

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

ORIGINAL

PRINTED: 11/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/06/2014
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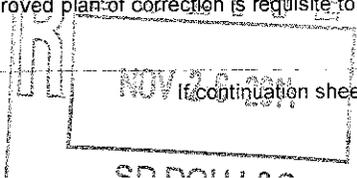
NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401
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F 000	INITIAL COMMENTS Surveyor: 22452 An extended/complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/4/14 through 11/6/14. Areas surveyed included nursing services and quality of care. Aberdeen Health and Rehab was found not in compliance with the following requirements: F224, F226, F278, F279, F309, F425, and F490.	F 000	<p><i>Addendums noted with an asterisk per 11/11/14 telephone to facility DON KR/SDDH/MF</i></p> <p>This Plan of Correction will serve as the facility's allegation of compliance.</p>	
F 224 SS=J	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, policy review, and job description review, the provider failed to ensure: *All licensed nurses were educated and followed the physician's orders for one of one sampled newly admitted resident (1) who required a skilled nursing procedure. *Medications were received from the pharmacy in a timely manner for administration for one of one sampled resident (1). *The physician and family were notified of a significant change of condition in a timely manner for one of one sampled resident (1).</p>	F 224	<p><i>* 11/21/2014 KR/SDDH/MF</i></p> <p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> 1. Resident #1 has been discharged. 2. All resident's records have been reviewed to ensure that the current medication and treatment orders are filled and administered. Any medications noted to be on order or unavailable were requested from pharmacy. Medications unable to be <p><i>* OTHER KR/SDDH/MF</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> DNS RN for Megan Kleinsasser, Admin	TITLE	(X6) DATE 11/25/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 224	<p>Continued From page 1</p> <p>*Pain was assessed and managed for one of one sampled resident (1) by the administration of pain medications in a timely manner.</p> <p>NOTICE:</p> <p>Notice of immediate jeopardy was given verbally to the director of nursing (DON) and the assistant DON on 11/5/14 at 2:40 p.m. The administrator was on medical leave and notified by phone by the DON. They were asked for a plan of correction to be given to the surveyors on 11/6/14 at 9:00 a.m. The provider informed the surveyors the plan of correction might not be completed until later on 11/6/14 pending the meeting with the pharmacy. They were asked that the plan of correction include:</p> <p>*The education of all licensed nurses regarding any residents' skilled nursing procedures. *How medications were going to be received to enable they were administered in a timely manner according to the physicians' orders.</p> <p>PLAN:</p> <p>A plan of correction for the education of all licensed nurses regarding any skilled nursing procedure and obtaining medications from the pharmacy in a timely manner was accepted on 11/6/14 at 4:00 p.m. The plan of correction also included education to all the licensed nurses on pharmacy guidelines and procedures and care of residents with impaired skin integrity. *All licensed personnel will be re-educated prior to their next scheduled shift on the following guidelines: -Medication administration. -Physician/practitioner notification. -Significant change of condition.</p>	F 224	<p>filled immediately by primary pharmacy will be filled by alternative pharmacy. The education identified in F224 was completed for all licensed staff and will continue to be ongoing. In addition, the pharmacy nurse provided education for all licensed nurses on 11/13/2014. Education provided regarding skin care for those with impaired skin integrity continues through completion of all staff including completion of wound monitoring form. Identified CNA's have been re-educated to work within their scope of practice. Pharmacy is being notified in writing of their failure to provide medications consistent with the desired operation of facility. All residents will continue to be comprehensively assessed including pain assessment upon admission, quarterly and with a significant change of condition.</p> <p>3. System changes include two licensed nurses will review transcription of orders for accuracy and completeness including daily weights, temperatures and notification of physician. Any</p>		

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F 224	Continued From page 2 *All licensed personnel will be re-educated on the following skills prior to performing: -Care of drainage tubes. -Intravenous therapy. -Gastrostomy (tube in the stomach) tube sites and medication administration. -Peripherally inserted central catheter care. -Wound vacuum assisted closure. -Any other skilled nursing procedure resident specific. *Licensed staff will be trained prior to their next scheduled shift on the following pharmacy guidelines and procedures: -Pharmacy related general grievances or complaints. -Pharmacy related occurrence reporting. -Medications ordered too soon. -Backorders. -Medication shortages/unavailable medications. -Emergency medication supplies. -General dose preparation and medication administration. -Delivery and receipt of medication and pharmacy documents from the facility to the pharmacy. -Delivery and receipt of routine deliveries. -Receipt of interim/stat/emergency deliveries. -New orders for schedule II controlled substances (medications). -New orders for schedule III-IV controlled substances. -New orders for non-controlled substances. -Reordering, changing, and discontinuing orders. -Physician/prescriber authorization and communication of orders to pharmacy. -Providing pharmacy products and services. *Consulting pharmacy nurse will provide an inservice by 11/20/14 regarding medication availability. *Skin care for residents with impaired skin	F 224	medication not delivered from pharmacy per schedule the DNS and/or her designee will be notified to ensure the alternative pharmacy is utilized and/or the physician is notified. Education will continue to be provided to licensed staff regarding specific skilled services as needed through verbal, return demonstration and/or education packets. Licensed staff will immediately contact the DNS and/or her designee if further education/training is needed on an individual basis. New admissions will have a complete review of all orders, medications ordered and delivered and plan of care is being followed per physician orders within 24 hours of admission. Pharmacy Occurrence reporting of errors will be maintained and reviewed daily. 4. The DNS and/or her designee will audit: completion of two person transcription check three times per week for four weeks and two times per week for eight weeks, completion of delivery of medications as ordered, notification of DNS and alternative pharmacy four times per week for four weeks		

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F 224	<p>Continued From page 3</p> <p>integrity (intactness) would be reviewed with all licensed staff.</p> <p>*Seventy-five percent of the licensed nursing staff had been provided the above at the time of the acceptance and removal of the immediate jeopardy on 11/6/14 at 4:00 p.m.</p> <p>Findings include:</p> <p>1. Review of resident 1's medical record revealed:</p> <p>*A 10/22/14 admission date at 5:30 p.m.</p> <p>*Diagnoses included:</p> <ul style="list-style-type: none"> -Hypertension (high blood pressure). -Diabetes mellitus (varying up and down blood sugars). -Congestive heart failure. -Chronic obstructive pulmonary disease (COPD). -Oxygen dependent. -Asthma. -Cholelithiasis (hard deposits called gallstones in the gallbladder.) Biliary drain (drainage tube from the liver) was placed on 10/19/14 in the hospital. <p>Review of resident 1's 10/22/14 admission orders transcribed and noted by registered nurse (RN) E and licensed practical nurse (LPN) B revealed:</p> <p>*Respiratory therapy (RT) evaluation and treatment as indicated once.</p> <p>*Interdry AG (moisture-wicking fabric with antimicrobial silver to keep skin dry and helps eliminate skin-on-skin friction). Use to abdominal folds for prevention or treatment of irrigated skin, change every five days or if soiled. Leave a two inch tail outside of each end of affected area to wick away the moisture.</p> <p>*Observe the site for signs of infection: increased pain, redness, foul odor or drainage, swelling, or fever above 100 degrees Fahrenheit orally.</p> <p>*If you observe signs of infection please call the</p>	F 224	<p>and three times per week for eight weeks, completion of skilled services education is provided and licensed staff perform services as ordered three times per week for four weeks and then two times per week for eight weeks, completion of new admission medical record review for orders transcribed, medications ordered and delivered and plan of care if being followed per physician orders three times per week for four weeks and then two times per week for eight weeks. The data collected will be presented to the Quality Assurance committee by the DNS. It will be reviewed/discussed and at this time the QA committee will make the decision/recommendation regarding follow-up or changes.</p> <p>Correction Action Completed: 12-2-2014</p> <p><i>*The DNS will present the data to QA quarterly. KR/SDDO/HMF</i></p>	

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F 224	Continued From page 4 physician or go to the nearest emergency room. *Flush tube with bacteriostatic 0.9 percent (%) sodium chloride (NaCl) twice daily as ordered. *Record the output from the drainage tube every shift. *Weigh yourself at the same time of the day and with the same amount of clothing. *Contact the doctor if a sudden weight gain of two to three pounds in a day or five pounds in a week. That a sign of fluid build-up. *If you were on an antibiotic take as instructed. *Medications as follows: -Acetaminophen 325 milligrams (mg) every four hours as needed (PRN) for pain. -Albuterol 0.083% nebulizer four times a day. -Allopurinol (gout) 100 mg one tablet daily (qd). -Allopurinol 300 mg one tablet qd. -Amoxicillin clavulanate potassium (antibiotic) one tablet twice a day (BID). -Bumetanide (fluid retention) one tablet BID. -Ferrous sulfate (iron) 325 mg one tablet qd. -Fluticasone (asthma) two sprays into each nostril qd. -Fluticasone 500-50 micrograms (mcg) one puff orally BID. -Gabapentin (anticonvulsant) 300 mg three capsules, four times a day (QID). -Novolog insulin 4 to 15 units subcutaneously (under the skin) four times a day with meals and bedtime. Use sliding scale (units per blood sugar test results). -Ipratropium (COPD) 0.06% nasal spray, two sprays into each nostril three times a day (TID). -Lantus insulin 20 units subcutaneously qd. -Levocetirizine (seasonal allergy) 5 mg one tablet qd in the evening. -Lisinopril (blood pressure) 5 mg one tablet BID. -Magnesium oxide (supplement) 400 mg one tablet BID.	F 224		

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F 224	<p>Continued From page 5</p> <ul style="list-style-type: none"> -Metoprolol succinate (blood pressure) 25 mg one tablet BID. -Miconazole 2% powder (skin rash) apply topically BID. -Montelukast (asthma) 10 mg one tablet qd at bedtime. -Omeprazole (stomach) 20 mg one tablet qd in the morning. -Oxycodone (narcotic for pain) 15 mg one tablet TID PRN as needed for moderate pain. -Oxycodone 20 mg one tablet TID. -Prednisone (steroid) 10 mg one tablet qd. -Roflumilast 500 mcg one tablet qd. -Senna-docusate (stool softner) 8.6-50 mg two tablets BID. -Sucralfate (stomach) one gram QID. -Theophylline (COPD) 300 mg one tablet BID. -Tiotropium (COPD) 18 mcg two inhalations qd per capsule. <p>Review of resident 1's 10/22/14 at 12:30 a.m. physician's orders revealed morphine sulfate (narcotic pain medication) 5 mg intramuscularly (IM) (injection into the muscle) every two hours PRN for pain until regular pain medications come.</p> <p>Review of resident 1's 10/23/14 physician's orders revealed: *Zofran (nausea medication) every six hours PRN. *Discontinue amoxicillin (Augmentin). Hospital transfer sheet listed Augmentin as an allergy. *Triple antibiotic to toe PRN.</p> <p>Review of resident 1's 10/22/14 through 10/27/14 progress notes by the following nurses revealed: *10/22/14 at 11:22 p.m. admission note by RN E "Pain at the time of admission was rated as 7 on a scale of 0-10 [1 being no pain and 10 being</p>	F 224			

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F 224	Continued From page 6 severe pain]. Is oriented [alert] to person, place, and time. Oxygen is in use at 2 liters per minute per nasal cannula. A nebulizer treatment has been ordered. Edema [swelling] is present." *10/23/14 at 1:19 p.m. by RN D "Short of breath [SOB] with exertion. Oxygen at 2 liters. Has drain to right abdomen that drains bile from gall bladder. Have emptied 420 milliliters [ml] since 6:00 a.m. Has mid abdominal pain. Received morphine sulfate 5 mg IM this a.m. Upset this a.m. because medications not delivered from pharmacy. Has not received gabapentin, magnesium oxide, oxycodone at 6:00 a.m. and 2:00 p.m., levothyroxine, allopurinol, rofumilist, and theophylline medication related to them not being here." *10/23/14 at 1:38 p.m. by RN D "Doctor here for rounds. Received order for Zofran, discontinue Augmentin, and triple antibiotic ointment to end of 3rd toe PRN." *10/24/14 at 12:40 a.m. by LPN G "Alert and oriented. PRN and scheduled pain medications arrived during the first run from pharmacy. PRN oxycodone for pain relief administered at 9:45 p.m. and then scheduled OxyContin 40 mg tablet administered at 10:00 p.m. Does have right upper quadrant pain from surgical procedure with gall bladder." 10/25/14 at 3:54 p.m. by RN H "Has request PRN Zofran for nausea. Has a drain in her abdomen which she says the area around it is tender at times. It is bright red around the insertion site. Was a small amount of tan drainage on the dressing when it was changed. Has been complaining of discomfort to her abdomen. Has scheduled pain medications." *10/26/14 at 12:28 a.m. by RN E "Has a tube from gallbladder emptied several times a shift with dark green bile. OxyContin 40 mg TID and	F 224			

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F 224	<p>Continued From page 7</p> <p>prn oxycodone for joint and abdominal pain." *10/26/14 at 3:11 p.m. by RN H "Has been complaining of nausea and has taken Zofran for the same with relief. Has drain in her right abdomen. It is red around the insertion site. She is complaining of discomfort to that area." *10/26/14 at 10:54 p.m. by RN E "Sleepy this p.m. Gets OxyContin 40 mg TID and OxyContin 15 mg PRN for abdominal pain and chronic generalized pain." *10/27/14 at 9:31 a.m. by RN A "Went into resident's room this a.m. to give morning medicine and check blood sugar. Her body was making jerking movements. She seemed coherent (oriented) but would make odd comments. Had a temperature of 101.6 [normal 98.6]. Her pulse ranged from 88-165 beats a minute [normal 60-80 beats a minute]. Her oxygen saturations [amount of oxygen in blood] ranged from 65% to 88% [normal greater than 90%] on 2 liters of oxygen. Called hospital and advised to use standing orders to send to the emergency room. Attempted to call daughter and number was bad. Called son and notified of same." 10/27/14 at 5:46 p.m. by RN A "Spoke with an RN at hospital. Resident is intubated [tube down throat and windpipe to maintain an airway] with severe septic shock [result of a severe infection in the blood that can lead to organ damage and death resulting from a drop in blood pressure]. Getting intravenous antibiotics through a central line [catheter placed into the large neck vein, chest, or groin to administer medications, fluids, and obtain blood tests]."</p> <p>Review of resident 1's 10/22/14 through 10/26/14 vital signs (blood pressure, pulse, respirations, and weight) revealed:</p>	F 224			

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F 224	<p>Continued From page 8</p> <p>*Weight on 10/25/14 was 294.2 pounds (lb) standing and on 10/26/14 in wheelchair was 298.3 lb (a 4.1 lb weight gain in one day).</p> <p>*Blood pressure (normal reading is at or below 120/80 milliliters/deciliter (mg/dl):</p> <p>-10/22/14: 145/84 mg/dl.</p> <p>-10/23/14: 130/85 mg/dl.</p> <p>-10/26/14: Two readings 104/68 mg/dl and 82/53 mg/dl (significant drop since admission).</p> <p>-There were no blood pressure readings documented for 10/24/14 and 10/25/14.</p> <p>*10/26/14: Temperature 100.5 degrees Fahrenheit.</p> <p>*10/26/14: Oxygen saturation was 90% on room air (resident had 10/22/14 physician's order for oxygen continuously).</p> <p>Review of resident 1's 10/22/14 through 10/26/14 drain tube drainage form documentation revealed:</p> <p>*10/22/14 (no time identified): 350 ml and 200 ml.</p> <p>*10/23/14 (no time identified): 400 ml.</p> <p>*10/23/14 at 7:30 a.m. and 1:00 p.m.: 120 ml and 300 ml.</p> <p>*10/23/14: There was no documentation regarding any further drainage from 1:00 p.m. to 11:59 p.m.</p> <p>*10/24/14: There was no documentation of any drainage for the entire twenty-four hour period.</p> <p>*10/25/14 at 10:00 p.m.: 300 ml, 200 ml, and 450 ml. There was no other drainage documented from 12:01 a.m. until 10:00 p.m.</p> <p>*10/26/14 (no times identified): 150 ml, 200 ml, and 350 ml.</p> <p>Review of resident 1's 10/22/14 through 10/28/14 daily wound monitoring record revealed:</p> <p>*There was no documentation for 10/24/14.</p> <p>*There was documentation the assessment had</p>	F 224			

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F 224	Continued From page 9 been done on 10/28/14 (she had been sent to the hospital on 10/27/14). Review of resident 1's 10/22/14 through 10/27/14 medication administration record (MAR), treatment record, and PRN record revealed: *Advair inhaler was not administered on 10/22/14 at bedtime (had not arrived from pharmacy). *Gabapentin capsules were not administered on 10/22/14 at 8:00 p.m. or on 10/23/14 at 8:00 a.m., 12:00 noon, 4:00 p.m., or 8:00 p.m. (had not arrived from pharmacy). *Senna was not administered at bedtime on 10/22/14 (had not arrived from pharmacy). *Lisinopril was not administered on 10/22/14 at 6:00 p.m. (had not arrived from pharmacy). *Magnesium oxide was not administered on 10/22/14 at 6:00 p.m. nor on 10/23/14 and 10/24/14 at 8:00 a.m. and 6:00 p.m. (had not arrived from pharmacy). *Metoprolol was not administered on 10/22/14 at 6:00 p.m. (had not arrived from pharmacy). *Miconazole powder was not administered on 10/22/14 at bedtime, on 10/23/14, 10/24/14, nor on 10/25/14 BID, and on 10/26/14 at 8:00 a.m. (had not arrived from pharmacy). *Montelukast was not administered at bedtime on 10/22/14 (had not arrived from pharmacy). *Oxycodone was not administered on 10/22/14 at bedtime nor on 10/23/14 at 6:00 a.m. and 2:00 p.m. (had not arrived from pharmacy). *Atrovent nasal spray was not administered on 10/22/14 at bedtime (had not arrived from pharmacy). *Levocetirizine was not administered on 10/22/14 at 6:00 p.m. (had not arrived from pharmacy). *Levothyroxine was not administered on 10/23/14 at 6:00 a.m. (had not arrived from pharmacy). *Lantus insulin was not administered on 10/22/14	F 224		

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F 224	<p>Continued From page 10</p> <p>at bedtime (had not arrived from pharmacy). *Novolog insulin was not administered on 10/22/14 at 5:00 p.m. and at bedtime (had not arrived from pharmacy). There was no documentation of any blood sugar readings. *Albuterol nebulizer was not administered on 10/22/14 at 8:00 p.m. (had not arrived from pharmacy). *There was no documentation the Augmentin had been administered related to her allergy. There was no other antibiotic documented. *Roflumilast was not administered on 10/23/14 at 8:00 a.m. (had not arrived from pharmacy). *Sucralfate was not administered on 10/22/14 at 8:00 p.m. (had not arrived from pharmacy). *Theophylline was not administered on 10/22/14 at 8:00 p.m. (had not arrived from pharmacy). *Intradry dressing was never documented as being administered (pharmacy record revealed it was delivered on 10/28/14 after she had been hospitalized). *There was no documentation her drain had been flushed on 10/23/14, on the 6:00 p.m. to 6:00 a.m. shift. *Zofran had been administered nine times for nausea: -Five of the doses had documentation of little or some relief of nausea. -Two of the doses had no documentation as to the effectiveness of the Zofran. *Morphine had been administered six times for abdominal pain: -Two of the doses had documentation of some relief. -One dose had no documentation as to the effectiveness of the morphine.</p> <p>Review of resident 1's 10/24/14 care conference summary sheet by LPN C revealed:</p>	F 224		

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F 224	<p>Continued From page 11</p> <p>**"Has had pain and got her medications." **"Does have complaints of nausea and does take medications for it."</p> <p>Review of resident 1's 11/2/14 medication return to pharmacy/destroyed record signed by RN E and RN H revealed the following discrepancies of what was sent from the pharmacy on 10/23/14, what was documented as administered on her MAR, and what was returned to the pharmacy or destroyed:</p> <p>*Advair inhaler: sixty doses had been dispensed. Seven doses had been documented as administered. Fifty-five doses had been documented as destroyed.</p> <p>*Spiriva inhaler: thirty doses had been dispensed. Four doses had been documented as administered. Twenty-seven doses had been documented as destroyed.</p> <p>*Albuterol nebulizer: seventy five doses had been dispensed. Sixteen doses had been documented as administered. Fifty-seven seven doses had been documented as destroyed.</p> <p>*Zofran: thirty doses had been dispensed. Nine doses had been documented as administered. Nineteen doses had been documented as returned to the pharmacy.</p> <p>*Levothyroxine: ten doses had been dispensed. Four doses had been documented as administered. Five doses had been documented as returned to the pharmacy.</p> <p>Review of resident 1's 10/29/14 DON investigation report from the following interviews revealed:</p> <p>**10/28/15 at 3:15 p.m. with RN A: She took care of resident on 10/24/14 from 6:00 a.m. to 6:00 p.m. She found the resident alert and oriented to person, place, and time, and was also answering</p>	F 224		

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F 224	Continued From page 12 questions appropriately. Her legs were edematous, but had no signs of cellulitis [redness and warmth]. No concerns. She was also in charge of resident's care on 10/27/14 starting at 6:00 a.m. I waited to assess her until after she ate breakfast because she does not like to take her medications until after she has eaten. Resident was found to be shaky and not quite right. She was answering questions appropriately but something was off. I took her vitals and her temperature was 101.6 degrees. I then called the emergency room to send her." **10/28/14 at 4:00 p.m. with certified nursing assistant (CNA) I: She gave the resident her shower on the evening of 10/24/14. The resident's abdominal folds had a small amount of whitish, yellowish yeast noted on her Intradry that was placed between her folds (Intradry was placed in the hospital prior to admission). The only red area was to her buttocks, but was present on admission to this facility. The folds were cleaned by the CNA. She stated the pharmacy had not sent any Intradry to replace the old one. This is when the resident suggested that we use the towels in-between her folds to keep the area dry. She placed the towels between the folds and reported this to the night nurse." **10/28/14 at 3:00 p.m. with RN H: She took care of the resident on 10/24/14 and 10/25/14 from 6:00 a.m. to 6:00 p.m. Legs had edema but did not look to have signs of cellulitis. Temperature was 98.0 on 10/25/14 and elevated a little to 99.2 degrees on 10/26/14. She was receiving Tylenol in her pain medications and per my assessment I did not see any signs of infection." **10/28/14 at 3:30 p.m. with RN E: She took care of the resident from 6:00 p.m. to 6:00 a.m. on 10/25/14 and 10/26/14. Legs were checked with no indication of cellulitis. Abdomen was tender to	F 224		

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F 224	Continued From page 13 touch, but was so on admission. She washed resident's abdominal folds and groin area both mornings around 5:00 a.m. She washed them with soap and water and patted them dry. Pharmacy was still having an issue getting the Intradry to us. I applied Desenex powder to the folds and groin and put clean towels in the folds and groin area to keep it dry. Resident did state she did not feel well on 10/26/14 in the evening. Zofran and oxycodone were given. At around 11:50 p.m. the resident stated she felt a lot better. She did start to get more of a fever in the night 100.5 degrees. Upon assessing her early in the morning of 10/27/14 she noticed the resident shake a few times. She questioned the resident about shaking and she said that was normal for her and happens every now and then." **10/28/14 at 6:00 p.m. with RN F: She took care of the resident on 10/24/14 and 10/25/14 from 6:00 p.m. to 6:00 a.m. She found that the resident was alert and oriented to person, place, and time. Biliary drain was flushed without problem. She had no concerns or issues with this resident." **10/29/14 at 10:45 a.m. with CNA P: She took care of the resident on 10/26/14 from 6:00 a.m. to 2:00 p.m. She did in fact wash the resident's abdominal folds and groin area with soap and warm water. She patted areas dry and put wash cloths inbetween folds and groin area to keep them dry. Intradry was still not available from the pharmacy." **Findings": -"Abdominal fold and groin area care was provided daily at minimal. She had no open areas to her abdomen or groin. Towels were used in lieu of Intradry until pharmacy could send it to the facility. Desenex was applied to abdominal folds and groin area on 10/26/14 only due to unavailability from the pharmacy."	F 224			

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F 224	<p>Continued From page 14</p> <p>-"Biliary drain was intact and flushed per nursing on all but one shift without problem. Drain site was slightly red with scant amount of drainage. Dressing was changed daily. Resident's legs showed no indication of cellulitis."</p> <p>-"Resident did have a temperature of 99.2 degrees on 10/26/14 during the day which continued to elevate to 100.5 degrees Sunday night (10/26/14) and then 101.6 degrees on Monday morning (10/27/14) at which time she was sent to the emergency room."</p> <p>**"Conclusion":</p> <p>-"Allegation of neglect is not substantiated."</p> <p>-"Upon reviewing documentation and interviewing staff, resident received appropriate nursing care while in this facility."</p> <p>Interview on 11/4/14 at 3:30 p.m. with RN A regarding resident 1 revealed:</p> <p>*The provider had done no inservice training or education regarding her biliary tube prior to her admission. She had been employed there three years and during that time had never cared for a resident with a biliary tube.</p> <p>*She thought all the nurses were familiar with the procedure, but knew the resident was telling her family it had not been taken care of properly from 10/22/14 through 10/26/14.</p> <p>*She felt comfortable flushing the tube.</p> <p>*The resident was alert and oriented and involved in her care by asking a lot of questions.</p> <p>*She required more time and attention due to her many care issues, pain, and nursing procedures.</p> <p>Interview on 11/5/14 at 9:35 a.m. with the DON and ADON regarding resident 1 revealed:</p> <p>*If medications were ordered from the pharmacy before 2:00 p.m. they would have been delivered on the 6:00 p.m. to 7:00 p.m. pharmacy delivery.</p>	F 224			

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F 224	<p>Continued From page 15</p> <p>If medications were ordered from the pharmacy after 2:00 p.m. they would have been delivered on the 11:00 p.m. to midnight pharmacy delivery. *Her medications were ordered on 10/22/14 at 6:00 p.m. from the pharmacy. RN E had told them she had contacted the pharmacy and was told by the pharmacist she would not get out of bed to deliver the medications. The DON or ADON had not been informed of that when it had occurred and not until 10/28/14 when they had interviewed her.</p> <p>*The physician had not been contacted the pharmacy had not delivered any of her medications on 10/22/14.</p> <p>*The resident's daughter's phone number was incorrect on the face sheet. RN A had been unable to contact her on 10/27/14 when she had sent her to the emergency room. Social services had inputted the wrong telephone number on the face sheet.</p> <p>*RN A stated she had informed the resident's son of her transfer to the emergency room on 10/27/14. She was aware the son and daughter-in-law had denied that had occurred. The documentation was in the medical record the son had been informed by RN A on 10/27/14 of the emergency room transfer.</p> <p>*They did not have a policy and procedure for the care of biliary drains prior to 10/22/14 and still had not put one together.</p> <p>*They confirmed they had done no education to the licensed staff regarding the care of her biliary tube. It was their expectation a nurse would come to them if they did not understand how to do a procedure.</p> <p>*They were aware the resident had told her family the nurses had not touched her biliary tube the whole time she was in the facility. The resident had not told them the nurses had not been</p>	F 224			

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F 224	<p>Continued From page 16</p> <p>flushing the tube, but they had not interviewed her since she was in the hospital.</p> <p>*They confirmed the documentation on the tube output shift was not complete as addressed above.</p> <p>*The physician had not been notified when pharmacy was unable to supply the Intradry and should have been. The pharmacy had told them it was back-ordered.</p> <p>*They had not notified the physician they did not have respiratory services and were unable to complete the evaluation ordered on 10/22/14.</p> <p>*The resident's primary physician was on vacation during 10/22/14 through 10/27/14, and the medical director (on-call physician for her doctor) saw her on 10/23/14. He discontinued her Augmentin due to her allergy. Another antibiotic was not ordered. No one informed the doctor in the out-of-town hospital that ordered the Augmentin if another antibiotic should be given in place of the Augmentin or that her local doctor had discontinued the Augmentin.</p> <p>*They were unsure why it was documented on 10/26/14 her oxygen saturation was 90% on room air. The physician's order for oxygen continuously was not being followed.</p> <p>*They confirmed no daily weight had been documented as it had not been done on 10/24/14. They were not aware of the 4.1 lb increase in weight from 10/25/14 to 10/26/14. According to the 10/22/14 admission orders the physician should have been notified of the weight gain.</p> <p>*They confirmed the blood pressure on 10/26/14 was significantly lower than her previous blood pressure readings.</p> <p>*Her temperature was elevated on 10/26/14 to 100.5 degrees F., and the physician should have been notified then according to the 10/22/14 physician's orders. RN E had told them she had</p>	F 224			

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F 224	<p>Continued From page 17</p> <p>given her Tylenol, and the resident had stated she felt fine. There was no documentation another temperature had been taken until the morning of 10/27/14 when it was elevated to 101.6 degrees F., and she was sent to the emergency room.</p> <p>*They confirmed no skin monitoring had not been documented on 10/24/14.</p> <p>*They had not reviewed the 10/22/14 through 10/26/24 MARs and were not aware of the discrepancy between what was dispensed by the pharmacy, what was documented as administered, and what had been destroyed or returned to the pharmacy. They had no explanation regarding the discrepancies.</p> <p>*They had no reason to doubt any of the interviews the nurses had provided them for the investigation. They did confirm there were gaps in the documentation they had not identified or seen as a problem during their investigation.</p> <p>*They did not think the medical director had been informed of the gaps in documentation or of the medication discrepancies.</p> <p>*No disciplinary action had been taken regarding any of the nurses.</p> <p>Interview on 11/5/14 at 2:55 p.m. with LPN G regarding resident 1 revealed she had:</p> <p>*Worked on 10/23/14 from 6:00 p.m. to 6:00 a.m. with her. She had "swapped shifts" with an RN.</p> <p>*Received no inservice training on the biliary tube and was not sure it was within her scope of practice to flush the tube. She had not worked with that type of tube before.</p> <p>*No problems when she had flushed the tube.</p> <p>*Checked in her admission medications from the pharmacy that night.</p> <p>*Assisted the resident to the bathroom after she had administered her oral pain medications.</p>	F 224			

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F 224	<p>Continued From page 18</p> <p>Phone interview on 11/5/14 at 3:10 p.m. with resident 1's primary physician revealed: *He and the medical director were in the same clinic. *The medical director had been covering for him during 10/22/14 through 10/27/14 as he was on vacation. *He was not aware of any of the medication discrepancies or lapses in documentation. *He was sure the medical director would have informed him if he had been made aware by the facility.</p> <p>Interview on 11/5/14 at 3:30 p.m. with RN D regarding resident 1 revealed she: *Had worked with her on 10/23/14. *Had faxed the pharmacy on 10/22/14 at 1:00 p.m. with the resident's list of admission medications. *Said the resident had told her the morphine shots were not as effective for pain control as the pills. *Had used blood pressure medications from another resident, so resident 1 could receive them on 10/23/14. *Had felt comfortable with the biliary tube. RN E had gone over it with her prior to her shift as she was not sure what the tube looked like. *Had received no formal inservice training on biliary tubes from the facility prior to caring for the resident.</p> <p>Interview on 11/5/14 at 3:50 p.m. with RN H regarding resident 1 revealed she: *Had worked with her on 10/25/14 and 10/26/14 from 6:00 a.m. to 6:00 p.m. *Had no problem flushing the biliary tube. There was not much drainage, so she did not have to drain it.</p>	F 224			

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F 224	<p>Continued From page 19</p> <p>*Said the CNAs informed her they had been draining the tube. She told them they should not have been draining the tube.</p> <p>Interview on 11/5/14 at 4:25 p.m. with RN E regarding resident 1 revealed:</p> <p>*She had not had any inservice training or education regarding biliary tubes prior to the resident being admitted.</p> <p>*She felt comfortable working with tubes from previous hospital experience.</p> <p>*The hospital had sent the transfer sheet with the resident's medications prior to her being admitted on 10/22/14 at 5:30 p.m.</p> <p>*RN D had told her she had faxed the transfer sheet with all her medications about 1:00 p.m.</p> <p>*The resident did report her pain at a 7 on a 0 to 10 scale upon admission. She thought she had not done the full initial assessment until 9:30 p.m. to 10:00 p.m. on 10/22/14.</p> <p>*When her medications had not arrived from the pharmacy on the first run between 5:00 p.m. and 6:00 p.m. she refaxed the transfer sheet with her medications to the pharmacy.</p> <p>*She called the on-call pharmacist between 9:30 p.m. and 10:00 p.m. on 10/22/14.</p> <p>*She called the on-call physician who was the medical director about 10:30 p.m. on 10/22/14. Since her pain medications had not arrived from the pharmacy he ordered morphine to be used from their emergency kit.</p> <p>*She called the on-call pharmacist back about midnight, and she said "I am not going to go to the pharmacy and you will have to wait until morning."</p> <p>*She did not notify the DON or ADON on the night of 10/22/14 of the pharmacy problems obtaining the resident's medications. Most of the medications did not arrive until later in the day on</p>	F 224			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2014
NAME OF PROVIDER OR SUPPLIER ABERDEEN HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401		
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F 224	<p>Continued From page 20</p> <p>10/23/14 and caused the resident to miss multiple medications.</p> <p>*She knew RN D had borrowed medications from other residents for as many as she could on 10/23/14 until the resident's medications arrived from the pharmacy.</p> <p>*The resident did express she did not like getting the shot and would have liked to have her oral pain medications. "The shot hurt as she really did not have much muscle to inject the morphine."</p> <p>*The DON had not reviewed with her during her investigation interview her weight gain or her elevated fever on 10/26/14. There had been no discussion she should have informed the physician of those symptoms on 10/26/14.</p> <p>*She should have notified the physician on 10/26/14 of her weight gain, her temperature, her decreased blood pressure, and her complaints of "not feeling well."</p> <p>*She had spoken to the resident early in the morning on 10/27/14 while she was doing her abdominal and groin care.</p> <p>Interview on 11/5/14 at 5:10 p.m. with RN F regarding resident 1 revealed she:</p> <p>*Worked with her on 10/23/14.</p> <p>*Had received no specific training for biliary tubes, but she had no problems with flushing the tube.</p> <p>*Had been informed to circle medications on the MAR if they were held or not given for a reason, but no one had told her to document anywhere why the medications had not been given.</p> <p>*Had spent three days with the staff development person when she had started on 6/23/14.</p> <p>*Had followed another nurse for about two and one-half days when she had first started, but she really had limited hands-on training.</p>	F 224		

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F 224	<p>Continued From page 21</p> <p>Interview on 11/5/14 at 5:25 p.m. with CNA I regarding resident 1 revealed she:</p> <ul style="list-style-type: none"> *Had worked with her on 10/22/14, 10/23/14, and 10/24/14. *Had given her a shower on 10/25/14. She had put a plastic bag over the dressing and taped it. *Had emptied the biliary tube bag "whenever it needed it. We usually do things like that." She reported to the nurse on duty the amount of any drainage she had emptied. <p>Phone interview on 11/6/14 at 10:10 a.m. with consultant pharmacist M regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *The transfer sheet from the hospital with her medications had been faxed from the facility on 10/22/14 at 1:33 p.m. It was a human error the orders were not processed like they should have been. The triage technician had accidentally hit a wrong button. When she had hit the curser the orders should have gone to admit but had gone somewhere else. *They had spoken to the triage technician regarding that error. *The first call from the facility regarding the resident came on 10/23/14 at 12:26 a.m. from RN E. RN E called them back at 12:51 a.m. and gave the pharmacist the on-call physician's phone number. *The pharmacist had spoken to RN E at 12:57 a.m. and told her it was okay to open the emergency kit to use the morphine for the resident. The pharmacist then asked RN E to refax her medication orders to the pharmacy. *The nurse should have called the on-call pharmacist instead of faxing her orders at supertime. The medications would then have been able to have been delivered on 10/22/14 on the 11:00 p.m. to midnight pharmacy run. 	F 224		

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F 224	<p>Continued From page 22</p> <p>Review of resident 1's 10/27/14 hospital admission and history revealed: *Septic shock (serious condition that occurs when a body-wide infection leads to a dangerously low blood pressure). *Acute chronic respiratory failure with hypercapnia (an increased amount of carbon dioxide in the blood). *Acute encephalopathy (a permanent or reversible brain injury due to direct injury to the brain or an illness remote from the brain). *Delirium (an acute confusional state caused by a physical or mental illness). *Sepsis (a potentially life threatening complication of an infection). *Cellulitis (a potentially serious bacterial skin infection) and abscess of leg. *Was found in nursing home not oriented and with low blood pressure. *"Sepsis is thought to be due to cellulitis in legs and groin verses more likely related to gallbladder disease." *"Also just got tube placed in an acute cholecystitis (inflammation of the gallbladder)" in an out-of-town hospital. *"Confused. Condition is serious."</p> <p>Review of the provider's 12/1/07 pharmacy Medication Shortages/Unavailable Medications policy revealed: *"Upon discovery the facility has an inadequate supply of medication to deliver to a resident, the facility staff should immediately initiate action to obtain the medication from pharmacy." *"If a medication shortage is discovered during normal pharmacy hours: -A facility nurse should call pharmacy to determine the status of the order. If the</p>	F 224		

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F 224	Continued From page 23 medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. -If the next available delivery causes delay or a missed dose in the resident's medication schedule, the facility nurse should obtain the medication from the emergency medication supply to administer the dose. -If the medication is not available in the emergency medication supply, the facility staff nurse should notify the pharmacy and arrange for an emergency delivery." *"If a medication shortage is discovered after normal pharmacy hours: -A licensed facility nurse should obtain the ordered medication from the emergency medication supply. -If the ordered medication is not available in the emergency medication supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action that may include emergency delivery or use on a emergency back-up third party pharmacist. -If an emergency delivery is unavailable, the facility nurse should contact the attending physician to obtain orders or directions. -If the medication is unavailable from the pharmacy due to formulary coverage, contraindication, drug-drug interaction, allergy, or other clinical reason, the facility should collaborate with the pharmacy and physician/prescriber to determine a suitable therapeutic alternative. -If facility nurse is unable to obtain a response from the attending physician/prescriber in a timely manner, facility nurse should notify the nursing supervisor and contact the facility's medical	F 224		

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F 224	Continued From page 24 director for orders/direction, making sure to explain the circumstances of the medication shortage." Review of the provider's 12/18/06 Pharmacy Related Occurrence Reporting policy revealed: **"A pharmacy related occurrence is an event which the facility believes: -Is not consistent with the desired operation of the facility with respect to pharmacy. -Or has caused, or had the potential to cause, an unexpected resident medical intervention, a change in intensity of care, or a health care impairment." **"The facility should notify the pharmacy of any possible dispensing occurrence." **"Facility should report the occurrence to pharmacy either verbally or in writing. An occurrence report or other appropriate document may be completed by the person identifying the occurrence and/or responsible manager."	F 224			
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to investigate thoroughly one of one sampled newly admitted resident's (1) adequacy of nursing care. Findings	F 226	F 226 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing	*11/06/14 KRS/DH/M	

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F 226	<p>Continued From page 25 include:</p> <p>1. Interview on 11/5/14 at 9:35 a.m. with the director of nursing and the assistant director of nursing regarding resident 1 revealed they had: *Interviewed all the nursing staff that had provided care to the resident from 10/22/14 when she had been admitted to 10/27/14 when she had been transferred to the emergency room. *No reason to believe the staff were not being accurate in their interviews regarding her care. *Not identified any lapses in their documentation regarding her daily weights, wound monitoring, or irrigating and emptying the biliary tube. *Not contacted the pharmacy after registered nurse (RN) E had difficulty obtaining her medications. The lapse in receiving her medications from pharmacy caused the resident to miss multiple doses of all her medications. *Not instructed the nursing staff to call the physician from out-of-town who had ordered the antibiotic that the antibiotic needed to be discontinued due to her allergy. She confirmed the resident was not on an antibiotic because of that from 10/22/14 through 10/27/14. *Not identified the discrepancies on the pharmacy return/destroy records for what amount of medications had been dispensed from the pharmacy, what had been documented as administered, and what had been destroyed/returned. *Not instructed the nursing staff to inform the physician of the inability of the pharmacy to provide the Intradry dressing ordered. *Put no other interventions in place regarding teaching of any new procedures for residents after this incident. They were still going to just ask the nurses to inform them if they had any questions about a particular procedure.</p>	F 226	<p>statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> 1. Resident #1 has been discharged. 2. Review of the investigation regarding Resident #1 was reviewed with the DNS to identify areas that needed further review. Education and mentoring with DNS continues through individual investigations including medical record review and interviews. 3. Current incidents and areas needing investigation are initiated at the facility with notification to the ED/DNS and/or her designee. ED/DNS will notify the Corporate RN for assistance, review and direction to ensure a thorough investigation including interview, medical record review and assistance from Medical Director as needed. 4. DNS or her designee will review each investigation for thoroughness and interventions initiated as indicated with oversight from the Corporate RN. The data collected will be presented to the Quality Assurance committee by the DNS. It will be reviewed/discussed and at this time the QA committee will <p><i>*quality assurance committee</i></p>	

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F 226	Continued From page 26 *Not identified that RN E should have informed the physician on 10/26/14 regarding her weight gain, low blood pressure, and temperature. *Not identified any issues with neglect regarding the resident's care from 10/22/14 through 10/27/14. Refer to F224, finding 1. Review of the provider's 12/11/11 Abuse, Neglect, and Misappropriation of Property Prevention policy revealed: *The facility supports a "Zero Tolerance" for patient abuse, neglect, and/or misappropriation of property. **Neglect is a failure, through inattentiveness, carelessness, seclusion, or omission, with a reasonable justification, to provide timely, consistent, and safe services, treatment, and care to a resident." **"All incidents will be investigated thoroughly by administration."	F 226	make the decision/recommendation regarding follow-up or changes. Correction Action Completed: 12-2-2014		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	F278 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing	* 12/02/14 KR/SDBH/mf	

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F 278	<p>Continued From page 27</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, and interview, the provider failed to appropriately assess one of one sampled resident (3) for pain. Findings include:</p> <p>1. Interview on 11/6/14 at 9:05 a.m. with MDS coordinator V revealed: *In the last assessment she completed on 10/16/14 he had denied pain. *She reviewed the prior five days of the MARs for PRN pain medication. *She had known he used the PRN pain medication hydrocodone-acetaminophen four out of the five days. *She had not identified that on the assessment and went by what he had said. *She had not care planned pain.</p> <p>Refer to F309, finding 1.</p>	F 278	<p>statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> 1. Resident #3 has been reassessed for pain and is currently receiving routine scheduled pain medication with relief. 2. All resident's medication administration records have been reviewed for PRN use pain medication and re-evaluated for routine pain medication, pain assessments completed as needed and addressed in care plan. Residents will be monitored for effectiveness of medication and documented in the medical record. Assessment of pain will occur at the time of use of a PRN medication for pain and the effectiveness will be documented on the MAR. All residents will continue to be comprehensively assessed including pain assessment upon admission, quarterly and with a significant change of condition. 3. Staff member V. has been counseled regarding accurate completion of comprehensive assessments, resident assessment including medication use for pain and completion of care plan. MDS 	

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F 278	<p>Continued From page 27</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, and interview, the provider failed to appropriately assess one of one sampled resident (3) for pain. Findings include:</p> <ol style="list-style-type: none"> 1. Interview on 11/6/14 at 9:05 a.m. with MDS coordinator V revealed: *In the last assessment she completed on 10/16/14 he had denied pain. *She reviewed the prior five days of the MARs for PRN pain medication. *She had known he used the PRN pain medication hydrocodone-acetaminophen four out of the five days. *She had not identified that on the assessment and went by what he had said. *She had not care planned pain. <p>Refer to F309, finding 1.</p>	F 278	<p>Coordinators have been re-educated to expectation of accurate comprehensive assessments including MAR review of pain medications used, effectiveness, need for physician notification and care planning of pain.</p> <p>4. DNS and/or her designee will audit three MDS assessments weekly for four weeks for accuracy regarding pain assessment, documentation in care plan and interventions and then two MDS assessments weekly for eight weeks. The data collected will be presented to the Quality Assurance committee by the DNS. It will be reviewed/discussed and at this time the QA committee will make the decision/recommendation regarding follow-up or changes.</p> <p>Correction Action Completed: 12-2-2014</p>	
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**QUALITY ASSURANCE*

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F 279 F 279 SS=D	Continued From page 28 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to address pain and address personal choice of dress for one of one sampled resident (3). Findings include: 1. Interview on 11/6/14 at 11:15 a.m. with the director of nursing and RN J regarding resident 3 revealed: *Their hope was all residents would deny being in pain, because it was controlled.	F 279 F 279	F 279 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Resident #3 has been reassessed for pain and is currently receiving routine scheduled pain medication with relief. Resident has stated he prefers to where a hospital gown all the time but on occasion will wear regular clothes. This has been care planned. 2. All resident's medication administration records have been reviewed for PRN use pain medication and re-evaluated for routine pain medication, pain assessments completed as needed and addressed in care plan.	*11/06/14 KPS/DDH/MF	

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<p>F 279 F 279 SS=D</p>	<p>Continued From page 28 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to address pain and address personal choice of dress for one of one sampled resident (3). Findings include:</p> <p>1. Interview on 11/6/14 at 11:15 a.m. with the director of nursing and RN J regarding resident 3 revealed: *Their hope was all residents would deny being in pain, because it was controlled.</p>	<p>F 279 F 279</p>	<p>3. Staff member V. has been counseled regarding accurate completion of comprehensive assessments, resident assessment including medication use for pain and completion of care plan. MDS Coordinators have been re-educated to expectation of accurate comprehensive assessments including MAR review of pain medications used, effectiveness, need for physician notification, care planning of pain and special clothing requests such as the desire to wear a hospital gown at all times.</p> <p>4. DNS and/or her designee will audit three MDS assessments weekly for four weeks for accuracy regarding pain assessment, documentation in care plan and interventions including special clothing requests such as the desire to wear hospital gown and then two MDS assessments weekly for eight weeks. The data collected will be presented to the Quality Assurance committee by the DNS. It will be reviewed/discussed and at this time the QA committee will make the decision/recommendation regarding follow-up or changes.</p>	
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*QUALITY ASSURANCE
COMMITTEE

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F 279	Continued From page 29 *Pain assessments should have been completed for each resident even if they denied being in pain. *The MDS coordinator should have identified in the comment section of the MDS pain assessment that he had been taking PRN hydrocodone-acetaminophen. *Pain should have been addressed on his care plan. *Non-medication interventions should have been identified and attempted. *They stated he preferred to be wearing a hospital gown, and that it should have been care planned.	F 279	Correction Action Completed: 12-2-2014		
F 309 SS=G	Refer to F309, finding 1. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to: *Ensure pain was controlled for one of one sampled resident (3). *Educate nursing staff regarding mobility assistance needed for one of one sampled resident (7) causing mental anguish and anxiety.	F 309	F 309 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Resident #3 has been reassessed for pain and is currently receiving	x 12/10/14 KP/ODD/HMF	

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F 309	<p>Continued From page 30</p> <p>Findings include:</p> <p>1. Observation on 11/4/14 from 2:50 p.m. through 3:07 p.m. of resident 3 revealed: *He was laying on his right side in bed in a hospital gown. *His legs were shaking. *He was moaning and mumbling loud enough to be heard in the hallway. *Three unidentified staff had walked by his room and had not checked in on him. *At 3:00 p.m. certified nursing assistant (CNA) I had stood by his door and asked CNA Q who had been walking by if he was okay. -CNA Q stated "Yeah, why?" *Neither CNA had stopped into his room and asked him what he needed. *At 3:07 p.m. the director of housekeeping had stopped into his room and asked him what he needed. *Interview at that time with the director of housekeeping revealed he had requested pain pills.</p> <p>Observation on 11/4/14 at 4:15 p.m. of resident 3 revealed he was resting in bed. His legs were no longer shaking.</p> <p>Observation and interview on 11/4/14 at 4:50 p.m. with resident 3 revealed: *His legs were shaking again. *He was hard to understand but had asked this surveyor for pain pills. *When asked what hurt he replied "my legs." *He put on his call light and asked an unidentified CNA for pain pills. *The unidentified CNA stated she would go tell the nurse and left the room.</p>	F 309	<p>routine scheduled pain medication with relief. Non-medication interventions have been offered and resident has consistently refused. Resident #7 continues to improve and care plan reflects current needs in regards to wheelchair use. Resident has been reassessed and care plan has been updated.</p> <p>2. Care plans have been reviewed to reflect specific direction to staff and identify accurate needs. Resident will be monitored for effectiveness of medication and documented in the medical record. Assessment of pain will occur at the time of use of a PRN medication for pain and the effectiveness will be documented on the MAR. All residents will continue to be comprehensively assessed including pain assessment upon admission, quarterly and with a significant change of condition.</p> <p>3. MDS Coordinators have been re-educated to expectation of accurate comprehensive assessments including care plans reflecting individual needs with specific direction to staff.</p> <p>4. DNS and/or her designee will audit three MDS assessments and</p>		

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F 309	<p>Continued From page 31</p> <p>Interview on 11/4/14 at 4:55 p.m. with registered nurse (RN) R regarding resident 3 revealed: *She was not his nurse, but she had given him as needed (PRN) pain pills (hydrocodone-acetaminophen) at 3:15 p.m. due to his nurse being on break at that time. *He would have to wait for other pain pills as he had just received some at 3:15 p.m.</p> <p>Observation on 11/4/14 at 5:10 p.m. revealed CNA I had reported to RN H resident 3 was in pain and requesting pain pills. RN H replied "he will have to wait for another pill." She had not gone to check on him at that time.</p> <p>Review of resident 3's 10/21/14 care plan revealed: *He had a diagnosis of restless leg syndrome. *He had no identified focus area for pain. *There had been one focus area that addressed the restless leg syndrome along with other health concerns. *Interventions for that focus area had included the following: -"Administer medications as ordered by physician. -Monitor and document signs and symptoms of acute disease. -Notify physician as needed. -Obtain and report labs [laboratory test results] as directed by physician." *There had been no non-medication interventions addressed for pain. *Wearing a hospital gown had not been care planned.</p> <p>Review of resident 3's 10/18/14 Minimum Data Set (MDS) assessment revealed: *He had not been on a scheduled pain regimen.</p>	F 309	<p>care plans weekly for four weeks for accuracy regarding pain assessment, care plan and interventions including special clothing requests such as the desire to wear hospital gown and specific direction to staff and then two MDS assessments and care plans weekly for eight weeks. The data collected will be presented to the Quality Assurance committee by the DNSA It will be reviewed/discussed and at this time the QA committee will make the decision/recommendation regarding follow-up or changes. Correction Action Completed: 12-2-2014</p>	

Reviewed by KR/SDD/HMF

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F 309	<p>Continued From page 32</p> <ul style="list-style-type: none"> *He had received PRN pain medications. *He had not received any non-medication interventions. *At the time of the assessment interview he had stated he was not in pain. *No further questions were asked of him. <p>Review of resident 3's 7/24/14 MDS assessment revealed:</p> <ul style="list-style-type: none"> *He had not been on a scheduled pain regimen. *He had received PRN pain medications. *He had not received any non-medication interventions. *During the assessment interview he had answered he experienced pain. *The pain he had experienced had been "almost constantly." *It had made it hard for him to sleep through the night. *The pain had limited his day-to-day activities. *He had a pain intensity of eight out of ten (zero would be no pain and ten would be the worst pain). *Review of the care area assessment revealed pain had been identified as an area of concern, but it had not been care planned. <p>Review of resident 3's 11/1/14 through 11/5/14 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> *He had been on a scheduled medication (Neurontin solution) for "pain in joint, upper arm" since 6/6/14. *He had received the hydrocodone-acetaminophen PRN pain medication seven times within those five days for leg pain. *On 11/2/14 and 11/3/14 the result of receiving the pain medication had not been documented. *11/4/14 hydrocodone-acetaminophen had been 	F 309		

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F 309	<p>Continued From page 33 given at 1515 (3:15 p.m.). *At 1515 (5:15 p.m.) on that same day it had been documented "still asking for pain meds [medication]." *No pain scale or pain assessment had been documented prior to or after administering pain medication those seven times.</p> <p>Review of resident 3's October 2014 MAR revealed: *He had received hydrocodone-acetaminophen thirty-seven times based on the PRN sheets. *Thirty-six of the thirty-seven times the medication had been given for leg pain. *"Resting, some relief, helped, and effective" had been used to explain if the medication had been effective. *No pain scale or pain assessment had been documented prior to or after administering the pain medication those thirty-six times.</p> <p>Interview on 11/6/14 at 9:00 a.m. with CNA T regarding resident 3 revealed: *If he was in pain he would holler out. *She had not had any instructions on specific non-medication interventions to use with him. *She would attempt to reposition him and then inform the nurse he was in pain.</p> <p>Interview on 11/6/14 at 9:02 a.m. with CNA U regarding resident 3 revealed no one had told her what non-medication interventions to use with him regarding his pain. If he was in pain she would notify the nurse.</p> <p>Interview on 11/6/14 at 9:05 a.m. with MDS coordinator V revealed: *In the last assessment she completed on 10/16/14 he had denied pain.</p>	F 309			

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F 309	<p>Continued From page 34</p> <p>*She reviewed the prior five days of the MARs for PRN pain medication.</p> <p>*She had known he used the PRN pain medication hydrocodone-acetaminophen four out of the five days.</p> <p>*She had not identified that on the assessment and went by what he said.</p> <p>*She had not care planned pain.</p> <p>Interview on 11/6/14 at 11:15 a.m. with the director of nursing and RN J regarding resident 3 revealed:</p> <p>*Their hope was all residents would deny being in pain, because it was controlled.</p> <p>*Pain assessments should have been completed for each resident even if they denied being in pain.</p> <p>*The MDS coordinator should have identified in the comment section of the MDS pain assessment that he had been taking PRN hydrocodone-acetaminophen.</p> <p>*Pain should have been addressed on his care plan.</p> <p>*Non-medication interventions should have been identified and attempted.</p> <p>*They stated he preferred to be wearing a hospital gown, and that it should have been care planned.</p> <p>Review of the provider's June 2009 Pain Management policy revealed:</p> <p>**"The management of pain must be a priority for nurses and other personnel who provide care to resident's in pain."</p> <p>**"Persons who are experiencing pain have the right to have their pain relieved to the greatest extent possible."</p> <p>**"A comprehensive nursing assessment includes the subjective description of pain, objective data,</p>	F 309			

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F 309	<p>Continued From page 35 and the identified need for psychosocial/spiritual support."</p> <p>**Nurses will use a standardized scale to periodically assess and document a resident's pain."</p> <p>**Nurses, along with the interdisciplinary team, develop and implement a plan of care that prevents and alleviates pain as much as possible."</p> <p>**Nurses intervene to address pain issues before pain becomes severe."</p> <p>**Nurses initiate non-pharmacological nursing interventions as indicated."</p> <p>**Pain management requires thorough pain assessment."</p> <p>**Pain assessment is an on-going process."</p> <p>**All residents should be assessed for pain with each new complaint of pain."</p> <p>**Standardized pain tools will be used and shall be appropriate to the condition of the resident."</p> <p>**A plan of care shall be implemented."</p> <p>**Both non-pharmacological and pharmacological interventions shall be implemented."</p> <p>Review of the provider's September 2011 Care Plan policy revealed all care plans should include all current acute and chronic conditions for which residents may be receiving medications, treatment, or care for including pain.</p>	F 309			

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F 309	Continued From page 36 Surveyor: 22452 2. Interview on 11/4/14 at 4:00 p.m. with resident 7 revealed he: *Had been admitted to the facility on 10/1/14 from the hospital after left hip surgery. *Was receiving skilled occupational therapy (OT) and physical therapy (PT). *Was planning on returning home when he was discharged. *Felt some of the staff liked him and some of them did not. He based that on some of the staff who liked him pushed him to meals and activities in his wheelchair. The staff that did not like him made him push his own wheelchair. *Said no one had explained to him he should have been pushing his own wheelchair to keep his upper body strength. Review of resident 7's 10/10/14 care plan revealed no documentation regarding if he should be propelling his own wheelchair or if staff were to assist him. Interview on 11/4/14 at 4:45 p.m. with licensed practical nurse (LPN) Minimum Data Set coordinator C regarding resident 7 revealed: *PT would tell them what the resident could or could not do. *His care plan stated "Extensive assistance of one with wheelchair." *She confirmed extensive assistance with wheelchair did not give specific directions to the staff if the resident should be propelling his wheelchair or if they should have been. Extensive assistance usually meant the staff were more	F 309			

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F 309	Continued From page 37 highly involved than the resident. *If a resident told them they did not want to do something "We do not push them." Review of resident 7's 10/6/14 care plan summary sheet by LPN C revealed "Wants to know a time for therapy and wants to know ahead of time." Interview on 11/6/14 at 3:30 p.m. with certified occupational therapy assistant S regarding resident 7 revealed: *Nursing had not spoken to OT regarding the wheelchair issue. *They had informed nursing he should have been propelling his own wheelchair as much as he could to maintain his upper body strength. She was unsure who documented that on the care plan. *She would visit with him and explain he should be propelling his wheelchair by himself as much as he was able to.	F 309			
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	F 425 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal	x 12/10/2014 KPS/DDH/ME	

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F 425	<p>Continued From page 38</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to ensure medications were delivered in a timely manner from the pharmacy for administration to four of eight sampled residents (1, 2, 5, and 6). Findings include:</p> <p>1. Review of resident 1's 10/22/14 through 10/27/14 medication administration record (MAR) and treatment record revealed: *Advair inhaler was not administered on 10/22/14 at bedtime (had not arrived from pharmacy). *Gabapentin capsules were not administered on 10/22/14 at 8:00 p.m. or on 10/23/14 at 8:00 a.m., 12:00 noon, 4:00 p.m., or 8:00 p.m. (had not arrived from pharmacy). *Senna was not administered at bedtime on 10/22/14 (had not arrived from pharmacy). *Lisinopril was not administered on 10/22/14 at 6:00 p.m. (had not arrived from pharmacy). *Magnesium oxide was not administered on 10/22/14 at 6:00 p.m. or on 10/23/14 and 10/24/14 at 8:00 a.m. and 6:00 p.m. (had not arrived from pharmacy). *Metoprolol was not administered on 10/22/14 at 6:00 p.m. (had not arrived from pharmacy).</p>	F 425	<p>law. Without waiving the foregoing statement, the facility states that with respect to:</p> <p>1. Resident #1 has been discharged; Resident #2, #5 and #6 have all ordered medications available.</p> <p>2. Resident's records have been reviewed to ensure that the current medication and treatment orders are filled and administered. Any medications noted to be on order or unavailable were requested from pharmacy. Medications unable to be filled immediately by primary pharmacy will be filled by alternative pharmacy. The education identified in F 224 was completed for all licensed staff. In addition, the pharmacy nurse provided education for all licensed nurses on 11/13/2014.</p> <p>3. System changes include two licensed nurses will review transcription of orders for accuracy and completeness including daily weights, temperatures and notification of physician. Any medication not delivered from pharmacy per schedule the DNS and/or her designee will be notified to ensure the alternative pharmacy is</p>	

**All KR/SDDH/MF*

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F 425	Continued From page 39 *Miconazole powder was not administered on 10/22/14 at bedtime , on 10/23/14, 10/24/14, or 10/25/14 BID and on 10/26/14 at 8:00 a.m. (had not arrived from pharmacy). *Montelukast was not administered at bedtime on 10/22/14 (had not arrived from pharmacy). *Oxycodone was not administered on 10/22/14 at bedtime or on 10/23/14 at 6:00 a.m. and 2:00 p.m. (had not arrived from pharmacy). *Atrovent nasal spray was not administered on 10/22/14 at bedtime (had not arrived from pharmacy). *Levocetirizine was not administered on 10/22/14 at 6:00 p.m. (had not arrived from pharmacy). *Levothyroxine was not administered on 10/23/14 at 6:00 a.m. (had not arrived from pharmacy). *Lantus insulin was not administered on 10/22/14 at bedtime (had not arrived from pharmacy). *Novolog insulin was not administered on 10/22/14 at 5:00 p.m. and bedtime (had not arrived from pharmacy). *Albuterol nebulizer was not administered on 10/22/14 at 8:00 p.m. (had not arrived from pharmacy). *Roflumilast was not administered on 10/23/14 at 8:00 a.m. (had not arrived from pharmacy). *Sucralfate was not administered on 10/22/14 at 8:00 p.m. (had not arrived from pharmacy). *Theophylline was not administered on 10/22/14 at 8:00 p.m. (had not arrived from pharmacy). *Intradry dressing was never documented as being administered (pharmacy record revealed it was delivered on 10/28/14 after she had been hospitalized). 2. Review of resident 2's October 2014 MAR revealed Latanoprost eye drops were not administered from 10/21/14 through 10/26/14 as "Not available."	F 425	utilized and/or the physician is notified. Education will continue to be provided to licensed staff regarding specific skilled services as needed through verbal, return demonstration and/or education packets. Licensed staff will immediately contact the DNS and/or her designee if further education/training is needed on an individual basis. New admissions will have a complete review of all orders, medications ordered and delivered and plan of care is being followed per physician orders within 24 hours of admission. Pharmacy Occurrence reporting of errors will be maintained and reviewed daily. 4. The DNS and/or her designee will audit: completion of two person transcription check three times per week for four weeks and two times per week for eight weeks, completion of delivery of medications as ordered, notification of DNS and alternative pharmacy four times per week for four weeks and three times per week for eight weeks, completion of skilled services education is provided and licensed staff perform services as ordered		

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F 425	Continued From page 40 3. Review of resident 5's October 2014 MAR revealed the following medications were not available from pharmacy for administration: *Cholecalciferol (vitamin D supplement) on 10/22/14 for the 8:00 a.m. dose. *Probiotic (supplement) on 10/22/14 for the 8:00 a.m. dose. *Fish oil on 10/21/14 and 10/22/14 for the 8:00 a.m. doses. *Vitamin B complex on 10/22/14 for the 8:00 a.m. dose. 4. Review of resident 6's October 2014 MAR revealed the following medications were not available from the pharmacy for administration: *Cal-mag zinc and vitamin D on 10/22/14 for the 8:00 a.m. dose. *Vitamin D3 on 10/22/14 for the 8:00 a.m. dose. *Lactobacillus (stomach) on 10/22/14 for the 8:00 a.m., 12:00 noon, and 6:00 p.m. doses. 5. Interview on 11/5/14 at 9:30 a.m. with the director of nursing (DON) and assistant director of nursing regarding the above revealed: *They had not informed the pharmacy of the above non-available medications. *The nurses had started a list of residents with missing medications and had given the list to the previous DON. They had not seen that list. *They had not notified the physician of the unavailability of the medications from the pharmacy, and had not considered those were medication errors. *They had planned on having a meeting with the pharmacy on 11/7/14 to go over pharmacy issues. It had been postponed when the administrator had gone on medical leave. They had no specific residents to visit with the	F 425	three times per week for four weeks and then two times per week for eight weeks, completion of new admission medical record review for orders transcribed, medications ordered and delivered and plan of care if being followed per physician orders three times per week for four weeks and then two times per week for eight weeks. The data collected will be presented to the Quality Assurance committee by the DNSA. It will be reviewed/discussed and at this time the QA committee will make the decision/recommendation regarding follow-up or changes. Correction Action Completed: 12-2-2014		

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F 425	<p>Continued From page 41 pharmacy about.</p> <p>Review of the provider's 12/1/07 pharmacy Medication Shortages/Unavailable Medications policy revealed: **Upon discovery the facility has an inadequate supply of medication to deliver to a resident, the facility staff should immediately initiate action to obtain the medication from pharmacy." **If a medication shortage is discovered during normal pharmacy hours: -A facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. -If the next available delivery causes delay or a missed dose in the resident's medication schedule, the facility nurse should obtain the medication from the emergency medication supply to administer the dose. -If the medication is not available in the emergency medication supply, the facility staff nurse should notify the pharmacy and arrange for an emergency delivery." **If a medication shortage is discovered after normal pharmacy hours: -A licensed facility nurse should obtain the ordered medication from the emergency medication supply. -If the ordered medication is not available in the emergency medication supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action that may include emergency delivery or use on a emergency back-up third party pharmacist. -If an emergency delivery is unavailable, the</p>	F 425		

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F 425	Continued From page 42 facility nurse should contact the attending physician to obtain orders or directions. -If the medication is unavailable from the pharmacy due to formulary coverage, contraindication, drug-drug interaction, allergy, or other clinical reason, the facility should collaborate with the pharmacy and physician/prescriber to determine a suitable therapeutic alternative. -If facility nurse is unable to obtain a response from the attending physician/prescriber in a timely manner, facility nurse should notify the nursing supervisor and contact the facility's medical director for orders/direction, making sure to explain the circumstances of the medication shortage." Review of the provider's 12/18/06 Pharmacy Related Occurrence Reporting policy revealed: *"A pharmacy related occurrence is an event which the facility believes: -Is not consistent with the desired operation of the facility with respect to pharmacy. -Or has caused, or had the potential to cause, an unexpected resident medical intervention, a change in intensity of care, or a health care impairment." *"The facility should notify the pharmacy of any possible dispensing occurrence." *"Facility should report the occurrence to pharmacy either verbally or in writing. An occurrence report or other appropriate document may be completed by the person identifying the occurrence and/or responsible manager."	F 425			
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that	F 490	F 490 The preparation of the following plan of correction for this deficiency	* 11/10/2014 KJ/SDE/HMF	

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F 490	<p>Continued From page 43</p> <p>enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, policy review, and job description review, the provider failed to make sure the facility was operated and administered in a manner that maintained the safety and overall well-being for all its seventy-nine residents by ensuring: *All licensed nurses were educated and followed the physician's orders for one of one sampled newly admitted resident (1) who required a skilled nursing procedure. *Medications were received from the pharmacy in a timely manner for administration for one of one sampled resident (1). *The physician and family were notified of a significant change of condition in a timely manner for one of one sampled resident (1). *Pain was assessed and managed for one of one sampled resident (1) by the administration of pain medications in a timely manner. *A thorough investigation was conducted of the adequacy of care and administration of medications for one of one sampled newly admitted residents (1). *A plan was put in place for the education and inservicing of all licensed nurses on the transitional care unit (TCU) regarding individual resident's skilled nursing needs. Findings include:</p> <p>1. Review of resident 1's medical record</p>	F 490	<p>does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to F224 and F 226 please refer to the responses documented. Correction Action Completed: 12-2-2014</p>		

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F 490	<p>Continued From page 44 revealed:</p> <ul style="list-style-type: none"> *A 10/22/14 admission date at 5:30 p.m. *Diagnoses included: <ul style="list-style-type: none"> -Hypertension (high blood pressure). -Diabetes mellitus (varying up and down blood sugars). -Congestive heart failure. -Chronic obstructive pulmonary disease (COPD). -Oxygen dependent. -Asthma. -Cholelithiasis (hard deposits called gallstones in the gallbladder.) Biliary drain (drainage tube from the liver) was placed on 10/19/14 in the hospital. *A 10/27/14 emergency discharge to the hospital. <p>Review of resident 1's 10/27/14 hospital admission and history revealed:</p> <ul style="list-style-type: none"> *Septic shock (serious condition that occurs when a body-wide infection leads to a dangerously low blood pressure). *Acute chronic respiratory failure with hypercapnia (an increased amount of carbon dioxide in the blood). *Acute encephalopathy (a permanent or reversible brain injury due to direct injury to the brain or an illness remote from the brain). *Delirium (an acute confusional state caused by a physical or mental illness). *Sepsis (a potentially life threatening complication of an infection). *Cellulitis (a potentially serious bacterial skin infection) and abscess of leg. *Was found in nursing home not oriented and with low blood pressure. ***Sepsis is thought to be due to cellulitis in legs and groin verses more likely related to gallbladder disease." ***Also just got tube placed in an acute cholecystitis (inflammation of the gallbladder)" in 	F 490			

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F 490	<p>Continued From page 45 an out-of-town hospital. **"Confused. Condition is serious."</p> <p>Review of the DON's 10/29/14 licensed nurses meeting notes revealed: **"Hold each other accountable for their work." **"If you do not know how to do a part of your job, it is your responsibility to come and talk to me so we can get you the education."</p> <p>Interview on 11/5/14 at 9:35 a.m. with the director of nursing and the assistant director of nursing regarding resident 1 revealed their internal investigation after she had been sent to the hospital confirmed there had been no neglect issues in her care from 10/22/14 through 10/27/14.</p> <p>Review of the provider's undated Administrator job description revealed: **"Coordinate overall education of facility staff." **"Provide leadership for facility staff and facility goals." **"Provide leadership for overall resident care."</p> <p>Review of the provider's undated Director of Nursing Services job description revealed: **"Develop and maintain nursing care objectives and standards of nursing care practices for this facility in cooperation with the assistant director of nursing." **"Cooperate with the assistant director in developing nursing care policies and procedures." **"Establish procedures for administration and control of medications." **"Regularly inspect the facility and nursing practices for compliance with federal, state, and local standards and regulations." **"On-call for emergencies that supervisory</p>	F 490			

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F 490	Continued From page 46 personnel cannot handle." **Assure proper handling and emergency care of residents, personnel, and visitors while on the job or in the building." Refer to F224, finding 1, and F226, finding 1.	F 490			