8/19 with regards to proper use of lift and accompanying pads. Any staff not inserviced will be inserviced prior to start of the employee□s next scheduled shift. Any change in a resident□s plan of care/KARDEX affecting delivery of care will be communicated directly to the charge nurse by a member of the IDT team using the Interdisciplinary form. The charge nurse will advised that it will be their responsibility to inform the direct care staff of the change and updated KARDEX as evidenced by applicable staff signatures on the Communication Form. DNS/Designee will inservice on/ before 2/16/19 all licensed nurses regarding: The importance of referring to resident□s KARDEX prior to resident care to be given added emphasis in New Employee Orientation for CNAs The importance for licensed nurses to oversee and monitor the staff under their supervision to assure the care protocols are followed will be given added emphasis in the New Employee Orientation for	

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dated 1/13/19 indicated the resident had a laceration of the forehead with repair using Dermabond (a skin adhesive that holds wound edges together) and a closed displaced fracture of the proximal phalanx of the right little finger. The resident's right 5th finger fracture was reduced (setting of the bone to ensure it healed properly) using gentle traction and a finger splint was applied. The resident was discharged from the ED to the facility on 1/14/19.

A review of the facility ' s follow-up report from the 1/13/19 incident read, "Resident recently admitted to facility. Resident was receiving ADL care while position on his side. Resident rolled off bed. Resident sent to ER (Emergency Room) for evaluation related to laceration above right eye and already right femur fracture. Resident will be two person assist when in bed during ADL care."

A review of Resident #6 ' s admission Minimum Data Set (MDS) dated 1/18/19 revealed the resident had moderately impaired cognitive skills for daily decision making. He had no behaviors nor rejection of care. Section G of the MDS assessment indicated the resident required extensive assistance with 2+ person physical assist for bed mobility, transfers, toileting and personal hygiene. He also required extensive assist from staff for locomotion on the unit, dressing, and eating. The resident was incontinent of bowel and bladder. Section K of the MDS revealed Resident #6 was 72 inches tall and weighed 237 pounds.

A review of the facility ' s Communication Log book kept on Resident #6 ' s hall revealed the log documented changes made to a resident ' s Kardex. A Kardex (also known as a Care Guide)

Licensed Nurses.
Any staff not inserviced will be inserviced prior to start of the employee□s next scheduled shift.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained

This Bed Mobility Audit will be completed at a minimum of 10 times weekly for four weeks, and as needed by the DNS/designee. Transfer audit will be completed at a minimum of 10 times weekly for four weeks and as needed by the Therapy Manager/Designee.

Outcomes of the scheduled audits will be discussed during the facility morning administrative (which members of the facility Quality Assurance (QA) Committee are present).
Any non-compliance will be addressed as observed.
Outcomes of compliance with established plan will also be brought to the facility monthly QA by the DNS/designee for committee review, discussion and changes needed in plan should they occur.
All discussion will be included in the QA meeting minutes.
Following the 4 weeks of Bed Mobility and Transfer audits, audits will continue with a minimum of 10 audits per month x 7 months, and as needed.
The outcomes of audits will be brought to the facility monthly QA meetings by the DNS to be reviewed by the QA Committee

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F 689	Continued From page 34 is a summary of individual patient needs, which included information for nursing assistants regarding the assistance required to meet the ADL care needs for a resident. A review of the Communication Log book included a sheet for Resident #6 and revealed a change was made on 1/13/19 to indicate the resident required 2-person assist with ADL care. A printed copy of Resident #6 ' s most recent (undated) Kardex was provided by the facility for the surveyor to review at 4:45 PM on 2/12/19. Each resident ' s Kardex was made available to the nursing assistants electronically via a Kiosk on the hall. Resident #6 ' s Kardex read in part, "Resident will be a two person assist with care." Review of an Incident Report dated 2/7/19 at 12:01 PM revealed Resident #6 experienced a fall in his room. The Nurse ' s Note on this report described the incident and revealed NA #2 notified the hall nurse (Nurse #2) after Resident #6, "fell on the floor while he was log rolling him to change him." The note indicated Resident #6 hit his head against the heating/air conditioning unit. Nurse #2 assessed the resident while he was lying on his left side. The nurse reported the resident had a laceration with bleeding above his left eyebrow and a skin tear on his right middle finger. A Witness Statement of what happened revealed NA #2 stated the resident fell while he was trying to log roll him. The resident was reported to have moved suddenly and rolled off the bed, hitting his head against the heating/air conditioning unit. The resident was transported to ED for evaluation and treatment. Hospital Emergency Department (ED) records dated 2/7/19 indicated the resident had a facial	F 689	members for compliance. Any discussion and/or revisions to the plan will be contained in the meeting minutes. Any revisions to the plan will require re-inservicing to applicable staff by the DNS/designee and require monitoring to begin again at 4b and continue as outlined. Licensed nursing staff will be monitored using the Nurse Monitor Sheet and will be conducted by the DNS/designee 10 times per week times 4 weeks, and as needed. Outcomes of the scheduled audits will be discussed during the facility morning administrative (which members of the facility Quality Assurance (QA) Committee are present). Any non-compliance will be addressed as observed. Following the initial 4 weeks, the Nurse Monitor Sheet will continue to be used at a minimum of 10 times per month X 7 months, or as needed. This monitoring will be conducted by the DNS/designee. The outcomes of audits will be brought to the facility monthly QA meetings by the DNS/designee to be reviewed by the QA Committee members for compliance. Any discussion and/or revisions to the plan will be contained in the meeting minutes. Any revisions to the plan will require re-inservicing to applicable staff by the DNS/designee and require monitoring to begin again at the 4 k and continue as outlined. The facility administrator will be responsible for implementing this plan and assuring monitoring is done as outlined.	

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F 689	Continued From page 35 wound repaired with Dermabond. X-ray films were taken and showed no evidence of a fracture. Resident #6 was discharged back to the facility for continued rehabilitation. A review of the facility ' s follow-up report from the 2/7/19 incident read, "Resident noted with a recent fall in facility and a history of recurrent falls prior to admission. (NA) notified nurse resident fell on the floor while he was log rolling him to change him. (NA) reported he hit his head against heating unit (heating/air conditioning unit). Nurse assessed resident, while resident was lying on his left side. Neuro checks initiated. Sent to ER (Emergency Room) for evaluation related to fall and laceration on left forehead and right middle finger. Resident return with negative CT (Computerized Tomography) Scan results and 1 cm (centimeter) laceration to the left forehead that was repaired with Dermabond. Resident will be a two person assist with ADL care." A telephone interview was conducted on 2/13/19 at 11:22 AM with NA #2. NA #2 was identified as the NA who was caring for Resident #6 at the time of his fall on 2/7/19. NA #2 described the incident that occurred on 2/7/19. The NA reported he came in to check on the resident for rounds and then went on to provide incontinence care for him. NA #2 stated he "log rolled" the resident so he was on his left side. When asked to describe the log roll, the NA reported he used a draw sheet, had the resident cross his right leg over the left and used a slight tug towards him to roll the resident on his left side. The NA reported he was on the right side of the bed (closer to the door) and the resident ' s bottom was facing the NA. As the NA reached back to the bedside table to get the wipes and briefs, the resident lifted his	F 689	In the event of the administrator□s absence, the DNS is responsible for assuring compliance with plan. The date the corrective action will be completed is 3/12/19.	

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left shoulder over to the right (like he was trying to get over more or re-position). At that moment, the resident, "plunged over and off of the bed. He lifted up and dipped more to his left ... and whoop he went over to his side." The NA reported the resident basically rolled forward and hit the heating/air conditioning unit with part of his body, then went down on the floor. He stated, "It went so quick." When asked if the NA was able to touch the resident as he fell off the bed, he responded by saying, "It happened too fast." Upon further inquiry, the NA stated he was alone in the room at the time of the incident.

During the telephone interview conducted with NA #2 on 2/13/19 at 11:22 AM, the NA reported he ran to get the nurse immediately after the fall occurred. He reported the resident was bleeding from the left side of his head above the eye and it appeared he had hit his hand on either the heating/air conditioning unit or the window sill. The nurse came back to the room with him, she assessed the resident, and they put a draw sheet under the resident and used it to slide him back to the bed. The NA reported 911 was called and "we stayed with him in the room" until EMS arrived. Resident #6 was then transported to the hospital. When NA #2 was asked if he was aware (before the fall) that the resident required 2-person assistance for ADL care in the bed, he stated he was not. NA #2 reported he had not checked the Kardex before the fall and did not think he needed 2 people to provide the care. After the fall, however, the NA stated he looked at the Kardex and saw it indicated the resident required 2-person assist for ADL care.

An interview was conducted on 2/12/19 at 2:56 PM with Nurse #2. Nurse #2 was the nurse who

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was assigned to care for Resident #6 on 2/7/19 (the date of the resident ' s second fall). During the interview, the nurse recalled when she went to assist the NA #2 after Resident #6 fell off of the bed the NA reported to her that he had a log-rolled the resident to do incontinence care in the bed. The nurse stated she had understood the resident continued to roll, and rolled over and off of the bed. When the nurse got to the room, the resident was lying on his left side and next to the heating unit (heating/air conditioning unit). He had a laceration over his left eye brow (bleeding) and a skin tear on his middle finger of the right hand. His little finger appeared swollen. The nurse reported she was talking with the resident and he was talking with her. When asked if anything was hurting on him, he said it was not. Once he said that, the nurse figured it was safe for her and the NA to put him back on the bed. Once safely on the bed, another nurse came and assessed him. The nurses decided to send the resident out "for safety sake." The on-call provider was contacted and an order received to send him to the ED.

During the interview conducted on 2/12/19 at 2:56 PM with Nurse #2, she was asked how many staff members were required to assist the resident with his ADLs such as incontinence care. The nurse reported that female aides always had two in the room together to do his incontinence care and bed mobility. When asked if there should have been two NAs providing the incontinence care on 2/7/19, she stated, "Yes, there should have been." The nurse added that there should be a care guide in the Kiosk to tell NAs how many people were needed for ADL care.

Interviews were conducted on 2/13/19 at 2:28 PM

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with the facility ' s Physical Therapist (PT) and Therapy Manager (a Speech Therapist). During the interview, the PT and Occupational Therapist (OT) notes for Resident #6 were reviewed. The therapy staff reported a PT and OT therapy evaluation was completed on day 1 or day 2 after a resident ' s admission. Since Resident #6 was admitted to the facility on a weekend, a PRN therapist (one who works as needed) did the assessment. Upon further inquiry, however, the therapists reported a resident ' s needs for bed mobility and ADL care within the bed were not addressed by therapy, except when moving from a lying down to sitting up position.

An interview was conducted on 2/13/19 at 4:40 PM with the facility ' s Director of Nursing Services (DNS). During the interview, the Communication Log book from Resident #6 ' s hall was reviewed. The DNS explained a Communication Log book was kept on each hall and was intended to communicate any changes that were made to a resident ' s care plan and electronic Kardex to the nursing staff. The DNS reported that nursing assistants were supposed to review the Communication Log book to see if any changes had been made for their residents. After reviewing a change noted in the log book, staff was supposed to sign the form in the log book to indicate he/she was aware of the change made to the resident ' s care. Review of a form for Resident #6 in the Communication Log book revealed a change was made on 1/13/19 which indicated the resident required 2-person assist with ADL care. However, the DNS noted that only two NAs had signed this form as having reviewed the information. The DNS stated the Communication Log Book was the facility ' s communication piece; and, she felt this was

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where the facility ' s system failed.

A follow-up interview was conducted on 2/15/19 at 4:20 PM with the DNS. During the interview, the DNS was asked how many staff members she would have expected to provide incontinence care to Resident #6 on 2/7/19. She responded by stating, "It should have been two like in the Kardex." The DNS added that NA #2 acknowledged this information was available in the Kardex at the time the resident ' s fell on 2/7/19.

On 2/14/19 at 10:30 AM, the facility ' s Executive Director, DNS, and Director of Operations and Compliance Officer were informed of the immediate jeopardy. The facility provided the following acceptable credible allegation of Immediate Jeopardy removal on 2/16/19 at 9:03 AM:

1) Resident #6 experienced a fall from bed on 1/13/19 during the 7-3am shift while Activities of Daily Living (ADL) care was being provided by CNA. The resident ' s initial plan of care related to ADL bed mobility stipulated "assistance needed with bed mobility". The plan of care was not clear if the assistance needed required one-person or two-person assistance. Resident Representative (RR) and attending physician notified and resident transported to Emergency Department (ED) for evaluation on 1/13/19 and returned same day with a report "sustaining a closed displaced fracture of the proximal phalanx of right little finger". Report was given to the RR following resident ' s return from ED.

Upon return to the facility, Resident #6 was re-assessed for care needs that were addressed

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through care planning and KARDEX.
Interventions initiated were as follows:
Resident to be a 2 person assist with ADLs added to resident plan of care and KARDEX
Intervention was communicated to line-staff by the Staff Development Coordinator (SDC) through the facility ' s Communication Log on 1/13/19

Resident #6 experienced a subsequent fall from bed on 2/7/19 during the 11pm-7am (12:58AM) shift while CNA was providing peri-care. Nurse was notified by CNA prior to moving resident for proper assessment and determined to have sustained a skin tear to left eyebrow and right middle finger. Physician notified and resident sent to ED for evaluation. RR notified of fall with transport on 2/7/19 to the ED for further evaluation Resident returned from ED to the facility on 2/7/19 6:55AM with a report of laceration to left eye.

The facility administrator interviewed the CNA involved in the incident of 2/7/19 regarding care delivery. When asked if the CNA had reviewed the resident ' s KARDEX prior to delivering care, the CNA responded that he did not review it prior to care, but did review it after the incident. When further questioned as to knowledge that reviewing the resident KARDEX prior to delivery of care is protocol, he responded he did, but did not review the KARDEX. The CNA received one-on-one counseling from the facility administrator regarding reviewing the KARDEX and remains suspended at this time.

2) Corrected Action for Residents with the potential to be affected:
All residents have the potential to experience an

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accident/incident due to impaired cognitive function, physical limitations, comorbidities, and/or effects of some medications. This plan of correction will address this potential for accident.

After review of the Resident #6 initial plan of care it was identified the plan was not clear on the amount of assistance needed by the resident. Based upon this, the facility ' s interdisciplinary team re-assessed 100% of all residents with regards to bed mobility and positioning on 2/13/19 to ensure the individual needs of residents are met without compromising safety. Identified needs, including the required assistance (one-person/two-person) were documented and updated on the resident ' s Kardex and Care Plan on 2/14/19.
Any resident identified through the re-assessment by the IDT team as needing assistance with bed mobility and positioning will be referred to therapy for screen/evaluation to assure the amount of assistance is accurate.

a. All CNAs (direct care) will be audited for referring to resident KARDEX before conducting bed mobility/positioning as identified in the resident ' s KARDEX. This audit will be conducted by the Director of Nursing Service (DNS), and designees on 2/13/19-2/14/19. Any staff not observed on/before 2/14/19 will be observed/audited by nursing administrative staff prior to the start of the employees ' next scheduled shift

3) Measures/systems implemented to ensure the deficit practice does not occur again:
·Staff education will be given to all CNAs by the DNS/designee on/before 2/14/19 regarding the following: Staff (CNA) to review each resident '

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F 689	Continued From page 42 s KARDEX prior to care. ·Any staff not inserviced will be inserviced prior to start of the employee ' s next scheduled shift. ·All Licensed Staff will be inserviced by the DNS/designee on/before 2/14/19 regarding: ·The importance and necessity to monitor staff under their supervision for following protocol in referencing the resident KARDEX for guidelines of care. Any staff not inserviced will be inserviced prior to start of the employee ' s next ·Any change in a resident ' s plan of care/KARDEX affecting delivery of care will be communicated directly to the charge nurse by a member of the IDT team using the Interdisciplinary form. The charge nurse will advised that it will be their responsibility to inform the direct care staff of the change and updated KARDEX as evidenced by applicable staff signatures on the Communication Form. ·The importance of referring to resident ' s KARDEX prior to resident care to be given added emphasis in New Employee Orientation for CNAs ·The importance for licensed nurses to oversee and monitor the staff under their supervision to assure the care protocols are followed will be given added emphasis in the New Employee Orientation for Licensed Nurses. 4. Compliance with the action plan established by the facility with regards to this area of concern will be monitored on a scheduled and routine basis. ·The Bed Mobility Audit which includes the following: o Name of staff person visually observing the CNA conduct bed mobility o Observe if position of resident was appropriate for care delivery o Type of assistance needed (one person/two person)	F 689		

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F 689	Continued From page 43 o Mobility completed per plan of care (KARDEX) o Height of bed appropriate o Any issues with performance and if so, how was the issue addressed This Bed Mobility Audit will be completed at a minimum of 10 times weekly for four weeks,and as needed by the DNS/designee. Outcomes of the scheduled audits will be discussed during the facility morning administrative (which members of the facility Quality Assurance (QA) Committee are present). Any non-compliance will be addressed as observed. Outcomes of compliance with established plan will also be brought to the facility monthly QA by the DNS/designee for committee review, discussion and changes needed in plan should they occur. All discussion will be included in the QA meeting minutes. Following the 4 weeks of Bed Mobility audits, Bed Mobility audits will continue with a minimum of 10 audits per month x 7 months, and as needed. The outcomes of audits will be brought to the facility monthly QA meetings by the DNS to be reviewed by the QA Committee members for compliance. Any discussion and/or revisions to the plan will be contained in the meeting minutes. Any revisions to the plan will require re-inservicing to applicable staff by the DNS/designee and require monitoring to begin again at the 10 times per week times 4 weeks. Licensed nursing staff will be monitored using the "Nurse Monitor Sheet" and will be conducted by the DNS/designee 10 times per week times 4 weeks, and as needed. This monitoring tool will assess the nurses ' compliance with 1) Intervention ordered 2) Intervention carried out as ordered 3) Follow any action taken 4) DNS	F 689		

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notified of non-compliance. Outcomes of the scheduled audits will be discussed during the facility morning administrative (which members of the facility Quality Assurance (QA) Committee are present). Any non-compliance will be addressed as observed.

Following the initial 4 weeks, the Nurse Monitor Sheet will continue to be used at a minimum of 10 times per month X 7 months, or as needed. This monitoring will be conducted by the DNS/designee. The outcomes of audits will be brought to the facility monthly QA meetings by the DNS/designee to be reviewed by the QA Committee members for compliance. Any discussion and/or revisions to the plan will be contained in the meeting minutes. Any revisions to the plan will require re-inservicing to applicable staff by the DNS/designee and require monitoring to begin again at the 10 times per week times 4 weeks.

The facility administrator will be responsible for implementing this plan and assuring monitoring is done as outlined. In the event of the administrator ' s absence, the DNS is responsible for assuring compliance with plan.

In keeping with the timeline of actions outlined, immediate jeopardy removal will be obtained by 2/14/19.

The facility ' s credible allegation of Immediate Jeopardy removal was validated on 2/16/19 at 1:20 PM. The validation was evidenced by interviews with both licensed nursing staff and non-licensed nursing staff on where to locate information regarding safety measures necessary for a resident ' s care, including the number of

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F 689	Continued From page 45	F 689		

persons required to provide ADL care. Review of on-going in-service records revealed licensed and unlicensed staff were in-serviced prior to working on the floor. A review of the Bed Mobility Audit Tool and the assessments of residents (with regards to bed mobility and positioning) was also conducted as part of the validation process.

2) Review of the manufacturer's instruction for the facility's mechanical lift used for resident transfers specified all three straps on both sides of the lifting pad must be used and attached to the lift's bar to safely lift a resident.

Resident #8 was admitted on 10/29/18 with cumulative diagnoses which included hypertension and anemia.

Review of the quarterly Minimum Data Set (MDS) assessment dated 11/4/18 coded the resident as alert and oriented who required limited assistance of 1 (one)staff for bed mobility and the transfer into and out of bed. His lower extremities were weak, and his balance was unsteady. Section K indicated Resident #8's height was recorded as 69 inches and a weight recorded as 392 pounds.

Record review revealed on 12/25/18 staff were trying to transfer Resident #8 from the bed to chair and was unable. Staff lowered the resident to the floor and no injuries were sustained. A mechanical lifting device was then used to transfer the resident off the floor. Staff were educated to use this mechanical lift for all resident transfers.

Review of the care plan dated 12/25/18 revealed an approach to use a mechanical lift for transfers.

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F 689	Continued From page 46 Observation on 2/14/19 at 10:25 AM was conducted during the transfer of Resident #8 from his bed to the wheelchair using the mechanical lift, performed by Nursing Assistant (NA) #6 and NA #7. The lifting pad used with the mechanical lift was placed underneath the resident. This lifting pad had 3 looped style straps on each side. The straps at the ends were attached to the lifting bar. The middle strap on each side was not attached to the lifting bar. NA #7 began to lift the resident with the mechanical lifting device until an inquiry was made about the lack of attachment of the middle strap to the bar. NA #7 lowered the lift and NA #6 then secured the middle straps to the bar. Resident #8 was then transferred into his wheelchair. Interview on 2/14/19 at 10:40 AM with NA #6 who stated he does not use the middle strap on the pad to secure the resident for lifting and no reason was provided. Interview on 2/16/19 at 10:52 AM with the Administrator and Director of Nurses (DON) was conducted. The DON expected the staff to attach each strap on the pad to the bar of the mechanical lift and follow the manufacturer's instruction.	F 689		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident ' s family, staff and physician interviews, and oncologist and facility record	F 760	Address how corrective action will be accomplished for those residents found to	3/12/19

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F 760	Continued From page 47 reviews, the facility failed to prevent a significant medication error by failing to initiate administration of and to correctly administer an antineoplastic medication used to treat cancer (lenalidomide) for 1 of 3 residents whose medications were reviewed (Resident #4). The resident ' s Oncologist noted on 10/12/18 that her lab results reflected a progression of her multiple myeloma. The medication was ordered by the oncologist on 10/30/18 from a specialty pharmacy, and brought to the facility by Resident #4 ' s family on 11/5/18. The medication was stored on the hall medication cart (unopened) and not administered until 1/10/19. A count of the lenalidomide capsules conducted on 2/14/19 revealed only 6 capsules had been administered to Resident #4 to date. Failure to receive the medication prescribed due to the progression of myeloma may have delayed the resident ' s response to the treatment. Immediate Jeopardy began on 11/5/18 when lenalidomide was available at the facility for administration to Resident #4 as prescribed by her oncologist. Immediate Jeopardy was removed as of 2/15/19 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level "E" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education and ensure monitoring systems put into place are effective. The findings included: Resident #4 was admitted to the facility on 8/28/17 with re-entry to the facility on 2/21/18.	F 760	have been affected by the deficient practice The resident identified as Resident #4, was admitted to Heartland Living and Rehabilitation Center on 8/28/17. As of 2/21/18, Resident #4 presented with the following diagnoses: multiple myeloma not having achieved remission, malignant neoplasm of unspecified of right female breast, and secondary malignant neoplasm of the bone. The resident was seen by the oncologist on 10/12/2018 and Revlimid (Lenolidomide) 5 milligrams (mg) -take one tab by mouth daily was ordered The DNS in-serviced transport driver on 2/14/19 that all consult paperwork must be given to the charge nurse upon return to the facility. This medication aide was in-serviced by the DNS on the importance of receiving medications and reporting to the charge nurse on 1/10/19 and re-inserviced on 2/14/19 regarding the process of receiving any new medications or consults, the medication aide must give both to the charge nurse. On 1/10/19, Resident #4, had a follow-up appointment at the oncologist. Upon the resident return it was discovered that resident had not received Revlimid (Lenolidomide) was initially ordered at the 10/12/18 appointment. The DNS verified that the medication was on the cart on 1/10/19 and the medication aides documented medication as given from 1/10/19-1/31/19 and 2/7/19 to 2/14/19; however, 22 pills were in the cart on the morning of 2/14/19 when the surveyor	

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F 760	Continued From page 48 Her cumulative diagnosis included multiple myeloma (a cancer that forms in a type of white blood cell called a plasma cell) not having achieve remission; malignant neoplasm (tumor) of unspecified site of right female breast; and secondary malignant neoplasm of the bone. A review of the facility ' s October 2018 Physician Order Summary for Resident #4 revealed her medications included 2.5 milligrams (mg) letrozole to be given as one tablet by mouth daily for breast cancer (initiated on 2/21/18). A review of the resident ' s medical record included an Oncology Consult Progress Note dated 10/12/18. The note indicated Resident #4 was seen at the oncology office by the Nurse Practitioner (NP) on 10/12/18. The following issues were addressed: multiple myeloma in relapse and malignant neoplasm of breast, Stage 4. The notes read, in part: "(Resident #4) is here today with her (family member) to discuss her myeloma progression and starting her on lenalidomide (brand name of Revlimid). She is receiving bortezomib (an antineoplastic agent used to treat multiple myeloma that is administered either subcutaneously or intravenously) every 2 weeks and is tolerating that well." Lenalidomide is an antineoplastic medication used to treat multiple myeloma in patients by multiple mechanisms, including inhibiting the growth of myeloma cells. The plan of treatment noted in the Oncology Consult Note for Resident #4 read, "(Resident #4) will start on lenalidomide 5 mg daily. (Name of oncologist) has prescribed this ....She will receive bortezomib today. She is tolerating that well. I reviewed with (name of family member) the labs that we drew that indicated a slow progression of her myeloma.	F 760	counted the medication with the medication aide. The oncologist has been notified by the DNS on 2/15/19 of the discovery of 22 pills and through verbal communication with the oncologist office today (2/15/19) at 12:45pm the order has been rewritten to the following, begin a 21-day cycle today at 1PM, and finish this cycle. After the 7-day rest period, begin the next 28-day cycle with nurse administration verifying daily dose given The ordered dose was given today at 1PM and will continue daily at 1PM X 20 days (ending on 3/7/19) Resident #4 will continue follow-up appointment with oncologist as scheduled. Resident will be sent to her appointment with the carbon Consultation Form for consulting MD to transcribe any new orders, treatments, and follow-up appointments. The form will be received by the transportation driver in a sealed envelope and brought back to the facility and handed to the charge nurse for the resident. The nurse will read consultation form thoroughly and notify attending physician of new orders, and transcribe orders onto the Resident #4□s MAR as ordered. The pink copy of the Consultation Form will be placed in the DNS box and reviewed at the Morning Meeting to ensure orders and directions of the consulting MD are followed. Next appointment scheduled for 2/21/19 was cancelled by the son. Appointment was rescheduled for 2/25/19 and resident was seen by the oncologist. Consult	

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F 760	Continued From page 49 I also gave him detailed info about the lenalidomide in (resident ' s) after visit summary." An addendum was made to the 10/12/18 Oncology Consult Progress Note by the oncologist which indicated he met with Resident #4 and a family member. At that time, her lab work indicating the progression of the multiple myeloma was discussed, along with the need to intensify her treatment. The oncologist noted, "There are many ways of doing this, but I think the simplest one would be to add lenalidomide..." The oncologist also indicated he had discussed the medication with their oral chemotherapy pharmacy specialist to help obtain the medication for Resident #4. A review of Resident #4 ' s electronic medical record (EMR) revealed the oncology consult report dated 10/12/18 was scanned into the resident ' s EMR at the facility on 10/16/18. Review of Resident #4s October 2018 Physician Order Summary revealed there was no order for lenalidomide. A review of the resident ' s October 2018 Medication Administration Record (MAR) reflected lenalidomide was not included on the record of medications administered to Resident #4. A review of the resident ' s medical record included another Oncology Consult Progress Note dated 10/30/18. The note indicated Resident #4 was seen at the oncology office on 10/30/18 with the following issues addressed: multiple myeloma not having achieved remission; lytic bone lesions on x-ray (areas of bone damage that result from cancerous plasma cells building up in the bone marrow); and malignant neoplasm of breast, Stage 4. The resident ' s	F 760	sheet was received by the DNS and new orders were initiated. Resident continues to receive medications/treatments as ordered by the attending physician and oncologist. Address how the facility will identify other residents having the potential to be affected by the same deficient practice A 100% review was conducted on 2/14/19 by the DNS /designee on all residents who have had appointments since October 1, 2018 to ensure all ordered medications, labs, and follow-up were followed according the MD orders. The Appointment Tracking Log will be filled out with the resident name, date, Provider name, new orders, description of the order, f/u appointment, f/u date and time, results to attending MD and consulting MD, MD signed results, new orders, and the initials of the person receiving the order. These logs will be placed in a notebook and kept in the DNS office. The DNS will be responsible for filling these logs daily (Mon-Fri) and the RN on duty (weekends). A 100% med cart audit was conducted on 2/15/19 by the licensed pharmacist and no other issues were identified in which resident□s were not currently receiving medications as order. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur	

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F 760	Continued From page 50 medication list from the oncology notes included 5 mg lenalidomide to be given as one capsule by mouth once daily. A review of Resident #4 ' s electronic medical record (EMR) revealed the oncology consult report dated 10/30/18 was scanned into the resident ' s EMR at the facility on 11/2/18. Review of the resident ' s medical record included a Progress Note authored by the facility ' s NP and dated 11/2/18. A review of the resident ' s medications indicated 5 mg lenalidomide was being initiated. Review of Resident #4s November 2018 Physician Order Summary revealed there was no order for lenalidomide. A review of the resident ' s November 2018 Medication Administration Record (MAR) reflected lenalidomide was not included on the record of medications administered to Resident #4. Review of the resident ' s medical record included a Physician ' s Progress Note dated 12/20/18. The note indicated Resident #4 was seen for a nursing facility follow up of chronic medical diagnoses. Her history of present illness (HPI) included the following notation, in part: "She was receiving infusion therapy for IgG kappa (a classification) multiple myeloma which is progressing slowly. She was last seen by oncology 10/12/18; that assessment was reviewed ...At the last visit lenalidomide was initiated ..." Review of Resident #4s December 2018 Physician Order Summary revealed there was no order for lenalidomide. A review of the resident ' s	F 760	All licensed nursing staff and medication aides have been in-serviced on 2/15/19 by the SDC on diversion, resident rights, and 6 rights of medication administration. Nurses and med-aides not in-serviced by 2/15/19 will be in-serviced prior to the next scheduled shift. All new nurses and medication aides will be in-serviced on 2/15/19 on diversion, resident rights, and 6 rights of medication administration in facility orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Medication Carts (at one cart a day) will be audited by the DNS/designee weekly x4 weeks, and as needed, then monthly thereafter x 6 months, and as needed to ensure compliance with the medication administration protocol. The audit will be monitoring residents medication orders compared to the medication in the cart and if any medications are not present. Should a medication not be present it will be obtained as soon as possible, either through the facility Omnicell, pharmacy, or back-up pharmacy. The DNS/designee will review the resident□s MAR for any miss doses, and if found a medication error report will be completed and the nurse/med aide will receive one-on-one counseling by DNS/designee regarding notification to charge nurse and pharmacy of any missing medication.	

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F 760	Continued From page 51 December 2018 Medication Administration Record (MAR) reflected lenalidomide was not included on the record of medications administered to Resident #4. A review of Resident #4 ' s most recent quarterly Minimum Data Set (MDS) dated 1/9/19 revealed the resident was assessed by staff to have severely impaired cognitive skills for daily decision making. She required extensive assistance by staff for all of her Activities of Daily Living (ADLs). Further review of Resident #4 ' s medical record included an Oncology Consult Progress Note dated 1/10/19. This note read, in part: "(Resident #4) returns today for follow-up and treatment of her estrogen receptor positive breast cancer as well as her history of multiple myeloma accompanied by her two (family members). As far as the breast cancer is concerned, she continues on letrozole, with good tolerance. She receives bortezomib every 2 weeks. She takes this with good tolerance. Also on 10/30/18 we prescribed lenalidomide at 5 mg daily. Receipt of this by the patient was confirmed 11/5/18 by our oral chemotherapy pharmacists." The oncologist noted, however, that lenalidomide was not included on the patient's list of medications from the facility. The plan of treatment noted in the Oncology Consult Note for Resident #4 read, "(Resident #4) looks clinically very stable and has no complaints. However her numbers (referring to lab work showing progression of the multiple myeloma) have been going up. She was supposed to have started lenalidomide certainly by the first week in November, but I do not find it in her MAR. I have written a request to Heartland Living to let us know whether the patient has	F 760	Audit Compliance (Medication Carts) will be discussed weekly by the DNS/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. The DNS/designee will bring results of Medication Cart audit the facility monthly QA meetings for committee review and input monthly X 7 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-inservicing by the DNS/designee and monitoring to begin again at the weekly audits until compliance is met. Results of audits will be presented to the facility QA committee by the DNS during monthly x3 and then quarterly thereafter, and as needed. All discussions, revisions to plan, and additional in-servicing will be noted in the QA Committee Meeting Minutes. The Executive Director is responsible for the implementation of this plan. The date the corrective action will be completed is 3/12/19.	

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been receiving the medication, how much medication she has been receiving, whether she has missed any doses, and whether they have noticed any side effects." The oncologist also noted he provided the direct line to his nurse to document the facility ' s response and asked her family members to inquire at the facility as to what happened to the medication they delivered in early November. The oncologist noted, "If she has been receiving lenalidomide and the labs today show further progression, we will need to intensify the bortezomib and move to weekly, or we can consider switching to carfilzomib (another antineoplastic medication indicated to treat multiple myeloma). Of course that she has not been receiving lenalidomide and that is what we need to do and then follow-up."

On 1/10/19 at 3:27 PM, a physician ' s order was received in accordance with the oncologist ' s recommendations to initiate the administration of lenalidomide. The medication order instructed 5 mg lenalidomide to be administered to Resident #4 as one capsule once daily for 21 days, stop for 7 days; then restart the same cycle.

A Med Error Report dated 1/31/19 revealed one extra daily dose (22 days versus 21 days) of lenalidomide was administered to Resident #4 due to a transcription error. The resident ' s physician was notified; no clinical harm was noted.

On 2/13/19 at 1:00 PM, a telephone interview was conducted with the oncologist ' s nurse. The nurse reported after Resident #4 ' s September appointment, additional lab results were received by the oncologist which indicated progression of her multiple myeloma. When the resident came

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in for her 10/12/18 appointment, it was decided lenalidomide would be initiated. The nurse reported while her condition was not curable, it was treatable and controllable. She stated lenalidomide was a medication that was dispensed from a specialty pharmacy and the process of acquiring it took some time. Upon review of Resident #4 ' s records, she stated the oncology office was still trying to obtain insurance authorization for the medication as of 10/17/18. Upon further review, the nurse reported their records indicated the medication was sent to the resident ' s family member on 11/3/18. The nurse recalled speaking with someone at the facility on 1/10/19 about Resident #4 ' s lenalidomide and the delay in getting her started on the medication. She reported there was a "huge communication problem."

A telephone interview was conducted with Resident #4 ' s oncologist on 2/13/19 at 1:21 PM. During the interview, the oncologist was asked how the delay in receiving lenalidomide would potentially affect Resident #4. He stated the lenalidomide was prescribed due to the resident ' s progression of the myeloma. Although the resident was reported to have a chronic condition that was not curable, the oncologist stated, "I would have preferred she had been started (on the medication) 2-3 months earlier." He stated, "It ' s been very difficult for us to understand what the problem was."

A telephone interview was conducted on 2/14/19 at 10:20 AM with a representative from the specialty pharmacy which dispensed Resident #4 ' s lenalidomide. During the interview, the representative reported 1 bottle of lenalidomide was shipped to the resident ' s family member on

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11/3/19; and, a second bottle was shipped to the family member on 2/5/19. Each bottle of lenalidomide contained 28 capsules.

A telephone interview was conducted on 2/14/18 at 8:20 PM with Resident #4 ' s family member. During the interview, the family member reported he attended the oncology consultation with Resident #4 on 10/12/18. He recalled being told by the oncologist ' s office that the resident ' s new medication (lenalidomide) could not be obtained through the facility. The family member reported the oncologist ' s office set up everything with the specialty pharmacy; he did not receive a printed prescription for the medication. Upon further inquiry, the family member stated he received the medication at his home and brought it to the facility within "a day or so" after it was delivered to him in early November. He stated he gave the medication bottle to the nurse and she put it in the medication cart. The family member was asked if he could recall who he gave the medication to. He stated, "Yes," but he declined to identify the staff member. When asked what he told the staff member when he handed her the medication bottle, he reported he explained what the medication was and that it was coming from the doctor. The family member reported that when he later went back to see the oncologist with Resident #4, "He (the doctor) was fussing at me" thinking he had not brought the medication in to the facility. The family member reported he went to the facility right after that appointment (1/10/19) and talked with the DNS. He stated the facility said they did not have an order for the medication, but they did find the medication bottle on the med cart. The family member stated, "It had been two months, that ' s crazy." When asked how he needed to obtain refills for the

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medication, he reported the specialty pharmacy called him about a week before they sent the second bottle of medication (lenalidomide) out to him. He reported he received the second bottle of medication a few days ago, but had not yet brought it into the facility.

During an interview conducted on 2/16/19 at 10:15 AM with the DNS, it was reported Med Aide #2 had indicated she was the staff member who received the first bottle of lenalidomide from Resident #4 ' s family member. The DNS reported that based on the family member ' s recollection, it had been determined the first bottle of the lenalidomide was brought in to the facility on 11/5/18.

An interview was conducted on 2/15/19 at 11:05 AM with the NP who helped care for Resident #4. Upon request, the NP reviewed the notation she wrote on 11/2/18. The NP reported the lenalidomide was listed on the resident ' s medication list with an authorization number. When asked, the NP stated the authorization number showed, "They are asking for (insurance) authorization." She further explained that once a medication was put on the list (even by another provider such as oncology), it would automatically go over to the med list for her note. The NP reported the next time she saw the resident was on 1/14/19. Lenalidomide was included as one of the current meds on the resident ' s medication list at that time.

An interview was conducted on 2/12/18 at 11:30 AM with the facility's Medical Director (who was also the resident ' s physician). During the interview, the Medical Director reported his records showed a NP facility note on 11/2/18

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which included lenalidomide on Resident #4 ' s medication list. The physician also reported he could see a progress note he himself authored on 12/20/18 which included lenalidomide on the resident ' s medication list (he was unsure why this was because the resident was not receiving it and did not have it ordered for administration at the facility). The physician reported the facility could not enter a new order unless he or the NP signed the order; he did not recall doing so until after the delay in the med administration for lenalidomide was identified on 1/10/19. The physician questioned whether the delay in receiving this medication would have made a difference for Resident #4.

An interview was conducted on 2/12/19 at 9:15 AM with the facility ' s Director of Nursing Services (DNS) in the presence of the Executive Director. During the interview, the nurse was asked to describe the facility ' s process of communication with outside consultants. The DNS reported a face sheet and current medication list (either the physician ' s orders or MAR) was sent with the transportation staff member when she took a resident to an outside consultation. Upon return from the consult appointment, a packet of information would come back with the resident. The DNS reported there may be a note written at the bottom of the consult form brought back to the facility. Whether or not there was a new order for the resident, the consultation information was supposed to be put in the provider box for the facility ' s NP or physician to review. She reported that if there was a new medication order, the nurse would fax the order to the facility ' s contracted pharmacy. When asked who would initiate a new medication order recommended by an outside consultation,

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the DNS stated the nurse receiving the consult back would usually do so.

A follow-up interview was conducted on 2/12/19 at 5:21 PM with the facility ' s DNS. The DNS reported she was first informed of a problem with the delay in Resident #4 receiving lenalidomide on 1/10/19. The resident ' s family member came directly from the oncologist ' s office visit on that date over to the facility. He was concerned because the oncologist ' s office made him aware the resident was supposed to be taking some medication that they noticed was not included on the med list sent to them by the facility. The DNS stated she understood the family member had obtained a prescription for the lenalidomide from the oncologist because the medication would only be covered by insurance through another pharmacy. Around the first part of November, 2018, the prescription for lenalidomide was filled and the family member brought the medication in to the facility. She reported the family member could not recall who he gave the medication to. The DNS stated after she checked the resident ' s physician ' s orders and her MAR, she confirmed the medication was not given. When she went to the med cart, she discovered an unopened bottle of lenalidomide labeled for Resident #4 was stored on the cart. When asked if anyone had questioned why the medication was on the med cart, she stated, "No." The DNS reported she called the oncologist ' s office and talked with his nurse on 1/10/19. The DNS received a verbal order for the administration of the lenalidomide and a fax with the order. The DNS was uncertain at that time why the facility had not been aware of the need to initiate lenalidomide for Resident #4.

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A second follow-up interview was conducted on 2/15/19 at 4:20 PM with the DNS. The DNS reported upon investigation, they discovered the resident ' s oncology consults did come to the facility. She reported consultation reports were sent from the oncologist to the attending physician, in addition to paperwork being sent to the facility via the transport driver. She stated the facility has identified a problem with the consult reports getting scanned into the electronic medical records before they were reviewed by a nurse, the NP, or the physician.

A telephone interview was conducted on 2/16/19 at 12:54 PM with the facility ' s transportation staff member. During the interview, the staff member reported when she previously transported Resident #4 back from an outside consult, she would typically put the consult packet (containing information from the outside consult) on the desk at the nursing station. She reported this process has recently been changed and she has been instructed to now place this packet of information directly in the hands of the nurse on duty to ensure the consult was reviewed.

The resident ' s February 2019 MAR indicated 5 mg lenalidomide was administered to Resident #4 once daily at 5:00 PM on 2/7/19 through 2/13/19 (representing 7 capsules for a total of 29 capsules administered to date). According to the MARs, a total of 29 lenalidomide capsules were documented as administered to the resident by the following staff members: Med Aide #1 administered 2 capsules; Med Aide #2 administered 20 capsules; Med Aide #3 administered 2 capsules; and Med Aide #4 administered 4 capsules; and Med Aide #5 administered 1 capsule.

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An observation and interview was conducted on 2/14/19 at 10:10 AM with Med Aide #1. Med Aide #1 was assigned to Resident #4 ' s hall medication cart. At that time, one bottle of lenalidomide labeled for Resident #4 was observed to be stored on the med cart. Labeling on the medication bottle also included an original prescription date of 10/30/18 and the date dispensed by the pharmacy (11/2/18). Upon request, Med Aide #1 counted the lenalidomide capsules remaining in the medication bottle. The Med Aide was observed as she poured the capsules out of the original container one at a time (while counting) into two medication cups. One medication cup was counted and contained 9 capsules. The second medication cup was counted and contained 11 capsules. After the capsules had been poured into the two medication cups for counting, two additional capsules were observed to be left at the bottom of the original container and were added to the total count. The Med Aide confirmed the counts. It was determined a total of 22 capsules remained in the medication bottle originally containing 28 capsules. After counting the capsules, Med Aide #1 was observed as she returned all capsules back to the original medication bottle, secured the cap on the bottle, and returned the lenalidomide medication bottle to a drawer on the medication cart.

An observation and interview was again conducted on 2/15/19 at 8:35 AM with Med Aide #1. Med Aide #1 was assigned to Resident #4 ' s hall medication cart. At that time, the resident ' s bottle of lenalidomide stored on the med cart was observed. Upon opening the bottle of lenalidomide, only 7 capsules were seen lying on

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the bottom of the bottle. The 7 capsules were clearly visible and easily counted without removing them from the container. The labeling on the medication bottle was confirmed to be the same as that observed on 2/14/19, and included the resident ' s name, an original prescription date of 10/30/18, and the date dispensed by the pharmacy (11/2/18). When asked, the Med Aide reported she did not recall the exact number of capsules that were counted from Resident #4 ' s lenalidomide bottle the previous morning (2/14/19). Upon further inquiry, however, Med Aide #1 stated, "It was more." A thorough inspection of all drawers and compartments in the medication cart conducted by Med Aide #1 revealed there were no other bottles of lenalidomide stored on the med cart.

An interview on 2/15/19 at 9:10 AM with the DNS and facility ' s Executive Director (ED). During the interview, the count discrepancy of Resident #4 ' s lenalidomide medication from 2/14/19 (22 capsules) to 2/15/19 (7 capsules) was discussed. At the time 22 capsules of lenalidomide were counted (10:10 AM on 2/14/19), Resident #4 ' s MAR documented the resident had received 29 capsules. However, the lenalidomide bottle originally contained 28 capsules, which indicated the resident could have only received a total of 6 lenalidomide capsules. The DNS and ED stated they had not been informed of the 2/14/19 count of lenalidomide. However, the DNS reported a medication audit was conducted the evening of 2/14/19. The DNS reported she observed 7 capsules of lenalidomide were remaining in the bottle at approximately 9:30 PM on 2/14/19. Based on the MAR documentation for this medication, the DNS indicated that she, too, had identified a concern because there should not

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have been any capsules remaining in the bottle of lenalidomide. The DNS reported the MAR documented that Med Aide #1, Med Aide #2, Med Aide #3 and Med Aide #4 had administered this medication to Resident #4. During the interview, the DNS confirmed only one bottle of lenalidomide was on the medication cart. She reported Resident #4 ' s family member brought in the second bottle of lenalidomide earlier that morning (on 2/15/19), which the DNS still had in her possession. The second bottle of lenalidomide was observed to be sealed (unopened). This medication was labeled with Resident #4 ' s name and a pharmacy dispensed date of 2/4/19.

A telephone interview was conducted on 2/16/19 at 10:30 AM with Med Aide #1 in presence of the DNS and ED. During the interview, the med aide was asked to describe the process used to count Resident #4 ' s lenalidomide on 2/14/19. Med Aide #1 reported the lenalidomide capsules were poured into two different medication cups on top of the med cart as the capsules were counted. When asked if she recalled how many capsules were in the bottle of lenalidomide when they were counted on the morning of 2/14/19, the med aide reported she could not remember. However she added, "But I know it was more than 7."

Med Aide #1 was also asked to describe the process she used to administer medications to a resident. The med aide reported she would first pull up the resident ' s profile on the computer, make sure she had the right resident, the right med, right dose, and right route of administration. She would then pull the med from the cart and hold it up against the electronic MAR to ensure the resident ' s name and medication was correct.

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After she administered the medication to the resident, the med aide reported she would sign off that the resident received the med on the electronic MAR.

A telephone interview was conducted on 2/16/19 at 10:41 AM with Med Aide #2. During the interview, the med aide was asked if Resident #4 ' s family member had given her a bottle of medication (lenalidomide) for the resident in November 2018. She stated, "No he didn ' t hand me a bottle ....the (family member) had just mentioned about (Resident #4) not receiving it." Although she was not sure of the date, she thought this probably occurred in December. The med aide stated since the resident was receiving another chemotherapy medication, she assumed that was the medication he was talking about. Med Aide #2 stated the family member told her he had a bottle of medication at home and she told him he could bring it in. The med aide stated she thought it might have been the next weekend when she saw the medication bottle (lenalidomide) on the med cart. Med Aide #2 reported sometime later (maybe in January), she looked at the medication bottle and saw this med was different from the one the resident had been receiving. The med aide reported she looked for this medication order in the computer and didn ' t see one, "but didn ' t think anything about it" and did not follow-up on this. During the interview, Med Aide #2 was asked to describe the process she used to administer medications to a resident. The med aide reported she would log into the computer, look at the medication and the person receiving it. After she double checked that it was the right medication, she would pop the med and put check on the "prepped" button in the electronic MAR. After she administered the med

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to the resident, she would record the med was administered on the electronic MAR. If the resident refused the medication, she would record the med as "refused" on the MAR. When asked, Med Aide #2 reported if her initials were on the MAR to indicate a medication was administered, the resident did receive the medication.

A telephone interview was conducted on 2/16/19 at 10:58 AM with Med Aide #3. During the interview, Med Aide #3 was asked to describe the process he used to administer medications to a resident. The med aide reported he would pull up the electronic MAR for the resident; pull the medication from the med cart; double check the name of the resident, the name of the medication and the dose; and then administer the medication to the resident. Once he administered the medication, he would then come back to the cart and record the medication administration on the electronic MAR.

An attempt to conduct a telephone interview with Med Aide #4 was unsuccessful.

An interview was conducted on 2/15/19 at 4:20 PM with the DNS. During the interview, the DNS was asked what her expectation was in regards to Resident #4 ' s lenalidomide. She responded by stating the facility determined the oncology consult reports were scanned into the electronic medical record before being reviewed by nursing staff, the NP, or the physician. The DNS indicated she would have expected the facility to have reviewed this information and known lenalidomide was initiated for the resident. If she would have been aware of the need for the medication, she could have followed up on it. When asked, the

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DNS also reported that once Resident #4 ' s lenalidomide was initiated, she would have expected the documentation on the MARs to be accurate and for the medication to have been administered to the resident as ordered.

On 2/14/19 at 10:30 AM, the facility ' s ED, DNS, and the Director of Operations and Compliance Officer were informed of the immediate jeopardy. The facility provided the following acceptable credible allegation of Immediate Jeopardy removal on 2/16/19 at 9:03 AM:

1. The resident identified as Resident #4, was admitted to Heartland Living and Rehabilitation Center on 8/28/17. As of 2/21/18, Resident #4 presented with the following diagnoses: multiple myeloma not having achieved remission, malignant neoplasm of unspecified of right female breast, and secondary malignant neoplasm of the bone. The resident was seen by the oncologist on 10/12/2018 and Revlimid (Lenolidomide) 5 milligrams (mg) -take one tab by mouth daily was ordered
·The DNS in-serviced transport driver on 2/14/19 that all consult paperwork must be given to the charge nurse upon return to the facility. This medication aide was in-serviced by the DNS on the importance of receiving medications and reporting to the charge nurse on 1/10/19 and re-inserviced on 2/14/19 regarding the process of receiving any new medications or consults, the medication aide must give both to the charge nurse.

· On 1/10/19, Resident #4, had a follow-up appointment at the oncologist. Upon the resident ' return it was discovered that resident had not received Revlimid (Lenolidomide) was initially

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ordered at the 10/12/18 appointment. The DNS verified that the medication was on the cart on 1/10/19 and the medication aides documented medication as given from 1/10/19-1/31/19 and 2/7/19 to 2/14/19; however, 22 pills were in the cart on the morning of 2/14/19 when the surveyor counted the medication with the medication aide. The oncologist has been notified by the DNS on 2/15/19 of the discovery of 22 pills and through verbal communication with the oncologist office today (2/15/19) at 12:45pm the order has been rewritten to the following, "begin a 21-day cycle today at 1PM", and finish this cycle. After the 7-day rest period, begin the next 28-day cycle with nurse administration verifying daily dose given" The ordered dose was given today at 1PM and will continue daily at 1PM X 20 days (ending on 3/7/19)

· Resident #4 will continue follow-up appointment with oncologist as scheduled. Next appointment scheduled for 2/21/19. Resident will be sent to her appointment with the carbon Consultation Form for consulting MD to transcribe any new orders, treatments, and follow-up appointments. The form will be received by the transportation driver in a sealed envelope and brought back to the facility and handed to the charge nurse for the resident. The nurse will read consultation form thoroughly and notify attending physician of new orders, and transcribe orders onto the Resident #4 ' s MAR as ordered. The pink copy of the Consultation Form will be placed in the DNS box and reviewed at the Morning Meeting to ensure orders and directions of the consulting MD are followed.

2. As all residents have the potential to have significant medication errors because of routine

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consultations and appointments with outside providers, the following actions have been put into place to prevent residents from medication errors as a result of not following MD orders.

· A 100% review was conducted on 2/14/19 by the DNS /designee on all residents who have had appointments since October 1, 2018 to ensure all ordered medications, labs, and follow-up were followed according the MD orders. The Appointment Tracking Log will be filled out with the resident name, date, Provider name, new orders, description of the order, f/u appointment, f/u date and time, results to attending MD and consulting MD, MD signed results, new orders, and the initials of the person receiving the order. These logs will be placed in a notebook and kept in the DNS office. The DNS will be responsible for filling these logs daily(Mon-Fri) and the RN on duty (weekends).
· A 100% med cart audit was conducted on 2/15/19 by the licensed pharmacist and no other issues were identified in which resident's were not currently receiving medications as order.

3. All licensed nursing staff and medication aides have been in-serviced on 2/15/19 by the SDC on diversion, resident rights, and 6 rights of medication administration. Nurses and med-aides not in-serviced by 2/15/19 will be in-serviced prior to the next scheduled shift.

All new nurses and medication aides will be in-serviced on 2/15/19 on diversion, resident rights, and 6 rights of medication administration in facility orientation.

4. The Medication Carts (at one cart a day) will be audited by the DNS/designee weekly x4 weeks,

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and as needed, then monthly thereafter x 6 months, and as needed to ensure compliance with the medication administration protocol. The audit will be monitoring residents medication orders compared to the medication in the cart and if any medications are not present. Should a medication not be present it will be obtained as soon as possible, either through the facility Omnicell, pharmacy, or back-up pharmacy. The DNS/designee will review the resident ' s MAR for any miss doses, and if found a medication error report will be completed and the nurse/med aide will receive one-on-one counseling by DNS/designee regarding notification to charge nurse and pharmacy of any missing medication.

Audit Compliance (Medication Carts) will be discussed weekly by the DNS/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. The DNS/designee will bring results of Medication Cart audit the facility monthly QA meetings for committee review and input monthly X 7 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-inservicing by the DNS/designee and monitoring to begin again at the weekly audits until compliance is met.

Results of audits will be presented to the facility QA committee by the DNS during monthly x3 and then quarterly thereafter, and as needed. All discussions, revisions to plan, and additional in-servicing will be noted in the QA Committee Meeting Minutes.

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F 760	Continued From page 68 The Executive Director is responsible for the implementation of this plan. Effective 2/15/19 The facility ' s credible allegation of Immediate Jeopardy removal was validated on 2/16/19 at 1:20 PM. The validation was evidenced by interviews with both licensed nursing staff and Med Aides on the 6 rights of medication administration and the facility process expected when a resident returned form an outside consultation. Review of on-going in-service records revealed licensed and unlicensed staff were in-serviced prior to working on the floor. A review of the pharmacy cart audit report and Daily Appointment Tracking Log was also was also conducted as part of the validation process.	F 760		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and facility, hospital, and oncology record reviews, the facility failed to provide the oversight of processes and effective leadership required to ensure a resident was free from neglect and a significant medication error when an antineoplastic medication used to treat cancer (lenalidomide) was not initiated or administered in accordance with an oncologist ' s recommendations for 1 of 3 residents (Resident	F 835	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #4 remains in the facility and had a follow-up appointment with the oncologist on 2/25/19. The consult sheet was reviewed by the Director of Nursing	3/13/19

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F 835	Continued From page 69 #4) whose medications were reviewed; and, to ensure Activities of Daily Living (ADL) care was safely provided with two person assistance as required for 1 of 3 sampled residents reviewed for accidents (Resident #6). The findings included: 1) Resident #4 was admitted to the facility on 8/28/17 with re-entry to the facility on 2/21/18. Her cumulative diagnosis included multiple myeloma not having achieve remission; malignant neoplasm (tumor) of unspecified site of right female breast; and secondary malignant neoplasm of the bone. A review of the resident ' s medical records included an oncology consult dated 10/12/18. The consult noted Resident #4 ' s lab results reflected a progression of her multiple myeloma, so the plan of treatment included initiation of 5 milligrams (mg) lenalidomide to intensify her treatment. The medication was ordered by the oncologist on 10/30/18 from a specialty pharmacy, and brought to the facility by Resident #4 ' s family on 11/5/18. A review of the resident ' s medical records included another oncology consult dated 1/10/19. This consult noted lenalidomide was not included on the patient's list of medications from the facility and a request was made to confirm the resident was receiving the lenalidomide as previously prescribed. On 1/10/19 at 3:27 PM, a physician ' s order was received in accordance with the oncologist ' s recommendations to initiate the administration of lenalidomide. The medication order instructed 5	F 835	Services (DNS). New orders were received and reviewed with the attending physician. Resident had another follow-up on 3/7/19 with no new orders. Resident has received medications as ordered by the oncologist and attending physician. Resident #6 discharged from the facility to home on February 8th. Address the facility will identify other residents having the potential to be affected by the same deficient practice: A 100% review was conducted on 2/14/19 by the DNS /designee on all residents who have had appointments since October 1, 2018 to ensure all ordered medications, labs, and follow-up were followed according the MD orders. The Appointment Tracking Log will be filled out with the resident name, date, Provider name, new orders, description of the order, f/u appointment, f/u date and time, results to attending MD and consulting MD, MD signed results, new orders, and the initials of the person receiving the order. These logs will be placed in a notebook and kept in the DNS office. The DNS will be responsible for filling these logs daily (Mon-Fri) and the RN on duty (weekends). A 100% med cart audit was conducted on 2/15/19 by the licensed pharmacist and no other issues were identified in which resident□s were not currently receiving medications as order. The facility□s interdisciplinary team re-assessed 100% of all residents with	

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F 835	Continued From page 70 mg lenalidomide to be administered to Resident #4 as one capsule once daily for 21 days, stop for 7 days; then restart the same cycle. An interview was conducted on 2/12/19 at 9:15 AM with the facility ' s Director of Nursing Services (DNS) in the presence of the Executive Director. During the interview, the nurse was asked to describe the facility ' s process of communication with outside consultants. The DNS reported a face sheet and current medication list (either the physician ' s orders or MAR) was sent with the transportation staff member when she took a resident to an outside consultation. Upon return from the consult appointment, a packet of information would come back with the resident. The DNS reported there may be a note written at the bottom of the consult form brought back to the facility. Whether or not there was a new order for the resident, the consultation information was supposed to be put in the provider box for the facility ' s NP or physician to review. She reported that if there was a new medication order, the nurse would fax the order to the facility ' s contracted pharmacy. When asked who would initiate a new medication order recommended by an outside consultation, the DNS stated the nurse receiving the consult back would usually do so. A follow-up interview was conducted on 2/12/19 at 5:21 PM with the facility ' s DNS. The DNS reported she was first informed of a problem with the delay in Resident #4 receiving lenalidomide on 1/10/19. The resident ' s family member came directly from the oncologist ' s office visit on that date over to the facility. He was concerned because the oncologist ' s office made him aware the resident was supposed to be taking some	F 835	regards to bed mobility and positioning on 2/13/19 to ensure the individual needs of residents are met without compromising safety. Identified needs, including the required assistance (one-person/two-person) were documented and updated on the resident□s Kardex and Care Plan on 2/14/19. Any resident identified through the re-assessment by the IDT team as needing assistance with bed mobility and positioning will be referred to therapy for screen/evaluation to assure the amount of assistance is accurate. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur DNS and Administrator received training on the new process for tracking outside consults on 2/14/19 by the Director of Operations. New appointment tracking log was put into place on 2/15/19 and DNS was made responsible for the new process. Facility Administrator and two IDT members attended a corporate led training on February 19th regarding Incident/Accident investigations, identifying root cause, implementing proper interventions and monitoring conducted by the Director of Quality and Clinical Education Checklist was provided to the IDT members on 2/18/19 by the Director of	

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medication that they noticed was not included on the med list sent to them by the facility. The DNS stated she understood the family member had obtained a prescription for the lenalidomide from the oncologist because the medication would only be covered by insurance through another pharmacy. Around the first part of November, 2018, the prescription for lenalidomide was filled and the family member brought the medication in to the facility. She reported the family member could not recall who he gave the medication to. The DNS stated after she checked the resident ' s physician ' s orders and her MAR, she confirmed the medication was not given. When she went to the med cart, she discovered an unopened bottle of lenalidomide labeled for Resident #4 was stored on the cart. When asked if anyone had questioned why the medication was on the med cart, she stated, "No." The DNS reported she called the oncologist ' s office and talked with his nurse on 1/10/19. The DNS received a verbal order for the administration of the lenalidomide and a fax with the order. The DNS was uncertain at that time why the facility had not been aware of the need to initiate lenalidomide for Resident #4.

An interview was conducted on 2/15/19 at 4:20 PM with the facility ' s Director of Nursing Services (DNS). During the interview, the DNS was asked what her expectation was in regards to Resident #4 ' s lenalidomide. She responded by stating the facility determined the oncology consult reports were scanned into the electronic medical record before being reviewed by nursing staff, the nurse practitioner, or the physician. The DNS indicated she would have expected the facility to have reviewed this information and known lenalidomide should have been initiated

Operations to assist them with investigating incidents/accidents and ensuring interventions are put into place.

Email alerts will be sent to the Administrator, DNS, Clinical Care Coordinator and Director of Operations when an incident/accident report is opened by the nursing staff.
Administrator will ensure an immediate action is put into place by the nursing staff. IDT members will continue to investigate the incident/accident to determine the root cause and appropriate interventions are put into place and noted on the care plan/Kardex.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained

Corporate staff/designee will be onsite 3-5 days each week for 8 weeks beginning the week of 2/18/19 to provide guidance/education in regards to policies, procedures and regulations to the Administrator, DNS and facility staff.
Administrative visits will be coordinated weekly and documented on the Administrative Weekly Schedule.
Weekly reviews of the med cart, resident right and bed mobility audits will be conducted by the Director of Operations/designee for 6 weeks and then monthly thereafter for 6 months.
Findings will be documented Corporate Verification Audit Checklist.
DNS and ED meetings will be held weekly for 6 weeks with Director of Operations to

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F 835	Continued From page 72 when the medication became available (on 11/5/18). A telephone interview was conducted on 2/16/19 at 12:54 PM with the facility ' s transportation staff member. During the interview, the staff member reported when she previously transported Resident #4 back from an outside consult, she would typically put the consult packet (containing information from the outside consult) on the desk at the nursing station. She reported this process has recently been changed and she has been instructed to now place this packet of information directly in the hands of the nurse on duty to ensure the consult was reviewed. An interview was conducted on 2/16/19 at 12:05 PM with the facility ' s Executive Director (ED). During the interview, the ED ' s expectations regarding the medication concerns identified for Resident #4 were discussed. The ED indicated the goal of all systems in place at the facility was to provide optimal care for the residents. However, he recognized imperfections may be identified in a system. If a problem with the current process was found, interventions needed to be implemented to improve upon the process to better meet the needs of the residents. 2) Resident #6 was admitted to the facility on 1/11/19 with a cumulative diagnoses which included recent surgical repair of a right hip fracture. Review of an Incident Report dated 1/13/19 at 11:20 AM revealed Resident #6 experienced a fall from the bed in his room while receiving a bed bath by a nursing assistant. The resident was transported to the Emergency Department (ED)	F 835	ensure processes and follow-up assignments are understood and carried out per facility protocols and state/federal regulations. Meeting documented on QM with QAPI-Team Discussions sheets. Results of weekly reviews and meetings will be presented to the facility monthly QA committee by the Administrator monthly x3 and then quarterly thereafter, and as needed. All discussions, revisions to plan, and additional in-servicing will be noted in the QA Committee Meeting Minutes. The date the corrective action will be completed is 3/13/19.	

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for evaluation and treatment.

Hospital Emergency Department (ED) records dated 1/13/19 indicated the resident sustained a laceration of the forehead and a closed displaced fracture of the proximal phalanx (the bone closest to the palm of the hand) of the right little finger. The resident was discharged from the ED to the facility on 1/14/19.

A review of the facility ' s follow-up report from the 1/13/19 incident read, "Resident recently admitted to facility. Resident was receiving ADL (Activities of Daily Living) care while position on his side. Resident rolled off bed. Resident sent to ER (Emergency Room) for evaluation related to laceration above right eye and already right femur fracture. Resident will be two person assist when in bed during ADL care."

A review of the facility ' s Communication Log book kept on Resident #6 ' s hall revealed the log documented changes made to a resident ' s Kardex. A Kardex (also known as a Care Guide) is a summary of individual patient needs, which included information for nursing assistants regarding the assistance required to meet the ADL care needs for a resident. A review of the Communication Log book included a sheet for Resident #6 and revealed a change was made on 1/13/19 to indicate the resident required 2-person assist with ADL care. A review of Resident #6 ' s most recent (undated) Kardex read in part, "Resident will be a two person assist with care."

Review of an Incident Report dated 2/7/19 at 12:01 PM revealed Resident #6 experienced a fall from the bed in his room when he was provided incontinence care by one nursing

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assistant. The resident was transported to ED for evaluation and treatment.

Hospital Emergency Department (ED) records dated 2/7/19 indicated the resident had sustained a facial wound from the fall. Resident #6 was treated and discharged back to the facility for continued rehabilitation.

An interview was conducted on 2/13/19 at 4:40 PM with the facility ' s Director of Nursing Services (DNS). During the interview, the Communication Log book from Resident #6 ' s hall was reviewed. The DNS explained a Communication Log book was kept on each hall and was intended to communicate any changes that were made to a resident ' s care plan and electronic Kardex to the nursing staff. The DNS reported that nursing assistants were supposed to review the Communication Log book to see if any changes had been made for their residents. After reviewing a change noted in the log book, staff was supposed to sign the form in the log book to indicate he/she was aware of the change made to the resident ' s care. Review of the form dated 1/13/19 for Resident #6 in the Communication Log book indicated the resident required 2-person assist with ADL care. However, the DNS noted that only two NAs had signed this form as having reviewed the information. The DNS stated the Communication Log Book was the facility ' s communication piece; and, she felt this was where the facility ' s system failed.

A follow-up interview was conducted on 2/15/19 at 4:20 PM with the DNS. During the interview, the DNS was asked how many staff members she would have expected to provide incontinence

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F 835	Continued From page 75 care to Resident #6 on 2/7/19. She responded by stating, "It should have been two like in the Kardex." An interview was conducted on 2/16/19 at 12:05 PM with the facility ' s Executive Director (ED). During the interview, the ED ' s expectations regarding the safe provision of ADL care for resident #6 was discussed. The ED indicated the goal of all systems in place at the facility was to provide optimal care for the residents. However, he recognized imperfections may be identified in a system. If a problem with the current process was found, interventions needed to be implemented to improve upon the process to better meet the needs of the residents.	F 835		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		3/12/19

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§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening

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HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

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F 842	Continued From page 77 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure documentation on a resident ' s Medication Administration Records (MARs) accurately reflected the administration of a medication to 1 of 3 sampled residents (Resident #4) whose medications were reviewed. The findings included: Resident #4 was admitted to the facility on 8/28/17 with re-entry to the facility on 2/21/18. Her cumulative diagnosis included multiple myeloma (a cancer that forms in a type of white blood cell called a plasma cell) not having achieve remission; malignant neoplasm (tumor) of unspecified site of right female breast; and secondary malignant neoplasm of the bone. A review of Resident #4 ' s medical record included a physician ' s order dated 1/10/19 at 3:27 PM which instructed 5 milligrams (mg) lenalidomide be initiated and given as one capsule once daily for 21 days, stopped for 7 days; then the same 28-day cycle repeated. Lenalidomide is an antineoplastic medication used to treat multiple myeloma. A review of Resident #4 ' s January 2019 MAR indicated 5 mg lenalidomide was administered to the resident as scheduled at 5:00 PM on 1/10/19	F 842	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Medication aides documented on the MAR that Resident #4 received the medication from 1/10/19-1/31/19 and 2/7/19 to 2/14/19. Resident #4 had a prescription for 28 pills and 22 pills remained which indicates that patient had not received medication as the medication aides had documented. The attending MD and oncologist was notified by the DNS of dose omission of Revlimid (Lenalidomide) and new orders received from the oncologist to restart 21-day cycle today. Lenalidomide 4mg, one tab by mouth daily for 21 days then hold x 7 days. Then begin 21-day cycle again. Resident received the dose @ 1pm on 2/15/19 @ 1 pm as ordered. Resident's oncologist stated that error did not cause harm yet resident should have received medication as ordered. As of 3/8/19, Nurses will now administer cancer drugs for Resident #4. Medication placed on a controlled substance count sheet and will be counted daily by the	

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to 1/31/19 (representing 22 capsules administered). The resident ' s February 2019 MAR indicated 5 mg lenalidomide was administered to Resident #4 once daily at 5:00 PM on 2/7/19 through 2/13/19 (representing 7 capsules). According to the MARs, a total of 29 lenalidomide capsules were documented as administered to the resident by the following staff members: Med Aide #1 administered 2 capsules; Med Aide #2 administered 20 capsules; Med Aide #3 administered 2 capsules; and Med Aide #4 administered 4 capsules; and Med Aide #5 administered 1 capsule. No doses of lenalidomide were documented on the MAR as having been refused by Resident #4.

A Med Error Report dated 1/31/19 revealed one extra daily dose (22 days versus 21 days) of lenalidomide had been administered to Resident #4 due to a transcription error. The resident ' s physician was notified; no clinical harm was reported.

An observation and interview was conducted on 2/14/19 at 10:10 AM with Med Aide #1. Med Aide #1 was assigned to Resident #4 ' s hall medication cart. At that time, one bottle of lenalidomide labeled as being dispensed from the pharmacy on 11/2/18 for Resident #4 was stored on the med cart. Upon request, Med Aide #1 counted the lenalidomide capsules remaining in the medication bottle. The Med Aide was observed as she poured the capsules out of the original container one at a time (while counting) into two medication cups. One medication cup was counted and contained 9 capsules. The second medication cup was counted and contained 11 capsules. After the capsules had been poured into the two medication cups for

nurses. Any discrepancies will be immediately reported to the DNS. Resident completed 21-day cycle on 3/7/19 as MD ordered.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice

Medication Aides were immediately suspended upon discovery of incident, and misappropriation of property filed with the Nurse Aide Registry

100% of all medication carts were audited by two licensed pharmacists on 2/15/19; pharmacists have counted each prescription against the MAR to ensure the prescription was available and medications were given. Results of the audit were given to the DNS; no further findings or suspected incidences were discovered to indicate inaccurate documentation.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

All licensed nursing staff and medication aides were in-serviced on 2/15/19 on diversion, resident rights, and 6 rights of medication administration with emphasis on not documenting MAR until after the medication is given.
Nurses and med-aides not in-serviced by 2/15/19 will be in-serviced prior to the next

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F 842	Continued From page 79 counting, two additional capsules were observed to be left at the bottom of the original container and were added to the total count. The Med Aide confirmed each count of the medication cups and the capsules remaining in the bottle. It was determined a total of 22 capsules had remained in the medication bottle. Manufacturer labeling on the medication bottle indicated the bottle originally contained 28 capsules. After counting the capsules, Med Aide #1 was observed as she returned all capsules back to the original medication bottle, secured the cap on the bottle, and returned the lenalidomide medication bottle to a drawer on the medication cart. An observation and interview was again conducted on 2/15/19 at 8:35 AM with Med Aide #1. Med Aide #1 was assigned to Resident #4 ' s hall medication cart. At that time, the resident ' s bottle of lenalidomide stored on the med cart was observed. Upon opening the bottle of lenalidomide, only 7 capsules were seen lying on the bottom of the bottle. The 7 capsules were clearly visible and easily counted without removing them from the container. The labeling on the medication bottle was confirmed to be the same as that observed the morning of 2/14/19, and included the resident ' s name and the date dispensed by the pharmacy as 11/2/18. When asked, the Med Aide reported she did not recall the exact number of capsules that were counted from Resident #4 ' s lenalidomide bottle the previous morning. Upon further inquiry, however, Med Aide #1 stated, "It was more." A thorough inspection of all drawers and compartments in the medication cart conducted by Med Aide #1 revealed there were no other bottles of lenalidomide stored on the med cart.	F 842	scheduled shift. Medication Aides in-serviced on Medical Records procedures to include accuracy, completeness of record, and charting properly when a medication is not administered. If any medication is held by the medication aide the nurse be notified. Med aide will verbally report and document on the Daily Medication Aide Report the following: a) resident name b) medication not administered c) reason not administered e) medication aide signature f) nurse signature All med aides not in-serviced on the Medical Records procedures were removed from schedule and will be in-serviced prior to next scheduled shift Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The DNS/designee will review the Medication Aide Report sheets daily x 4 weeks and then bi-weekly x4,, then monthly thereafter to address any medication administration issues. All instances in which a medical record is found to be incomplete, inaccurate, and/or insufficient will be addressed by the DNS, Disciplinary action will be enforced as deemed appropriate by the DNS. Begin 3/7/19 10% of Resident MAR and medications will be audited by the DNS/Designee daily x4 weeks, bi-weekly x4, and then monthly thereafter to ensure medication is given as ordered and as signed by nurses and medication aides. Findings documented	

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F 842	Continued From page 80 An interview was conducted on 2/15/19 at 9:10 AM with the facility ' s Director of Nursing Services (DNS) and Executive Director (ED). During the interview, the count discrepancy for Resident #4 ' s lenalidomide medication from 2/14/19 (22 capsules) to 2/15/19 (7 capsules) was discussed. At the time, 22 capsules of lenalidomide were counted (10:10 AM on 2/14/19), Resident #4 ' s MAR documented the resident had been administered 29 capsules of the medication. However, 22 of the original 28 lenalidomide capsules remained in the medication bottle as of 10:10 AM on 2/14/19, which indicated the resident could have only received a total of 6 lenalidomide capsules. The DNS and ED stated they had not been informed of the 2/14/19 count of lenalidomide. However, the DNS reported a medication audit was conducted the evening of 2/14/19. The DNS reported she observed 7 capsules of lenalidomide were remaining in the bottle at approximately 9:30 PM on 2/14/19. Based on the MAR documentation for this medication, the DNS indicated that she, too, had identified a concern because there should not have been any capsules remaining in the bottle of lenalidomide. The DNS reported the MAR documented that Med Aide #1, Med Aide #2, Med Aide #3 and Med Aide #4 had administered this medication to Resident #4. During the interview, the DNS confirmed the bottle of lenalidomide observed on the medication cart the mornings of 2/14/19 and 2/15/19 was the first and only bottle available for Resident #4 at the facility to date. She reported Resident #4 ' s family member brought in the second bottle of lenalidomide earlier that morning (on 2/15/19), which the DNS still had in her possession. The second bottle of lenalidomide was observed to be sealed (unopened). This	F 842	on the Medication Cart Audit Form. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DNS/designee and monitoring to begin again at the weekly audits until compliance is met. Results of audits will be presented to the facility QA committee by the DNS during monthly x3 and then quarterly thereafter, and as needed. All discussions, revisions to plan, and additional in-servicing will be noted in the QA Committee Meeting Minutes. The Executive Director is responsible for the implementation of this plan. The date the corrective action will be completed is 3/12/19.	

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bottle of medication included labeling with Resident #4 ' s name and a pharmacy dispensed date of 2/4/19.

A telephone interview was conducted on 2/16/19 at 10:30 AM with Med Aide #1 in presence of the DNS and ED. During the interview, the med aide was asked to describe the process used to count Resident #4 ' s lenalidomide on 2/14/19. Med Aide #1 reported the lenalidomide capsules were poured into two different medication cups on top of the med cart as the capsules were counted. When asked if she recalled how many capsules were in the bottle of lenalidomide when they were counted on the morning of 2/14/19, the med aide reported she could not remember. However she added, "But I know it was more than 7." Med Aide #1 was also asked to describe the process she used to administer medications to a resident. The med aide reported she would first pull up the resident ' s profile on the computer, make sure she had the right resident, the right med, right dose, and right route of administration. She would then pull the med from the cart and hold it up against the electronic MAR to ensure the resident ' s name and medication was correct. After she administered the medication to the resident, the med aide reported she would sign off that the resident received the med on the electronic MAR.

A telephone interview was conducted on 2/16/19 at 10:41 AM with Med Aide #2. During the interview, Med Aide #2 was asked to describe the process she used to administer medications to a resident. The med aide reported she would log into the computer, look at the medication and the person receiving it. After she double checked that it was the right medication, she would pop

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the med and put a check on the "prepped" button in the electronic MAR. After she administered the med to the resident, she would record the med was administered on the electronic MAR. If the resident refused the medication, she would record the med as "refused" on the MAR. When asked, Med Aide #2 reported if her initials were on the MAR to indicate a medication was administered, the resident did receive the medication.

A telephone interview was conducted on 2/16/19 at 10:58 AM with Med Aide #3. During the interview, Med Aide #3 was asked to describe the process he used to administer medications to a resident. The med aide reported he would pull up the electronic MAR for the resident; pull the medication from the med cart; double check the name of the resident, the name of the medication and the dose; and then administer the medication to the resident. Once he administered the medication, he would then come back to the cart and record the medication administration on the electronic MAR.

An attempt to conduct a telephone interview with Med Aide #4 was unsuccessful.

An interview was conducted on 2/15/19 at 4:20 PM with the DNS. During the interview, the DNS stated she would have expected the documentation on the Resident #4 ' s MARs to be accurate and for the medication to have been administered to the resident as ordered.