

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

PRINTED: 10/12/2015
FORM APPROVED
OMB NO. 0938-0391

Poc #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/29/2015
NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS Complaint investigation of #35074, 35430, 35545, 35583, 35628, 35933, 35934, 35952, 36216, 36315, 36215, 36324, 36325, 36552, 36636, 36849, 36944, 37106, 37141, 37321 was conducted at Boulevard Terrace 9/15/15 - 9/29/15. Complaints #36216, 36522, 36849, 36944, 37141, 37321 were substantiated without deficient practice; #35430, 35952, 36234 were unsubstantiated with no deficient practice; #35074, 35545, 35583, 35933, 35934, 36325, 36636, 37106 were substantiated with deficiencies; #35620, 36215, 36315 were unsubstantiated with deficiencies.	F 000	This Plan of Correction affirms our allegation of compliance for the deficiencies cited, however, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction has been respectfully developed and submitted as required for compliance with federal and state regulations		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and facility investigation documentation and interview, the facility failed to report the alleged abuse immediately, per facility policy, for 2 (Resident #12, 14) of 44 residents reviewed. The findings included: Review of the facility policy "Abuse Prevention Standard" revised on 5/2015, revealed	F 223	F 223 1. Resident #12 and #14 alleged verbal and physical abuse was reported to the Administrator on 4/3/15 instead of 4/2/15, the incident was investigated and reported to the state on 4/7/15. 2. An audit was done on 10-19-15 by the Social Services Director who interviewed current residents to determine if they had any concerns related to mental, verbal, physical, sexual or financial abuse. No concerns were identified. 3. Education for facility staff (administration, dietary, housekeeping, laundry, nursing, therapy) on all shifts began on 10-13-15 by the Administrator on the types of abuse (mental, verbal, physical, sexual, financial and neglect), to report abuse to the Administrator and to report the abuse immediately to the Administrator. Facility Administrator or designee will complete the education by 11-13-15.	11-13-15	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ornella Bagwood, RN, Administrator</i>			TITLE		(X6) DATE 10-31-15

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 223	Continued From page 1 "...Reporting- All employees are required to immediately notify administrative or nursing supervisory staff that is on duty of any complaint, allegation, observation or suspicion of resident abuse, mistreatment or neglect so that the resident's needs can be attended to immediately and investigation can be undertaken promptly..." "...Investigation...An immediate investigation into the alleged incident, during the shift it occurred..." Medical record review revealed Resident #12 was admitted on 9/23/12 and re-admitted to the facility on 5/7/15, with diagnoses including Pneumonia, Dementia with Behavioral Disturbances, Congestive Heart Failure, Atrial Fibrillation, Vascular Dementia with Delusions and Depressed Mood, Convulsions, and Chronic Pain. Medical record review of the Quarterly Minimum Data Set (MDS) dated 4/4/15 revealed Resident #12 was moderately cognitively impaired, required extensive 1 person assistance for bed mobility, locomotion on/off the unit, and personal hygiene; and was total dependence with 2 person assistance for transfers and toileting. Further review revealed the resident was always incontinent of bowel and bladder. Further review revealed the resident had minimum difficulty hearing, had clear speech, could make self understood and could understand others. Medical record review revealed Resident #14 was admitted to the facility on 5/6/14 with diagnoses including Alzheimer's Disease, Dementia with Behavioral Disturbances, Chronic Pain, Parkinson's Disease, Anxiety, Depression and Failure To Thrive.	F 223	4. Any allegation of abuse will be tracked by the Administrator or designee to establish time identified and time reported 5x a week times 4 weeks, weekly x4 weeks and monthly x1 month Results will be reviewed in QAPI monthly x3 months. Any aberrancies will be addressed, interventions developed and corrective action taken. 5. 11-13-15	11-13-15	

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F 223 Continued From page 2
Medical record review of the Significant Change MDS dated 4/28/15 revealed the resident had impaired memory, rejected care, physical and verbal behavior directed at others, was totally dependent with 1-2 person assistance for bed mobility, transfers, locomotion on/off unit, dressing, eating, toileting, personal hygiene and bathing. Further review revealed Resident #14 was always incontinent of bowel and bladder, had clear speech, sometimes could make self understood and sometimes could understand others.

F 223

Review of a facility investigation dated 4/2/15 revealed the accusation of a Certified Nurse Aide (CNA) being verbally and physically rough during personal hygiene care for Resident #12 and 14. Further review of the facility investigation revealed CNA #1 reported the incident the day (4/3/15) after the incident occurred. CNA #1 failed to report the incident, per facility policy, by immediately notifying administrative or nursing supervisory staff that was on duty

Interview with the Administrator on 9/17/15 at 2:25 PM in the Administrator's office confirmed the facility failed to report the allegation immediately per facility policy.

F 225
SS=E 483.13(c)(1)(ii)-(iii), (c)(2) - (4)
INVESTIGATE/REPORT
ALLEGATIONS/INDIVIDUALS

F 225

F 225

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;

1. Residents #19 and #20 no longer reside at this facility. Resident #19 was discharged to the hospital 11-15-14 and Resident #20 was discharged to the hospital 1-13-15. 11-13-15

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F 225	Continued From page 4 residents reviewed; The findings included: Review of the facility policy entitled "Falls Standard" revised 11/2014, revealed the Procedure Post Fall included: 4. Do neurochecks for all unwitnessed falls and any time resident witnessed or reportedly hit head during fall. 6. If the resident is a diabetic or you suspect blood glucose problems, perform capillary blood glucose testing. 9. Orthostatic blood pressure must be done every 8 hours for 3 days post fall. 10. Accident/Incident Report, Post Fall Investigation report, clinical record and care plan to be reviewed within 24 hours for complications. Review of the facility policy "Abuse Prevention Standard" revised on 5/2015, revealed "...Investigation...An immediate investigation into the alleged incident, during the shift it occurred...Interview resident or other resident witness...to be dated, documented...interview staff member implicated...narrative dated and signed...Interview all staff on the unit, as well as other staff or other available witness...written narrative signed and dated..." Medical record review revealed Resident #19 was admitted to the facility on 10/16/14, with diagnoses including Chronic Kidney Disease Stage IV, Hypertension, Dysphagia (difficulty swallowing), Chronic Obstructive Pulmonary Disease, Gastroesophageal Reflux Disease, Atherosclerotic Cardiovascular Disease, Congestive Heart Failure, Depression, and	F 225	4. The DON and the clinical Interdisciplinary team (unit managers, MDS nurse, activities director and social worker) will audit post fall documentation during the morning clinical meeting to verify adherence to policy, proper documentation and notifications, effective interventions and care plan properly updated. This audit will be done weekdays and will be ongoing. The results of the audits will be brought to the monthly QA Meeting by the DON. Any aberrancies will be addressed, interventions developed and corrective action taken. 5. 11-13-15 Conduct a complete investigation for abuse: 1. Residents #3, 10, 11, and 14 no longer reside at this facility. Resident #3 was discharged to the psychiatric hospital 5-21-15, Resident #10 was discharged to the psychiatric hospital 4-20-15, Resident #11 was discharged to another nursing facility 3-24-15 and Resident #14 passed away on 5-28-15. For Resident #12, there have been no reported allegations of abuse for this resident since 4-8-15. 2. All residents have the potential to be affected by the deficient practice of failure to follow facility policy regarding conducting abuse and/or neglect investigation. An internal facility four point action plan was initiated on 8-11-15 related to staff following policies and	11-13-15	11-13-15

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F 225	Continued From page 5 Diverticulosis. Medical record review of the 30 day Minimum Data Set (MDS) dated 11/13/14, revealed the resident was moderately cognitively impaired. Continued review of the MDS revealed the resident required assistance of 1 person for transfers, dressing, and grooming; required extensive assistance of 1 person for bathing; was independent with eating after setup; and was continent of bowel and bladder. Medical record review of a fall investigation dated 10/25/14, revealed the resident slid to the floor from a sitting position on the side of the bed after a shower. Continued investigation review revealed the resident stated she hit her arm on the walker and she had 2 skin tears to the left arm. Further review of the investigation revealed the recommendation was non-skid socks on. Continued review of the investigation revealed no documentation of vital signs every 8 hours for 3 days and no documentation of neuro checks completed per facility policy. Medical record review of a fall investigation dated 10/26/14, revealed the resident was found at the left side of the foot of the bed sitting on her buttocks with the walker in front of her. Continued review of the investigation revealed the resident stated she was ambulating from the bathroom with her walker; sat on the corner of the bed; slid off the bed because the blanket produced a slippery surface. Further review of the investigation revealed the resident was counseled to use the call light and it was recommended a foot board be placed on the bed. Continued review of the investigation revealed the resident had full thickness skin tears to left anterior upper	F 225	(2, continued) procedures for investigation follow up related to state reportable events. There have been three facility events reported to state since 8-11-15 which were all audited by the facility Regional Director of Clinical Operations and determined to be complete. 3. Education on conducting abuse investigation was provided to the Administrator on 8-12-15 by the Director of Risk Management related to the investigation process. Education included a review of policy to interview likely witnesses to allegations such as staff and other witnesses that were present during the time of the allegation and assessing non-interviewable residents that may have been present for signs or symptoms of abuse or neglect to ensure their safety. This education was given to the facility Director of Nursing and two unit managers on 8-18-15 by the Director of Risk Management and the Social Worker was educated on 10-19-15 by the Facility Administrator 4. Weekly Audits of facility reportable events will be performed by the Administrator or designee x3 months to ensure compliance. Results will be reviewed in QAPI monthly x3 months. Any aberrancies will be addressed, interventions developed and corrective action taken. 5. 11-13-15	11-13-15	

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F 225	Continued From page 6 arm and left posterior upper arm. Continued review of the investigation revealed no documentation of vital signs every 8 hours for 3 days and no documentation of neuro checks completed per facility policy. Medical record review of a fall investigation dated 11/6/14, revealed the resident was found sitting on her buttocks on the left side of the bed. Continued review of the investigation revealed the resident stated she was attempting to ambulate to the bathroom. Further review of the investigation revealed recommendations included toileting the resident as needed and especially during the night between 2 - 4 AM. Continued review of the investigation revealed no documentation of vital signs every 8 hours for 3 days and no documentation of neuro checks. During interview on 9/24/15, at 1:00 PM, in the conference room, the Director of Nursing confirmed vital signs were not taken every 8 hours for 3 days; neuro checks were not completed; and the care plan was not updated to reflect interventions so the investigation was incomplete. Medical record review revealed Resident #20 was admitted to the facility on 9/23/12 with diagnoses including Diabetes Mellitus Type 2, Hypertension, Anxiety, Depression, Dementia with Behavioral Disturbances, and Chronic Kidney Disease Stage 4. The resident was discharged to the hospital on 1/13/15 for flu like symptoms. Medical record review of the Quarterly MDS dated 11/30/14 revealed Resident #20 was moderately cognitively impaired, was independent with bed mobility, transfers, ambulation and	F 225	Completely investigate injuries of unknown origin. 1. Resident #27 passed away on 05-01-15. 2. All residents have the potential to be affected by the deficient practice of failure to follow facility policy regarding investigations of injuries of unknown origin. A four point action plan was initiated on 10-19-15 related to staff following policies and procedures for investigation of any injury of unknown origin (which are state reportable). There have been three facility events reported to state since 8-11-15 which were all audited by the facility Regional Director of Clinical Operations and determined to be complete. 3. Education on conducting an injury of unknown origin investigation was provided to the Administrator on 10-12-15 by the Director of Risk Management related to the investigation process. Education included a review of policy to interview likely witnesses to allegations such as staff and other witnesses that were present during the time of the allegation and assessing non-interviewable residents that may have been present for signs or symptoms of abuse or neglect to ensure their safety. This education was given to the facility Director of Nursing and two unit managers on 8-18-15 and the Social Worked was educated on 10-19-15.	11-13-15	11-13-15

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F 225 Continued From page 7
toileting. Further review revealed the resident was always continent of bowel, occasionally incontinent of bladder and had no falls since the prior assessment.

Medical record review of the Fall Risk Screen dated 11/29/14 revealed Resident #20 was at moderate risk for falls. Further review revealed the current interventions in place were "...call light within reach; non-skid socks in place..."

Medical record review of the Nursing Weekly Summary dated 1/3/15 revealed Resident #20 was independent with bed mobility, transfers, toileting, ambulation, was oriented to person, place and time, and was continent of bladder.

Medical record review of the Nursing SBAR-Change in Condition Observation dated 1/10/15 at 11:50 PM and the Neuro Check forms dated 1/11/15 at 12:34 AM and on 1/11/15 at 5:00 AM revealed Resident #20 vital signs (VS) dated 1/11/15 at 12:34 AM were as follows: blood pressure (BP) was 120/76 left arm while lying down and pulse (P) was regular at 72. Further review revealed the most recent documentation for respiration (R) was dated 1/8/15 at 11:02 AM of 18 respirations. Further review revealed the section for information of recent laboratory results was not completed.

Medical record review of the nurses progress note dated 1/11/15 at 12:01 AM revealed "...UNUSUAL OCCURRENCE NOTE...CNA (Certified Nurse Aide) found res [resident] sitting on buttocks in front of bathroom floor. Res is usually independent in ambulation. Was moved into a new room yesterday...is typically alert without confusion however did have mild

F 225
4. Weekly Audits of facility reportable events will be performed by the Administrator or designee x3 months to ensure compliance. Results will be reviewed in QAPI monthly x3 months. Any aberrancies will be addressed, interventions developed and corrective action taken.
5. 11-13-15

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F 225 Continued From page 8
confusion earlier in shift...did not utilize her walker when ambulating to BR [bathroom]. Found with reg [regular] socks on. Obtained non-skid socks and placed on res. Denied hitting head. Denies pain..."

F 225

Medical record review of the nurses progress note dated 1/12/15 at 6:00 AM revealed "...UNUSUAL OCCURRENCE NOTE...CNA was responding to...BR bell...observed res on BR floor. Found on back with her head towards the wall...next to trash can...Neuro-checks WNL [within normal limits]...VS taken. Found to be hypotensive with BP 62/46..."

Medical record review of the Fall Risk Screen dated 1/12/15 at 4:30 AM revealed the new interventions included "...Check orthostatic BP x [times] 5 days for assessment..."

Medical record review of the Neuro Checks form dated 1/12/15 at 4:30 AM revealed the following VS: BP from the right arm was 62/46 while sitting, P was regular at 92, and the R was 18.

Medical record review of the Vital Summary form revealed the following:

1. On 1/11/15 at 12:34 AM: BP 120/76 lying down left arm, P regular at 72, R was 18.
2. On 1/12/15 at 4:30 AM: BP 62/46 sitting right arm; at 8:35 PM BP was 84/34 sitting down right arm; at 8:40 PM BP was 102/54 while standing right arm.
3. On 1/12/15 at 6:19 AM the P was regular at 92 and the R was 18.

Review of the medical record for laboratory testing collected on 1/12/15 at 1:20 AM revealed the Glucose (blood sugar level) was elevated at

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F 225	<p>Continued From page 9</p> <p>125 milligrams/deciliter (mg/dl), normal range was 70-105 mg/dl.</p> <p>Interview with the Director of Nursing on 9/16/15 at 3:00 PM in the conference room and the Administrator on 9/17/15 at 8:30 AM in the conference room confirmed the facility failed to obtain the orthostatic blood pressure every 8 hours post fall per the facility policy. Further interview confirmed the facility failed to perform blood glucose testing if the resident was diabetic per facility policy after a fall.</p> <p>Medical record review revealed Resident #3 was admitted to the facility on 10/16/14, with diagnoses including Gastroesophageal Reflux Disease, Chronic Kidney Disease IV, Hypertension, Chronic obstructive Pulmonary Disease, Anxiety, Congestive Heart Failure, Peripheral Vascular Disease, and Chronic Pain.</p> <p>Medical record review of the Quarterly Minimum Data Set (MDS) dated 4/30/15, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 2/15, indicating Resident #3 was severely impaired cognitively. Continued review of the MDS revealed Resident #3 required extensive assistance with transfers, dressing, grooming, and bathing; was independent with eating; and was always incontinent of bowel and bladder.</p> <p>Medical record review revealed Resident #10 was admitted to the facility on 4/17/15, with diagnoses including Diabetes Mellitus, Depression, Dementia, Chronic Obstructive Pulmonary Disease, and Paranoia.</p> <p>Medical record review of the 5 day MDS dated 4/20/15, revealed Resident #10 was severely</p>	F 225		

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F 225 Continued From page 10
impaired cognitively; required supervision with transfers and ambulation; required assistance of one person for dressing, grooming, and bathing; was independent with eating; and was occasionally incontinent of bowel and bladder.

Medical record review of nursing notes dated 4/20/15, revealed the Certified Nursing Aide (CNA) stated Resident #10 was standing over the bed of Resident #3 and yelling "Get the hell out of my room". Continued review revealed the Licensed Practical Nurse (LPN) removed Resident #10 from the room and took her to the nurses' station. Continued review revealed Resident #3 stated Resident #10 was bothering her but would not answer when asked if Resident #10 had threatened or hit her.

Medical record review of nursing notes dated 4/21/15, revealed Resident #3 was ambulating out of the bathroom and Resident #10 was sitting in her wheelchair just outside the doorway. Continued review revealed Resident #10 yelled in an agitated state "I couldn't get in the room because of your damn door in my way. Ya know this is my room, you stupid bitch." Further interview revealed Resident #3 responded "You better hush. I didn't do anything wrong." Continued review revealed the LPN witnessed Resident #10 raise her hand and hit Resident #3 on the arm. Further review revealed Resident #10 began to shake the wheelchair of Resident #3 so the LPN took Resident #10 to the nurses' station.

Review of the facility investigation revealed no interviews with the CNA who observed Resident #10 standing over the bed of Resident #3 nor was there an interview with the LPN who witnessed Resident #10 strike Resident #3. Continued

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NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130
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F 225	<p>Continued From page 11</p> <p>review of the facility investigation revealed Resident #10 was transferred to a psychiatric hospital for evaluation and treatment.</p> <p>Interview with the DON on 9/24/15, at 1:30 PM in the conference room, confirmed the investigation was incomplete since the LPN and CNA were not interviewed.</p> <p>Medical record review revealed Resident #11 was admitted to the facility on 9/23/12 and readmitted on 1/30/15 with diagnoses including Hypothyroidism, Multiple Sclerosis, Restless Leg Syndrome, Personality Disorder, Diabetes Mellitus, Opioid Dependence, Anxiety Disorder, and Peripheral Vascular Disease. Resident #11 was discharged on 3/24/15.</p> <p>Record review of the 14-day MDS revealed a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>Review of the facility investigations for 2 allegations of abuse of Resident #11 with occurrence dates of 1/8/15 and 2/2/15, revealed the facility had failed to obtain statements from residents or staff.</p> <p>Interview with the Administrator on 9/16/15 at 1:05 PM in the Administrator's office revealed the facility had no further documentation related to the incident investigations, confirming the investigation was incomplete.</p> <p>Medical record review revealed Resident #12 was admitted on 9/23/12 and re-admitted to the facility on 5/7/15, with diagnoses including Pneumonia,</p>	F 225		

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F 225	<p>Continued From page 12</p> <p>Dementia with Behavioral Disturbances, Congestive Heart Failure, Atrial Fibrillation, Vascular Dementia with Delusions and Depressed Mood, Convulsions, and Chronic Pain.</p> <p>Medical record review of the Quarterly MDS dated 4/4/15 revealed Resident #12 was moderately cognitively impaired, required extensive 1 person assistance for bed mobility, locomotion on/off the unit, and personal hygiene; and was total dependence with 2 person assistance for transfers and toileting. Further review revealed the resident was always incontinent of bowel and bladder. Further review revealed the resident had minimum difficulty hearing, had clear speech, could make self understood and could understand others.</p> <p>1.) Review of a facility investigation dated 4/2/15 revealed the accusation of a Certified Nurse Aide (CNA) being verbally and physically rough during personal hygiene care for Resident #12.</p> <p>Review of the facility investigation revealed, aside from the reporting CNA #1, no other staff members on duty on 4/2/15 were interviewed, and there was no evidence residents that were not able to be interviewed were assessed to ensure their safety.</p> <p>Interview with the Administrator on 9/17/15 at 2:45 PM in the Administrator's office confirmed the facility failed to follow their Abuse policy by not interviewing staff on duty at the time of the incident, failed to assess non-interviewable residents to ensure their safety.</p> <p>2.) Review of the facility investigation</p>	F 225		
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F 225	<p>Continued From page 13</p> <p>documentation of an incident dated 4/8/15 revealed an employee was overheard responding to Resident #12's request to go to the bathroom by stating "...you don't use the bathroom you always go on the floor..."</p> <p>Observation on 9/21/15 at 9:35 AM revealed 2 staff in the resident's room preparing to get Resident #12 out of the bed by using a hooyer lift.</p> <p>Telephone interview with CNA #2, alleged perpetrator, on 9/21/15 at 10:09 AM, when asked if she recalled the event, stated the resident was on the edge of the wheelchair in the hall asking to go to the bathroom. The CNA stated she told the resident she did not use the bathroom and was going on the floor as the CNA was repositioning the resident back into the wheelchair.</p> <p>Interview with CNA #3 and CNA #4 on 9/21/15 at 10:30 AM and 1:50 PM in the B hall confirmed they were the staff present in the resident's room at 9:35 AM using the hooyer lift. Further interview revealed due to the size of the resident and the size of the resident's wheelchair, required for transport, the resident could not get into the bathroom in the resident's room and has worn briefs for incontinence for a long time. Further interview revealed when the CNA was asked if the CNA had ever taken the resident to use the bathroom the CNA stated "...never tried to use the bathroom..." Further interview revealed the resident could reposition herself on the wheelchair and lean forward as if coming out of the chair.</p> <p>Interview with Resident #12 on 9/21/15 at 12:30 PM in the dining room when asked if staff had ever talked to her in a mean manner or were</p>	F 225			

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F 225 Continued From page 14

rough in handling her during personal care revealed the resident could not recall any staff being rude to her or rough while turning her, or during bathing or person hygiene care. The resident stated "I don't recall anyone treating me bad."

Interview with CNA #5 and CNA #6, on 9/21/15 at 3:35 PM in the B hall confirmed both CNAs provided direct care to the resident. Further interview revealed a hoyer loft was primarily used for the resident, the resident self propels a large wheelchair, and the wheelchair does not fit in bathrooms in resident rooms. Further interview revealed the resident had been incontinent for a long time and used briefs.

Review of the incident investigation revealed no staff members on duty on the date of the incident were interviewed as to the care the alleged perpetrator (CNA #2) provided or any interaction with CNA #2 on that day for reference as to the CNA's state of mind. Further review revealed no non-interviewable residents were checked to ensure their safety was intact. Further review revealed the facility had a video camera in the area of the incident and the investigation had no documentation as to review of the video.

Interview with the Administrator on 9/22/15 at 9:45 AM in the Administrator's office confirmed the surveyor had received all investigative documentation available. Further interview revealed the video on 4/8/15 was no longer available to review and should have been reviewed at the time of the incident. Further interview confirmed the facility failed to investigate the 4/8/15 incident by interviewing staff on duty, and checking the residents that

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F 225	Continued From page 15 were not able to be interviewed to ensure their safety. Medical record review revealed Resident #14 was admitted to the facility on 5/6/14 with diagnoses including Alzheimer's Disease, Dementia with Behavioral Disturbances, Chronic Pain, Parkinson's Disease, Anxiety, Depression and Failure To Thrive. Medical record review of the Significant Change MDS dated 4/28/15 revealed the resident had impaired memory, rejected care, physical and verbal behavior directed at others, was totally dependent with 1-2 person assistance for bed mobility, transfers, locomotion on/off unit, dressing, eating, toileting, personal hygiene and bathing. Further review revealed Resident #14 was always incontinent of bowel and bladder, had clear speech, sometimes could make self understood and sometimes could understand others. Review of a facility investigation dated 4/2/15 revealed the accusation of a CNA being verbally and physically rough during personal hygiene care for Resident #14. Review of the facility investigation revealed, aside from the reporting CNA #1, no other staff members on duty on 4/2/15 were interviewed, and there was no evidence residents that were not able to be interviewed were assessed to ensure their safety. Interview with the Administrator on 9/17/15 at 2:45 PM in the Administrator's office confirmed the facility failed to follow their Abuse policy by not interviewing staff on duty at the time of the	F 225			

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F 225	<p>Continued From page 16 incident and failed to assess non-interviewable residents to ensure their safety.</p> <p>Medical record review revealed Resident #27 was admitted to the facility on 7/27/12, with diagnoses including Stage III Pressure Ulcer, Dementia, Hypertension, Osteoarthritis, and Congestive Heart Failure.</p> <p>Medical record review of a Significant Change MDS dated 2/24/15, revealed Resident #27 had a BIMS score of 3, indicating she was severely impaired cognitively. Continued review of the MDS revealed Resident #27 was dependent and required two person assistance for transfers and bathing; was dependent and required one person assistance for dressing, eating, and grooming; and was always incontinent of bowel and bladder.</p> <p>Medical record review of nursing notes dated 12/14/15, revealed the right leg of Resident #27 was swollen, warm, and red with the resident crying out on palpitation of the area. Continued review of nursing notes revealed the resident received one dose of Rocephin (antibiotic) intramuscularly and was started on Keflex (antibiotic) 500 milligrams (mg) three times daily for 7 days. Further review of nursing notes dated 12/17/14, revealed Resident #27 cried when anyone touched her ankle and the right ankle and foot had prominent swelling. Continued review of nursing notes dated 12/18/14 revealed the right ankle was swollen, discolored, and tender to touch and this was diagnosed as cellulitis. Further review of nursing notes revealed an x-ray was done of the right leg and ankle which revealed fractures of the right distal tibia and fibula (fracture of two main bones of lower leg near the ankle).</p>	F 225		
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F 225	Continued From page 17 Review of the facility investigation dated 12/17/14, revealed CNA #7 requested Resident #27 be seen by the primary nurse, RN #3 because "...something just isn't right and she's moaning..." Continued review of the investigation revealed LPN #1 went to assess the resident since RN #3 didn't acknowledge the CNA's request. Further investigation revealed LPN #1 touched the resident's leg and she flexed and moaned so the LPN told the CNA she needed RN #3 right now. Continued review of the investigation revealed RN #3 stated "There is nothing wrong; she's on antibiotics for cellulitis." Continued review of the facility investigation revealed CNA #7 wrote a statement dated 12/18/14, she ..."went to the room of Resident #27 at 5:00 AM to get the resident up. I pulled the covers all the way back and her leg didn't look good. I barely lifted the leg and the resident screamed out in pain and her leg also popped. (named RN #3) came and said it was nothing; it looked like cellulitis; and it was nothing to worry about..." Further review of the facility investigation revealed a note by the DON stating "...told (named daughter-in-law) (named Resident #27) got her leg bumped and had a fracture of the right distal tibia and fibula. I told her I was not finished with the investigation..." Continued review of the investigation revealed a statement from the roommate of Resident #27 dated 12/18/14, in which she stated "...I heard my roommate scream as 2 girls put her to bed. They hit her leg trying to get her out of her chair. I heard them say "It's broke". Her chair hit my bed	F 225			

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F 225	Continued From page 18 as they were moving her..." Further review of the investigation revealed an interview dated 12/23/14, with the Administrator, DON, and RN #3. Continued review revealed the CNA went to get Resident #27 up at 6:15 AM, and LPN #1 went in to help. Further review revealed they called RN #3 down and propped the resident's feet up. Continued review revealed they went back to read the resident's notes then checked the resident who was fine, but the day nurse looked at the resident's leg and said it looked broken. Further review revealed CNA #7 did not ask RN #3 to look at the leg. Continued review revealed "...I didn't know if it needed an x-ray; I had been told you need permission for an x-ray to be done. The physician had already been called for her feet and it was cellulitis. I didn't think to fill out an incident report..." Continued review of the investigation revealed the two "girls" who were trying to put Resident #27 into her bed and banged the chair on her roommate's bed were not interviewed. Further review revealed no statements from these two individuals and there was also no interview with the day nurse who stated she felt the leg was broken. During interview on 9/24/15, at 1:30 PM, in the conference room, the DON confirmed this was an incomplete investigation.	F 225			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	F 280 1. Resident #16 was discharged home from the facility on 7-9-15 Resident # 21's care plan was updated on 6-29-15 with the focus being "has potential to demonstrate physical behaviors r/t dementia"	11-13-15	

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F 280 Continued From page 19 participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on facility policy, medical record review, and interview, the facility failed to ensure the resident care plans were updated to reflect changes in care and follow-up post incident for 2 (#16, 21) of 44 residents reviewed.

The findings included:

Review of the facility policy entitled "Abuse Prevention Standard" and the section on Resident-to-Resident Abuse, revealed:

1. If a resident-to-resident incident occurs, staff should intervene immediately. Separate the residents and take them to areas away from each other until the situation has diffused.
2. If the resident has been injured provide immediate first aid.
4. If the resident is cognitively alert, counsel the

F 280

2. The MDS department did an audit on 10-19-15 on all of the behavior notes from 9-25-15 to 10-19-15 to ensure residents with documented behaviors have an accurate and up to date care plan. Care plans were adjusted and updated accordingly.
3. Education was done on 10-19-15 with the MDS department and Social Services related to updating care plans after incidents or behaviors occur by the Administrator.
4. Behavior notes and care plans audits will be done by the Director of Social Services or designee 5x a week times 4 weeks, weekly x4 weeks and monthly x1 month to ensure resident care plans are updated appropriately. Results will be reviewed in QAPI monthly x3 months. Any aberrancies will be addressed, interventions developed and corrective action taken.
5. 11-13-15

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F 280	Continued From page 20 resident on proper behavior. 8. All incidents are to be documented in the resident's medical record with intense monitoring to continue at least 72 hours. The resident's care plan is to be updated to reflect interventions to reduce the risk of recurrence of this behavior. Medical record review revealed Resident #16 was admitted to the facility on 5/27/15, with diagnoses of Hypertension, Hip Contusion, and Seizures. Medical record review of the 30 day Minimum Data Set (MDS) dated 6/24/15, revealed Resident #16 scored 5/15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was severely impaired cognitively. Continued review of the MDS revealed Resident #16 required extensive assistance of one person for transfers and ambulation; assistance of one with dressing and hygiene; was dependent on one person for bathing; was independent with eating; and was frequently incontinent of bowel and bladder. Medical record review revealed Resident #21 was admitted to the facility on 6/25/15 with readmission on 7/7/15, with diagnoses including Diabetes Mellitus, Dementia, Transient Ischemic Attack (mini stroke), Gastroesophageal Reflux Disease, and Hypertension. Medical record review of the 30 day MDS of Resident #21 revealed she scored 3/15 on the BIMS, indicating she was severely impaired cognitively. Continued review of the MDS revealed Resident #21 required assistance of one person with transfers; required extensive assistance with ambulation, dressing, and grooming; was dependent on one person for bathing; and was frequently incontinent of bowel	F 280			

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F 280	Continued From page 21 and bladder. Review of the facility investigation dated 6/27/15, revealed Resident #16 stated she was awakened in the middle of the night to find Resident #21 standing over her bed stating all the things in the room belonged to her (Resident #21). Continued review of the investigation revealed Resident #16 said this was not true, Resident #21 hit her and walked away. Further review of the investigation revealed Resident #21 was noted to wander around the room with no purpose, unaware of surroundings and situation. Continued review of the investigation revealed Resident #21 denied knowledge of the incident. Medical record review of nursing notes dated 6/28/15, at 11:25 PM, revealed "... (named Resident #16) daughter called me from out of town worried about a bruise noted on the left side of her nose that a granddaughter had taken a picture of Sunday and sent to her. Daughter states the family takes pictures of her everyday to compare them to the day before. Daughter was worried about an incident that happened Friday night or Saturday day regarding an alleged incident where (named Resident #21) her roommate at the time attacked her. Daughter said Resident #16 told her she was scared. I assured daughter the resident had been moved out of the room and down the hall and the staff would be checking on her mother frequently..." Medical record review of a nursing note dated 6/29/15 at 12:15 AM, revealed two nurses assessed the bruise on Resident #16's face. Continued review revealed the "...bruise was 2 cm (centimeters) x (by) 5 cm bruise to the left side bridge of the nose; asked the patient how did	F 280			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/29/2015
NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130		
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F 280	Continued From page 22 that bruise get there patient stated "It was where that lady attacked me" and then patient further stated "she was clawing my eyes out." Medical record review of a nursing note by the Director of Nursing (DON) dated 6/29/15 at 4:35 PM, revealed "...area to left side of nose assessed. area is very questionable as to being a bruise or an age spot..." Medical record review of a nursing note by the DON dated 7/3/15 at 4:00 PM, revealed "...area to left side of nose is an age spot, no change in color or size of area..." Medical record review of a nursing note dated 7/6/15, at 6:56 AM, revealed "...found patient up at her door, assisted patient back to bed. patient then started talking about a woman that was going to send her to the hospital because she was sick and patient stated she was scared to death because she did not want to leave here. patient also stated she did not want this woman to hurt her..." Medical record review of nursing notes dated 7/7/15, at 9:17 AM, revealed "...pt (patient) stated she is nervous about "that woman". Stated she seen her walk by her room just a few minutes ago. Reassured pt that the resident in question is no longer here at this time..." Medical record review of nursing notes dated 7/9/15, at 3:53 AM, revealed "...patient somewhat fearful and anxious tonight, patient stated "don't let her get me". stayed with the patient until her fear was calmed down, instructed patient to call out my name whenever she felt scared, patient verbalized understanding and stated "that makes	F 280			

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F 280	Continued From page 23 me feel better". Medical record review of nursing notes dated 7/9/15 at 11:00 AM, revealed "...resident discharged to home with family members..." Medical record review of the care plan revealed the fear and anxiety experienced by Resident #16 after the incident, were not addressed, and there were no interventions to assist the resident to cope with the feelings. During interview on 9/24/15 at 1:30 p.m., in the conference room, the DON confirmed the care plan was not updated to reflect Resident #16's fear and anxiety.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to follow its policy regarding resident falls for 2 (#19, 20) of 44 residents reviewed. The findings included: Review of the facility policy entitled "Falls Standard" revised 11/2014, revealed the Procedure Post Fall included: 4. Do neurochecks for all unwitnessed falls and any time resident witnessed or reportedly hit head	F 281	1. Residents #19 and #20 no longer reside at this facility. Resident #19 was discharged to the hospital 11-15-14 and Resident #20 was discharged to the hospital 1-13-15. 2. All residents have the potential to be affected by the deficient practice of failure to follow facility policy regarding resident falls. An audit of facility falls from 9-25-15 to 10-18-15 was done by the RN Unit Manager on 10-19-15 to determine other residents at risk for the facility failure to follow our fall policy. 15 residents were identified for the facility failing to follow our fall policy regarding neuro checks on unwitnessed falls, 72 hour charting and orthostatic vitals being done on every shift for 3 days. All 15 of the resident's care plans were updated to prevent further falls and reassessed with no noted injuries as a result of the missed charting.	11-13-15	

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F 281	<p>Continued From page 24 during fall.</p> <p>6. If the resident is a diabetic or you suspect blood glucose problems, perform capillary blood glucose testing.</p> <p>9. Orthostatic blood pressure must be done every 8 hours for 3 days post fall.</p> <p>10. Accident/Incident Report, Post Fall Investigation report, clinical record and care plan to be reviewed within 24 hours for complications. Review of the Post Fall Standard revealed:</p> <p>4. Revise/update intervention on the Plan of Care.</p> <p>6. Review and revise Interdisciplinary Plan of Care/CNA Kardex.</p> <p>Medical record review revealed Resident #19 was admitted to the facility on 10/16/14, with diagnoses including Chronic Kidney Disease Stage IV, Hypertension, Dysphagia (difficulty swallowing), Chronic Obstructive Pulmonary Disease, Gastroesophageal Reflux Disease, Atherosclerotic Cardiovascular Disease, Congestive Heart Failure, Depression, and Diverticulosis.</p> <p>Medical record review of the 30 day Minimum Data Set (MDS) dated 11/13/14, revealed the resident was moderately cognitively impaired. Continued review of the MDS revealed the resident required assistance of 1 person for transfers, dressing, and grooming; required extensive assistance of 1 person for bathing; was independent with eating after setup; and was continent of bowel and bladder.</p> <p>Medical record review of a fall investigation dated 10/25/14, revealed the resident slid to the floor from a sitting position on the side of the bed after a shower. Continued investigation review revealed the resident stated she hit her arm on</p>	F 281	<p>3. In-Servicing on facility policy for caring for any resident that may have experienced a fall was completed by the Director of Nursing/designee to licensed personnel on all shifts from 10-13-15 to 11/13/15. Post fall policy includes obtaining vitals every shift for 3 days, neuro checks for any fall with a blow to the head and all unwitnessed falls, as well as blood glucose measurement for falls that are suspected to be related to blood glucose problems. New hire clinical staff will receive in-service education on facility policy regarding falls and all clinical staff will receive education on fall prevention and standards of practice annually by the Director of Nursing or designee.</p> <p>4. The DON and the clinical Interdisciplinary team (unit managers, MDS nurse, activities director and social worker) will audit post fall documentation during the morning clinical meeting to verify adherence to policy, proper documentation and notifications, effective interventions and care plan properly updated. This audit will be done weekdays and will be ongoing. The results of the audits will be brought to the monthly QA Meeting by the DON. Any aberrancies will be addressed, interventions developed and corrective action taken.</p> <p>5. 11-13-15</p>	11-13-15	

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F 281	<p>Continued From page 25</p> <p>the walker and she had 2 skin tears to the left arm. Further review of the investigation revealed the recommendation was non-skid socks on. Continued review of the investigation revealed no documentation of vital signs every 8 hours for 3 days; no documentation of neuro checks; and no update of the care plan.</p> <p>Medical record review of a fall investigation dated 10/26/14, revealed the resident was found at the left side of the foot of the bed sitting on her buttocks with the walker in front of her. Continued review of the investigation revealed the resident stated she was ambulating from the bathroom with her walker; sat on the corner of the bed; slid off the bed because the blanket produced a slippery surface. Further review of the investigation revealed the resident was counseled to use the call light and it was recommended a foot board be placed on the bed. Continued review of the investigation revealed the resident had full thickness skin tears to left anterior upper arm and left posterior upper arm. Continued review of the investigation revealed no documentation of vital signs every 8 hours for 3 days; no documentation of neuro checks; and the care plan was not updated to include use of the call light and a foot board on the bed.</p> <p>Medical record review of a fall investigation dated 11/6/14, revealed the resident was found sitting on her buttocks on the left side of the bed. Continued review of the investigation revealed the resident stated she was attempting to ambulate to the bathroom. Further review of the investigation revealed recommendations included toileting the resident as needed and especially during the night between 2 - 4 AM. Continued review of the investigation revealed no documentation of vital</p>	F 281			

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F 281	<p>Continued From page 26</p> <p>signs every 8 hours for 3 days; no documentation of neuro checks; and the care plan was not updated to reflect the recommendations.</p> <p>During interview on 9/24/15, at 1:00 PM, in the conference room, the Director of Nursing confirmed vital signs were not taken every 8 hours for 3 days; neuro checks were not completed; and the care plan was not updated to reflect interventions as stated in the facility policy on Falls.</p> <p>Medical record review revealed Resident #20 was admitted to the facility on 9/23/12 with diagnoses including Diabetes Mellitus Type 2, Hypertension, Anxiety, Depression, Dementia with Behavioral Disturbances, and Chronic Kidney Disease Stage 4. The resident was discharged to the hospital on 1/13/15 for flu like symptoms.</p> <p>Medical record review of the Quarterly MDS dated 11/30/14 revealed Resident #20 was moderately cognitively impaired, was independent with bed mobility, transfers, ambulation and toileting. Further review revealed the resident was always continent of bowel, occasionally incontinent of bladder and had no falls since the prior assessment.</p> <p>Medical record review of the Fall Risk Screen dated 11/29/14 revealed Resident #20 was at moderate risk for falls. Further review revealed the current interventions in place were "...call light within reach; non-skid socks in place..."</p> <p>Medical record review of the Nursing Weekly Summary dated 1/3/15 revealed Resident #20 was independent with bed mobility, transfers, toileting, ambulation, was oriented to person,</p>	F 281			

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F 281	<p>Continued From page 27 place and time, and was continent of bladder.</p> <p>Medical record review of the Nursing SBAR-Change in Condition Observation dated 1/10/15 at 11:50 PM and the Neuro Check forms dated 1/11/15 at 12:34 AM and on 1/11/15 at 5:00 AM revealed Resident #20 vital signs (VS) dated 1/11/15 at 12:34 AM were as follows: blood pressure (BP) was 120/76 left arm while lying down and pulse (P) was regular at 72. Further review revealed the most recent documentation for respiration (R) was dated 1/8/15 at 11:02 AM of 18 respirations. Further review revealed the section for information of recent laboratory results was not completed.</p> <p>Medical record review of the nurses progress note dated 1/11/15 at 12:01 AM revealed "...UNUSUAL OCCURRENCE NOTE...CNA (Certified Nurse Aide) found res [resident] sitting on buttocks in front of bathroom floor. Res is usually independent in ambulation. Was moved into a new room yesterday...is typically alert without confusion however did have mild confusion earlier in shift...did not utilize her walker when ambulating to BR [bathroom]. Found with reg [regular] socks on. Obtained non-skid socks and placed on res. Denied hitting head. Denies pain..."</p> <p>Medical record review of the nurses progress note dated 1/12/15 at 6:00 AM revealed "...UNUSUAL OCCURRENCE NOTE...CNA was responding to...BR bell...observed res on BR floor. Found on back with her head towards the wall...next to trash can...Neuro-checks WNL [within normal limits]...VS taken. Found to be hypotensive with BP 62/46..."</p>	F 281			

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F 281	Continued From page 28 Medical record review of the Fall Risk Screen dated 1/12/15 at 4:30 AM revealed the new interventions included "...Check orthostatic BP x [times] 5 days for assessment..." Medical record review of the Neuro Checks form dated 1/12/15 at 4:30 AM revealed the following VS: BP from the right arm was 62/46 while sitting, P was regular at 92, and the R was 18. Medical record review of the Vital Summary form revealed the following: 1. On 1/11/15 at 12:34 AM: BP 120/76 lying down left arm, P regular at 72, R was 18. 2. On 1/12/15 at 4:30 AM: BP 62/46 sitting right arm; at 8:35 PM BP was 84/34 sitting down right arm; at 8:40 PM BP was 102/54 while standing right arm. 3. On 1/12/15 at 6:19 AM the P was regular at 92 and the R was 18. Review of the medical record for laboratory testing collected on 1/12/15 at 1:20 AM revealed the Glucose (blood sugar level) was elevated at 125 milligrams/deciliter (mg/dl), normal range was 70-105 mg/dl. Interview with the Director of Nursing on 9/16/15 at 3:00 PM in the conference room and the Administrator on 9/17/15 at 8:30 AM in the conference room confirmed the facility failed to obtain the orthostatic blood pressure every 8 hours post fall per the facility policy. Further interview confirmed the facility failed to perform blood glucose testing if the resident was diabetic per facility policy after a fall.	F 281		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333	F 333 1. Res # 31 - The med error was found on 8-10-15 by the morning shift nurse. The patch was removed, disposed of, vitals were taken and the MD/RP was made aware. Facility NP assessed resident on 8-10-15 and gave no new orders related to the medication error.	11-13-15

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F 333	<p>Continued From page 29</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the Controlled Substance/Controlled Drug Record, and interview the facility failed to prevent a significant medication error occurrence for 1 (Resident #31) of 24 residents reviewed for medications.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #31 was admitted to the facility on 5/20/15 and readmitted on 7/20/15 with diagnoses including Chronic Pain, Convulsions, Anxiety, Hypertension, and Osteoarthritis.</p> <p>Medical record review of the Order Listing Report revealed an order dated 6/8/15 for Fentanyl Patch (a topical pain medication) 72 hour 100 micrograms (mcg)/hour (hr), apply 1 patch transdermally every 72 hours related to chronic pain and remove per schedule. Continued review revealed the order for Fentanyl Patch 100 mcg/hr was discontinued on 7/19/15. Continued review revealed, an order dated 7/20/15 for Fentanyl Patch 72 hour 25 mcg/hr.</p> <p>Medical record review of the Medication Administration Record for Resident #31 documented on 8/9/15 at 2056 (8:56 PM) Registered Nurse (RN) #1 administered a Fentanyl Patch 25 mcg/hr to the resident.</p>	F 333	<p>2. An audit was conducted on all current residents on 8-13-15 on all med carts to ensure only current meds were in the cart by the facility Unit Managers.</p> <p>3. RN #1 was given a corrective action and then quit without notice Licensed Nurses on all shifts received education beginning on 8-17-15 about pulling meds from the cart by the Director of Nursing and designee after a resident is discharged. Licensed Nursing staff on all shifts will be re-educated by the DON or designee by 11-13-15 regarding the medication destruction policy. Education began on 8-17-15 regarding following physician orders by the Director of Nursing and designees. The Administrator started re-education with the Licensed Nurses on all three shifts on 10-13-15 regarding following physician orders. The Administrator or designee will complete education by 11-13-15. Nurses were educated by the DON and Administrator starting on 9/4/15 to verify that every narcotic that is signed out on the controlled substance record is signed out on the MAR.</p> <p>4. Discontinued Medications will be audited 5x a week times 4 weeks, weekly x4 weeks and monthly x1 month by reviewing telephone orders and comparing orders to Point Click Care and validating that the medications were pulled from the cart. This audit will be done by the DON or designee to ensure facility protocol is followed.</p>	11-13-15	

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F 333 Continued From page 30
Review of a Controlled Substance Record/Controlled Drug Record for Fentanyl Patch 25 mcg/hr revealed no documentaton of a 25 mcg/hr patch having been signed out for Resident #31 on 8/9/15. Continued review revealed a Controlled Substance Record labeled Fentanyl Patch 100 mcg/hr with documentation of a 100 mcg/hr patch signed out by RN #1 on 8/9/15 at 9:00 PM for Resident #31. Continued review revealed the remaining Fentanyl Patches 100 mcg/hr were disposed of on 8/13/15, 25 days after the medication was discontinued.

Interview with the DON on 9/24/15 at 3:45 PM in the conference room revealed RN#1 on 8/9/15 had incorrectly administered Fentanyl Patch 100 mcg/hr instead of Fentanyl Patch 25 mcg/hr as ordered. Continued interview revealed RN #1 had incorrectly documented the dosage of the Fentanyl Patch 100mcg/hr she administered on 8/9/15 as Fentanyl Patch 25 mcg/hr. Further interview revealed the facility had not disposed of the Fentanyl Patch 100 mcg/hr after it was discontinued on 7/19/15 and remained available for resident use until it was disposed of on 8/13/15. Continued interview confirmed this incident resulted in a significant drug error.

F 514 SS=E 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient

F 333 (4. continued)
Discharged residents will be reviewed during the clinical meeting and then carts will be checked to verify medications are pulled. This audit will occur 5x a week times 4 weeks, weekly x4 weeks and monthly x1 month by the DON or designee to ensure facility protocol is followed.
The Unit Manager or designee will audit new orders to verify accuracy 5x a week times 4 weeks, weekly x4 weeks and monthly x1
The DON or designee will audit the controlled substance record to the eMAR 5x a week x4 weeks, weekly x4 weeks and monthly x1 month to verify accurate medications are given.
Results will be reviewed in QAPI monthly x3 months
5. 11-13-15

F 514 1. Resident #7 will have 16 Norco 5/325mg credited back to their account by 11-13-15 due their inaccurate and complete medical record. Resident #8 will have 3 Hydrocodone-Acetaminophen 5/325mg credited back to their account by 11-13-15 due their inaccurate and complete medical record. Resident #9 ll have 15 Hydrocodone-Acetaminophen 7.5/325mg credited back to their account by 11-13-15 due their inaccurate and complete medical record

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F 514	<p>Continued From page 31</p> <p>information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain accurate and complete medical records related to the dispensing and administration of controlled substance medications for 24 (Resident (#7, 8, 9, 11, 22, 23, 24, 26, 28, 29, 30, 31, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44) of 24 residents reviewed for administration of controlled substances.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #7 was admitted to the facility on 2/25/2014 with diagnoses including Atherosclerotic Heart Disease, Chronic Pain, Disorder of the Bone and Anxiety.</p> <p>Medical record review revealed the resident had an order for Norco 5/325mg tablet (Hydrocodone-Acetaminophen). Give 1 tablet by mouth every 6 hours as needed for pain with a start date of 2/28/2014.</p> <p>Review of the Controlled Substance Record (CSR) revealed Norco 5/325mg was signed out 3 times in 12/2014 and not documented on the Medical Administration Record (MAR) as administered to the resident. Continued review the same medication was signed out 7 times in</p>	F 514	<p>Resident #11 will have 31 Oxycodone-Acetaminophen 10-325mg and 1 Morphine Sulfate 15mg tablet credited back to their account by 11-13-15 due their inaccurate and complete medical record. Resident #23 will have 3 Hydrocodone/Acetaminophen 10/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #24 will have 15 Hydrocodone/Acetaminophen 5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #24 will have 7 Xanax 0.25mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #26 will have 12 Oxycodone 10 mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #26 will have 2 Ativan 2mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #26 will have 7 Ativan 0.5mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #28 will have 8 Hydrocodone/Acetaminophen 5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #29 will have 12 Hydrocodone/Acetaminophen 5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record.</p>	11-13-15

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F 514	<p>Continued From page 32</p> <p>1/2015 and 6 times in 2/2015 without being documented on the MAR as administered to the resident.</p> <p>Interview with the Administrator on 9/24/2015 at 12:35 PM in the conference room confirmed the nursing documentation was inaccurate.</p> <p>Medical record review revealed Resident #8 was admitted to the facility on 2/7/2015 with diagnoses including Encephalopathy, Cerebral Vascular Accident, Aphasia, Peripheral Vascular Disease and Chronic Pain.</p> <p>Medical record review revealed the resident had an order for Hydrocodone-Acetaminophen 5/325mg tablet. Give 1 tablet by mouth every 6 hours as needed for pain with a start date of 1/13/2015.</p> <p>Review of the CSR revealed Hydrocodone-Acetaminophen 5/325mg was signed out 3 times in 2/2015 and was not documented on the MAR as administered to the resident.</p> <p>Interview with the Administrator on 9/24/2015 at 12:35 PM in the conference room confirmed the nursing documentation was inaccurate.</p> <p>Medical record review revealed Resident #9 was admitted to the facility on 1/30/2013 with diagnoses including Dementia, Rheumatoid Arthritis, Osteoarthritis, Spinal Stenosis, Anxiety and Chronic Pain.</p> <p>Medical record review revealed an order for Norco 7.5/325mg (Hydrocodone-Acetaminophen)</p>	F 514	<p>Resident #30 will have 2 Oxycodone/Acetaminophen 5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #30 will have 29 Hydrocodone/Acetaminophen 5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #31 will have 9 Lyrica credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #31 will have 41 Alprazolam credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #31 will have 127 Oxycodone credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #33 will have 1 Hydrocodone/Acetaminophen 10/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #33 will have 2 Lorazepam 0.5mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #33 will have 3 Diazepam 5mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #34 will have 43 Hydrocodone/Acetaminophen 10/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #34 will have 32 Ambien 5mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record.</p>	11-13-15	

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F 514 Continued From page 33
tablet. Give 1 tablet by mouth every 6 hours as needed for pain with a start date of 11/9/2013.

Review of the CSR revealed Hydrocodone-Acetaminophen 7.5/325mg was signed out 5 times in 12/2014, 6 times in 1/2015, 3 times in 2/2015 and 1 time in 3/2015 and was not documented on the MAR as administered to the resident.

Interview with the Administrator on 9/24/2015 at 12:35 PM in the conference confirmed the nursing documentation was inaccurate.

Medical record review revealed Resident #11 was admitted to the facility on 9/23/12 and readmitted on 1/30/15 with diagnoses including Hypothyroidism, Multiple Sclerosis, Restless Leg Syndrome, Personality Disorder, Diabetes Mellitus, Opioid Dependence, Anxiety Disorder, and Peripheral Vascular Disease.

Medical record review of the MAR included a Physician order dated 1/30/15 for Oxycodone-Acetaminophen Tablet 10-325mg. Give 1 tablet every 8 hours as needed for pain. Further review of the physician's order included an order for Morphine Sulfate Tablet 15mg. Give 1 tablet by mouth two times a day related to chronic pain.

Medical record review of the CSR and the MAR for 2/2015 revealed 31 incidents of Oxycodone-Acetaminophen and 1 dose of Morphine signed out on the CSR and not documented as given on the MAR.

Interview with the DON on 9/24/15 at 3:15 PM in the conference room confirmed the incidents of

F 514 Resident #34 will have 12 Alprazolam 0.25mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #35 will have 11 Hydrocodone/Acetaminophen 5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #36 will have 3 Hydrocodone/Acetaminophen 10/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #36 will have 1 Hydrocodone/Acetaminophen 7.5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #37 will have 2 Hydrocodone/Acetaminophen 5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #39 will have 2 Hydrocodone/Acetaminophen 5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record.

Resident #39 will have 1 Hydrocodone/Acetaminophen 7.5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #39 will have 2 Lorazepam 0.5mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #40 will have 14 Oxycodone 20mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record.

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F 514	<p>Continued From page 34</p> <p>pain medications documented as given on the CSR but not documented as administered in the MAR resulting in inaccurate and incomplete medical records.</p> <p>Medical record review revealed Resident #22 was admitted to the facility on 5/14/12 with diagnoses including Cerebral Vascular Accident with Hemiplegia and Hemiparesis, Aphasia and Pain.</p> <p>Medical record review revealed an order for Hydrocodone-Acetaminophen 5/325mg tablet. Give 1 tablet by mouth every 12 hours as needed for pain with a start date of 9/16/2014.</p> <p>Review of the CSR revealed Hydrocodone-Acetaminophen 5/325mg was signed out 2 times in 1/2015 and 6 times in 2/2015 and was not documented on the MAR as administered to the resident.</p> <p>Interview with the Administrator on 9/24/2015 at 12:35 PM in the conference room confirmed the nursing documentation was inaccurate.</p> <p>Medical record review revealed Resident #23 was admitted to the facility on 2/6/2015 and expired in the facility on 2/16/2015 with diagnoses including Lung Cancer, Chronic Obstructive Pulmonary Disease, Hypertension and Cerebral Edema.</p> <p>Medical record review revealed an order for Norco 10/325mg tablet (Hydrocodone-Acetaminophen). Give 1 tablet by mouth every 4 hours as needed for pain with a start date of 2/10/2015.</p> <p>Review of the CSR revealed Hydrocodone-Acetaminophen 10/325mg was</p>	F 514	<p>Resident # 41 will have 2 Xanax 0.25mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #41 will have 7 Morphine 5mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #42 will have Hydrocodone/Acetaminophen 5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident # 43 will have 18 Oxycodone/Acetaminophen 5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record. Resident #44 will have 10 Hydrocodone/Acetaminophen 5/325mg credited back to their account by 11-13-2015 due to their inaccurate and complete medical record.</p> <p>2. An audit by the Director of Risk Management and designees was started on 9/23/15 auditing September and August MARS to identify other residents who would not have accurate and complete medical records. Residents with variances will receive a credit from pharmacy by 11-13-15. Nurses who fail to document on the eMar medication signed on the controlled substance log will receive a corrective action.</p>		

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F 514 Continued From page 35
signed out 3 times in 2/2015 and was not documented on the MAR as administered to the resident.

Interview with the Administrator on 9/24/2015 at 12:35 PM in the conference room confirmed the nursing documentation was inaccurate.

Medical record review revealed Resident #24 was admitted to the facility on 4/12/13 with diagnoses including Dementia, Parkinson's, Anxiety, Schizoaffective Disorder and Chronic Pain.

Medical record review revealed an order for Hydrocodone-Acetaminophen 5/325mg tablet. Give 1 tablet by mouth every 6 hours as needed for pain with a start date of 8/19/14. Continued review revealed another order for Xanax (also known as Alprazolam, an anti-anxiety medication) 0.25mg tablet. Give 1 tablet by mouth every 24 hours as needed for severe agitation with a start date of 9/14/2014.

Review of the CSR revealed Hydrocodone-Acetaminophen 5/325mg was signed out 5 times in 1/2015 and 10 times in 2/2015 and was not documented on the MAR as administered to the resident. Continued review of the CSR revealed Xanax 0.25mg was signed out 3 times in 12/2014 and 4 times in 1/2015 and was not documented on the MAR as administered to the resident.

Interview with the Administrator on 9/24/2015 at 12:35 PM in the conference room confirmed the nursing documentation was inaccurate.

Medical record review revealed Resident #26 was admitted to the facility on 11/4/2013, was on

F 514 3. Education began on 8-17-15 by the Director of Nursing and designees regarding following physician orders. The Administrator started re- education with the Nurses on 10-13-15 regarding following physician orders. The Administrator or designee will complete education by 11-13-15. On 9-18-15 a controlled substance action plan, a physician orders action plan and a physician orders verification action plan was initiated by the Director of Nursing.

4. Licensed Nurses on all shifts were educated by the DON and Administrator starting on 9/4/15 to verify that every narcotic that is signed out on the controlled substance record is signed out on the MAR. Re-education was given to Licensed Nurses on all shifts on 9-19-15 by the DON and then 10-13-15 thru 11-13-15 the Administrator and designee did education on signing meds out on the MAR when they sign it out on the CSR.

Education began on 9-29-15 by the Administrator with the licensed nurses on all shifts regarding proper documentation on the controlled substance log. Discontinued Medications will be audited 5x a week times 4 weeks, weekly x4 weeks and monthly x1 month by reviewing telephone orders and comparing orders to Point Click Care and validating that the medications were pulled from the cart. This audit will be done by the DON or designee to ensure facility protocol is followed.

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F 514	<p>Continued From page 36</p> <p>hospice and expired in the facility on 6/9/15 with diagnoses including Breast Cancer, Dementia with Behavioral Disturbances, Anxiety, Cardiomegaly and Emphysema.</p> <p>Medical record review revealed an order for Oxycodone 10mg tablet. Give 10mg by mouth 2 times a day for pain with a start date of 10/31/2014 to be administered at 5:00 AM and 5:00 PM daily and stopped on 4/27/2015. Continued review revealed an order for Ativan (also known as Lorazepam, an anti-anxiety medication) 2mg tablet. Give 1 tablet by mouth 2 times a day related to anxiety with a start date of 10/20/2014 to be administered at 9:00 AM and 9:00 PM daily. Continued review revealed an order for Ativan 0.5mg tablet. Give 0.5mg by mouth every 4 hours as needed for anxiety with a start date of 1/3/14. Continued review revealed an order for Oxycodone 10mg tablet. Give 1 tablet by mouth every 4 hours as needed for pain with a start date of 4/27/2015.</p> <p>Review of the MAR revealed Oxycodone 10mg 2 times a day was not documented as administered to the resident 4 times in 1/2015, 2 times in 2/2015, and 2 times in 3/2015. Ativan 2 mg 2 times a day was not documented as administered to the resident 1 time in 2/2015 and 1 time in 3/2015. Ativan 0.5mg every 4 hours as needed for anxiety was not signed out on the CSR but documented on the MAR as administered to the resident on 2/3/2015 at 1:00 AM. Continued review revealed Ativan 0.5mg every 4 hours as needed for anxiety was signed out on the CSR 1 time in 2/2015, 1 time in 3/2015, 2 times in 4/2015 and 3 times in 5/2015 but was not documented on the MAR as administered to the resident. Review of the CSR for PRN (as</p>	F 514	<p>(4. continued)</p> <p>Discharged residents will be reviewed during the clinical meeting and then carts will be checked to verify medications are pulled. This audit will occur 5x a week times 4 weeks, weekly x4 weeks and monthly x1 month by the DON or designee to ensure facility protocol is followed.</p> <p>The Unit Manager or designee will audit new orders to verify accuracy 5x a week times 4 weeks, weekly x4 weeks and monthly x1</p> <p>The DON or designee will audit the controlled substance record to the eMAR 5x a week x4 weeks, weekly x4 weeks and monthly x1 month to verify accurate medications are given.</p> <p>Results will be reviewed in QAPI monthly x3 months. Any aberrancies will be addressed, interventions developed and corrective action taken.</p> <p>5. 11-13-15</p>	11-13-15	

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F 514	<p>Continued From page 37</p> <p>needed) Oxycodone 10mg revealed no documentation of the medication being signed out. Continued review revealed the discontinued Oxycodone 10mg 2 times daily CSR contained documentation the medication was signed out 4 times in May through 5/21/15 but there was no documentation on the MAR the resident received the medication.</p> <p>Interview with the Administrator on 9/24/2015 at 12:35 PM in the conference room confirmed the nursing documentation was inaccurate.</p> <p>Medical record review revealed Resident #28 was admitted to the facility on 12/16/14 with diagnoses including Coronary Atherosclerosis, Hyperlipidemia, Depressive Disorder, Hypothyroidism, Chronic Pain and Muscle Weakness.</p> <p>Medical record review of the Physician's order included Norco Tablet 5-325mg dated 2/9/15. Give 1 tablet by mouth every 4 hours as needed for pain.</p> <p>Record review of the CSR dated 2/14/15-2/22/15 compared to the same dates on the MAR revealed 8 occasions of Norco being taken off the CSR and not documented as given on the MAR.</p> <p>Interview with the DON on 9/24/15 at 3:15 PM in the conference room confirmed the incidents of pain medications documented as given on the CSR but not documented as administered in the MAR resulting in inaccurate and incomplete medical records.</p> <p>Medical record review revealed Resident #29 was admitted to the facility on 1/28/15 with diagnoses</p>	F 514			

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F 514	<p>Continued From page 38 of Chronic Pain, Cerebrovascular Disease, Gouty Arthropathy, Chronic Airway Obstruction, diabetes, Type II and Insomnia.</p> <p>Medical record review of the MAR and the CSR dated 2/15 revealed 12 incidents of medication being signed out on the CSR and not documented on the MAR and 1 incident of medication being documented on the MAR but not signed out on the CSR. The incidents occurred from 2/7/15 through 2/23/15.</p> <p>Medical record review revealed an order for Norco 5/325tablet. Give 1 tablet by mouth every 6 hours as need for pain with a start date of 2/4/15.</p> <p>Medical record review of the MAR and the CSR dated 2/15 revealed 12 incidents of Norco 5/325mg missing or not given per physicians orders.</p> <p>Review of the CSR revealed Norco 5/325 mg was signed out 12 times in 2/15 and was not documented on the MAR as administered to the resident.</p> <p>Interview with the DON on 9/24/15 at 3:30 PM in the conference room confirmed 13 incidents of pain medications not being documented on the MAR or CSR.</p> <p>Medical record review revealed Resident #30 was admitted to the facility on 2/1/10 and readmitted on 6/2/15 with diagnoses including Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Anxiety, Senile Dementia with Depressive Features, and Aftercare for Healing Traumatic Fracture of Hip.</p>	F 514		
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F 514	Continued From page 39 Medical record review of the March 2015 physician orders revealed the pain medications included Percocet (Oxycodone-Acetaminophen) 5-325 mg 1 tablet po (by mouth) every 4 hours as needed from 3/26/15 to 3/31/15; Percocet 5-325 mg 2 tablets po every 4 hours as needed from 3/26/15 to 3/31/15; and Lortab (Hydrocodone-Acetaminophen) 5-325 mg po four times daily from 3/31/15 to 4/29/15; Review of the pharmacy delivery tickets, the March 2015 MAR, the CSR, med select (medication back-up), and nurses notes documentation revealed the following: 1. Percocet 5-325 mg 1 or 2 tablet po every 4 hours as needed: 5 tablets were provided by the pharmacy on 3/26/15. The MAR documented 3 (three) 1 tablet doses and 2 (two) 2 tablet doses for a total of 7 tablets from 3/27/15-3/28/15. The CSR form documented 5 (five) 1 tablet doses from 3/27/15-3/28/15. The med select form revealed Percocet was not dispensed on 3/28/15 for 2 tablets. Further review of the med select form revealed Percocet 1 tablet was obtained on 3/30/15 at 6:29 PM and the facility failed to document the administration on the MAR. Review of a nursing note dated 3/31/15 at 9:19 PM revealed "...med [medication] [Lortab] not here gave Oxy [Oxycodone]..." Further review of the CSR form revealed on 3/31/15 1 tablet was dispensed on 3/31/15 at 9:00 PM and the facility failed to document the administration on the MAR. 2. Lortab: The MAR revealed the administration on 3/31/15 at 5:00 PM and the facility failed to have a CSR or med select documenting the dispensing of the medication. Medical record review of the April 2015 physician	F 514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/29/2015
NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 40</p> <p>orders revealed the pain medications included Lortab 5-325 mg po four times a day and Oxycodone-Acetaminophen 5-325 mg 2 tablets po every 4 hours as needed for pain.</p> <p>Review of the pharmacy delivery tickets, the April 2015 MAR, the CSR, and med select, and nursing notes revealed the following:</p> <ol style="list-style-type: none"> The facility failed to document the Lortab administration four times daily, per physician order, on the MAR on 4/2/15 at 9:00 PM, 4/5/15 at 5:00 PM, 4/17/15 at 9:00 PM, and 4/22/15 at 9:00 PM. The CSR revealed on 4/23/15 at 9:00 AM 1 dose remained of the 26 doses provided and the med select form revealed Lortab was not dispensed from 4/23/15 at 1:00 PM through 4/29/15 at 9:00 AM (MAR documented medication held). The MAR revealed administrations of the Lortab but the CSR revealed no medication was dispensed on 4/6/15 at 5:00 PM, on 4/10/15 at 5:00 PM, on 4/21/15 at 5:00 PM, on 4/24/15 at 1:00 PM, 5:00 PM, 9:00 PM, on 4/25/15 and 4/26/15 at 9:00 AM, 1:00 PM, 5:00 PM, 9:00 PM, on 4/27/15 at 9:00 AM, 1:00 PM, 5:00 PM, and on 4/28/15 at 1:00 PM, 5:00 PM (the 9:00 AM and 9:00 PM MAR documented the medication was held). There was no CSR from 4/23/15 9:00 AM through 4/29/15 at 9:00 AM. The CSR revealed medication was dispensed and the facility failed to document the administration on the MAR on 4/2/15 at 9:00 PM, and on 4/17/15 at 9:00 PM. <p>Interview with the Administrator, Director of Nurses, and the Corporate Quality Improvement Consultant on 9/24/15 at 3:00 PM in the conference room confirmed the facility failed to</p>	F 514			

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F 514	<p>Continued From page 41</p> <p>document the administration of the medication on the MAR, the CSR and/or the med select form failed to document the dispensing of the medication, nurses notes failed to document the reason for the failure to administer the medication, and there was no Hydrocodone CSR from 4/23/15 9:00 AM through 4/29/15 at 9:00 AM. Further interview confirmed the facility medical records were not complete or accurate.</p> <p>Medical record review revealed Resident #31 was admitted to the facility on 5/20/15 and readmitted on 7/20/15 with diagnoses including Chronic Pain, Convulsions, Anxiety, Hypertension, and Osteoarthritis.</p> <p>Medical record review revealed the Order Listing Report for Resident #31 revealed the resident was to have received Lyrica (a pain medication, a controlled substance) 50 mg every 8 hours from 5/23/15-7/19/15. On 7/20/15 the Lyrica dosage was changed to 25 mg three times a day.</p> <p>Continued review of the Order Listing Report revealed an order dated 5/21/15 for Alprazolam (a drug for anxiety, a controlled substance) 0.5 mg every 12 hours as needed (prn) for anxiety; 5/22/15 the Alprazolam was changed to 0.25 mg every 8 hours prn anxiety; on 6/29/15 the dosage of Alprazolam remained 0.25 but the frequency was changed to every 6 hours prn; 7/3/15 the frequency was changed to every 8 hours; 7/7/15 the frequency was changed to every 6 hours; on 7/19/15 Alprazolam was discontinued.</p> <p>Continued review of the Order Listing Report revealed an order dated 5/20/15 for Oxycodone (a narcotic pain medication, a controlled substance) 20 mg every 4 hours prn pain.</p>	F 514			

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F 514	<p>Continued From page 42</p> <p>Further review revealed an order dated 8/15/15 to decrease the dosage of Oxycodone to 5 mg and change the frequency to every 6 hours prn.</p> <p>Medical record review of the resident's MAR from 5/20-9/22/15 compared to the CSR for the same time frame revealed a total of 9 instances when the medication Lyrica was documented as being administered to the resident on the MAR but the drug was not signed out on the CSR as having been obtained from locked storage. This occurred once in May, 6 times in June, once in July and once in August. Further review revealed 2 episodes occurred in May when the Alprazolam was documented on the MAR as having been given but was not documented as having been obtained on the CSR. Continued review of documentation on the MAR and CSR of Alprazolam revealed 41 occurrences of the drug having been documented as obtained on the CSR but not documented as administered to the resident on the MAR. These occurrences took place as follows: 3 times in May, 16 times in June, and 22 times in July. Further review of the MAR compared to the CSR for Oxycodone revealed 127 occurrences when the medication was documented as having been obtained on the CSR but not documented as having been administered to the resident from 5/20-9/22/15. These occurrences took place as follows: 11 times in May, 41 times in June, 40 times in July, 18 times in August, and 17 times in September.</p> <p>Interview with the Corporate QIC on 9/28/15 at 10:25 AM in the conference room revealed she had audited the resident's MAR and CSR for 5/23/15-9/22/15 and had found the following:</p> <p>1. Nine occurrences of Lyrica documented on the MAR as having been given but no documentation</p>	F 514			

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F 514	<p>Continued From page 43</p> <p>on the CSR of the medication having been obtained. The Lyrica drug counts on the CSR were correct and therefore the drug could not have been administered as documented because the drug had not been obtained from the locked storage.</p> <p>2. Two occurrences of Alprazolam 0.25mg documented as having been administered to the resident on the MAR at 1413 (2:13 PM) on 5/23/15 and at 8:30 AM on 5/25/15 but was not documented as having been obtained on the CSR. The Alprazolam drug count sheet was correct for May, therefore the drug couldn't have been administered as documented.</p> <p>3. Forty-one occurrences of Alprazolam having been documented on the CSR as having been obtained but was not documented on the MAR as having been administered to the resident.</p> <p>4. One hundred twenty-seven occurrences of Oxycodone having been documented on the CSR as having been obtained but was not documented as having been administered to the resident.</p> <p>Continued interview confirmed the documentation on the MAR and CSR was inaccurate/incomplete.</p> <p>Medical record review revealed Resident #33 was admitted to the facility on 8/14/15 and readmitted on 9/16/15 with diagnoses including Chronic Pain, Hypertrophy of Prostate, Anxiety, Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Peripheral Vascular Disease. The resident was hospitalized from 8/31/15 to 9/16/15.</p> <p>Medical record review of the August 2015 physician orders revealed pain medication included Norco (Hydrocodone-Acetaminophen) 5-325 mg po every 8 hours as needed and the</p>	F 514			

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medications for anti-anxiety included Lorazepam (Ativan) 0.5 mg po every 8 hours as needed, Diazepam (Valium) 5 mg intramuscularly one time only from 8/21/15 5:15 PM to 8/21/15 at 11:59 PM, Diazepam 5 mg po twice daily as needed from 8/22/15 to 8/31/15, and Diazepam 1 ml (milliliter) intramuscularly every 12 hours as needed from 8/24/15 to 8/31/15.

Review of the August 2015 MAR, the CSR, and med select form, revealed the following:

1. Hydrocodone: The CSR revealed Hydrocodone was dispensed on 8/26/15 at 11:03 PM followed by 8/26/15 at 10:00 PM. The MAR revealed on 8/26/15 an administration at 11:03 PM and no further documentation after 11:03 PM. The MAR revealed on 8/27/15 the medication administration at 8:50 PM and the CSR revealed no medication was dispensed.
2. Lorazepam: The CSR revealed Lorazepam was dispensed on 8/22/15 at 6:30 PM and 8/23/15 at 5:00 PM. The MAR revealed no documentation of the administration of the medication on those dates.
3. Diazepam 5 mg po every 12 hours as needed: The MAR revealed on 8/23/15 at 8:00 AM the administration of the medication and the med select form revealed one 2 mg tablet was dispensed (short 3 mg per physician order). The med select form revealed 3 (three) 2 mg tablets were dispensed on 8/23/15 at 7:18 PM and the MAR revealed no documentation of the administration of the medication.
4. Review of the CSR and/or med select form for the dispensing of the medication and the MAR for the medication administration revealed the following charting issues:
Lorazepam: On 8/18/15 the medication was dispensed at 5:30 PM and administered at 7:58

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F 514	<p>Continued From page 45</p> <p>PM, on 8/19/15 the medication was dispensed at 8:30 PM and administered at 9:44 PM, and on 8/21/15 the medication was dispensed at 9:00 AM and administered at 7:57 AM.</p> <p>Hydrocodone: On 8/21/15 the dispensing time was difficult to read, on 8/29/15 the medication was dispensed at 9:40 AM and administered at 9:19 AM, and on 8/31/15 the medication was dispensed at 12:00 (no AM/PM indicated) and administered at 8:51 AM.</p> <p>Medical record review of the September 2015 physician orders revealed the anti-anxiety medication Lorazepam 0.5 mg po four times a day.</p> <p>Review of the September 2015 MAR, the CSR, and med select form revealed the following:</p> <p>1. Lorazepam: The MAR revealed on 9/16/15 at 1:00 PM, 5:00 PM and 9:00 PM the medication was administered and the med select form revealed the medication was dispensed at 3:01 PM and 10:14 PM only. The MAR revealed on 9/21/15 at 9:00 PM the medication was administered and the CSR form revealed the medication was not dispensed on 9/21/15 at 9:00 PM but was dispensed on 9/22/15 at 1:33 AM. The MAR revealed on 9/24/15 at 9:00 AM the medication was administered and the CSR form revealed no medication was dispensed.</p> <p>2. Review of the CSR and/or med select form for the dispensing of the medication and the MAR for the medication administration revealed the following charting issues:</p> <p>Lorazepam: On 9/6/15 the medication was dispensed at 3:01 PM and administered at 1:00 PM, on 9/6/15 the medication was dispensed at 10:14 PM and administered at 9:00 PM.</p>	F 514			

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F 514	<p>Continued From page 46</p> <p>Interview with the Administrator on 9/28/15 at 10:49 AM in the conference room confirmed the facility failed to document the administration of the medication on the MAR, the CSR and/or the med select form failed to document the dispensing of the medication and nurses notes failed to document the reason for the failure to administer the medication. Further interview confirmed the facility medical records were not complete or accurate.</p> <p>Medical record review revealed Resident #34 was re-admitted to the facility on 3/20/14 with diagnoses including Osteoporosis, Congestive Heart failure, Cellulitis, Major Depressive Disorder, Chronic Pain, and Anxiety.</p> <p>Medical record review of the August 2015 physician orders revealed the pain medications included Lyrica 200 mg po three times a day, and Norco (Hydrocodone-Acetaminophen) 10-325 po every 4 hours as needed; anti-hypnotic medication to treat insomnia Ambien (Zolpidem) 5 mg po as needed; anti-anxiety medication, Alprazolam (Xanax) 0.25 mg po at bedtime, and Alprazolam 0.25 mg every 24 hours as needed.</p> <p>Review of the August 2015 MAR, the CSR, and med select form revealed the following:</p> <ol style="list-style-type: none"> 1. Lyrica: The MAR documented administration of Lyrica on 8/4 at 3:00 PM, 8/5/15 at 3:00 PM and 9:00 PM but the CSR and the med-select form revealed the medication was not dispensed. 2. Hydrocodone: The CSR and/or the med select form documented the Hydrocodone was dispensed but the MAR revealed no administration of the medication on 8/2/15 at 3:00 PM, 8/3/15 at 3:00 PM, 9:00 PM, 8/4/15 at 5:00 PM, 8/6/15 at 9:00 AM, 8/8/15 at 11:00 PM, 	F 514		
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F 514	<p>Continued From page 47</p> <p>8/13/15 at 9:00 PM, 8/14/15 at 10:00 AM, 8/15/15 9:00 PM, 8/16/15 at 10:00 PM, 8/21/15 2:00 (no AM/PM identified), 8/23/15 through 8/25/15 at 9:00 PM, 8/26/15 at 3:00 PM, 9:00 PM, 8/27/15 at 8:00 PM, 8/28/15 at 9:00 PM, 8/29/15 at 9:00 AM, 3:00 PM, 9:00 PM, 8/30/15 and 8/31/15 at 3:00 PM, and 9:00 PM.</p> <p>3. Ambien: The CSR and/or med select form documented the Ambien was dispensed but the MAR revealed no administration of the medication at 9:00 PM for 8/3/15, 8/8/15, 8/13/15, 8/15/15 through 8/17/15, 8/19/15, 8/21/15, 8/22/15 through 8/31/15.</p> <p>4. Alprazolam: The MAR documented the administration of Alprazolam on 8/24/15 for the bedtime dose and on 8/27/15 for the as needed dose but the CSR and/or the med select form revealed the medication was not dispensed.</p> <p>5. Review of the CSR and/or med select form for the dispensing of the medication and the MAR for the medication administration revealed the following charting issues: Ambien: On 8/12/15 Ambien was dispensed at 9:00 PM however the MAR revealed the administration at 8:00 AM. Hydrocodone: On 8/6/15 the Hydrocodone was dispensed at 9:00 PM but the MAR revealed the medication was administered at 7:46 PM; on 8/25/15 the medication was dispensed at 9:00 AM and administered at 11:31 AM, the medication was dispensed at 3:00 PM and was administered at 4:29 PM.</p> <p>Medical record review of the September 2015 physician orders revealed the pain medications included Lyrica 200 mg po three times a day, and Norco (Hydrocodone-Acetaminophen) 10-325 po every 4 hours as needed; anti-hypnotic medication to treat insomnia Ambien (Zolpidem) 5</p>	F 514			

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F 514	Continued From page 48 mg po as needed, and anti-anxiety medication, Alprazolam (Xanax) 0.25 mg every 24 hours as needed. Review of the September 2015 MAR, the CSR, and med select form revealed the following: 1. Lyrica: The MAR revealed the administration of Lyrica but the CSR and/or med select form revealed the medication was not dispensed, although it was available, on 9/8/15 at 3:00 PM, and on 9/24/15 through 9/27/15 at 9:00 AM, 3:00 PM and 9:00 PM. 2. Hydrocodone: The CSR and/or med select form revealed the medication was dispensed but the MAR revealed the medication was not administered at 9:00 AM for 9/8/15, 9/11/15; at 3:00 PM on 9/26/15; and at 9:00-10:00 PM on 9/1/15 through 9/3 15, 9/9/15, 9/10/15, 9/12/15, 9/14/15, 9/15/15, 9/18/15; unreadable time on 9/16/15. The MAR revealed the administration of the medication but the CSR and/or med select form revealed the medication was not dispensed, although the medication was available, on 9/4/15 at 3:11 AM. 3. Ambien: The CSR revealed the Ambien was dispensed but the MAR revealed the medication was not administered at 8:00-10:00 PM on 9/1/15 through 9/3/15, 9/6/15, 9/8/15 through 9/16/15, and 9/18/15. The MAR revealed the Ambien was administered but the CSR and/or med select form revealed the medication was not dispensed, although it was available, at 8:00-10:20 PM on 9/24/15 through 9/26/15. 4. Alprazolam: The CSR revealed the Alprazolam was dispensed but the MAR revealed the medication was not administered at 9:00-10:00 PM on 9/1/15, 9/3/15, 9/8/15 through 9/12/15, and 9/14/15-9/18/15. The MAR revealed the Alprazolam was administered but the CSR	F 514			

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F 514	<p>Continued From page 49</p> <p>and/or med select form revealed the medication was not dispensed, although it was available, at 8:00-10:20 PM on 9/24/15 through 9/26/15.</p> <p>5. Review of the CSR and/or med select form for the dispensing of the medication and the MAR for the medication administration revealed the following charting issues:</p> <p>Hydrocodone: On 9/7/15 the medication was dispensed at 9:00 AM and administered at 7:70 AM, on 9/14/15 the medication was dispensed at 9:00 AM and administered at 12:48 PM, on 9/16/15 the time the medication was dispensed was not readable, on 9/20/15 the medication was dispensed at 3:00 PM and administered at 1:45 PM.</p> <p>Interview with the Director of Risk Management on 9/29/15 beginning at 9:15 AM in the nurse education room, confirmed the facility failed to document the administration of the medication on the MAR, the CSR and/or the med select form failed to document the dispensing of the medication and nurses notes failed to document the reason for the failure to administer the medication. Further interview confirmed the facility medical records were not complete or accurate.</p> <p>Medical record review revealed Resident #35 was admitted to the facility on 8/10/2015 and was readmitted on 9/4/2015 with diagnoses including Ischemic Heart Disease, Peripheral Vascular Disease, Rheumatoid Arthritis, Edema and Chronic Pain.</p> <p>Medical record review revealed an order for Hydrocodone-Acetaminophen 10/325mg tablet. Give 1 tablet by mouth every 4 hours as needed for pain with a start date of 8/10/2015 and a</p>	F 514			

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F 514	<p>Continued From page 50 discontinued date of 8/21/2015. Continued review revealed an order for Norco 5/325mg (Hydrocodone-Acetaminophen) tablet. Give 1 tablet by mouth every 4 hours as needed for pain with a start date of 9/4/2015.</p> <p>Review of the CSR and MAR for Hydrocodone -Acetaminophen 10/325mg beginning 8/12/2015 revealed the medication was documented as administered before it was signed out on the CSR 3 times in 8/2015. Continued review revealed the medication was documented on the MAR as administered on 8/11/2015 at 3:59 PM but there was no medication signed out on the CSR for that date and time. Review of the Hydrocodone -Acetaminophen 5/325mg CSR revealed the medication was signed out 11 times in 9/2015 and was not documented as administered to the resident on the MAR. Continued review revealed the medication was documented as administered before it was signed out on the CSR 5 times in 9/2015.</p> <p>Interview with the Transitional DON (Corporate) on 9/29/2015 at 11:00 AM in the conference room confirmed the CSRs and the MARs for both the Hydrocodone-Acetaminophen 10/325mg tablets and 5/325mg tablets for 8/2015 and 9/2015 had incorrect dates, administration times and missing documentation.</p> <p>Medical record review revealed Resident #36 was admitted to the facility on hospice on 4/29/2015 with diagnoses including Lung Cancer, Saddle Embolus of the Pulmonary Artery and Chronic Pain.</p> <p>Medical record review revealed an order for Norco 10/325mg (Hydrocodone-Acetaminophen)</p>	F 514		
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F 514	Continued From page 51 tablet. Give 1 tablet by mouth every 4 hours as needed for pain with a start date of 4/29/2015 and discontinued 8/24/2015. Continued review revealed an order for Norco 7.5/325mg (Hydrocodone-Acetaminophen) tablet. Give 1 tablet by mouth every 6 hours as needed for pain with a start date of 9/14/2015 and an order for Morphine Sulfate Extended Release 15mg tablet. Give 2 tablets by mouth 2 times a day related to chronic pain with a start date of 9/23/2015 at 9:00 PM. Review of the CSR and MAR for Hydrocodone 10/325mg for the month of 8/2015 revealed 3 doses were signed out on the CSR but not documented as administered to the resident on the MAR. Continued review revealed on 8/9/2015 the medication was signed out at 9:00 AM and administered at 10:00 AM. On 8/24/2015 the medication was signed out at 9:00 AM and administered at 11:40 AM. Continued review revealed 8 instances where the medication was documented as administered to the resident before it was signed out on the CSR. Review of the CSR and MAR for Hydrocodone-Acetaminophen 7.5mg for the month of 9/2015 revealed the medication was signed out on 9/17/15 at 4:00 AM and not documented on the MAR as administered to the resident. Interview with the Transitional DON (Corporate) on 9/29/2015 at 11:00 AM in the conference room confirmed the Hydrocodone 10/325mg was documented it was administered before it was signed out on the CSR 8 times in 8/2015. Continued interview revealed the Transitional DON was unable to explain the documentation of the count on the CSR for the Morphine 15mg	F 514			

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F 514	Continued From page 52 beginning 9/25/15. Medical record review revealed Resident #37 was admitted to the facility on 5/30/15 and readmitted on 9/17/15 with diagnoses including Congestive Heart Failure, Diabetes Mellitus II, Depression, Anxiety, Degeneration Intervertebral Disc, and Osteoarthritis. Medical record review of physician orders revealed an order for Lyrica 100 mg 1 capsule by mouth three times a day with a start date of 9/18/15. Further review revealed an order for Hydrocodone-Acetaminophen (a controlled substance given for pain) 5-325 mg 1 tablet by mouth every 6 hours prn pain. Medical record review of the resident's MAR from 9/18-9/28/15 and the CSR for September 2015 revealed: 1. Lyrica 100 mg was documented on the MAR as having been administered to the resident on 9/18/15 at 2100 (9:00 PM), however, there was no documentation on the CSR of the drug being signed out as having been obtained for this date and time. 2. Hydrocodone-Acetaminophen 5-325 mg was documented on the CSR as having been signed out/obtained on 9/20/15 at 1700 (5:00 PM) and again at 2240 (10:40 PM), however there was no documentation on the MAR of the medication being administered to the resident on that date and times. Interview with the Transitional Director of Nursing (Corporate) on 9/30/15 at 11:15 AM confirmed the Lyrica was not obtained from the locked storage on 9/18/15 at 9:00 PM and, therefore, could not have been administered to the resident as	F 514			

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F 514	<p>Continued From page 53</p> <p>documented on the MAR. Continued interview confirmed the two doses of Hydrocodone-Acetaminophen 5-325 mg on 9/20/15 were not documented as having been administered to the resident resulting in incomplete/inaccurate documentation.</p> <p>Medical record review revealed resident #38 was admitted to the facility on 9/23/12 with diagnoses including Obstructive Chronic Bronchitis with Exacerbation, Osteoarthritis, Depression, Anxiety, Chronic Pain, and Nuclear Sclerosis.</p> <p>Medical record review revealed a physician's order for Norco 5-325mg give half tablet by mouth every 8 hours with a start date of 1/19/15.</p> <p>Medical Record review of the MAR and CSR for 8/1/15-9/11/15 revealed documentation on the MAR of Norco 5-325 having been administered to the resident at midnight on 8/3/15, however there was no documentation on the CSR of the drug being signed out/obtained for this date and time.</p> <p>Interview with the Transitional Director of Nursing on 9/28/15 at 11:30 AM in the conference room revealed the Norco 5-325mg had not been signed out as having been obtained on the CSR for midnight on 8/3/15 but had been documented on the MAR as having been administered to the resident. Further interview confirmed the pill count on the CSR was correct, therefore, the medication could not have been administered which resulted in inaccurate documentation.</p> <p>Medical record review revealed Resident #39 was admitted to the facility on 4/24/15 with diagnoses of Dementia with Behavioral Disturbances, Chronic Pain, Edema, Essential Hypertension,</p>	F 514			

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F 514	<p>Continued From page 54 Anxiety, Atrial Fibrillation and Chronic Kidney Disease.</p> <p>Medical record review revealed an order for Norco 5/325 mg tablet. Give 1 tablet by mouth every 4 hours as needed for pain with a start date of 6/22/15. Continued review revealed an order for Norco 7.5/325 mg tablet. Give 1 tablet by mouth every 8 hours with a start date of 7/20/15. Continued review revealed an order for Lorazepam 0.5 mg. Give 1 tablet by mouth every 24 hours as needed for anxiety with a start date of 8/7/15.</p> <p>Review of the CSR revealed Norco 5/325 mg was signed out 2 times but not documented on the MAR as administered to the resident.</p> <p>Review of the CSR revealed Norco 7.5/325 mg was signed out 1 time but not documented on the MAR as administered to the resident.</p> <p>Review of MAR revealed Norco 7.5/325 mg was documented 4 times on the MAR but not signed out on the CSR. Continued review revealed Norco 7.5/325 mg had been documented 2 times on the MAR and CSR at different times.</p> <p>Review of MAR revealed Lorazepam 0.5 mg was documented on the MAR 2 times as late and 1 time with different times.</p> <p>Review of the CSR revealed Lorazepam 0.5 mg was signed out 2 times but not documented on the MAR as administered to the resident.</p> <p>Interview with the Administrator on 9/29/15 at 12:00 PM in the conference room confirmed inaccurate documentation of medications.</p>	F 514			

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F 514	Continued From page 55 Medical record review revealed Resident #40 was admitted to the facility on 7/10/15 with diagnoses of Heart Failure, Left above Knee Amputation, Hydrocele, Anemia, Hypothyroidism, Major Depressive Disorder, Diabetes, Type II, Anxiety and Chronic Pain. Medical record review revealed an order for Oxycodone HCL 20 mg. Give 1 tablet by mouth every 4 hours as needed for pain with a start date of 7/10/15. Continued review revealed and order for OxyContin 20 mg. Give 3 tablets by mouth every 12 hours related to other chronic pain with a start date of 7/10/15, then discontinued on 8/23/15 and then a restarted on 8/23/15. Continued review revealed Lyrica Capsule 150 mg. Give 1 capsule by mouth two times a day related to chronic pain. Medical record review of the MAR and CSR dated 8/15 and 9/15 revealed 24 incidents of inaccurate documentation with pain medications, 14 incidents of not being documented on the MAR, 6 incidents of not being signed out on the CSR, 3 incidents of different times and 1 incident of a missing dose. The incidents occurred from dates 8/2/15 through 9/23/15. Review of the CSR revealed Oxycodone HCL 20 mg was signed out 14 times but not documented on the MAR as administered to the resident. Continued review revealed Oxycodone HCL 20 mg documented 1 time on the CSR and MAR with different times. Review of the MAR revealed Oxycodone HCL 20 mg was documented 1 time on the MAR but not signed out on the CSR.	F 514			

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F 514	<p>Continued From page 56</p> <p>Review of the MAR revealed OxyContin 20 mg was documented 2 times, but not signed out on the CSR. Continued review revealed OxyContin HCL 20 mg was documented 2 times on the CSR and MAR at different times.</p> <p>Review of the MAR revealed Lyrica 150 mg was documented 3 times but not signed out on the CSR. Continued review revealed Lyrica 150 mg was documented 1 time on the CSR and MAR at different times.</p> <p>Interview with the Administrator on 9/29/15 at 12:00 PM in the conference room confirmed 24 incidents of pain medications not being documented on the MAR or CSR and different times on the MAR and CSR resulting in inaccurate documentation and an inaccurate medical record.</p> <p>Medical record review revealed Resident #41 was admitted on 5/9/15 with diagnoses including Cerebral Infarction, Dementia, Chronic Pain, Anxiety Disorder and Incontinence.</p> <p>Medical record review of the Physician order dated 5/13/15 revealed Morphine Sulfate 5 mg/ml. Inject 1 ml every 1 hour as needed for pain and Xanax Tablet (Alprazolam) 0.25 mg. Give 1 tablet by mouth at bedtime for anxiety.</p> <p>Record review of the CSR and MAR for the month of 8/2015 revealed 2 incidents of Xanax and 7 incidents of Morphine signed out on the CSR and not being documented in the MAR as being given.</p> <p>Interview with the Administrator on 9/29/15 at</p>	F 514		
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F 514 Continued From page 57
12:30 PM in the conference room confirmed the dates and times of missing documentation on the MAR, resulting in medical records that were not complete or accurate.

Medical record review revealed Resident #42 was admitted to the facility on 9/23/12, with diagnoses including Cerebrovascular Accident with Aphasia (unable to speak or understand speech), Hemiplegia, Depression, Gastroesophageal Reflux Disease, Hypertension, and Subarachnoid Hemorrhage (bleeding into brain).

Medical record review of physician's orders dated 2/8/15, revealed an order for Hydrocodone-Acetaminophen 5/325 milligrams (mg) 1 tablet three times a day.

Medical record review of the Controlled Substance Record (CSR) for September 2015, revealed on 9/3/15, at 6:20 AM, 1 tablet of Hydrocodone was signed out for Resident #42. Medical record review of the MAR for the month of September 2015, revealed the box where the administration would be documented was blackened with no explanation. Continued review of the CSR revealed no signatures for administration of the Hydrocodone on 9/22/2015, but the medication was documented as being administered on the MAR. Further review of the CSR revealed 60 tablets of Hydrocodone were received on 8/31/15, with the last entry on the CSR dated 9/21/15, at 2:10 PM, revealed one tablet remained. Continued review of the CSR revealed 60 tablets of Hydrocodone were received on 9/22/15 and the first dose was administered on 9/23/15, at 6:00 AM.

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F 514 Continued From page 58
During interview on 9/24/2015, at 1:30 PM in the conference Room, the DON confirmed the inaccurate and incomplete documentation resulting in an incomplete medical record.

Medical record review revealed Resident #43 was admitted to the facility on 8/21/15, with diagnoses including Osteomyelitis of Ankle and Foot, Gas Gangrene, and Diabetes Mellitus.

Medical record review of physician's orders dated 8/22/15, revealed an order for Oxycodone-APAP 5/325 mg every 4 hours as needed. Medical record review of the CSR for August and September revealed 1 tablet signed out each evening from 8/25/15 - 9/3/15 at 9:00 PM by the same nurse, as well as doses on 9/8/15 - 9/12/15, 9/14/15, 9/15/15, 9/16/15. Continued review of the CSR revealed the dose for 9/19/15 was signed out before the dose on 9/18/15. Continued review of the CSR for August revealed Oxycodone was signed out on the CSR on 8/25/15, 8/26/15, and 8/30/15, but was not documented as being administered on the MAR. Further review of the MAR revealed the dose on 8/29/15 was signed out on the CSR at 9:00 PM, but was not documented on the MAR as being administered until 10:24 PM. Continued review of the MAR revealed the dose on 8/31/15 was signed out on the CSR at 9:00 PM, but was not documented on the MAR as being administered until 11:16 PM.

During interview on 9/24/15, at 1:30 PM, in the conference room, the DON confirmed medications were not signed out appropriately and documented as being administered correctly.

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F 514	<p>Continued From page 59</p> <p>Medical record review revealed Resident #44 was admitted on 10/14/13 with a diagnoses including Parkinson's, Chronic Pain, Hypokalemia, Polyosteoarthritis and Hypertension.</p> <p>Medical record review of the MAR included a Physician order for Norco Tablet 5-325mg with a start sate of 12/15/14. Give 1 tablet as needed for pain every 4 hours.</p> <p>Record review of the MAR and CSR for the months of 8/2015 and 9/2015 revealed 10 instances of Norco being signed out on the CSR and not being documented as given on the MAR.</p> <p>Interview and record review on 9/29/15 at 12:15 PM in the conference room with the DON confirmed incomplete and inadequate medical records.</p>	F 514		
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