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F 000	INITIAL COMMENTS The Division of Health Service Regulation, Nursing Home Section conducted an onsite complaint investigation. The survey team exited on 07/24/19. There were 50 allegations and 7 of the allegations were substantiated. Additional information was obtained and on 08/08/19 the survey team re-entered the facility and investigated seven additional complaint allegations. The exit date was changed to 08/08/19. A total of 57 allegations were investigated and 9 were substantiated. Substandard Quality of Care was identified at: CFR 483.25 at tag F 697 scope and severity H. An extended survey was conducted.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		8/27/19

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

Electronically Signed | 08/27/2019

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F 580	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, interview with the nurse practitioner and record review the facility failed to notify the attending physician or nurse practitioner when a resident with diabetes mellitus experienced hyperglycemia and had no order for insulin on the Medication Administration Record for 11 days.	F 580	This plan of constitutes our written plan of compliance for deficiencies cited; however, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements	

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F 580	Continued From page 2 This was evident in 1 of 3 residents reviewed for significant medication errors (Resident #10). Findings included: Resident #10 was admitted to the facility on 07/13/19 with diagnoses that included diabetes mellitus, osteoarthritis and left knee replacement. Review of the admission nursing assessment dated 07/13/19 revealed Resident #10 was cognitively intact and required one-person assistance with most activities of daily living (ADL). Resident #10 was noted to have a diagnosis of diabetes. The assessment revealed Nurse #1 noted there were no issues noted with Resident #10's physician orders. Review of Resident #10's discharge medication reconciliation from the hospital dated 07/13/19 revealed an order for Insulin syringe needle u-100 units to be resumed at discharge. Review of Resident #10's Medication Administration Record (MAR) dated July 2019 revealed an order initiated on 07/15/19 which read to obtain Resident #10's blood glucose level before meals and at bedtime. The review revealed Resident #10's glucose ranged in the 200-300's during 7 of the 9 days checked reaching a max glucose level of 365. The review revealed no orders for insulin on Resident #10's MAR. On 07/24/19 at 4:00 PM an interview was conducted with Nurse #8. Nurse #8 stated she had admitted Resident #10 on 07/13/19. She stated proper protocol for completing admissions included obtaining the medication orders from the	F 580	established by state and federal law. Resident #10 no longer resides in facility. To identify other residents who have the potential to be affected, all residents that have orders or finger stick blood glucose checks are at risk for this deficient practice. Therefor on 7/25/2019 an audit of all residents receiving blood glucose checks were completed for the last 7 days. Any blood sugars outside of parameters were provided to the medical provider for follow up. To prevent this from re-occurring, beginning on 7/25/19 Director of Nursing and Assistant Director of Nursing started education to licensed staff responsible for physician notification on the requirement of notifying the medical provider of blood glucose levels outside of the ordered parameters and the process for transcription of orders. Education will be completed on or before 8/27/2019. Newly hired staff will receive this same training. To monitor and maintain ongoing compliance, beginning 8/12/19, the Director of Nursing or designee will observe 5 residents per week for 12 weeks to ensure that blood glucose values outside of ordered parameters have been provided to medical provider. Any identified concerns will be addressed. The monitoring will be placed on the audit tool by the DON. The results of the audits will be forwarded	

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F 580	Continued From page 3 hospital and entering them into the computer system. She stated she put all of Resident #10's orders into the system except her insulin order which needed clarification from the Nurse Practitioner (NP). Nurse #8 stated Resident #10 was admitted during shift change and she had given report to Nurse #3. She stated she highlighted the insulin orders and asked Nurse #3 to notify the NP of the need for clarification regarding Resident #10's orders. On 07/24/19 at 3:30 PM an interview was attempted with Nurse #3 with no success. The facility also attempted to contact Nurse #3 with no success. On 7/24/19 at 3:10 PM an interview was conducted with Resident #10. Resident #10 stated she had been in the facility for two weeks following a left knee replacement. She stated she had been a diabetic for 22 years, receiving insulin injections while at home and in the hospital. Resident #10 stated at home she liked to maintain her glucose below 120. The interview revealed she had not received an insulin injection since she had been admitted into the facility on 07/13/19. Resident #10 stated the nurses had been monitoring her glucose 4 times daily but when her glucose reading was high, she did not receive any insulin or hear anything else about it. The interview revealed Resident #10 did not want to question the facilities nursing care. On 07/24/19 at 10:07 AM an interview was conducted with the Director of Nursing (DON). The DON stated based on the MAR Resident #10 hadn't received insulin during the 11 days she had been in the facility. The interview revealed his expectations were for the nurses to take the	F 580	to the facility QAPI committee by the DON for further review and recommendations for the duration of the audits. Director of Nursing is responsible for compliance. The date of compliance is 8/27/2019.	

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F 580	Continued From page 4 orders from the hospital discharge summary and enter them into the MAR. He stated if there were questions regarding a medication the NP should be notified to receive clarification. The DON stated if a resident's glucose was consistently elevated the NP should be notified. On 07/24/19 at 10:00 AM an interview was conducted with the Nurse Practitioner (NP). She stated today was her first day evaluating Resident #10 and had noticed her elevated glucose with no insulin orders. The interview revealed she hadn't received any notification from the nurses of an issue with Resident #10's blood sugars or insulin orders. The NP stated her expectation was for the nurses to contact her and receive clarification on what to do for an elevated glucose level or questions with insulin orders.	F 580		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, family, staff, Nurse Practitioner (NP), and Medical Doctor (MD) interviews, the facility failed to perform finger stick blood sugar (FSBS) testing and administer sliding scale insulin (SSI) for a resident (Resident #1) and failed to administer medications as ordered by the physician for one resident (Residents #2). This affected 2 of 3 residents reviewed for unnecessary medications.	F 658	Resident #1 no longer resides in the facility. Resident #2 had medications delivered on 6/12/2019 and administered as ordered after delivery. To identify other residents who have the potential to be affected, on 7/24/2019, a review of the last 7 days of admissions had been reviewed and corrections made for current residents. A review of all	8/27/19

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F 658	Continued From page 5 Findings included: 1. Resident #1 was readmitted to the facility on 07/01/19 with diagnoses which included quadriplegia, neurogenic bladder and diabetes mellitus among others. He was discharged home on 07/21/19 with a family member after 20 days of rehab. Review of the hospital discharge summary dated 07/01/19 read in part: "Current Discharge Medication List" Continue these medications which have CHANGED" Insulin glargine (Basaglar Kwikpen U-100 Insulin) 100 units/milliliter (ml) (3 ml) Injection - inject 20 units into skin daily "Continue these medications which have NOT CHANGED" Insulin aspart U-100 (NOVOLOG) 100 unit/ml injection - 4-6 units daily with meals and nightly. Sliding scale: 0-200 = 0 units, 201-300 = 4 units, 301-400 = 6 units, 401-999 = 10 units and call provider. Review of the physician's orders at the facility dated 07/01/19 revealed the following: Basaglar KwikPen Solution Pen -Injector 100 unit/ml (insulin Glargine) inject 20 units subcutaneously one time a day for diabetes mellitus (DM) II (start date: 07/02/19 at 8:00 AM) HumaLog 100 unit/1 ml vial Insulin Inject as per sliding scale: 0-200 = 0, 201-300 = 4, 301-400 = 6, 401-999 = 10 call provider, subcutaneously before meals for DM II (start date: 07/02/19 at 12:00 noon).	F 658	current residents was completed on 7/25/2019 to ensure all medications were available for administration. Resident #1 no longer resides in the facility. Resident #2 medication was delivered on 6/12 and was administered as ordered after delivery. To identify other residents who have the potential to be affected, on 7/24/19, a review of last 7days of admissions have been reviewed and any corrections made for current residents. Review of all current residents to ensure all medications are available was completed 7/25/19. To prevent this from recurring, beginning on 7/24/19, the Director of Nursing and Assistant Director of Nursing started education to all nurses on transcription of orders, and ensuring all medications are available to administer as ordered. Education will be completed on or before 8/27/2019. New hires will have this same education. Progress notes will be reviewed along with medication availability during morning clinical meeting to identify any concerns with medication availability. This monitoring will begin 8/26/2019. To monitor and maintain ongoing compliance, the Director of Nursing or designee will review 10 resident medication administration records for accuracy and completeness weekly for 12 weeks. The Director of Nursing or	

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F 658	Continued From page 6 Resident #1's most recent admission Minimum Data Set (MDS) dated 07/08/19 specified the resident's cognition was intact, he required extensive assistance with most activities of daily living (ADL) and he received insulin injections daily. Review of a physician's order dated 07/11/19 revealed the following: HumaLog Solution 100 units/ml insulin - inject as per sliding scale: 0-200 = 0, 201-300 = 4, 301-400 = 6, 401-999 = 10 call provider, subcutaneously at bedtime for DM II (start date: 07/11/19 at 8:00 PM) On 7/22/19 at 11:08 AM an interview was conducted with Resident #1's family member. She stated she and Resident #1 had complained since admission on 07/01/19 that his blood sugars were not being tested at night and he was going from before supper to the next morning without his blood sugar being tested and without him getting insulin. The family member stated they finally got a nurse to listen to them after he had already been there for 10 days and she got the orders changed so he was tested at bedtime as well. She stated they also changed his long acting insulin to be given in the evening instead of the morning. On 07/24/19 at 4:20 PM an interview was conducted with Nurse #4. She stated she remembered his nurse (could not recall name) was having issues with he and his family member about his blood sugars and sliding scale insulin not being done at bedtime. Nurse #4 said she went back to his record and looked at the discharge summary from the hospital and stated they had in fact been doing it wrong. She stated	F 658	designee will review each new admission for medication reconciliation accuracy for 12 weeks. Any discrepancies will be corrected. The results of the audits will be forwarded to the facility QAPI committee by the DON for further review and recommendations for the duration of the auditing. The facility Director of Nursing is responsible for compliance. The date of compliance is 8/27/2019.	

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the blood sugar checks and sliding scale insulin at bedtime had been omitted from the original order. Nurse #4 stated she contacted the Nurse Practitioner (NP) and clarified the order with her and wrote the order for Resident #1 to have his blood sugar checked at bedtime and have sliding scale insulin given per the orders. She stated she then explained to Resident #1 and his family member that it was an oversight and had been corrected.

On 07/24/19 at 4:30 PM the Director of Nursing (DON) was interviewed and stated the error should have been caught by the nurses and/or the pharmacy. He stated he was not sure what had happened with the order but would trace the steps back and find out where the error occurred, so it would not happen again. The DON added they were going to be looking into issues with the pharmacy as well. He stated it was his expectation that medications be given as prescribed by the physician.

On 07/25/19 at 11:56 AM a phone interview with the Nurse Practitioner (NP) was conducted. The NP indicated she had been called about clarifying an order on Resident #1's blood sugars and sliding scale insulin and stated she had verified the order for the nurses to do them before meals and at bedtime. The NP stated she was unsure what happened with the original order but stated in talking with the Medical Director (MD) they had discovered some issues with the pharmacy and was unsure if this issue was related.

On 07/23/19 at 1:40 PM an interview was conducted with the Medical Director (MD) regarding Resident #1's insulin orders. The MD stated when the resident was admitted to the

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facility his discharge orders from the hospital indicated he was on long acting insulin twice daily. She stated once the wife expressed concerns and the staff brought it to the attention of the Nurse Practitioner (NP) she changed his orders so that he was on FSBS and sliding scale insulin before meals and at bedtime. The MD stated for residents on sliding scale insulin and long acting insulin if their blood sugar was over 400 she would expect the nurse to give the insulin per sliding scale and put a note in the communication book to the physician. She stated it would not be necessary to call the physician. The MD went on to say that she and the staff had discovered some issues with the pharmacy services not getting medications to the facility in a timely manner and stated she and the staff were working to resolve those issues. The MD said she recalled talking with Resident #1 and his family member several times and thought all their concerns had been addressed.

2. Resident #2 was admitted to the facility on 05/25/19 with diagnoses that included psychosis and hyperlipidemia among others.

A physician's order dated 05/25/19 specified Resident #2 was to have 1 mg (milligram) of Risperdal (antipsychotic) by mouth every night for psychosis and 40 mg of Simvastatin (lipid-lowering medication).

The most recent Minimum Data Set (MDS) dated 06/01/19 specified the resident's cognition was intact, no behaviors were exhibited, and she received an antipsychotic medication daily.

Review of Resident #2's Medication Administration Record (MAR) for June 2019

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revealed on 06/19/19 and 06/20/19 Risperdal and Simvastatin were not administered to the resident.

A nurse's entry dated 06/19/19 made by Nurse #7 specified the nurse was waiting on pharmacy to deliver the Risperdal and Simvastatin.

Further review of the medical record revealed there was no documentation for 06/20/19 to explain why Risperdal and Simvastatin were not administered to Resident #2.

On 07/21/19 at 4:06 PM Resident #2 was interviewed in her room and reported that her medications "were all messed up." Resident #2 explained that one time she had to go two or three days without her Risperdal and Simvastatin because a nurse forgot to reorder the medication. Resident #2 stated that she started to get anxious because she had missed the medication.

On 07/26/19 at 4:26 PM Nurse #7 was interviewed and explained the process for reordering medications, stating that scheduled medications should be reordered 1 to 2 days in advance. She added that medications could be reordered using the electronic system to send a request to the pharmacy by a certain time. And then, she added if it was after hours, she could fax a request or call the pharmacy. Nurse #7 was not certain of the time she had to have a refill request in to the pharmacy to have the medication the same day. Nurse #7 stated that medications were delivered twice daily to the facility, a small run was made at lunch and then a large batch of medications were delivered around midnight.

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In the same interview, Nurse #7 recalled the incident when Resident #7 did not have Risperdal and Simvastatin available. Nurse #7 explained that when she went to give the medications, there were none. Nurse #7 stated that the medications had not been reordered by a previous unknown nurse. She added that she completed an online refill request sometime in the evening and waited for the medication to be delivered with the midnight medication run. She stated the Risperdal and Simvastatin were not delivered at midnight and were not given to Resident #2 on 06/19/19. Nurse #7 reported that she checked for the medications in the Omnicell (a backup medication dispensing system) but there was none. Nurse #7 explained that on 06/20/19, she made a second pharmacy request by calling the pharmacy, but the medication was not delivered on 06/20/19 and was not given either because the request was not made in time to have the medication on hand on 06/20/19.

On 07/22/19 at 9:40 AM the physician was interviewed and stated she would expect nursing to follow protocol for reordering medications. The physician added that Risperdal was an important medication for Resident #2 but missing the Simvastatin was no big deal.

On 07/22/19 at 11:20 AM the consultant pharmacist was interviewed on the telephone and stated she would investigate the reorder request for Risperdal and Simvastatin to determine why the medications were not available on 06/19/19 or 06/20/19. The consultant pharmacist did not call the State Agency with her findings but notified the interim Director of Nursing.

On 07/22/19 at 5:00 PM the interim Director of

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F 658	Continued From page 11 Nursing reported that the consultant pharmacist stated the reorder request was made after hours for same day delivery on 06/19/19. On 07/23/19 at 2:09 PM the interim Director of Nursing (DON) was interviewed and stated that medications should be reordered 1 to 2 days prior to running out. He stated that if a medication was not available the nurses had access to a backup medication dispense system. He added that if a medication was still unavailable then he would expect a nurse to communicate with someone in nursing leadership to handle the situation. The DON stated that the nurse did not do enough to obtain the medication for Resident #2.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interviews, the facility failed to provide care and grooming of a resident's hair for 1 of 3 dependent residents reviewed for activities of daily living (ADL) (Resident #8). Findings included: Resident #8 was admitted to the facility on 06/11/19 with diagnoses which included muscle weakness, pressure ulcer left heel and posterior calf - unstageable, pressure ulcer right heel and posterior calf - unstageable and stage III pressure ulcer of sacrum.	F 677	Hair care was provided to Resident #8 on 7/25/19 per his request. To identify other residents who have the potential to be affected, on 7/26/19, the clinical managers completed an audit of all residents to ensure that no resident was in need of grooming care. Any grooming needs were corrected. To prevent this from re-ocurring, beginning on 7/25/19, the Director of Nursing and Assistant Director of Nursing, started in-servicing the nurses and aides	8/27/19

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F 677	Continued From page 12 A review of Resident #8's quarterly Minimum Data Set (MDS) dated 06/18/19 revealed he was cognitively intact for daily decision making and required extensive assistance with all activities of daily living (ADL) except eating. The resident was frequently incontinent of urine and always incontinent of bowel. A review of his care plan dated 06/18/19 revealed he was care planned for actual self-care deficit. The goal was the resident will have ADL met daily through the next review date. The interventions included: bathing/hygiene with assist of 1 staff with total assistance, dressing/grooming with assist of 1 staff with total assistance, eating with assist of 1 staff, toileting with assist of 1 staff total assistance with bedpan and urinal and transfer with assist of 2 staff total lift due to non-ambulatory and non-weight bearing to bilateral lower extremities. An observation on 07/22/19 at 3:45 PM of Resident #8 revealed him lying in bed with the head of his bed slightly elevated. A family member was in the room visiting him and he was dressed in a tee shirt and brief with covers pulled up over him. He had his feet in boots bilaterally and stated he had pressure sores on both feet and calves and on his sacrum. His hair appeared greasy with white flakes from his scalp in his hair. He stated he received bed baths at least 2 times per week and sometimes more. Resident #8 stated he had not received a shower because he was bedridden and did not think he could tolerate being on a shower stretcher. An observation on 07/23/19 at 8:52 AM of Resident #8 revealed him lying in bed with the	F 677	on the need to ensure all residents receive hair grooming as part of their Activities of Daily Living and plan of care services. Education will be completed on or before 8/27/2019. New hired staff will receive this same education. Resident ADL grooming needs will be monitored through routine round observations and correction will be made as identified. To monitor and maintain ongoing compliance, beginning 8/12/19, the Director of Nursing or designee will observe 20 residents per week for 12 weeks, to ensure that all ADL grooming needs are met. This information will be placed on an audit tool. Any identified areas of concern will be corrected. The results of the audits will be forwarded to the facility QAPI committee by the DON for further review and recommendations for the duration of the auditing. The facility Director of Nursing is responsible for compliance. The date of compliance is 8/27/2019.	

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head of his bed elevated and his Nurse Aide (NA) was in the room assisting him with his meal. The resident was dressed in a tee shirt that was clean and his hair appeared greasy with white flakes from his scalp in his hair.

An interview on 7/23/19 with Resident #8 revealed he would like to have his hair washed but stated it would be impossible due to him not being able to get in the shower. He stated he was not aware there was a cap that could clean your hair without water and being in the shower and stated he would like to try that for his hair.

An observation on 07/23/19 at 2:00 PM of Resident #8 revealed the resident lying in bed with the head of his bed elevated and eyes closed and appeared to be sleeping. The resident was dressed in a tee shirt that was clean and his hair still appeared greasy with white flakes from his scalp on his hair.

An interview on 07/23/19 at 2:10 PM with Nurse Aide (NA) #1 revealed she had taken care of Resident #8 quite a bit and stated she gave him bed baths regularly. She stated it was difficult due to his pain with being moved so she tried to coordinate his bed bath with his wound care and get them both done at the same time with the help of the Wound Certified Medication Aide (CMA). NA #1 stated she knew Resident #8's hair needed cleaning but stated they were unable to take him to the shower and the facility did not have the caps to use on residents' hair that clean it without water. NA #1 stated she had not asked anyone about getting the no-rinse shampoo caps.

An interview on 07/24/19 at 10:00 AM with the Director of Nursing revealed he was aware the

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F 677	Continued From page 14 facility did not have the No-Rinse Shampoo Caps to use for residents that did not get in the shower. He stated he had called, and the facility had some on the way to them. He stated he would make sure Resident #8 got his hair cleaned with a bonnet. The DON stated they could have been ordered earlier if he had known they were needed.	F 677		
F 697 SS=H	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff and Medical Doctor (MD) interviews, the facility failed to manage and treat complaints of pain for 2 of 3 sampled residents (Residents #8 and #10) reviewed for pain. The facility failed to manage Resident #8's pain during pressure ulcer dressing changes which resulted in the resident experiencing severe pain and anxiety. The facility also failed to administer pain medication to Resident #10 who had a recent knee surgery and was undergoing therapy which resulted in the resident experiencing pain during her therapy sessions. Findings included: 1. Resident #8 was admitted to the facility on 06/11/19 with diagnoses which included Guillain Barre (an autoimmune disorder in which the	F 697	Pain medication was provided to resident #8 and new orders obtained by the physician during the survey. Resident #10 no longer resides in the facility. To identify other residents who have the potential to be affected, on 7/24/19, the wound nurse assessed all residents who receive wound care to ensure that they are as free from pain as possible. No other concerns were identified. By 7/26/19, all residents were interviewed or observed to ensure that they were not in pain, or had received effective results from their pain medication To prevent this from re-occurring, beginning 7/24/19, the Director of Nursing and designee began in-servicing licensed	8/27/19

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F 697	Continued From page 15 immune system attacks healthy nerve cells), neuropathy, muscle weakness, pressure ulcer left heel and posterior calf - unstageable, pressure ulcer right heel and posterior calf - unstageable and stage III pressure ulcer of sacrum. A review of his care plan dated 06/18/19 revealed he was care planned for pain and the potential for pain related to neuropathy, decreased mobility, abdominal cramping, declining wound care and incontinent care due to pain. The goal was for the resident to express pain level within satisfactory limits. The interventions included administer pharmacological interventions as indicated per physician and monitor the effectiveness, assess for verbal and nonverbal signs and symptoms relating to pain: grimacing, guarding, crying, moaning, increase anxiety, assess need to medicate prior to procedures, implement non-pharmacological interventions to release the pain like distraction techniques, relaxation and breathing exercises, music therapy and repositioning, Nurse Practitioner (NP) to review pain medication regime, provide education to resident and family, and provide rest periods to promote relief, sleep and relaxation. A review of Resident #8's quarterly Minimum Data Set (MDS) dated 06/18/19 revealed he was cognitively intact for daily decision making and required extensive assistance with all activities of daily living (ADL) except eating. The resident was frequently incontinent of urine and always incontinent of bowel. The resident was admitted with pressure ulcers to the right malleolus (bony prominence of the side of the ankle) and heel that was unstageable, right calf that was unstageable, left heel that was unstageable, left calf that was unstageable and sacrum that was a stage 3. He	F 697	staff, medication aides, and the treatment aide, on monitoring for pain, and providing interventions as needed when residents voice pain, or display non-verbal indicators of pain. This education will be completed on or before 8/27/2019. This same education will be provided to new hires. During routine rounds, staff will monitor for signs of pain or verbal indicators of pain and will report findings to the nurse. To monitor and maintain ongoing compliance, beginning 7/26/19, the Director of Nursing or designee will interview/observe 10 residents weekly times 12 weeks for adequate pain control based on the resident□s' plan of care. A part of this sample will include residents receiving wound care. The results of these audits will be placed on an audit tool. Any negative findings will be followed up on immediately. The results of the audits will be forwarded to the facility QAPI committee by the DON for further review and recommendations for the duration of the auditing. The facility Director of Nursing is responsible for compliance. The date of compliance is 8/27/2019.	

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occasionally had pain at a level of 7 and took pain medication daily.

A review of the physician orders for Resident #8 dated 07/01/19 revealed the following orders:

1. Apply betadine solution to right malleolus and heel wound, clean with wound cleanser and cover with foam dressing and wrap with kerlix one time a day for wound care (wound care initiated on 06/14/19).

2. Apply betadine solution to left heel wound, clean with wound cleanser and cover with foam dressing and wrap with kerlix one time a day for wound care (wound care initiated on 06/14/19).

3. Apply betadine solution to right calf wound topically, clean with wound cleanser and apply padded dressing one time a day for wound care (wound care initiated on 06/14/19).

4. Apply betadine solution to left calf wound topically, clean with wound cleanser and apply padded dressing one time a day for wound care (wound care initiated on 06/14/19).

5. Flagyl tablet 250 milligrams (mg) crush and apply to sacrum wound topically two times a day for wound infection for 14 administrations, clean with wound cleanser and apply Dakin's soaked gauze with Flagyl to wound bed and apply ABD pad two times a day for wound care (wound care initiated on 06/14/19, Flagyl initiated on 07/17/19).

6. Lyrica Capsule 75 mg - give 1 capsule two times a day for pain (initiated on 06/12/19 and scheduled at 8:00 AM and 8:00 PM).

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7. Alprazolam Tablet 0.25 mg by mouth two times a day for anxiety and insomnia (initiated on 06/14/19 and scheduled at 8:00 AM and 8:00 PM).

8. Norco Tablet 5-325 mg (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain (initiated on 06/14/19 and last dose given at 6:54 PM on 7/22/19).

Observation on 07/23/19 at 9:52 AM of Resident #8's wound care revealed the wound care was done by the Wound Certified Medication Aide (CMA) with the Wound Nurse in the room, along with a Nurse Aide (NA) to assist in holding the resident. Resident #8 was sweating and said, "wait and let me get ready" and was taking deep breaths and wanted to count to 3 before being moved for the dressing changes. The staff counted with the resident and turned him on the count of 3. He was sweating and asked the Wound CMA to wait a minute while he prepared himself for the dressing changes. She explained that she was going to start with his heels and calves. When his boots were removed, and his leg was lifted to remove the old dressing on his left leg he yelled out "oh, oh, oh." The Wound Nurse told him she was not going to lift his leg up any more but was going to hold it, so the Wound CMA could remove his old dressing. The Wound Nurse moved her hand to hold his foot and he yelled "don't touch my foot there, it hurts" and his face was grimaced, and he was sweating. When asked by the surveyor about his pain level Resident #8 stated it was an 8 out of 10. The Wound CMA asked if he was ok to continue with the wound care and Resident #8 told her to "go ahead and get it over with." The Wound CMA

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cleaned the wounds with wound cleanser, painted with betadine and applied a thick foam adhesive dressing to his heel. The wounds were eschar but the area around the wound bed was blanchable and firm. The Wound CMA moved to his right leg and the Wound Nurse raised it to allow her to remove the old dressing and Resident #8 yelled out again in pain and stated, "don't raise my leg so high - it hurts." Again, his face was grimaced, and he was sweating. The CMA proceeded with cleaning the heel and posterior calf with wound cleanser and painted them with betadine and the heel was covered with a thick foam dressing and the posterior calf was cleaned, painted with betadine and covered with a Telfa island dressing. The wounds on the right heel and posterior calf were eschar and the surrounding tissue was blanchable and firm. Resident #8's boots were placed back on and adjusted. The Wound CMA then moved to the head of the bed and gently removed the pillow from underneath his left arm and gently placed it on his chest. Resident #8 during this time stated "oh, oh, be gentle" and stated he had a lot of nerve pain in his left arm that made it hard for him to move in the bed. He stated "ok, ok wait and let me get ready before you turn me." Resident #8 was grimacing and sweating and asked the staff to wait and then on a count of 3 turn him on his right side. The staff counted to 3 and as he was turned he was yelling out about his feet and not to lift them too high and to hold them in place, so the Wound Nurse was attempting to hold his feet. The Wound CMA started taking off the old dressing and cleaned the wound gently with wound cleanser and the resident yelled out again and when asked by the surveyor the resident stated his pain was an 8 out of 10. The Wound CMA placed Dakin's (a diluted solution of bleach)

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soaked gauze with crushed Flagyl (an antibiotic medication) on it directly on the wound bed and added more Dakin's soaked gauze at the request of the resident. Resident #8 stated it felt better with the additional gauze on it. The Wound CMA then placed an abdominal pad (ABD) over the wound and taped it in place. The CMA and NA along with the Wound Nurse helped the resident turn back onto his back and again he yelled out "my leg, my leg" and the Nurse held his legs as he turned back over. The Wound CMA gently placed the pillow back under his arm and Resident #8 was grimacing and sweating. The CMA cleaned up her supplies and discarded the trash and left the room. The Wound Nurse stated she was going to find his Nurse to get him some pain medication.

An interview on 07/23/19 at 10:00 AM with Resident #8 revealed he had acute Guillain Barre syndrome and it had affected the myelin sheath (insulation around nerve that facilitates the transmission of nerve impulses) around his nerves and caused him to have severe nerve pain. He stated it started on 03/23/19 when he struggled to stand up and fell and had to go to the hospital. He stated he was transferred to the facility for rehab and to be close to his family member. Resident #8 said he had terrible pain and anxiety with his dressing changes since being at the facility and stated it causes him to sweat and hold his breath. He stated he would like to get his pain medication before his dressing change so it was not so painful. According to Resident #8 the wounds were present when he was admitted, and he had been having daily dressing changes since admission and it was always painful and stressful for him due to the pain. He stated his pain medication was only

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ordered for twice daily and it was just not working for his pain especially during his dressing changes. Resident #8 said he was supposed to see the doctor today and he was going to ask about getting his pain medication administered before his dressing changes. The resident stated as long as he was still in the bed and no one was touching him he was able to tolerate the pain but stated when someone started touching him and moving him the pain started to increase. According to the resident anytime anyone touched him or moved him the pain increased. Resident #8 said he was waiting for his pain medication along with his 7/23/19 morning meds and stated he had not received any of his medications this morning.

An interview on 07/23/19 at 4:10 PM with the Wound CMA revealed she had been doing wounds for some time. She stated Resident #8 was "always in excruciating pain and had lots of anxiety during his dressing change." The Wound CMA stated since she had to have help in holding the resident during the wound care, she had to coordinate it with his NA because it took 2 people to move him and one to hold him while the dressing changes were done. She stated when Resident #8 stated his pain level was an 8 out of 10 she should have stopped and asked his Nurse to give his pain medication or offered an intervention to alleviate his pain. The Wound CMA stated the pain and anxiety the resident had during the observed wound care was no different than usual for him. She said anytime he was moved he was yelling out in pain and the only time his pain had been tolerable was if he is still in the bed and no one was touching him. The Wound CMA stated she had not addressed his pain during dressing changes with the nurse or

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the physician. She stated she was not aware the resident had not had his morning medications prior to his dressing change and stated she should have asked his nurse.

An interview on 07/23/19 at 12:00 PM with the Director of Nursing (DON) revealed he would have expected the Wound CMA or Wound Nurse to have stopped the dressing change and had his Nurse to have administered Resident #8 his pain medication. He stated he would expect them to give the medication time to work and then resume the wound care. The DON stated he would have expected the Wound CMA and Wound Nurse to have stopped and found some way to give an intervention to have alleviated Resident #8's pain. He stated he was not aware of the resident's high level of pain and signs of anxiety until it was brought to his attention by the surveyor. According to the DON, it was unacceptable for a resident to have this much pain during dressing changes. The DON was not aware Resident #8 had not received his morning medications on 07/23/19, including his pain medication, prior to his dressing change taking place and stated he would follow up with his nurse to find out what had happened.

An interview on 07/23/19 at 1:40 PM with the Medical Director (MD) revealed she had a long conversation with Resident #8 and his family member. The MD agreed that his pain needed to be controlled during his dressing changes and stated she had offered the option of using Morphine but stated the family member was concerned about the resident being too sedated and developing an addiction. The MD stated she had compromised and doubled his current pain medication and written an order for it to be given

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30 minutes before his dressing change so he would not have so much pain during his dressing changes. She stated she had wanted to see the wound but stated he could not tolerate being moved again for her to see it due to the nerve pain. The MD stated she was concerned about his pain level with movement and stated she was going to work with the staff to get his pain better controlled so he could tolerate being moved and turned and positioned without so much pain.

An interview on 07/23/19 at 2:10 PM with Nurse Aide (NA) #1 revealed she had taken care of Resident #8 quite often. She stated he had a lot of pain and anxiety with dressing changes but also had pain any time they moved or positioned him. NA #1 said she often tried to coordinate with the Wound CMA, so she could get his bed bath done at the same time of his dressing change so he only had to be moved once for care.

An interview on 07/23/19 at 3:00 PM with Nurse #1, who was Resident #8's nurse on first shift on 07/23/19, revealed she had not given the resident his morning medications, including his pain and antianxiety medications, prior to his dressing change. She stated she was not aware they were doing his wound care and had not given him his morning Lyrica 75 mg or Xanax 0.25 mg prior to his dressing change. Nurse #1 said she did not get the keys from the night nurse until 8:00 AM which put her behind and stated it was hard to catch up once you started behind. According to Nurse #1 Resident #8 had not received his morning medications on 07/23/19 until 10:50 AM.

A review of Resident #8's medical record on 07/23/19 revealed new orders written on 07/23/19 as follows by the Medical Director (MD):

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1. Give Ativan 0.25 milligrams (mg) - 1 tablet by mouth 3 times daily for anxiety or insomnia.
2. Give Norco 5-325 mg - 2 tablets by mouth daily 30 minutes before dressing change to wounds.
3. Give Lyrica capsule 150 mg by mouth one time a day for neuropathy (initiated on 07/23/19 and scheduled at 8:00 AM).

A review of Resident #8's Medication Administration Record (MAR) on 07/24/19 revealed he had been medicated with Norco 5-325 mg - 2 tablets by mouth at 3:00 PM.

An observation of Resident #8's wound care on 07/24/19 at 3:50 PM revealed the resident only yelled out once when his leg was moved and once while the Wound Medical Doctor (MD) debrided his wound but otherwise he tolerated it well. When the resident called out and moved slightly during debridement the Wound MD stopped and stated he would debride more of the wound later. During this wound care observation Resident #8 was not sweating and was not holding his breath as he had done on 07/23/19 during his wound care.

An interview on 07/24/19 at 4:15 PM with the Wound Medical Doctor (MD) revealed Resident #8's wounds looked better today than last week. The Wound MD stated he performed further debridement of the sacral wound on 07/24/19 after numbing the area with lidocaine and Resident #8 tolerated it well. The Wound MD stated he was not aware of Resident #8's pain with dressing changes but stated he understood the Medical Director had written new orders for pain management and stated the resident tolerated his wound care and debridement well on

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07/24/19.

An interview on 08/08/19 at 1:00 PM with the Minimum Data Set (MDS) Coordinator revealed she was familiar with Resident #8 and stated she had completed his care plan for pain. The MDS Coordinator stated she was not sure what if any of the non-pharmacological measures to decrease the resident's pain had been implemented. She went on to say that she usually had not followed up with nursing until the next review was done unless there was a problem. The MDS Coordinator stated the care plan was accessible to the nursing staff and assumed they followed up on the interventions.

An interview on 08/08/19 with the Nurse Practitioner (NP) revealed Resident #8 had been evaluated several times for pain. The NP stated he had been evaluated 2 weeks ago by both she and the MD on the same day and they had discussed his care several times. She stated he was complicated but thought he was doing better now that he received pain medication prior to his dressing changes. Resident #10 seemed to be progressing with therapy now that he had better pain relief and seemed to be in better spirits now. The NP stated she and the MD discussed stronger medication being utilized for the resident but stated he and his family member were concerned about him not being able to participate in therapy and stated they were concerned about addiction related to their experience with another family member. She stated they were continuing to evaluate Resident #10's pain medication and would increase it as needed.

2. Resident #10 was admitted to the facility on 07/13/19 with diagnoses that included diabetes

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mellitus, osteoarthritis and left knee replacement.

Review of the admission nursing assessment dated 07/13/19 revealed Resident #10 was cognitively intact and required one-person assistance with most activities of daily living (ADL). Resident #10 was noted to have a surgical incision located on her left knee.

On 7/24/19 at 3:10 PM an interview was conducted with Resident #10. Resident #10 stated she had been in the facility for two weeks following a left knee replacement. She stated she had been experiencing pain at a level of 10 on a 0 to 10 scale while working with physical therapy however had not received any pain medication. The interview revealed Resident #10 had asked the nurses for pain medication and was told she did not have anything ordered. Resident #10 stated she knew this information was incorrect because she had seen a prescription for Norco pain medication written for her while she was at an Orthopedic appointment on 07/22/19. She stated she handed the prescription to Nurse #1.

Multiple attempts were made to contact Nurse #1 and were not successful.

Review of Resident #10's medical record revealed no report of the Orthopedic appointment progress note dated 07/22/19.

Review of Resident #10's medication administration record (MAR) dated July 2019 revealed an order dated 07/13/19 which read, "Norco tablet 5/325mg 1 tablet by mouth every 4 hours as needed for pain for 5 days". The order was discontinued on 07/19/19. The review revealed no order for pain medication initiated on

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07/22/19 for Resident #10.

Review of Resident # 10's medical record revealed a prescription which had been scanned into point click care by the facility on 07/24/19. The prescription dated 07/22/19 read, "Norco 5/325 milligrams (mg) by mouth every 6 hours as needed for pain".

On 07/24/19 at 3:30 PM an interview was attempted with Nurse #3. The surveyor was unable to leave a voicemail due to her voice mailbox being full. The facility attempted to make contact with Nurse #3 with no success.

On 07/24/19 at 3:48 PM an interview was conducted with Nurse #9. Nurse #9 stated she was taking care of Resident #10 during this shift. She stated Resident #10 did not have anything ordered for pain. Nurse #9 stated the protocol once a resident returned from an appointment was for the nurse on duty to enter the orders into point click care and fax the prescription to the pharmacy.

On 07/24/19 at 3:35 PM an interview was conducted with the Director of Nursing (DON). The DON stated Resident #10 did have a prescription for pain medication dated 07/22/19 that had not been put into the system as a physician order by Nurse #1. The interview revealed the order should have been placed onto Resident #10's MAR by 07/22/19 so she could receive pain medication as needed. The DON stated his expectations were for the nurses to receive the prescriptions from the physicians and enter the orders into the system or call the physicians to clarify the orders if they have questions and to fax the prescription to the

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F 697	Continued From page 27 pharmacy. The interview revealed it was unacceptable for Resident #10 to go two days without receiving pain medication. On 08/08/19 at 1:30 PM an interview was conducted with the Occupational Therapist (OT). The OT stated Resident #10 did have some pain while participating in therapy but stated it had not prevented her from being able to complete her therapy. She stated if Resident #10 had complained of pain due to therapy she would have taken her to the nurse and requested the resident receive her medication. On 08/08/19 at 2:35 PM an interview was conducted with the Physical Therapy Assistant (PTA). The PTA stated Resident #10 had some pain during therapy but stated it had not prevented her from participating and reaching her goals. She stated looking back at the resident's physical therapy notes it had been documented on all but 2 days the resident was having knee pain. Resident #10 as the PTA recalled stated she was having knee pain as more of a comment than a concern or complaint but stated it had been documented she was having knee pain during therapy. The PTA stated usually if a resident is unable to complete therapy due to pain, they take them to their room and notify their nurse they need pain medication. She stated she had not had to do that with Resident #10 and stated she had participated in her therapy daily.	F 697		
F 760 SS=E	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.	F 760		8/27/19

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F 760	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on record reviews and resident, staff and Nurse Practitioner interviews, the facility failed to clarify an insulin order for a resident with a diagnosis of diabetes which resulted in the insulin order not being transcribed to the Medication Administration Record for 1 of 3 residents (Resident #10) reviewed for significant medication errors. Resident #10 was not administered insulin for a total of 11 days while in the facility. The findings included: Resident #10 was admitted to the facility on 07/13/19 with diagnoses that included diabetes mellitus, osteoarthritis and left knee replacement. Review of the admission nursing assessment dated 07/13/19 revealed Resident #10 was cognitively intact and required one-person assistance with most activities of daily living (ADL). Resident #10 was noted to have a diagnosis of diabetes. The assessment revealed Nurse #1 noted there were no issues noted with Resident #10's physician orders. Review of Resident #10's discharge medication reconciliation from the hospital dated 07/13/19 revealed an order for Insulin syringe needle u-100 units to be resumed at discharge. Review of Resident #10's medication administration record (MAR) dated July 2019 revealed an order initiated on 07/15/19 which read to obtain Resident #10's blood glucose level before meals and at bedtime. The review revealed Resident #10's glucose ranged in the	F 760	Resident #10 no longer resides in the facility. To identify other residents who have the potential to be affected, on 7/24/2019, a review of the last 7 days of admissions had been reviewed and corrections made for current residents. To prevent this from re-occurring, beginning on 7/24/19, the Director of Nursing and Assistant Director of Nursing started education to all nurses on transcription of orders. This education will be completed on or before 8/27/2019. New hires will have this same education. To monitor and maintain ongoing compliance, beginning 8/12/2019, the Director of Nursing or designee will review 10 resident medication administration records for accuracy and completeness weekly for 12 weeks. The Director of Nursing or designee will review each new admission for medication reconciliation accuracy for 12 weeks. Any discrepancies will be corrected. This information will be placed on an audit tool. The results of the audits will be forwarded to the facility QAPI committee by the DON for further review and recommendations for the duration of the auditing. The facility Director of Nursing is responsible for compliance.	

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F 760	Continued From page 29 200-300's during 7 of the 9 days checked reaching a max glucose level of 365. The review revealed no orders for insulin on Resident #10's MAR. On 07/24/19 at 4:00 PM an interview was conducted with Nurse #8. Nurse #8 stated she had admitted Resident #10 on 07/13/19. She stated proper protocol for completing admissions included obtaining the medication orders from the hospital and entering them into the computer system. She stated she put all of Resident #10's orders into the system except her insulin order which needed clarification from the Nurse Practitioner (NP). Nurse #8 stated Resident #10 was admitted during shift change and she had given report to Nurse #3. She stated she highlighted the insulin orders and asked Nurse #3 to notify the NP of the need for clarification regarding Resident #10's orders. On 07/24/19 at 3:30 PM an interview was attempted with Nurse #3 with no success. The facility also attempted to contact Nurse #3 with no success. On 7/24/19 at 3:10 PM an interview was conducted with Resident #10. Resident #10 stated she had been in the facility for two weeks following a left knee replacement. She stated she had been a diabetic for 22 years, receiving insulin injections while at home and in the hospital. Resident #10 stated at home she liked to maintain her glucose below 120. The interview revealed she had not received an insulin injection since she had been admitted into the facility on 07/13/19. Resident #10 stated the nurses had been monitoring her glucose 4 times daily but when her glucose reading was high, she did not	F 760	The date of compliance is 8/27/2019.	

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receive any insulin or hear anything else about it. The interview revealed Resident #10 did not want to question the facilities nursing care.

On 07/24/19 at 10:07 AM an interview was conducted with the Director of Nursing (DON). The DON stated based on the MAR Resident #10 hadn't received insulin during the 11 days she had been in the facility. The interview revealed his expectations were for the nurses to take the orders from the hospital discharge summary and enter them into the MAR. He stated if there were questions regarding a medication the NP should be notified to receive clarification. The DON stated if a resident's glucose was consistently elevated the NP should be notified.

On 07/24/19 at 10:00 AM an interview was conducted with the Nurse Practitioner (NP). She stated today was her first day evaluating Resident #10 and had noticed her elevated glucose with no insulin orders. The interview revealed she hadn't received any notification from the nurses of an issue with Resident #10's blood glucose levels or insulin orders. The NP stated her expectation was for the nurses to contact her and receive clarification on what to do for an elevated glucose level or questions with insulin orders.