STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING _____ B. WING _____	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF FOREST GLENN	1101 HARTWELL STREET GARNER, NC 27529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 03/11/19 through 03/15/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # E5MJ11.	E 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to place a resident's (Resident #14) call light in reach to allow resident to request staff assistance if needed for 1 of 1 residents reviewed for accommodation of needs. A review of Resident #14's medical record indicated that he was originally admitted to the facility on 02/14/18 with a cumulative diagnosis of Encephalopathy, Cerebral Palsy, Epilepsy, Dysphagia, Dementia with behavioral disturbance and Schizoaffective disorder, Bipolar Type. Record review of the Admission Minimum Data Set (MDS) Assessment for the named resident dated 2/14/18 indicated that he was cognitively intact (BIMS15). A review of the most recent quarterly MDS dated 11/23/19 documented that Resident #14 had no behaviors or rejection of care. He required	F 558	The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is April 12, 2019. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F558 Reasonable Accommodations Needs and Preferences. Corrective Action Resident #14's call light was placed back	4/12/19

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

Electronically Signed | 04/03/2019

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F 558	Continued From page 1 extensive to total dependence of 1 person for bed mobility, dressing, toilet use and personal hygiene, supervision of 1 for eating meals. The MDS indicated that he was incontinent of bowels and bladder and was on a mechanically altered diet, had no weight loss and no dental or skin issues. During an interview with the resident on 03/11/19, 1:35 PM the call light was found on the floor. A staff member came in during the interview, noting that the call light was on the floor. After realizing that the call light was intertwined underneath the bed, she moved the bed from against the wall, threaded it out from underneath the bed and placed it within the resident's reach, giving him instructions to "hold on to this tightly." The resident voiced an understanding. The resident then stated that his call light falls behind the bed a lot of times. The resident was unable to state a reason for why it continues to fall. During an observation on 03/13/19 4:58 pm, the resident's call light was observed on the floor at foot of the resident's bed. During an observation on 03/14/19 at 8:51 AM, the resident's call light was observed on the resident's floor under the bed on the floor between his bed and the bed of his roommate's. The aide was notified and placed it within the resident's reach and obtained a clip for the call light so that it could be secured to his pillow/sheets. On 3/14/19 at 0929, the resident's call light was found on the floor under resident bed at 0929. Again, the aide was notified and placed it within the resident's reach.	F 558	within reach after observation. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. Education will be provided to all staff on making sure call lights are in reach to allow resident to request staff assistance if needed. The Director of Nursing and nurse managers, are conducting audits to ensure call lights are in reach to allow resident to request staff assistance if needed. Systemic Changes The Director of Nursing and/or Nurse manager will educate all staff on making sure call lights are in reach to allow residents to request staff assistance if needed. Monitoring The Director of Nursing, and/or her nurse managers, will perform audits (5) five times weekly for (1) one month and (3) three times weekly for (2) two months, and ongoing random observations to ensure call lights are in reach to allow resident to request staff assistance if needed. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are	

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F 558	Continued From page 2 On 03/11/19 at 1450, Interview with the DON revealed that it was her expectation that every resident would have their call light within their reach. The staff should ensure that each resident has a call bell every time they leave the residents room. 03/15/19 at 5:15 PM An interview with the Administrator revealed that all residents should have their call light within reach.	F 558	carried out.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to accurately assess a resident for behaviors and failed to code a resident receiving Hospice services for 1 of 1 residents (Resident #22) reviewed for Hospice care. The findings included: 1. Resident #22 was initially admitted to the facility 04/06/09 with diagnosis of Type II Diabetes, Psychosis, Anxiety and Heart failure. Resident #22 was re-admitted on 05/24/18 following a hospital stay. Review of the quarterly MDS dated 02/11/19 revealed severely impaired cognition with no psychosis, no behaviors and no rejection of care. Review of that care plan dated 3/4/2019 indicated a focus in the resident's noncompliance related to	F 641	F641 Accuracy of Assessments Corrective Action Educate staff on documentation of behaviors in Point Click Care's (PCC) Point of Care behavior tab. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. Education will be provided to all licensed nurses and Certified Nursing Assistants (CNA) to record all behaviors in the facility's Electronic Medical Record (EMR) Point Click Care's (PCC) Point of Care behavior tab by 4/12/2019. Education will be provided to all other staff that witness behaviors happening in the facility, to let	4/12/19

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F 641	Continued From page 3 diet, thickened liquids, allow to be in low position due to falls, ask for assistance at times, and attempts to self-transfer. The care plan further stated that the resident likes to place himself on the floor and doesn't want the staff to get him up at times. "He can be combative with staff." Interventions include encouragement to follow diabetic diet; instruct related to adverse effects of his choices and re-approach at a later time. A review of the Medication Administration Record revealed that Resident #22 was administered and Ativan 1mg, ordered as needed (prn) for agitation on 18 of 31 days during the month of Jan; 7 of 28 days in Feb and a daily dose of Ativan 0.5 mg, ordered prn, was administered daily for agitation from March 1 through 13, 2019. A review of nursing notes revealed a note dated 5/9/18, where the resident "threw himself onto the floor out of the wheelchair and refused to allow staff to check vitals. Resident #22 continued to be combative with ER staff who had to restrain and sedate the resident. A review of nursing notes further revealed a note dated 5/18/18 that documented the resident becoming very agitated as he was attempting to exit the facility. When staff intervened, Resident #22 began kicking at the staff and the medication cart and became verbally abusive to staff members. A review of the monthly behavior data and Analysis reports from November 2018 through March 2019 revealed no documented behaviors for Resident #22 except for 1 isolated incident on December 6, 2018.	F 641	the nurse know of the behavior so that they can accurately update the PCC Point of Care behavior section by 4/12/2019. An audit will be done on 4/5/2019 of all residents that are coded on MDS to have behaviors has been done. All variances have been changed and the MDS has been updated. Systemic Changes MDS Coordinator to check behind Social Worker for documented behaviors in section E to ensure it was coded accurately. Monitoring The MDS Coordinator and/or Administrative Nurses will do a 100% audit on behaviors for residents. All new admissions and re-admissions will be reviewed for behaviors. The MDS and care plans will be reviewed for these guests to ensure accuracy of coding and care planning. Audits will include 100% for (1) one week, 50% for (2) two weeks, and 25% for (2) two weeks, then once a quarter for (1) one quarter. Results of the audit will be reported to the Regional Clinical Resource Specialist and communicated to the Director of Nursing. The Director of Nursing will report any variances to the Quality Assurance committee during the monthly meeting. Continued monitoring will occur through routine chart audits by the Regional Clinical resource specialist and communicated to the Director of Nursing.	

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F 641	Continued From page 4	F 641		

A review of Social Worker notes dated 02/11/19 documented that Resident #22 has a history of Depression with psychosis and is being followed by Mental Health management and Behavior Management.

The social worker was interviewed on 03/13/19 at 11:00 AM, she states that she was aware of the resident's behaviors but when assessing the resident for behaviors for purposes of completing the MDS, she strictly reviews monthly behavior documentation tool to review the resident's behaviors as documented by the staff. She states that she does not interview the staff.

During an interview on 3/12/19 at 12:47 PM with the assigned day aide #1, he stated that the resident can be agitated easily and has been aggressive and physical; he states that the resident has been known to throw himself out of the chair and bed as recently as a couple of weeks ago.

During an interview with the DON on 3/13/19 at 11:50 AM and she stated that the resident exhibits behaviors "all the time." He has been known to throw himself from the bed and the wheelchair onto the floor and not allow the staff to get him up. Facility staff felt that a low bed with mat was the safest position possible for this resident and he is care planned effectively. She further stated that it is her expectation that all residents will be accurately coded according to state/federal guidelines.

On 03/15/19 at 6:30 PM, the Administrator stated that his expectation is that each resident would be accurately coded on the MDS.

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F 641	Continued From page 5	F 641		

2. Resident #22 was initially admitted to the facility 04/06/09 with diagnosis of Type II Diabetes, Psychosis, Anxiety and Heart failure. Resident #22 was re-admitted on 05/24/18 following a hospital stay.

On 6/5/18, the resident elected his Hospice benefit due to his continued physical and mental decline and diagnosis of Bladder Cancer.

Review of Resident #22's Significant Change Minimum Data Set (MDS) dated 06/06/18, revealed an assessment of severely impaired cognition with no psychosis, The resident required extensive assistance of 1 person with Activities of Daily Living (ADLs) and supervision of 1 person for eating. No swallowing disorders were documented on that assessment. Resident required a mechanically altered therapeutic diet. No hospice care services were indicated on that assessment.

Review of the Quarterly MDS dated 12/6/18 revealed No hospice care services were indicated on that assessment. Review of Resident #22's care plan dated 03/04/19 revealed Resident #22 was receiving Hospice related to diagnosis of Cancer, Vascular Dementia and Chronic Obstructive Pulmonary Disease (COPD). The care plan documented interventions to administer medication and treatments as ordered; coordinate with hospice to provide equipment; assist with hygiene activities as needed; assistance with fluids, provision of medications, physician notification of abnormal findings and refer to hospice plan of care.

A review of progress notes revealed Hospice

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F 641	Continued From page 6 nursing visits for 03/06/19 and 03/11/19. A review of nursing notes revealed note dated 1/4/19 stating "Attending MD and Hospice in Agreement to keep Ativan on hand due to the sporadic and extreme level of agitation with combative behaviors guest has historically experienced." During an interview with the DON on 3/13/19 at 11:50 AM and she stated that the resident was on hospice and that it is her expectation that all residents will be accurately coded according to state/federal guidelines. On 03/15/19 at 6:30 PM, the Administrator stated that his expectation is that each resident would be accurately coded on the MDS.	F 641		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		4/12/19

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F 761	Continued From page 7 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and manufacturer's information, the facility failed to maintain the manufacturer's temperature storage parameters of the refrigerator for Procrit, Lumigan eye drops, Risperdal Consta Injections, Multivitamin injections and Multiple Insulins in 1 (100 hall) of 2 medication rooms. Findings included: Review of the manufacturer's storage parameters are as follows: 1) Procrit 10,000 units vial-The packaging insert indicated to store between 36-46 degrees F. Do not freeze. 2) Lumigan eye drops. The packaging insert indicated to store between 36-77 degrees F. 3) Risperdal Consta Injections. The packaging insert indicated to store between 36-46 degrees F. 4) MVI-13 Adult Infuvite Multivitamins The packaging insert indicated to store between 36-46 degrees F. 5) Humalog U-100 Kwik pens. The packaging insert indicated to store between 36-46 degrees F. 6) 70/30 Kwik Pens. The packaging insert indicated to store between 36-46 degrees F. 7) Humulin 100 Kwik pen. The packaging insert indicated to store between 36-46 degrees F.	F 761	F761 Label/Store Drugs and Biologicals Corrective Action All 10 identified medications were returned to pharmacy for disposal and replaced on 03-16-2019. Temperature was adjusted to obtain desired temperature in the range of 36 degrees to 46 degrees. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. Pharmacy representative to educated licensed nurses on appropriate temperature range and educated them on action to be taken if outside a desired range 36 degrees to 46 degrees. The Director of Nursing and nurse managers, are conducting audits to ensure desired temperature of 36 degrees to 46 degrees is met. Systemic Changes Pharmacy representative to educated	

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F 761	Continued From page 8 8) Levemir Flex Pens. The packaging insert indicated to store between 36-46 degrees F. 9) Lantus Solostar pens. The packaging insert indicated to store between 36-46 degrees F. 10) Humulin R multidose vials. The packaging insert indicated to store between 36-46 degrees F. Review of the facility's policy for "Refrigerator Temperature Records" for Medication Refrigerators states that 1) the Medication refrigerator and freezer temperatures are to be checked at least twice daily and 2) the acceptable range for medication refrigerators is 33-35 degrees F. If the refrigerator and/or freezer temperature does not fall in the acceptable range, adjust the refrigerator thermostat and re-check the temperature in 30-60 minutes. If temperatures do not return to the acceptable range, report it immediately to the Maintenance Director or his/her designee. Review of the facility's "Nursing Refrigerator Temperature Log" indicates that the acceptable range for refrigerator temperature is 35-45 degrees. On 03/14/19 12:46 PM the100-hall medication room was observed with Nurse #1. An observation made of the refrigerator thermometer revealed a thermostat reading of 32 degrees. The medication refrigerator log showed the following morning (am) temperature recordings for March 2019: 1) 3/1/19 No temperature recorded 2) 3/2/19 34 degrees 3) 3/3/19 36 degrees	F 761	licensed nurses on appropriate temperature range and educated them on action to be taken if outside a desired range 36 degrees to 46 degrees. Monitoring The Director of Nursing, and/or her nurse managers, will perform audits (5) five times weekly for (1) one month and (3) three times weekly for (2) two months, and ongoing random observations to ensure desired temperature of 36 degrees to 46 degrees is met. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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F 761	Continued From page 9	F 761		

4) 3/4/19 35 degrees
5) 3/5/19 30 degrees
6) 3/6/19 36 degrees
7) 3/7/19 34 degrees
8) 3/8/19 36 degrees
9) 3/9/19 34 degrees
10) 3/10/19 30 degrees
11) 3/11/19 34 degrees
12) 3/12/19 32 degrees
13) 3/13/19 No temperature recorded
14) 3/14/19 32 degrees

The 100-hall medication room logs for February further reveal missing am temperature readings for 2/1, 2/3, 2/11, 2/13, 2/16, 2/24, 2/27, and 2/28. Of the readings recorded, 9 temperatures are documented as 32 degrees or below and another 7 of them are outside of the acceptable range of 35-45 degrees required by the facility's policy. There are no evening (pm) temperatures recorded for the month of February 2019.

The medication refrigerator on 100-hall was observed with the following medications:

1) 1-Procrit 10,000 units vial
2) 2-Lumigan eye drops
3) 2-Boxes of Risperdal Consta Injections
4) 2-MVI-13 Adult Infuvite Multivitamin vials
5) 6-Humalog U-100 Kwik pens
6) 2-70/30 Kwik Pen
7) 1-Humulin 100 Kwik pen
8) 3-Levemir Flex Pens
9) 5-Lantus Solostar pens
10) 2-Humulin R multidose vials

During an interview with Nurse #1, who works first shift, she stated that it is the responsibility of

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night and evening shift nurses to check and document the refrigerator temperatures. Most medications housed in the refrigerator serve as back-up medications for the residents on the 100-hall as well as overflow medications for residents on the 200-hall. Overflow medications generally consist of any medications that will not fit in the 200-hall refrigerator due to size, such as TPN

Interview with Nurse #2, who works the night shift, stated that it is her responsibility to check the 100-hall refrigerator and document on the log. She was unable to recall the acceptable range but stated that if the reading on the refrigerator was out of range, she would adjust the refrigerator thermostat and if that did not work then notify her supervisor. She does not recall the temperature of 100 hall refrigerator being out of range.

During an Interview with Assistant Director of Nursing (ADON), she stated that the night nurse reads and records the am temperatures and then and after lunch she has been the one responsible for entering the evening temperatures on the refrigerator log for the 100 hall refrigerator Mon-Fri. At the end of the month, the staff bring the completed logs and place them in the DON's box. She stated that she reviews them just to make sure everything is filled in and then files them in a folder in her office. She stated that some of the staff have a hard time reading the thermometers or don't know how to read them. She further stated that if the logs were out of range and could not be adjusted using the thermometer, she would contact someone to come and fix the refrigerator.

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F 761	Continued From page 11 Interview with Maintenance Director stated that he was not made aware of inaccurate temp readings for any medication refrigerators and had he known he would have investigated it. The DON stated that she was not aware of any issues with the medication refrigerator on the 100-hall. She further stated that her expectation is that the refrigerator temperatures would be recorded correctly and if readings were out of range, maintenance would be notified. The Administrator stated that his expectation is that the refrigerators would be checked per facility policy and if not operating properly, it would be reported for maintenance.	F 761		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet	F 849		4/12/19

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professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice

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representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible

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for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.

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F 849	Continued From page 15 (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observations, staff and hospice nurse interviews and record review, the facility failed to coordinate care with Hospice when a resident had a change in condition and failed to change the route of a medication to timely treat an elevated temperature for 1 of 1 resident (Resident #22) being reviewed for Hospice services. The findings included: . A review of the written agreement between the facility and Hospice services dated 01/01/19 stated that the facility will communicate and collaborate with the hospice regarding changes in the resident's condition. Resident #22 was initially admitted to the facility 04/06/09 with diagnosis of Type II Diabetes,	F 849	F849 Hospice Services Corrective Action Hospice was notified of Resident #22's change and condition on 03-14-2019. Corrective Action for those having the potential to be affected All residents have the potential to be affected by this alleged deficient practice. Education will be provided to all licensed nurses on notifying Hospice of any changes in condition that occur. Education will be provided on recognizing when there needs to be a change in route for a medication to timely treat. The Director of Nursing and nurse managers,	

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F 849	Continued From page 16 Psychosis, Anxiety and Heart failure. Resident #22 was re-admitted on 05/24/18 following a hospital stay. On 6/5/18, the resident elected his Hospice benefit due to his continued physical and mental decline and Bladder Cancer. Review of Resident #22's Significant Change Minimum Data Set (MDS) dated 06/06/18, revealed an assessment of severely impaired cognition with no psychosis, but does display physical and verbal behaviors and rejection of care 1-3 days. The resident required extensive assistance of 1 person with Activities of Daily Living (ADLs) and supervision of 1 person for eating. No swallowing disorders were documented on that assessment. Resident required a mechanically altered therapeutic diet. No hospice care services were indicated on that assessment. Review of Resident #22's care plan dated 03/04/19 revealed Resident #22 was receiving Hospice services coordinated with the assistance of Heartland Hospice related to Dx of Cancer, Vascular Dementia and Chronic Obstructive Pulmonary Disease (COPD). The care plan did not indicate which specific hospice services received by Resident #22. This care plan documented interventions to administer medication and treatments as ordered; coordinate with hospice to provide equipment; assistance provision of medications, physician notification of abnormal findings and to refer to hospice plan of care. Review of the MAR revealed Morphine Sulfate (MS) 0.25 mg ordered 02/25/19 was first initiated on 3/13/19 at 11:39 PM.	F 849	are conducting audits to ensure notifications are done and in a timely manner, and that the appropriate medication and route it was given. Systemic Changes The Director of Nursing and/or Nurse manager will educate all licensed nursing on notifying Hospice of any changes in condition that occur, and recognizing when there needs to be a change in route for a medication to timely treat. Monitoring The Director of Nursing, and/or her nurse managers, will perform audits (5) five times weekly for (1) one month and (3) three times weekly for (2) two months, and ongoing random observations to ensure staff are notifying Hospice of any changes in condition that occur, and they recognizing when there needs to be a change in route for a medication to timely treat. Results of the audits will be reviewed at the monthly Quality Assurance Committee meeting for any further recommendations. The Administrator will be responsible to ensure any further recommendations are carried out.	

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Review of the MAR revealed that Levsin 0.125 mg ordered 02/25/19 was first initiated on 03/13/19 at 11:43 PM.

Nurse #2 was interviewed on 03/14/19 at 5:59 PM. She stated just before midnight, the resident #22 began experiencing SOB and breathing heavily and agitated. At 11:39 PM, she she administered prn MS for SOB and prn Levsin for drooling. She also stated that she initiated O2 at 2L/NC. She further stated that she did not notify Hospice services or the physician.

Review of physician's orders revealed an order dated 10/19/17 for Tylenol Extra Strength Tablet 500 mg; give 2 tablets by mouth two times a day for pain.

Review of the Medication Administration Record (MAR) revealed that on 03/14/19, the 9 am dose Tylenol Extra Strength Tablet 500 mg was held due to the resident's inability to swallow.

Review of Resident #22's physician's orders revealed an order dated 3/14/19 for Acetaminophen Suppository 650 mg, insert 1 suppository rectally every 4 hours as needed for General Discomfort.

On 03/14/19 at 9:06 AM, the nurse was at the bedside of the resident attempting vital signs. Resident #22 was observed non-responsive; eyes were glazed over, and the resident's pillow and gown were saturated with perspiration. Audible coarse lungs sounds were noted on inspiration and expiration.

During an interview with nurse #3 on 03/14/19 at 09:55 AM, he stated that upon his morning

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assessment of resident #22, he noted that the resident was wet and clammy. He reviewed his vital signs which were BP 118/66, 139 HR, Temperature 103.4, Resp 28; O2 sat @ 90%. The resident was unable to tolerate any oral medications and was not able to take any food or drink by mouth. He reported his findings to the unit manager and facility NP. He stated he had contacted Hospice who planned a visit today. He further stated that he was aware of the resident's elevated temperature but was waiting for the Hospice nurse, who would visit shortly.

Later, during an interview with nurse #3, on 03/14/19 at 2:33 PM, Nurse #3 stated that he had spoken again with the Hospice nurse via phone but failed address problems with the route of the oral medications for his temperature. He stated that the hospice nurse decided not to visit today. He further stated had not yet treated Resident #22's elevated temperature as the resident was still unable to take the ordered Tylenol by mouth.

During an interview on 03/15/19 11:23 AM with the facility's Nurse Practitioner (NP), she stated yesterday morning, she was notified by nurse #3 of Resident #22's elevated temperature. She informed nurse #3 to give him Tylenol per the Hospice orders. She was not aware of the route of the Tylenol, but assumed it was appropriate. Later that same afternoon, between 2-3 pm, she was approached again by nurse #3, who informed her that the route of the Tylenol was not appropriate for the resident as he could not swallow. It was then that she gave an order to address the route of administration for the Tylenol. She states that when a resident is on Hospice, the facility physician's will normally not get involved unless there is an emergency

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because we don't like to have too many hands involved.

On 03/15/19, at 2:20 pm, during an interview with Hospice Nurse, she stated on 03/14/19 around 11:40 AM, nurse #3 called her stating Resident #22's oral medications were being held due to his difficulty swallowing his morning medication. Nurse #3 also indicated that Resident #22 had an elevated temperature. Around 2:46 pm, nurse #3 called her back to obtain new orders to increase O2 settings. She stated that she was unaware of the need for a route change for the Tylenol order. After speaking with Nurse #3, she decided that a nursing visit was no longer warranted because she had ensured the facility staff had what they needed. She stated that it was her responsibility to work closely with the facility's staff, but it is her expectation that the facility nurse call with any change in resident's condition or if there is a question/concern or a need for a change in the route of medication.

Interview with the Director of Nursing (DON) was conducted 03/15/19 at 11:00 am. She states that when a Hospice resident has a change in condition, it is expected that they initiate a change in condition assessment and notify the physician, Hospice and responsible party. She further stated that she would expect the nurse to contact the hospice nurse or physician to receive or clarify orders.

The Administrator at 03/15/19 @ 3:45 pm stated that his expectations are that when there is a change in a Hospice resident's condition, the physician and Hospice nurse would be notified by the nurse.