

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

PRINTED: 03/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT SAINT FRANCIS	STREET ADDRESS, CITY, STATE, ZIP CODE 6007 PARK AVE MEMPHIS, TN 38119
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F 000	<p>INITIAL COMMENTS</p> <p>The re-certification survey and investigation of complaints #TN35448, TN35431, TN35231, TN35489, TN35399 and TN35564 was conducted on 1/12/15 through 2/11/15 with an extended survey conducted on 2/4/15-2/11/15. The survey team identified Immediate Jeopardy (IJ) and Substandard Quality of Care related to administration of medications without orders, evidence of significant medication errors and lack of monitoring of blood levels with anticoagulant therapy. Deficiencies were cited related to complaint #TN35448, TN35431, TN35231, TN35489, TN35399. There were no deficiencies cited related to complaint #TN35564.</p> <p>Immediate Jeopardy is a situation in which the provider's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.</p> <p>The facility was cited IJ at F282-K, F309-K, F329-K, F333-L, F386-K, F490-L, F501-L, F502-K, F505-J, F514-K and F520-L.</p> <p>The facility failed to notify the physician of subtherapeutic and critical high bleeding time results, failed to ensure physician orders were transcribed accurately; failed to ensure orders were signed and dated; and failed to ensure residents were free from significant medication errors, which resulted in IJ.</p> <p>The facility failed to ensure residents were free from significant medication errors when medications were not transcribed correctly for Resident #252, 299, 116, 403, 411, 229, 222, 81, 151, 131, 358 and 394.</p>	F 000	<p>Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State law.</p> <p>This facility will continue to inform each resident in writing of Medicaid benefits and services available including charges not covered under Medicare.</p> <p style="text-align: right;">RECEIVED MAY 29 2015</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Doreen Ann McGraw</i>	TITLE Administrator	(X6) DATE 5/27/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	<p>Continued From page 1</p> <p>The facility failed to ensure the physician was notified of abnormal, critical low and/or critical high laboratory test results for Resident #43, 211, 252, 410, 411 and 8, which resulted in IJ.</p> <p>The facility failed to ensure the Medical Director coordinated medical care and provided clinical guidance to the facility and failed to ensure the Quality Assurance (QA) committee identified and addressed concerns related to medication errors, physician notification and maintaining an accurate medical record which had the potential to affect all residents and resulted in IJ.</p> <p>The facility's Quality Assessment (QA) and assurance committee failed to implement plans of actions to correct identified concerns of medication and transcription errors; failed to ensure residents were not administered unnecessary medications; residents were free of significant medication errors; the physician was notified of critical laboratory results; physician orders were signed and dated and the medical records were complete and accurate.</p> <p>The Administrator was informed of the IJ in the activity room on 1/27/15 at 3:15 PM.</p> <p>The IJ was effective 1/27/15 and continued until an allegation of compliance (AOC) was received on 1/30/15 at 12:05 PM and validated on 2/2/15 through 2/6/15 and was removed on 1/30/15.</p> <p>Substandard Quality of Care was cited for F314 at a level of "H", F-309 and F-329 at a level of "K" and F-333 at a scope and severity level of "L".</p> <p>Non-compliance of the IJ continues at a scope</p>	F 000			

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F 000	Continued From page 2 and severity of an "E" level for F282, F309, F329, F386, F502, F505 and F514 and a scope and severity of an "F" level for F333, F490, F501 and F520. The facility is required to submit a plan of correction for all tags.	F 000			
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to develop a care plan to include care for anticoagulant therapy and deep venous thrombosis (DVT) for 3 of 37 (Residents #294, 407 and 412) sampled residents of the 53 residents included in the stage	F 279	1: Resident #294 and #407, 412 are discharged. 2: All current residents have the potential to be affected by the same deficient practice. All current residents' care plans were reviewed by the MDS department on 2/26/15 to ensure that residents currently receiving anticoagulant therapy with a DVT are care planned. All current residents are receiving weekly skin assessments and treatments are being performed according to physicians order.	5/28/2015	

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F 279	<p>Continued From page 3</p> <p>2 review. The failure of the nurses to complete weekly skin assessments on a resident, who is at high risk for developing pressure ulcers, and the failure to provide treatments as ordered when a Stage 2 pressure ulcer deteriorated to a Stage 3 pressure ulcer, resulted in actual harm for Resident #294.</p> <p>The findings included:</p> <p>1. Closed medical record review for Resident #294 documented an admission date of 9/9/14 with diagnoses of Acute and Chronic Respiratory Failure, Acute and Chronic Renal Failure, Anemia and CVA - Main Brainstem Infarction, Ventilator Dependence via Tracheostomy, History of Drug and Alcohol Abuse, Percutaneous Endoscopy Gastrostomy Tube and Pulmonary Embolus. Review of a "PRESSURE ULCER RECORD" dated 9/24/14 documented Resident #294 did have a Stage 2 sacral pressure ulcer. Review of the "PRESSURE ULCER RECORD", completed by the treatment nurse, dated 9/24/14 documented a stage 2 pressure ulcer (loss of the skin presenting as a shallow open ulcer with a red pink wound bed) measuring "L (cm) 3.5 x W (cm) 3.0 x D (cm) < 0.1... WOUND BED Dark pink/red tissue 100% [percent]..." was present on the resident's sacrum/coccyx. The date of origin was 9/24/14. There was no corresponding nursing documentation. The resident's medical record had no skilled nursing notes from 9/19/14 through 9/29/14 or generic nurse's notes documenting the identification of the pressure ulcer; however the resident had remained in the facility. The next pressure ulcer record documentation was due on 10/8/14; it was not completed. Review of the pressure ulcer record dated 10/31/14 documented a deterioration of the</p>	F 279	<p>3:</p> <p>A new Minimum Data Set Coordinator was identified as of 3/23/15. Licensed nurses will receive in-service by 3/31/15 regarding appropriate care planning of residents with anti-coagulation therapy and diagnosis of DVT by Staff Development Coordinator (SDC). Licensed nurses were in-serviced beginning 2/15/15 regarding completion of weekly skin assessments by SDC. Licensed nurses were in-serviced by 3/31/15 regarding performing wound care treatments according to physicians order by SDC. Care plans will be reviewed at the first clinical meeting after admission for identification of completion of the interim plan of care and any updates related to new physician's orders.</p>		

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F 279	<p>Continued From page 4</p> <p>resident's sacral pressure ulcer to a stage 3 (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss) measuring "...l (cm) 3.0 X w (cm) 2.0 X D (cm) 1.0...WOUND BED Dark pink/red tissue 50%...Slough - moist yellow or gray necrotic [dead] tissue 50%..."</p> <p>Review of the pressure ulcer record dated 11/27/14 documented a deterioration of the resident's sacral wound to unstageable (full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined; but it will be either a stage 3 or 4) and measured the same as on 11/20/14 with 100% slough covering the wound bed.</p> <p>Review of a "CARE PLAN CONFERENCE SUMMARY" dated 10/3/14 did not document any concerns of skin. Review of a "CARE PLAN CONFERENCE SUMMARY" dated 12/16/14 did not document any concerns of skin.</p> <p>The facility was unable to provide a care plan for pressure ulcer for Resident #294.</p> <p>During an interview in the 4th floor Assistant Director of Nursing/Respiratory's office on 1/23/15 at 10:10 AM, Nurse #2 was asked if the resident's skin assessments had been completed. Nurse #2 stated, "The weekly skin assessment - if the nurse didn't write a note. The skin assessment will not show up in the computer." The facility was unable to provide documentation of weekly skin assessments for Resident #294.</p> <p>The failure of the nurses to complete weekly skin</p>	F 279	<p>4:The Shower Schedule Audit and Wound Treatment Audit will be completed by DON/ designee to ensure weekly skin assessments are completed and wound treatments are performed according to physician's order. Audits to be completed by DON/ designee 5 times a week to ensure completion of skin assessments for 2 months; 3 times a week for 1 month; then 1 time a week until compliance is demonstrated. A sample of care plans will be audited using the care plan by the MSDS / designee weekly for 8 weeks until compliance is demonstrated. Any issues identified will be corrected immediately. Results will be reported by the ADON or Designee to the QAPI Committee for review and further recommendation.</p> <p>If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of audit.</p>	

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F 279	<p>Continued From page 5</p> <p>assessments on a resident, who is at high risk for developing pressure ulcers, and the failure to provide treatments as ordered when a Stage 2 pressure ulcer deteriorated to a Stage 3 pressure ulcer, resulted in actual harm for Resident #294.</p> <p>2. Medical record review for Resident #407 documented an admission date of 12/23/14 and a readmission date of 1/20/15 with diagnoses of Congestive Heart Failure, Abdominal Aortic Aneurysm , Hypertension, Pulmonary Embolus and late effect Cerebrovascular Accident and Severe End Stage Cardiomyopathy. Resident #407's care plans did not include the use of Coumadin.</p> <p>Review of the initial Minimum Data Set (MDS) dated 12/30/14 revealed Pulmonary Embolus (PE) was not marked, nor was the anticoagulant Warfarin (Coumadin) marked as Resident #407 receiving it in the 7 day review period.</p> <p>During an interview in the MDS office on 1/22/15 at 8:45 AM, the MDS Coordinator stated, "There is no care plan on the chart for anticoagulant."</p> <p>3. Medical record review for Resident #412 documented an admission date of 7/10/14 with diagnoses of Stage IV Metastatic Colon Cancer, Hypertension, Right Lower Extremity Deep Vein Thrombosis, Failure to Thrive, Malnutrition, Pleural Effusion and Post Hemicolectomy and Ileostomy.</p> <p>Review of physician's order sheet dated 7/25/14 documented, "...Warfarin [Coumadin] 2.5 mg [milligram]... daily (take with 3 mg tablet TTD [the total dose] = [amount to be given] 5.5 mg)..." The resident remained on this dosage of Warfarin</p>	F 279			

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F 279	Continued From page 6 during the stay at the facility until 8/7/14 when he was discharged. The facility was unable to provide a care plan for this resident. During an interview in the MDS office on 1/28/15 at 11:32 AM, the MDS Coordinator stated, "No care plans on the chart."	F 279		
F 282 SS=K	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, review of a formal complaint lodged with the facility, observation and interview, it was determined the facility failed to ensure care plan interventions were followed related to monitoring laboratory (lab) tests for residents receiving anticoagulants, failed to ensure weekly skin assessments were done for residents at risk of impaired skin integrity, failed to ensure Activities of Daily Living (ADLs) were performed for residents that were unable to perform the activities independently, failed to ensure psychiatric (psych) services were obtained for residents with behaviors and/or failed to ensure catheter care was provided for 13 of 37 (Residents #211, 252, 410, 411, 8, 222, 81, 62, 151, 294, 358, 394 and 409) sampled residents reviewed of the 53 residents included in the stage	F 282	1: Residents # 151, 211, 252, 410, 411 have been discharged. #8 Blood levels are being monitored per physician orders. Residents # 222, 81 have been Discharged Residents # 409, 222, 81, 410 have been Discharged Residents # 62, 394 are currently receiving weekly skin assessments by licensed staff. Residents # 252, 222, 294 have been Discharged Resident # 409 Discharged Resident # 358 currently being seen by psychiatric services.	5/28/2015

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F 282	<p>Continued From page 7</p> <p>2 review. The failure of the facility to ensure blood levels were monitored per orders and facility protocol placed Residents #211, 252, 410, 411 and 8 in immediate jeopardy (IJ) a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident. The facility's failure to administer anticoagulants with orders and the failure to monitor blood levels placed residents receiving anticoagulants at risk for serious injury related to abnormal bleeding and/or hemorrhage, harm, impairment or death. The facility's failure to perform weekly skin assessments resulted in actual harm when Resident #222 developed a suspected deep tissue injury (SDTI) that went unnoticed until pointed out by the family. The facility's failure to perform weekly skin assessments and failure to provide pressure prevention for Resident #81 who was at risk of developing pressure ulcers resulted in actual harm to Resident #81 when Resident #81 developed a Stage 2 pressure ulcer of her right ear from nasal oxygen tubing.</p> <p>The facility failed to ensure care plan interventions were followed for lab monitoring for residents receiving anticoagulants (Resident #s 211, 252, 410, 411, and 8), failed to ensure weekly skin assessments were done (Resident #s 222, 81, 410, 62, 394, and 409), failed to ensure psychaitric services were obtained (Resident #s 151 and 358), failed to ensure catheter care was provided (Resident #s 252, 222, and 294) and failed to ensure ADLs were performed (Resident #409).</p> <p>A meeting was conducted in the activity room on 1/27/15 at 3:15 PM with the Administrator when</p>	F 282	<p>2:</p> <p>All residents have the potential to be affected by the same practice. A complete laboratory audit was completed by Nursing on 1/28/2015 on all active residents to ensure labs were performed according to physicians order as indicated on care plan and physician being notified when abnormal results are obtained and documented on a telephone order if change and treatment is required. A complete audit of all current residents receiving Coumadin therapy was completed by DON, ADON and designee on 1/27/15 ensuring that physician/nurse practitioner were notified of any abnormal lab values and is documented on a telephone order if change and treatment is required.</p>		

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F 282	<p>Continued From page 8 she was informed of the IJ.</p> <p>The survey team received an acceptable Allegation of Compliance (AOC) from the Administrator on 1/30/15 at 12:05 PM.</p> <p>The AOC documented the following: It is the policy of this facility to ensure all resident's lab results are obtained when ordered by a physician and abnormal lab results are reported to the physician or Nurse Practitioner timely. It is also the policy of this facility to ensure that all physician orders are signed and dated. As well as orders for medications and treatments will be consistent with principles of safe and effective order writing. It is also the policy of this facility to maintain clinical records on each resident that are complete, accurately documented, readily accessible and systematically organized.</p> <p>Validation of the Credible Allegation of Compliance was accomplished on site 2/2/15 through (-) 2/6/15, through record review, review of facility documents, observation and interviews with nursing, administration and corporate staff.</p> <p>The facility provided evidence of in-service training with sign in sheets for all licensed nursing staff dated 1/28/15 through 1/30/15 related to 24 hour chart checks, physician orders, admission orders, telephone orders, physician order sheets, reconciliation of medications with physician orders, lab ordering and tracking and reporting abnormal labs.</p> <p>The facility provided evidence of auditing tools utilized for 24 hour chart checks, physician orders, admission orders, telephone orders, physician order sheets, reconciliation of</p>	F 282	<p>All current residents are receiving weekly skin assessments and any areas identified are reported to the physician. Wound care treatments are being performed according to physician's order with preventative measures listed on the care plan.</p> <p>Residents are receiving psychiatric services per physician orders. Residents with indwelling catheters are receiving catheter care per physician orders as indicated in the care plan.</p> <p>Current Residents are receiving ADL care according to Care Plan.</p>		

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F 282	<p>Continued From page 9</p> <p>medications with physician orders, lab ordering and tracking and reporting abnormal labs.</p> <p>Medical record review on 2/5/15 documented 9 of 9 new admission charts admitted on or after 1/30/15 included the admission to the facility order, reconciliation of admission medication and treatment orders, Physician Order Sheets (POS), labs, admission nurses notes documenting verification of orders and admission skin assessments to ensure the process of chart checks was being done and any follow up was occurring.</p> <p>The licensed staff currently on leave of absence, vacation or per diem was sent a certified letter on 1/30/15 informing staff of the in-service and training and that the training must be completed prior to returning for their next scheduled shift.</p> <p>Observations were conducted on 2/2/15 of licensed staff's shift change reporting methods to validate pertinent resident information including anticoagulant medications, resulted and/or pending lab testing with utilization of the lab tracking tool, new admissions and documented reconciliation of medications ordered by a physician, was reported to the oncoming shift.</p> <p>Interviews with facility licensed nursing staff were conducted on 2/4/15 through 2/5/15 with staff from all floors and all shifts validating 24 hour chart checks, physician orders, lab ordering and tracking, reconciliation of medications with physician orders and clinical pathway for lab reporting and monitoring.</p> <p>The facility provided documentation of a complete laboratory audit completed on 1/28/15 on all</p>	F 282	<p>3: Education was provided to licensed nurses regarding process for developing and following care plans on 3/5,10,11,12,15,16/ 2015 by the Staff Development Department.</p> <p>4: Audits will be completed by DON/designee to ensure weekly skin assessments are completed and wound treatments are performed according to physician's order. Audits to be completed by DON/designee 5 times a week to ensure completion of skin assessments for 2 months; 3 times a week for 1 month; then 1 time a week until compliance is demonstrated.</p> <p>20% of the resident population will be audited 5 times per week for 4 weeks then 20% will be audited 3 times per week for 8 weeks to validate that personal</p>		

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F 282	<p>Continued From page 10</p> <p>active residents to ensure labs were performed according to physician orders as indicated on the care plan and the physician being notified when abnormal results are obtained and documented on a telephone order if change and treatment is required. The audits were reviewed and current to date and are ongoing.</p> <p>Interviews with the Administrator and Corporate Staff (Health Information Management) on 2/4/15 revealed the facility would continue monitoring by: A Quality Assurance (QA) meeting to be held weekly for four weeks beginning 2/5/15 and then monthly for findings, recommendations and follow up regarding the plan. The frequency of the audits to be maintained will be decided by the QA committee based on the findings of the audits.</p> <p>The survey team validated the AOC on 2/2/15 through 2/6/14. The IJ was removed as of 1/30/15.</p> <p>Non-compliance of the IJ continues at a scope and severity of an "E" for monitoring or corrective actions. The facility is required to submit a plan of correction for all tags.</p> <p>The findings included:</p> <p>1. Review of the facility's comprehensive care plan policy documented, "...An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident... Each resident's comprehensive care plan is designed to: Incorporate identified problem areas; Incorporate risk factors associated with identified problems... Reflect</p>	F 282	<p>hygiene standards are being maintained. An audit will be completed daily by DON/ADON/ designee to validate that physician orders are obtained and transcribed correctly.</p> <p>A 20% sample of care plans will be audited weekly X 8 weeks by the MDSC or designee.</p> <p>All results of audits will be reported at QAPI meeting for review by the ADON / Designee.</p> <p>If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of audit.</p>	
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F 282	<p>Continued From page 11</p> <p>treatment goals, timetables and objectives in measurable outcomes... Reflect currently recognized standards of practice for problem areas and conditions... Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making... "</p> <p>Review of the facility's "Clinical Pathway for Laboratory Reporting" policy documented, "The facility is expected to follow notification from AMDA [American Medical Director's Association] standards... The following results MUST be called immediately: STAT [immediately] labs, Alert or panic labs... The following abnormal labs: INR [International Normalized Ratio - measure in seconds the ability of blood to form a clot] greater than 3.0 or less than 2.0..."</p> <p>The facility utilizes the hospital laboratory services for lab testing the PT/INR. The hospital lab reference range for the PT is 11.7 -14.9 and for INR is 0.00-1.13. The suggested therapeutic ranges are Low Risk 2.0 - 3.0.</p> <p>2. Medical record review for Resident #211 documented an admission date of 1/25/13 with diagnoses of Cerebrovascular Accident (CVA), Anoxic Brain Injury, Hypertension, Chronic Respiratory Failure, Myelopathy and Tracheostomy. Review of the care plan dated 5/19/14 documented, "...Resident is at risk for abnormal bleeding or hemorrhage related to the use of anticoagulant medication and Aspirin... Approach... Schedule lab tests as ordered by the physician to monitor coagulation factors..."</p>	F 282		

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F 282	<p>Continued From page 12</p> <p>Review of a Nurse Practitioner (NP) progress note dated 4/7/14 at 1:33 PM documented, "...Currently on Warfarin [Coumadin]for CVA... Today's INR critical value 5.22 [therapeutic range 2.0 to (-) 3.0]. This value was not called to me."</p> <p>Review of a physician order dated 4/7/14 documented, "...Hold Warfarin x 2 days. Give Vitamin K .1 mg [milligram] IM [intramuscular]/SQ [subcutaneous] Now. Recheck INR in AM..."</p> <p>The INR was not done as ordered on 4/8/14.</p> <p>Review of a NP progress note dated 4/10/14 at 11:38 AM, documented "...Patient seen today f/u [follow up] INR... Last INR 5.22 on 4/7/14. Patient was given Vitamin K IM. Warfarin was held x [times] 2 days. INR was supposed to be rechecked 4/8/14 but was not done..."</p> <p>Review of a physician's order dated 4/10/14 documented, "...STAT PT [Prothrombin Time - measures the ability of blood to form a clot] and (/) INR now."</p> <p>Review of lab results dated 4/10/14 at 5:00 PM documented, "...PT 15.9 [reference range 11.7-14.9], INR 1.33 [reference range 0.00-1.13]..." There was no documentation the results were called to the NP.</p> <p>Review of a NP progress note dated 4/11/14 documented, "...Patient seen today for anticoagulation management. INR was not called to me as ordered. INR subtherapeutic at 1.33. Last INR was 5.22. Patient received Vitamin K."</p> <p>Review of elevated lab results dated 6/28/14 documented, "...PT 17.3... INR 1.49..." The facility</p>	F 282			

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F 282	<p>Continued From page 13</p> <p>was unable to provide documentation the NP was notified of these lab results.</p> <p>Review of a physician's order dated 8/22/14 documented, "...Hold Coumadin [8/23/14] Recheck PT/INR in AM [8/24/14]..."</p> <p>Review of a NP progress note dated 9/3/14, documented "...Results of PT/INR not on chart for... 8/24/14..." The facility was unable to provide documentation a PT/INR was completed on 8/24/14.</p> <p>During an interview in the Director of Nursing's (DON) office on 2/3/15 at 10:45 AM, the DON confirmed the PT/INR was not done as ordered on 4/8/14, and the NP was not notified of Resident #211's abnormal lab results on 4/7/14 and 4/10/14. The DON stated, "I see what you are saying, just put it in the tag [deficiency]..."</p> <p>The facility failed to follow the care plan interventions for monitoring labs which placed Resident #211 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>3. Medical record review for Resident #252 documented an admission date of 8/28/14 with diagnoses of Atrial Fibrillation, Deep Vein Thrombosis (DVT) of the Left Lower Extremity, Anemia, Type 2 Diabetes Mellitus, Chronic Renal Insufficiency, Hypertension, Peripheral Neuropathy and Mixed Hyperlipidemia.</p> <p>a. Review of the care plan dated 9/10/14 documented, "Resident [#252] is at risk for abnormal bleeding or hemorrhage related to use of anticoagulant / Coumadin therapy due to DVT</p>	F 282		

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F 282	<p>Continued From page 14</p> <p>& [and] AFib [Atrial fibrillation]... Administer anticoagulant meds and other medications as ordered by physician... Schedule lab tests as ordered by the physician to monitor coagulation factors..."</p> <p>Review of a NP's telephone order dated 8/30/14 at 1:00 PM documented, "Hold Coumadin x 2 days, recheck PT/INR on Monday 9/1/14..." The facility was unable to provide results for the 9/1/14 PT/INR.</p> <p>Review of a NP's telephone order dated 9/3/14 at 2:00 PM documented, "Coumadin 3 mg 1 tab [tablet] po [by mouth] q [every] HS [hour of sleep]. PT/INR 9/8/14 AM..."</p> <p>Review pf Resident #252's September 2014 medication administration record (MAR) documented the Coumadin 3 mg dose was not started until 9/4/14.</p> <p>Review of a NP's telephone order dated 9/19/14 at 10:10 AM documented, "...PT/INR NOW..." The facility was unable to provide results for this PT/INR.</p> <p>Review of a NP's telephone order dated 9/19/14 at 1:30 PM documented, "...Transfer to [Named Hospital] (Per Family Request) Facial Drooping..."</p> <p>The hospital emergency department (ED) form documented, "...9/19/14 Hospital Encounter... Your Plan... ASK your doctor about these medications..." and listed 2 different doses of Coumadin, a 7.5 mg dose to be taken every evening and a 10 mg dose to be taken once daily for 3 days. The form documented the resident</p>	F 282		
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F 282	<p>Continued From page 15</p> <p>[#252] was to "...ask about: Which instructions should I use..." The facility was unable to provide documentation the nurse identified, or clarified the Coumadin order of 9/19/14 on the hospital return.</p> <p>There was no documentation in Resident #252's medical record the NP or physician was called to clarify the resident's correct dose of Coumadin. Prior to the hospital ED visit, the resident was receiving 4 mg of Coumadin by mouth every evening since 9/16/14.</p> <p>Review of a physician order dated 9/16/14 documented, "...[sign for increase] Coumadin to 4 mg po q HS..."</p> <p>Review of Resident #252's September 2014 MAR documented the resident was given 10 mg of Coumadin on 9/20/14, 9/21/14 and 9/22/14. There was no clarification order for the resident to receive Coumadin 10 mg. On 9/23/14 there was no documentation the resident received any Coumadin. The resident received 4 mg of Coumadin on 9/24/14 through 9/30/14.</p> <p>Review of a laboratory report dated 9/23/14 documented a PT/INR with results of 20.2 and 1.83. There was no NP or physician order for a PT/INR to be completed on this date.</p> <p>Review of a NP's telephone order dated 9/23/14 documented, "...[symbol for increase] Coumadin to 4 mg tab po q HS. [obtain] PT/INR 9/29/14 AM..."</p> <p>Review of a lab report dated 9/29/14 printed at 12:09 PM documented, "...PT... 31.6... INR... 3.30...", an elevated blood level. There was no</p>	F 282		
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F 282	<p>Continued From page 16</p> <p>documentation the NP or physician was notified of the 9/29/14 elevated PT/INR. Resident #252's MAR documented Coumadin 4 mg was given every evening on 9/29/14, 9/30/14, 10/1/14, 10/2/14 and 10/3/14 although the PT/INR was elevated above therapeutic INR blood level of 2-3.</p> <p>Review of a NP's telephone order dated 10/3/14 at 3:00 PM documented, "PT/INR 10/6/14 [symbol for decrease] 4.5 mg Coumadin po q HS..." The 4.5 mg dose of Coumadin was actually an increase in Resident #252's Coumadin.</p> <p>Review of Resident #252's October 2014 MAR documented the resident was given Coumadin 4.5 mgs on 10/4/14, 10/5/14 and 10/6/14, although the most recent lab results were elevated above therapeutic blood levels. There was no documentation provided that the NP was notified for clarification of the Coumadin increase in dose order.</p> <p>Review of a lab report for Resident #252 dated 10/6/14 printed at 8:38 AM documented, "...PT... 34.4... INR... 3.69...", which was elevated above therapeutic blood level range.</p> <p>Review of a NP's telephone order dated 10/6/14 at 1:20 PM documented, "...Hold Coumadin today. PT/INR in A.M. [symbol for decrease] to 3.5 mg po q HS..."</p> <p>The October 2014 MAR revealed Resident #252 was given the higher dose (Coumadin 4.5 mg) on 10/6/14. Resident #252 did not receive any Coumadin on 10/7/14 or 10/8/14 and the 3.5 mg dose of Coumadin was not started until 10/9/14. There was not an order to hold Coumadin on</p>	F 282		
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F 282	<p>Continued From page 17 10/7/14 or 10/8/14.</p> <p>Review of a NP's telephone order dated 10/28/14 at 3:00 PM documented, "[symbol for increase] Coumadin to 4 mg po q HS. PT/INR 11/3/14 AM..." There was no documentation on the MAR the resident received any Coumadin on 10/28/14. The 4 mg dose of Coumadin was not documented as given until 10/29/14. There was not an order to hold the Coumadin on 10/28/14.</p> <p>Review of a lab report dated 11/1/14 documented, "...PT... 15.2... INR... 1.25..." There was no NP or physician's order documented for a PT/INR to be done on 11/1/14.</p> <p>Review of a NP's telephone order dated 11/1/14 at 1:35 PM documented, "increase Coumadin to 4.5 mg and recheck PT/INR in the AM..." The facility was unable to provide documentation a PT/INR was done on 11/2/14 as ordered.</p> <p>The facility failed to follow the care plan interventions for monitoring labs and giving Coumadin as ordered by a physician which placed Resident #252 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>During an interview at the 3rd floor nurses' station on 2/9/15 at 4:00 PM, Nurse #6 confirmed the nurse had given the resident the higher dose of Coumadin even though the blood level was above the therapeutic range. Nurse #6 stated, "The [Coumadin] order [dated 10/3/14]needed clarification."</p> <p>b. Review of the care plan dated 9/10/14 documented, "Resident has a potential for</p>	F 282		

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F 282	<p>Continued From page 18</p> <p>complications associated with incontinence of bowel and/or bladder... 10/6/14 Foley cath [catheter] Add for wound care... catheter care q [every] shift..."</p> <p>Review of a NP's telephone order dated 10/6/14 documented, "...Foley cath placement..."</p> <p>The facility was unable to provide documentation Resident #252 was provided catheter care after the catheter was inserted on 10/7/14.</p> <p>During an interview at the 3rd floor nurses' station on 2/4/15 at 12:10 PM, Nurse #6 was asked about the facility's protocol for catheter care and where the nurse would document the care provided. Nurse #6 stated, "First, if the resident has a foley catheter, it goes in the EZMAR [electronic medication and treatment record] by selecting the template for the foley. Catheter care is done every shift and as needed... Change the bag as needed... We will change it [catheter] every 30 days... You [nurses] know the patient has the foley, you have the order template, it has to be addressed. If not addressed, you risk missing it, not providing the care." Nurse #6 confirmed the catheter care was not documented on Resident #252's EZMAR.</p> <p>4. Medical record review for Resident #410 documented an admission date of 12/3/14 with diagnosis of Atrial Fibrillation and a history of Chronic Coumadin therapy, Pain in Limb, Hypertension, Right Hip Fracture, Personal History of Fall and Hypothyroidism. The diagnosis of DVT of the right arm was added on 12/6/14.</p> <p>a. Review of the care plan dated 12/19/14 documented, "...[Named Resident #410] is at risk</p>	F 282			

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F 282	<p>Continued From page 19</p> <p>for abnormal bleeding or hemorrhage related to use of anticoagulant... Approach... Administer anticoagulant meds and other medications as ordered by the physician... Schedule lab tests as ordered by the physician to monitor coagulation factors..."</p> <p>Review of a NP's telephone order dated 1/16/15 at 12:20 PM documented, "Hold Coumadin today and tomorrow. Resume Coumadin 4 mg po q HS [beginning] 1/18/14..."</p> <p>Review of the resident's January 2014 MAR revealed the Coumadin 4 mg dose was not restarted until 1/19/15.</p> <p>The facility failed to follow the care plan interventions for monitoring labs and giving Coumadin as ordered by a physician, this placed Resident #410 at risk for the high potential for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>b. Review of the care plan dated 12/19/14 documented, "...[Named Resident #410] is at risk for developing skin breakdown related to episodes of incontinence, decreased mobility... Approach... Complete Weekly Skin Check..."</p> <p>The facility was unable to provide documentation of weekly skin assessments for Resident 410 for December 2014 and January 2015.</p> <p>During an interview at the 2nd floor nurses' station on 1/21/15 3:00 PM, Nurse #13 was asked if weekly skin assessments had been completed for Resident #410. Nurse #13 stated, "We do it in the computer now. There are none [skin assessments] in the computer. The surveyor</p>	F 282		

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F 282	<p>Continued From page 20</p> <p>asked have weekly skin assessments been done. Nurse #13 stated, "No Ma'am."</p> <p>5. Medical record review for Resident #411 documented an admission date of 12/30/14 with diagnoses of Hypoglycemia, Hypertension (HTN), Coronary Artery Disease, Atrial Fibrillation, Upper Extremity Deep Vein Thrombosis, Aneurysm Repair and Resolved Respiratory Failure.</p> <p>Review of the hospital "Medication Reconciliation by Therapeutic Class -Transfer" form dated 12/29/14 documented an order for Aspirin 325 mg tablet daily and Coumadin 1 mg tablet daily.</p> <p>Review of the hospital transfer and referral form dated 12/30/14 documented an order for an INR to be checked every 48 hours and increase the dose of Coumadin from 1 mg to 2 mg.</p> <p>Review of an interim care plan dated 12/30/14 documented, "...At risk for complication from anticoagulant therapy... Anticoagulant as ordered... Lab as ordered..." Review of the revised care plan dated 1/8/15 documented, "...Resident is at risk for abnormal bleeding or hemorrhage related to use of anticoagulant... Approach... Schedule lab tests as ordered by the physician to monitor coagulation factors... Administer anticoagulant meds... as ordered by the physician..."</p> <p>The facility was unable to provide documentation that INRs were done for Resident #411 on 1/1/15, 1/3/15, 1/5/15, 1/8/15, 1/10/15, 1/12/15, 1/16/15, 1/18/15 or 1/20/15.</p> <p>Review of the resident's January 2015 MAR revealed Resident #411 received 2 mg of</p>	F 282			

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F 282	<p>Continued From page 21</p> <p>Coumadin on 1/1/15 through 1/6/15 and on 1/9/15 through 1/22/15. There was no documentation Resident #411 was given Coumadin on 1/7/15 or 1/8/15.</p> <p>During an interview at the 2nd floor nurses' station on 1/22/15 at 10:30 AM, Nurse #3 was asked about the every 48 hour INR. Nurse #3 stated, "They aren't there." Nurse #3 was shown the reconciliation order of Coumadin 1 mg and transfer sheet with an order for Coumadin 2 mg and asked how the medication should be transcribed. Nurse #3 stated, "Call the doctor for clarification." Nurse #3 was asked if she could show the surveyor where the doctor was called for clarification orders. Nurse #3 looked through chart and stated, "There is nothing there."</p> <p>During an interview in the activity room on 1/27/15 at 11:00 AM, the DON confirmed the reconciliation order was what the nurse goes by for orders. The DON stated, "Do not use that transfer form to take off orders." The DON was asked what dose of Coumadin was Resident #411 on. The DON stated, "1 mg." The DON pulled the January 2015 MAR and stated, "She got 2 mg. [Nurses] Should have clarified the order."</p> <p>The facility failed to follow the care plan interventions for monitoring labs and giving Coumadin as ordered, this placed Resident #411 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>6. Medical record review for Resident #8 documented an admission date of 6/21/12 with diagnoses of CVA, Right Tibia/Fibula Fracture,</p>	F 282		

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F 282	<p>Continued From page 22</p> <p>Chronic Anticoagulation, Diabetes and Neuropathy. Review of a care plan dated 5/20/14 documented, "...Resident is at risk for abnormal bleeding or hemorrhage related to use of anticoagulant medication... Resident should be free of signs and symptoms of abnormal bleeding... Schedule labs as ordered by the physician..."</p> <p>Review of a physician order dated 7/1/14 documented, "...Recheck INR monthly..." The facility was unable to provide documentation of an INR for the month of October 2014.</p> <p>During an interview at the 5th floor nurses' station on 2/3/15 at 3:45 PM, Nurse #5 confirmed there was an order written 7/1/14 for INR to be done monthly. Nurse #5 stated, "No, there aren't any PT/INR for the month of October 2014 on the chart or in the overflow record."</p> <p>The facility failed to follow the care plan intervention for monitoring labs when receiving anticoagulant medication which placed Resident #8 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>7. Medical record review for Resident #222 documented an admission date of 6/26/13 and a readmission date of 12/22/14 with diagnoses of History of Seizure Disorder, History of Chronic Respiratory Failure on Mechanical Ventilation via Tracheostomy, History of Pneumonia, Cardiac Dysarrhythmias, Traumatic Brain Injury, Hypertension, Diabetes and Vegetative State.</p> <p>Review of the Braden scale for predicting pressure sore risk dated 12/22/14 documented,</p>	F 282		
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F 282	<p>Continued From page 23</p> <p>Resident #222's "...Total Score... 11 [10- [to] 12 High Risk]..."</p> <p>Review of the care plan dated 9/9/14 documented, "...Problem... Resident is at risk for developing skin breakdown r/t [related to] decreased mobility, Incontinence... Goal... Resident will have intact skin, free of redness, blisters, or discoloration over a bony prominence through next review date... Approach... Complete Skin check weekly and pm [as needed]... elimination device for bladder elimination. Resident has an indwelling foley catheter... Approach... Provide catheter care per policy..."</p> <p>Review of an interim care plan dated 9/16/14 documented, "...[checked] Alteration in skin integrity [checked] Actual [checked] Potential... Skin assessment weekly..."</p> <p>Review of the care plan dated 1/14/15 documented, "...Problem... Resident has SDTI [purple or maroon localized area of discolored intact skin or blood filled blister] to right and left feet & Stage II [Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed] pressure ulcer to sacrum..."</p> <p>The facility was unable to provide documentation of weekly skin assessments or of catheter care being completed for Resident #222 in October, November, December 2014 and January 2015.</p> <p>Observations in Resident #222's room on 1/14/15 at 1:20 PM and on 1/15/15 at 11:10 AM, revealed Resident #222 lying on his back with feet in boots. There was a quarter size purple/red area on right inner ankle/bony prominence, a nickel size purple/red area on the left heel and the</p>	F 282		

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F 282	<p>Continued From page 24</p> <p>sacrum was excoriated with a 1 cm opening at the tail bone area that was pink. There was no odor or drainage present.</p> <p>Observations in Resident #222's room on 1/22/15 at 10:10 AM, revealed Resident #222 lying on his back with his feet in boots. Resident #222's right inner foot next to the heel had a purplish blister and the left outer ankle had a purplish area and the left heel had a purplish blister.</p> <p>During an interview in Resident #222's room on 1/14/15 at 1:20 PM, Resident #222's family member stated the resident had breakdown on his right inner ankle and left heel. He has been in the same position from 10:15 AM until 1:15 PM today. Resident #222's wife also stated she has reported the problem with the staff not turning her husband to the floor Assistant Director of Nursing (ADON) today and that she had already told the treatment nurse about the pressure areas on his feet.</p> <p>During an interview in the 4th floor ADON's office on 1/15/15 at 4:35 PM, Nurse #2 was asked for the weekly skin assessments for Resident #222. Nurse #2 stated, "If there's not a skin assessment on the chart, then assessments were not done... weekly skin assessments have not been ordered." Nurse #2 was asked would his nursing staff complete a weekly skin assessment if it wasn't on the orders. Nurse #2 stated, "Some [nurses] do more than others."</p> <p>During an interview in the DON's office on 1/20/15 at 11:55 AM, the DON was asked when did she expect her nursing staff to complete skin assessments on the residents. The DON stated, "They [nurses] are supposed to be doing skin</p>	F 282			

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F 282	<p>Continued From page 25</p> <p>assessments on their patients weekly." The DON was asked if the nursing staff had been following the facility's policy on skin assessments for Resident #222. The DON stated, "It fell through the cracks. Upon our investigation, we did not find the skin assessments documented."</p> <p>During an interview outside Resident #222's room on 1/22/15 at 9:02 AM, Nurse #11 was asked when Resident #222's SDTI and Stage II were identified. Nurse #11 stated, "The CNA [Certified Nursing Assistant] and the resident's wife brought it to my attention on 1/14/15."</p> <p>During an interview in the activity room on 1/22/15 at 1:30 PM, the Administrator was asked what she expected for follow up on issues such as this. The Administrator stated, "Nursing administration should be on it. I expect weekly skin assessments."</p> <p>During an interview in the activity room on 1/29/15 at 10:35 AM, Resident #222's family member stated, "They [the staff] tell me they don't have time to turn him. Have too many patients. I try to look all over him cause if I don't report it nobody will."</p> <p>During an interview at the 4th floor nurses' station on 2/3/15 at 3:35 PM, Nurse #1 was asked to pull up the MARs for Resident #222's catheter care. Nurse #1 stated, "It [catheter care] is not there." Nurse #1 was asked if the MAR [December 2014] was blank did that mean the catheter care was not done. Nurse #1 looked at the January 2015 MAR and stated, "I don't know why it is blank until the end. I'll tell you why because it was not picked up for the orders until 1/30/15." Nurse #1 stated, "I would think so. It looks like it was not entered</p>	F 282			

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F 282	<p>Continued From page 26 until 1/30/15 and that means someone picked up the template for catheter. It must not have been done when the nurse entered the admission orders. Someone picked up the template later."</p> <p>The facility failed to follow the care plan intervention for weekly skin assessments and catheter care. The facility failed to perform weekly skin assessments as care planned which resulted in actual harm when Resident #222 developed a suspected deep tissue injury that went unnoticed until pointed out by the family.</p> <p>8. Medical record review for Resident #81 documented an admission date of 7/1/09 with a readmission date of 12/22/14 with diagnoses of Alzheimer's Disease, Diabetes Mellitus, Stage 3 Pressure Ulcer, HTN, Hyperlipidemia and Seizures.</p> <p>Review of the interim care plan dated 12/23/14 documented, "...Alteration in skin integrity... Potential [checked]... skin assessment weekly [checked]..." Resident #81 was admitted with a Stage 3 pressure ulcer on 12/22/14.</p> <p>Review of a "PRESSURE ULCER RECORD" dated 12/23/14 documented, "...Sacrum ...Stage III...Length 4.0 [cm] x Width 4.0 [cm] x Depth 2.0 [cm]..."</p> <p>Review of the care plan dated 1/3/15 documented, "...Resident has Pressure Ulcer... Sacrum wound... Area behind R [right] ear... Treatments as ordered... Provide pressure relieving or reduction mattress... Complete Weekly Skin Check..."</p>	F 282		
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F 282	<p>Continued From page 27</p> <p>Review of a "PRESSURE ULCER RECORD" dated 1/3/14 documented, "...Rt [right] ear...Stage II "...Length 1.0 [cm] x 1.0 [cm] x Depth < 0.1 [cm]..."</p> <p>Review of Resident #81's medication treatment records revealed the following:</p> <p>a. December 2014 - "...Cleanse Sacral wound with wound cleanser, pat dry. Apply skin prep to peri wound. Apply calcium alginate to wound bed, cover with hydrocolloid, change every 2 days... Sacral Wound... O [order onset]:12/23/14..." This treatment was not documented as being done on 12/23, 12/25 or 12/29/14.</p> <p>December 2014 - "...SANTYL OINTMENT COLLAGENASE CLOSTRIDIUM... APPLY TO WOUND DAILY... Sacral Wound... O: 12/30/14..." This treatment was not documented as being done on 12/30 or 12/31/14.</p> <p>b. January 2015 - "...SANTYL OINTMENT COLLAGENASE CLOSTRIDIUM... Irrigate wound to Sacrum with daskin's [Dakin's] solution, pat dry. Skin prep to periwound. Apply santyl to wound bed. Pack lightly with gauze. Cover with foam dressing. Change daily/PRN [as needed]... O: 1/13/15..." This treatment was not documented as being done on 1/13, 1/14, 1/15, 1/16, 1/19, 1/20, 1/21, 1/22, 1/26, 1/27, 1/28, 129, 1/30 or 1/31/15.</p> <p>January 1/1/15 to 1/31/15 - documented "...SANTYL OINTMENT COLLAGENASE CLOSTRIDIUM... APPLY TO WOUND DAILY... O: 12/30/14..." This treatment was not documented as being done on 1/2, 1/5, 1/6, 1/7,</p>	F 282			

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F 282	<p>Continued From page 28</p> <p>1/8, 1/9, 1/12, 1/13, 1/14, 1/15, 1/16, 1/20, 1/21, 1/22, 1/23, 1/26, 1/27, 1/28, 1/29, 1/30 or 1/31/15.</p> <p>Review of a physician's order dated 1/3/15 for Resident #81 documented, "...Cleanse ulcer noted to R [right] ear [sign for with] wound cleanser pat dry, apply alginate, cover [sign for with] cover dressing daily..." Review of the treatment record for January 2015 revealed this treatment was not done on 1/3, 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, 1/12 or 1/13/15.</p> <p>The facility was unable to provide documentation of weekly skin assessments and treatments consistently being done as ordered since the admission of 12/22/14.</p> <p>Observations in Resident #81's room on 1/29/15 at 1:15 PM, revealed Resident #81 in bed receiving oxygen per nasal cannula. The nasal cannula tubing was over both ears. Resident #81's right ear had a rubber strip on the tubing; the left ear did not have a rubber strip on the tubing or any gauze padding on the ear.</p> <p>During an interview on the 5th floor on 1/26/15 at 4:15 PM, Nurse #4 was asked if he could print the weekly skin assessments for Resident #81. Nurse #4 stated, "I am not familiar with that. You mean that thing with the picture [picture of a person's body for marking skin impairments]." The surveyor told Nurse #4, "Yes, that was what was needed." After looking in the computer, Nurse #4 stated, "No, not there."</p> <p>During an interview in the activity room on 1/27/15 at 9:30 AM, Nurse #11 stated, "She [Resident #81] wears oxygen. The tubing caused the open area on her ear. It is scabbed over now</p>	F 282		

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F 282	<p>Continued From page 29</p> <p>she has protectors in place now but there was nothing in place prior to noticing the wound."</p> <p>During an interview in the ADON's office on 1/27/15 at 2:00 PM, Nurse #2 was asked if there would be a written order for every treatment change for pressure ulcers for Resident #81. Nurse #2 stated, "The new orders should be on a telephone order and on the chart. If it's not on the chart then it is not. The POS [Physician's Order Sheet] for December should be in the chart if it's not it's not done."</p> <p>During an interview in Resident #81's room on 1/28/15 at 8:50 AM, Nurse #11 was asked if Resident #81 had any preventative pressure relief measures in place for the left ear. Nurse #11 stated, "Yes she does, and there it is laying on the bed [referring to a piece of soft rubber that should have been between the skin and tubing]."</p> <p>During an interview in the activity room on 1/28/15 at 4:20 PM, Nurse #11 was asked to provide the treatment orders for 12/23/14 and 12/30/14. After looking through the medical record, Nurse #11 stated, "I don't see it, doesn't make sense."</p> <p>During an interview in Resident #81's room on 1/29/15 at 1:15 PM, Certified Nursing Assistant (CNA) #1 confirmed there was no gauze padding or rubber cushion on the tubing over Resident #81's left ear.</p> <p>The facility failed to follow the care plan interventions of weekly skin assessments, provide treatments as ordered and failed to provide pressure relief to Resident #81's left ear.</p>	F 282		
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F 282	<p>Continued From page 30</p> <p>9. Medical record review for Resident #62 documented an admission date of 8/28/13 and readmitted 12/9/14 with diagnoses of Chronic Respiratory Failure, Anemia, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), HTN, CVA, Seizures and Reflux Disease.</p> <p>Review of the interim care plan dated 3/4/14 documented, "...Alteration in skin integrity... Actual [marked]... Skin assessment weekly..."</p> <p>Review of a nurses ' note dated 3/5/14 documented, "...Pt [patient] is high risk for skin breakdown Braden score 10 ...Stage II R [right] trochanter 3. [0] [centimeters [cm] x 2. [0] [cm]. Scattered scab D [dry] / I [intact] on L [left] lateral knee 2.5 [cm] x 1.3 [cm]. R Anterior knee 1.0 [cm]x 1.5 [cm] . L Anterior knee 0.8 [cm] x 0.8 [cm]L foot proximal lateral 0.7 [cm] x 0.7 [cm] L foot Distal lateral 1.5 [cm]x 3.0 [cm] & 5th digit L foot dorsal & lateral 2.5 [cm x 2[cm ...] ... "</p> <p>Review of the care plan dated 3/11/14 documented, "...Resident has impaired skin integrity r/t [related to] wounds... Weekly skin checks..."</p> <p>Review of a weekly skin integrity review form for Resident #62 was not dated and there was no assessments documented.</p> <p>The facility was unable to provide documentation of weekly skin assessments for March 2014.</p> <p>During an interview in the activity room on 2/9/15 at 4:33 PM, Nurse #3 was asked for the March 2014 treatment records, weekly skin assessments and the wound assessments. Nurse #3 stated, "No ma'am I don't see it. No</p>	F 282		

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F 282	<p>Continued From page 31 they are not in here."</p> <p>The facility failed to follow the care plan intervention for weekly skin assessments.</p> <p>10. Medical record review for Resident #151 documented an admission date of 10/7/14 and a readmission date of 12/1/14 with diagnoses of COPD, Personal History of Fall, Chronic Kidney Disease, Diabetes Mellitus Type 2, Hypertension, Congestive Heart Failure, Hypothyroidism, Bipolar Disorder Disease, Dementia and Anemia.</p> <p>Review of the care plan dated 12/19/14 documented, "...[Named Resident #151] is at risk for adverse side effects of psychotropic medication... Approach... Refer to psychological / psychiatric consult as needed..."</p> <p>Review of a signed physician order dated 12/4/14 documented, "...Psych [psychiatric] Eval [Evaluation] 2nd [secondary to] verbal harmful plans to self..."</p> <p>Review of referral for services dated 12/4/14 documented, "...PSYCHOLOGY [marked] PSYCHIATRY [marked]... [Named Resident #151]... Pt. [patient] asked staff for name badge to use pin to stick it in her throat b/c [because] she is tired... Depression [marked]... cancelled referral 12/5/14 [initials of Social Worker #2]..."</p> <p>Review of a referral of services form dated 12/5/14 documented, "...PSYCHOLOGY [marked]... Talk Therapy..." The referral was not documented as being done.</p> <p>During an interview in the activity room on 1/16/15 at 12:29 PM, Social Worker (SW) #1 was</p>	F 282		
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT SAINT FRANCIS			STREET ADDRESS, CITY, STATE, ZIP CODE 6007 PARK AVE MEMPHIS, TN 38119		
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F 282	<p>Continued From page 32</p> <p>asked if the psychiatric (psych) referral had been done. SW #1 stated, "It was not done."</p> <p>During an interview in the activity room on 1/20/15 at 4:50 PM, the DON was asked if the psych referral had been done for 12/4/14. The DON stated, "We did not do that visit. SW #2 decided she [Resident #151] did not need that consult. She [SW #1] did not feel that a psych visit was warranted."</p> <p>11. Closed medical record review for Resident #294 documented an admission date of 9/9/14 with diagnoses of Acute and Chronic Respiratory Failure, Acute and Chronic Renal Failure, Anemia and CVA - Main Brainstem Infarction, Ventilator Dependence via Tracheostomy, History of Drug and Alcohol Abuse, Percutaneous Endoscopy Gastrostomy Tube and Pulmonary Embolus. Review of the nursing admission dated 9/9/14 documented, "...Foley Y [yes]..."</p> <p>Review of the care plan dated 10/13/14 documented, "...Resident has potential risk for complications related to altered elimination device for bladder elimination... Change catheter per policy... Change drainage bag per policy..."</p> <p>Review of the facility's order template list dated 9/9/14 documented, "PROVIDE CATHETER CARE WITH SOAP AND H2O [water] EVERY SHIFT... CHANGE CATHETER WITH BSB [bedside bag] MONTHLY..."</p> <p>Review of the nurses' notes and MARs for September, October, November and December 2014 documented documented a foley catheter change on 9/30/14 and 12/31/14. The facility was unable to provide documentation of a catheter</p>	F 282			

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F 282	<p>Continued From page 33 change for the months of October and November 2014.</p> <p>The facility was unable to provide documentation of catheter care or change of drainage bag for September, October, November or December 2014.</p> <p>During an interview at the 3rd floor nurses' station on 2/4/15 at 12:10 PM, Nurse #6 was asked about the facility's protocol for catheter care and where the nurse would document the care provided. Nurse #6 stated, "First, if the resident has a Foley catheter it goes in the EZMAR by selecting the template for the foley. Catheter care is done every shift and as needed. Change the bag as needed. We will change it [catheter] every 30 days. You [nurses] know the patient has the Foley, you have the order template, it has to be addressed. If not addressed, you risk missing it, not providing the care.</p> <p>The facility failed to follow the care plan interventions for changing the catheter and drainage bag.</p> <p>12. Medical record review for Resident #358 documented an admission date of 10/3/14 with diagnoses of HTN, Parkinson's Disease, Depressive Disorder, Failure to Thrive- Adult, System Lupus, Acute Pancreatitis, Malignant Neoplasm Parotid, Malignant Salivary Glands and Gastrostomy.</p> <p>Review of a NP referral form dated 10/22/14 documented an order for a psych consult. Review of a referral for services dated 12/18/14 documented, "...Urgent... Conditions / Issues Classification (check the box(es) that pertain to</p>	F 282		

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F 282	<p>Continued From page 34</p> <p>this person) ASAP [as soon as possible]... (...provider is on site today and new patient needs to be seen today)... Depression... refusing meals..."</p> <p>Review of the care plan dated 1/9/15 for Resident #358 documented, "...Resident is at risk for and/or experiencing depression AEB [as evidenced by] variable p.o. intake, dx [diagnosis] of depression health condition, dx FTT [failure to thrive]... Approach... Refer to psychological / psychiatric consult as needed..."</p> <p>Review of social service progress notes dated 10/22/14 for Resident #358 documented, "...This SW spoke c [sign for with] this pt [patient] about her not eating and feeling depressed... this SW feels that there is no need for consult..."</p> <p>During an interview in the activity room on 1/20/15 at 2:25 PM, the DON was asked if the psych referral for 10/22/14 and 12/18/14 were done and on the chart. The DON confirmed the consults were not on the chart and the referral for 10/22/14 was not sent. The DON was then asked about the ordered consult for 12/18/14. The DON stated, "Here is the referral (confirmed urgent written on the request [12/18/14]) but the consult is not on this chart."</p> <p>During an interview in the activity room on 1/20/15 at 2:45 PM, SW #2 was asked about the ordered psych consult on 12/18/14 that was not acknowledged until 12/22/14. Social Worker #2 stated, "The referral was sent and got missed at the agency some sort of way." SW #2 was then asked who was responsible for following up to make sure the consult had been done. SW #2 stated, "I would be." SW #2 was asked what is</p>	F 282		
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F 282	<p>Continued From page 35</p> <p>the normal time between referral and the actual consult being done. SW #2 stated, "Usually within a few days." SW #2 was asked if there was a request for an urgent consult what the normal time frame would be. SW #2 stated, "They make a phone call, get medicine and are here the next day." SW #2 was asked at what point the follow up would be to ensure consults are done. SW #2 stated, "The next day. We dropped the ball."</p> <p>During an interview in the activity room on 1/20/15 at 4:50 PM, the DON stated, "For the referral on 12/18/14 for [named Resident #358] we just did not get that done."</p> <p>The facility failed to follow the care plan intervention for psych referrals.</p> <p>13. Medical record review for Resident #394 documented an admission date of 11/28/14 with diagnoses of COPD, Hypertension, DVT, Degenerative Joint Disease, Tracheostomy, Osteoarthritis, HTN, Respiratory Failure and Morbid Obesity.</p> <p>Review of the interim care plan dated 11/29/14 documented, "...[checked] Alteration in skin integrity [actual]... Skin assessment weekly ... "</p> <p>The facility was unable to provide documentation of weekly skin assessments for the month of December 2014.</p> <p>The facility failed to follow the care plan intervention for weekly skin assessments.</p> <p>14. Medical record review for Resident #409 documented an admission date of 12/12/14 with diagnoses of History of Pulmonary Embolus,</p>	F 282			

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F 282	<p>Continued From page 36</p> <p>HTN, Orthostatic Hypotension, Left Shoulder Fracture, Personal History of Fall, Dehydration and Hyperlipidemia.</p> <p>Review of a "Formal Complaint Concerning Care Received By [named Resident #409]... between 12/12/2014 and 1/12/2015" documented, "...He [Resident #409] had been wearing the same [left] shoulder immobilizer for 10 days and it was beginning to have a foul odor. We asked if a second immobilizer could be obtained so they could be switched out for laundering. We also noted that someone had unfastened the immobilizer in order to put a shirt on under it. I asked when he would be getting a bath and a change of clothes. I was told that bath days were Mon. [Monday], Wed. [Wednesday], and Fri [Friday] and that only therapy could do anything with the immobilizer... 12/16/14 He was still wearing the same clothes he was admitted in. Begged O.T. [Occupational Therapist] to find out who was supposed to be assisting him with personal care. She left his room, stayed gone for some time and returned with bathing supplies, saying she guessed she'd do it herself. She had him lay on his back, unfastened the immobilizer and washed his front... She never washed any part of his back... 12/22/14... The shoulder immobilizer had now been in place for 19 days without being laundered. It smelled horrible... 12/25/14 [Named Resident #409's] son-in-law assisted him with bathing since [Named Resident #409] stated that he was still not getting the assistance he required... 12/29/14... [Named Nurse #8 and Named Rehab Personnel #1] came to [Named Resident #409's] room to discuss the personal care issue... They asked [Named Resident #409] why the nursing assistants were not assisting him with bathing.</p>	F 282		
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F 282	<p>Continued From page 37</p> <p>He stated he didn't know because none of them had ever mentioned helping him with bathing. They asked if anyone had assisted him with bathing since he had been there. He stated that [Named Rehab Personnel #1] had helped him once and that my husband had helped him once. I told them that [Named CNA #11] and I had also helped him once. [Named Nurse #8 and Named Rehab Personnel #1] assisted him with bathing and putting on clean clothes..."</p> <p>Review of the interim care plan dated 12/12/14 documented, "...Self care deficit [checked]... Provide assistance as needed..."</p> <p>Review of Resident #409's "Bath Report" for the month of December 2014 documented only 3 full baths/showers were given for the month.</p> <p>Review of a coaching and counseling session dated 12/29/14 documented, "...Please describe the Stakeholder's conduct and indicate the specific policy that has been violated. Failed to give Resident a shower. Future Expectations and Timeline: Perform CNA duties in a timely manner w [with] / each Resident each time, including showers and grooming..."</p> <p>During an interview in the activity room on 1/13/15 at 11:25 AM, a family member of Resident #409 came into the room to verbalize some concerns with the lack of care received by this resident. The family member stated, "Shoulder immobilizer was on for 10 days and it smelled bad. They were not allowed to remove immobilizer but they would check on it. Wore the same clothes for 4 days. They never made any attempt to wash him [reported to Nurse #8]. OT did give him a partial bath but never made any</p>	F 282			

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F 282	<p>Continued From page 38 attempt to wash anything but his front."</p> <p>During an interview in the activity room on 1/21/15 at 10:10 AM, CNA #4 was asked if she gave Resident #409 a shower on 12/29/14. CNA #4 stated, "No, that was a mistake [documented shower]." CNA #4 was asked if her documentation was accurate for that day. CNA #4 stated, "No, it is not."</p> <p>The facility failed to follow the care plan intervention to provide assistance as needed. The facility did not wash or change the immobilizer after it began to have a foul odor, only provided 3 baths/showers for the month, and the facility allowed the resident to wear the same clothes for 4 days after admission.</p> <p>15. The facility failed to follow the care plan interventions for administering anticoagulant medications and failed to monitor blood levels for anticoagulant therapy, this placed Residents #211, 252, 410, 411 and 8 in immediate jeopardy (IJ) a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The facility failed to perform weekly skin assessments as care planned, this resulted in actual harm when Resident #222 developed a suspected deep tissue injury that went unnoticed until pointed out by the family. The facility's failure to perform weekly skin assessments and failure to provide pressure prevention for Resident #81 who was at risk of developing pressure ulcers resulted in actual harm to Resident #81 when Resident #81 developed a Stage 2 pressure ulcer of her right ear from nasal oxygen tubing.</p>	F 282		

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F 309 SS=K	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of job description, reference review of "Sorenson and Luckmann's Basic Nursing", review of "PharMerica 2012" specialized long-term care nursing drug handbook, medical record review and interview, it was determined the facility failed to ensure services were provided to attain or maintain the highest as practical physical, mental and psychosocial well-being in accordance with the plan of care when medication regimens were not transcribed on admission, laboratory (lab) tests were not done as ordered, labs were done without an order, medications were not administered as ordered, medications were administered without an order and the physician and nurse practitioner (NP) failed to sign and date orders for 21 of 37 (Residents #43, 252, 299, 410, 211, 8, 84, 116, 192, 403, 411, 412, 222, 229, 358, 361, 394, 81, 151, 131 and 29) sampled residents of the 53 residents included in the stage 2 review. The facility failed to administer anticoagulants as ordered, failed to monitor blood levels and failed to notify the physician or NP of critical or subtherapeutic lab results, this placed Residents #43, 252, 299, 410, 211, 8, 84, 116, 192, 403, 411 and 412 at risk for</p>	F 309	<p>1. The Director of Nursing who was present during the survey is no longer employed at the facility. Resident #'s 29, 43, 81, 151, 192, 211, 252, 403, 410, 411 and 412 are discharged. Resident #'s 8, 84, 116, 131, 222, 229, 299, 358, 361 and 394 have current signed physician order statements, laboratory tests are being completed according to physician order as well as receiving medications according to physician order. Resident #'s 8, 84, 116 and 299 are receiving anti-coagulants according to physician order. Any critical or abnormal results are being reported to physician or nurse practitioner.</p> <p>2. A baseline laboratory audit was completed by nursing on 1/28/15 to validate labs were performed according to physician order and care plan. If results were abnormal, validation of the physician being notified and a telephone order written if change in treatment was required.</p>	5/28/2015	

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F 309	<p>Continued From page 40</p> <p>serious injury related to abnormal bleeding and/or hemorrhage, harm, impairment or death, which resulted in an immediate jeopardy (IJ), a situation in which the provider's non compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm or death to a resident.</p> <p>A meeting was conducted in the activity room on 1/27/15 at 3:15 PM with the Administrator and she was informed of the IJ.</p> <p>The survey team received an acceptable Allegation of Compliance (AOC) from the Administrator on 1/30/15 at 12:05 PM.</p> <p>The AOC documented the following: It is the policy of this facility to ensure all resident's lab results are obtained only when ordered by a physician and abnormal results are reported to the physician / NP timely. It is also the policy of this facility to ensure that all physician orders are signed and dated. As well as orders for medications and treatments will be consistent with principles of safe and effective order writing. It is also the policy of this facility to maintain clinical records on each resident that are complete, accurately documented, readily accessible and systematically organized.</p> <p>Validation of the Credible Allegation of Compliance was accomplished on site 2/2/15 through 2/6/15, through record review, review of facility documents, observation and interviews with nursing, administration and corporate staff.</p> <p>The facility provided evidence of in-service training with sign in sheets for all licensed nursing staff dated 1/28/15 through 1/30/15 related to 24</p>	F 309	<p>A baseline audit of resident receiving Coumadin therapy was completed by DON, ADON or designee on 1/27/15 validating the physician/nurse practitioner were notified of any abnormal lab values and telephone order was written if change in treatment was required. A baseline audit will be conducted to validate that medications are administered according to physician order.</p> <p>A baseline audit was conducted by MDSC 2/19/2015 of residents receiving hospice services to validate a physician order is present, a progress note indicating initiation date of hospice services and care plan reflects hospice service and coordination of care.</p>		

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F 309	<p>Continued From page 41</p> <p>hour chart checks, physician orders, admission orders, telephone orders, physician order sheets, reconciliation of medications with physician orders, lab ordering and tracking and reporting abnormal labs.</p> <p>The facility provided evidence of auditing tools utilized for 24 hour chart checks, physician orders, admission orders, telephone orders, physician order sheets, reconciliation of medications with physician orders, lab ordering and tracking and reporting abnormal labs.</p> <p>Medical record review on 2/5/15 documented 9 of 9 new admission charts admitted on or after 1/30/15 included the Admission to the facility order, Reconciliation of admission medication and treatment orders, Physician Order Sheets (POS), labs, Admission nurses notes documenting verification of orders and admission skin assessments to ensure the process of chart checks was being done and any follow up was occurring.</p> <p>The licensed staff currently on leave of absence, vacation or per diem was sent a certified letter on 1/30/15 informing staff of the in-service and training and that the training must be completed prior to returning for their next scheduled shift.</p> <p>Observations on 2/2/15 of licensed staff's shift change reporting were made to validate pertinent resident information was being passed on to the oncoming shift including anticoagulant medications, resulted and/or pending lab testing, new admissions with orders and medication therapy with changes.</p> <p>Interviews with facility licensed nursing staff were</p>	F 309	<p>3. Education and training initiated on 1/28/15 with all licensed nursing staff by the Staff Development Coordinator or RN Supervisor regarding the procedure of printing monthly physician order statements and obtaining physician signature.</p> <p>Licensed nurses also received education and training on 1/29/15 by the SDC regarding processing of physician orders related to obtaining, transcribing and obtaining signature.</p> <p>Education and training also provided to licensed nurses on 1/29/15 by the SDC regarding medication reconciliation of physician orders and completion of 24 hour chart checks for active residents.</p> <p>Education and training also provided to licensed nurses by SDC on 1/29/15 regarding writing Physician orders will be written at the time of admission indicating admission to the facility, physician assigned and also indicate that physician orders were verified with a physician.</p>	
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F 309	<p>Continued From page 42</p> <p>conducted on 2/4/15 through 2/5/15 with staff from all floors and all shifts validating 24 hour chart checks, physician orders, lab ordering and tracking, reconciliation of medications with physician orders, and clinical pathway for lab reporting and monitoring.</p> <p>The facility provided documentation of a complete laboratory audit completed on 1/28/15 on all active residents to ensure labs were performed according to physician orders as indicated on the care plan and the physician being notified when abnormal results are obtained and documented on a telephone order if change and treatment is required. The audits were reviewed and current to date and are ongoing.</p> <p>Interviews with the Administrator and Corporate Staff (Health Information Management) on 2/4/15 revealed the facility would continue monitoring by a Quality Assurance (QA) meeting to be held weekly for four weeks beginning 2/5/15 and then monthly for findings, recommendations, and follow up regarding the plan. The frequency of the audits to be maintained will be decided by the QA committee based on the findings of the audits.</p> <p>The survey team validated the AOC on 2/2/15 through 2/6/14. The IJ was removed as of 1/30/15.</p> <p>The IJ for F309-K constitutes substandard quality of care.</p> <p>An extended survey was conducted on 2/4/15 through 2/11/15.</p> <p>Non-compliance of the IJ continues at a scope and severity of an "E" level for F309 for</p>	F 309	<p>Education and training initiated on 1/28/15 and completed on 1/30/15 with all licensed nursing staff by the Staff Development Coordinator or RN Supervisor regarding facility's policy on performing labs according to physician's orders and physician notification with documentation on the lab when abnormal results are obtained.</p> <p>The licensed nurses that were on leave of absence, vacation or per diem were sent a certified letter on 1/30/15 indicating training regarding the procedure of printing monthly</p> <p>physician order statements and obtaining physician signature, processing of physicians orders related to obtaining, transcribing and obtaining signature and medication reconciliation of physician orders, completion of twenty-four chart checks for current resident and physician orders will be written at the time of admission indicating admission to the facility, physician assigned and that physician orders were verified with a physician must be completed prior to returning for next scheduled shift.</p> <p>Education regarding medication administration will be conducted with licensed nurses utilizing Learn 365 online training with return demonstration by April 28, 2015.</p>		

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F 309	<p>Continued From page 43</p> <p>monitoring of corrective actions. The facility is required to submit a plan of correction for all tags.</p> <p>The findings included:</p> <p>1. Review of the facility's change in resident condition or status policy documented, "...The Nurse Supervisor / Charge Nurse will notify the resident's Attending Physician... when there has been: A need to alter the resident's medical treatment significantly... Instructions to notify the physician of changes in the resident's condition... A "significant change" of condition is a decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions... The Nurse Supervisor / Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status..."</p> <p>Review of the medication administration policy documented, "...Medications are administered only as ordered by the physician..."</p> <p>Review of the facility's Physician visits and medical orders policy documented, "...All residents admitted to this facility must be under the direct supervision of a member of the active staff... Only those physicians with delineated clinical privileges to admit resident are allowed to do so... A medical assessment is completed by a physician within 72 hours of admission... The attending physician shall visit the resident at least once during the 30 days after admission and/or as required by the resident's needs... Medical orders are obtained from the physician or other licensed independent practitioner according to applicable laws and regulations..."</p>	F 309	<p>4. If audits demonstrate substantial compliance and QAPI committee approves, the frequency will be reduced periodically, over time, as indicated.</p> <p>An audit will be conducted daily by DON, ADON or designee to validate new admission orders verified, new admission medications reconciled, physician orders obtained transcribed and printed correctly, 24 hour chart check are completed daily, new orders for hospice correctly transcribed and obtained, hospice initiated as ordered and care planned until substantial compliance is maintained. Trends will be reported by the ADON / Designee to the QAPI committee for review and further recommendation of continued auditing.</p> <p>If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of audit.</p>		

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F 309	<p>Continued From page 44</p> <p>Review of the facility's "Clinical Pathway for Laboratory Reporting" policy documented, "...The following results MUST be called immediately... abnormal labs... INR [International Normalized Ratio] greater than 3.0 or less than 2.0..."2.</p> <p>2. Review of the facility's Director of Nursing's (DON) job description documented, "...Summary: To manage the overall operations of the Nursing Department in accordance with... standards of nursing practices and governmental regulations so as to maintain excellent care of all residents' needs... Essential Duties & [and] Responsibilities: Make daily rounds of the nursing department to verify that all nursing service personnel are performing their work assignments in accordance with acceptable nursing standards... Regularly inspect the facility and nursing practices for compliance with federal, state, and local standards and regulations..."</p> <p>3. Review of Sorenson and Luckmann's Basic Nursing A Psychophysiologic Approach, Third Edition, Chapter 46, pages 1257, 1258, 1259 and 1262 documented, "...physicians are legally responsible for ordering medication, nurses are responsible for assessing the client [resident]... and providing the physician with data that assist in the diagnosis and continuing need for the medication... safely administering the ordered medication... Medication prescriptions and orders are written by physicians... When accepting a verbal or telephone order, repeat to the person prescribing the medication the name, dosage, route, and frequency of administration. This verification prevents errors in communication..."</p> <p>4. Medical record review for Resident #43</p>	F 309		
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F 309	<p>Continued From page 45</p> <p>documented an admission date of 9/23/14 with diagnoses of Heart Failure, Hypertension, Urinary Tract Infection, Diabetes Mellitus, Coronary Artery Disease, Congestive Heart Failure, Cardiac Arrhythmia, Atrial Fibrillation, Diabetes Mellitus, Pulmonary Disease, Anxiety and Depression.</p> <p>Review of a signed physician's order dated 9/23/14 documented, "...COUMADIN 10 MG [milligram]... DAILY... INR in 3 days..." There was no PT [prothrombin time] / and INR [international normalized ratio] done as ordered on 9/26/14.</p> <p>Review of a lab report for Resident #43 dated 9/24/14 documented, "...PT 18.2 sec. [seconds] Ref [reference] range 11.7-14.9... INR 1.59 Ref Range 0.00-1.13..." There was no order for the PT/INR to be done on 9/24/14.</p> <p>Review of a physician's order dated 9/24/14 documented, "...PT/INR in AM..." There was no PT/INR done on 9/25/14 as ordered.</p> <p>Review of a physician's order dated 10/6/14 documented, "...Contact [Named Doctor] to get Coumadin dose... Increase Coumadin to 11 mg [milligrams]... PT/INR in AM. Review of a lab report dated 10/7/14 documented, "...PT 15.0... INR... 1.23..." There was no documentation provided that the physician or NP was notified of the elevated lab results.</p> <p>Review of a physician's order dated 10/23/14 documented, "...PT/INR... 10/27/14..." Review of the lab result dated 10/27/14 documented, "PT 21.3... INR... 1.96..." There was no documentation provided that the physician or NP was notified of the elevated lab results.</p>	F 309			

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F 309	<p>Continued From page 46</p> <p>Review of a telephone order dated 11/18/14 documented, "INR q [every] week (next due 11/25/14)."</p> <p>Review of a physician order dated 11/26/14 documented, "...Hold Coumadin today INR in AM & [and] call results to [named NP]..." Review of a lab report dated 11/27/14 documented, "...PT 19.6... INR 1.75..." There was no documentation the NP was notified of the elevated labs as ordered.</p> <p>The facility was unable to provide documentation the weekly PT/ INR was done on 12/16/14, 12/23/14 or 12/30/14 as ordered on 11/18/14.</p> <p>Review of a physician order dated 1/1/15 documented, "...Transfer resident to [named hospital] ER [emergency room] d/t [due to] nosebleed out of control..."</p> <p>Review of a hospital lab report dated 1/1/15 documented, "PT 27.7... INR... 2.77..."</p> <p>Review of a telephone order dated 1/1/15 documented, "...Hold Coumadin until seen by ENT [Ear Nose Throat Specialist]..."</p> <p>Review of a physician order dated 1/5/15 documented, "...Restart Coumadin after observation and [symbol for no] sign of cont. [continued] bleeding..." There was no clarification order for the dose of Coumadin to be administered. The order was not signed or dated by the physician or NP.</p> <p>During an interview in the Director of Nursing (DON) office on 1/20/15 at 12:00 PM, the DON was asked if Resident #43's telephone order</p>	F 309		
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F 309	<p>Continued From page 47</p> <p>dated 1/5/15 was complete. The DON stated, "I see where you are going cause [because] it doesn't say the dose of the Coumadin." The DON was asked how she expected her nursing staff to write a medication order. The DON stated, "I would want to make it totally clear to state the dose of the Coumadin."</p> <p>The facility failed to follow orders for lab monitoring and failed to obtain a clarification order for correct dosage of a significant medication (anticoagulant) to be given, which placed Resident #43 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>5. Medical record review for Resident #252 documented an admission date of 8/28/14 with diagnoses of Deep Vein Thrombosis (DVT), Chronic Renal Insufficiency, Hypertension, Diabetes Mellitus Type 2, Atrial Fibrillation, Peripheral Neuropathy, Anemia, Hyperlipidemia and Osteoarthritis.</p> <p>There were no signed physician orders for medications from 8/28/14 to September 2014 - exact date illegible. Review of the August 2014 Medication Administration Record (MAR) documented Coumadin 5 mg was administered on 8/29/14 with no physician order.</p> <p>Review of a NP's telephone order dated 8/29/14 at 10:30 AM documented, "...stat [immediately] PT/INR..." Review of a lab report dated 8/29/14 documented, "...PT 38.3... INR 4.25..." The 4.25 INR was above the therapeutic range of 2 to 3.</p> <p>The facility utilizes the hospital laboratory services for lab testing the PT/INR. The hospital</p>	F 309		
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F 309	<p>Continued From page 48</p> <p>lab reference range for the PT is 11.7 -14.9 and for INR is 0.00-1.13. The suggested therapeutic ranges are Low Risk 2.0 - 3.0.</p> <p>There was no documentation the NP was notified of the elevated INR until 8/30/14.</p> <p>Review of a NP's telephone order dated 8/30/14 at 1:00 PM documented, "Hold Coumadin x [times] 2 days, recheck PT/INR on Monday 9/1/14..." The facility was unable to provide documentation that the PT/INR being done on 9/1/14 as ordered.</p> <p>A lab report dated 9/2/14 documented, "...PT 14.2... INR 1.15..." There was no documentation the subtherapeutic INR level was called to the NP or physician.</p> <p>Review of a NP's telephone order dated 9/3/14 at 2:00 PM, documented, "Coumadin 3 mg 1 tab [tablet] po [by mouth] q [every] HS [hour of sleep]. PT/INR 9/8/14 AM..." Resident #252's September 2014 MAR documented the Coumadin 3 mg dose was not started until 9/4/14.</p> <p>Review of a NP's telephone order dated 9/8/14 at 11:30 AM documented, "[symbol for increase] Coumadin to 3.5 mg po q HS. PT/INR in [one] wk..." Review of a lab report dated 9/15/14 documented, "...PT 17.8... INR 1.55..." There was no documentation the subtherapeutic level INR was called to the NP or physician.</p> <p>Review of a NP's telephone order dated 9/16/14 documented, "[symbol for increase] Coumadin to 4 mg po q HS. PT/INR 9/22/14 AM..." Review of a lab report dated 9/22/14 documented, "...PT 17.9... INR 1.56..." There was no documentation</p>	F 309			

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F 309	<p>Continued From page 49</p> <p>the subtherapeutic INR was called to the NP or physician.</p> <p>Review of a NP's telephone order dated 9/19/14 at 10:10 AM documented, "...PT/INR NOW..." There was no documentation the PT/INR was done as ordered.</p> <p>Review of a NP's telephone order dated 9/19/14 at 1:30 PM documented, "... Transfer to [named hospital] (Per Family Request) Facial Drooping..."</p> <p>Review of the hospital emergency department (ED) form documented, "...9/19/14 Hospital Encounter... Your Plan... ASK your doctor about these medications..." and listed 2 different doses of Coumadin, a 7.5 mg dose to be taken every evening and a 10 mg dose to be taken once daily for 3 days. The form documented the resident was to "...ask about: Which instructions should I use..."</p> <p>There was no documentation the physician or the NP was contacted to clarify Resident #252's correct dose of Coumadin. Prior to the hospital ED visit, Resident #252 had received 4 mgs of Coumadin every evening since 9/16/14.</p> <p>Review of Resident #252's MAR for September 2014 documented the resident was given 10 mg of Coumadin on 9/20/14, 9/21/14 and 9/22/14.</p> <p>Review of a laboratory report dated 9/23/14 documented, "...PT 20.2... INR 1.83..." There was no order for this lab to be done on this date.</p> <p>Review of a NP's telephone order dated 9/23/14 documented, "...[symbol for increase] Coumadin to 4 mg tab [tablet] po [by mouth] q HS. PT/INR 9/29/14 AM..."</p>	F 309			

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F 309	Continued From page 50 Review of Resident #252's lab report dated 9/29/14 printed at 12:09 PM documented, "PT 31.6... INR 3.30..." There was no documentation the NP or physician was notified of the elevated INR. Resident #252's September 2014 MAR documented the nurse continued to give the resident Coumadin 4 mg every evening 9/29/14, 9/30/14, 10/1/14, 10/2/14 and 10/3/14 although the INR was elevated above therapeutic blood levels. Review of a NP telephone order dated 10/3/14 at 3:00 PM for Resident #252 documented, "PT/INR 10/6/14. [symbol for decrease] 4.5 mg Coumadin po q HS..." The 4.5 mg dose of Coumadin was actually an increase in Resident #252's Coumadin. The MAR documented on 10/4/14, 10/5/14 and 10/6/14 the resident received the higher dose of Coumadin although the most recent INR was elevated above therapeutic blood levels. There was no documentation the nurse clarified the Coumadin order. Review of a lab report dated 10/6/14 printed at 8:38 AM documented, "...PT 34.4... INR 3.69..." Review of a NP telephone order dated 10/6/14 at 1:20 PM documented, "...Hold Coumadin today. PT/INR in A.M. [symbol for decrease] to 3.5 mg po q HS..." The MAR documented on 10/6/14 Resident #252 continued to receive the higher dose, of 4.5 mg of Coumadin, and did not receive any Coumadin on 10/7/14 or 10/8/14. Review of Resident #252's lab report dated 10/7/14 documented, "...PT 31.2... INR 3.24..." There was no documentation the NP or the physician was notified of the elevated INR.	F 309			

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F 309	<p>Continued From page 51</p> <p>Review of a lab report dated 10/27/14 printed at 7:21 AM documented, "...PT 14.3... INR 1.16..." There was no documentation the NP or the physician was notified of the subtherapeutic INR level.</p> <p>Review of a NP's telephone order dated 10/28/14 at 3:00 PM documented, "[symbol for increase] Coumadin to 4 mg po q HS. PT/INR 11/3/14 AM..." There was no documentation on the MAR that Resident #252 received any Coumadin on 10/28/14. The 4 mg dose of Coumadin was not documented as given until 10/29/14.</p> <p>Review of a lab report dated 11/1/14 documented, "...PT 15.2... INR 1.25..." There was no documentation of a NP or physician order for this lab, however, a corresponding NP telephone order dated 11/1/14 at 1:35 PM documented, "increase Coumadin to 4.5 mg and recheck PT/INR in the AM..." There was no documentation the lab was completed as ordered on 11/2/14.</p> <p>Review of a lab report dated 11/3/14 printed at 7:28 AM documented, "...PT 15.2... INR 1.25..." There was no documentation the NP or physician was notified of the subtherapeutic INR level.</p> <p>Resident #252, who was initially admitted to the facility with Atrial Fibrillation (an irregular heart rhythm), history of DVT and currently with a DVT in her left lower extremity, was discharged home on 11/5/14. The last PT/INR completed at the facility was subtherapeutic at 1.25. The standard recommended level for DVT prevention is an INR of 2 to (-) 3.</p> <p>During an interview in the activity room on</p>	F 309		

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F 309	<p>Continued From page 52</p> <p>1/27/15 at 11:00 AM, the DON was asked about the facility's protocol for performing PT/INR labs. The DON stated, "Protocol is to do weekly PT/INR if on Coumadin."</p> <p>During an interview at the 3rd floor nurses' station on 2/9/15 at 4:00 PM, Nurse #6 confirmed the nurse had given Resident #252 the higher dose of Coumadin even though the blood level was above the therapeutic range. Nurse #6 stated, "The order needed clarification."</p> <p>During an interview at the 3rd floor nurses' station on 2/9/15 at 4:50 PM, Nurse #6 was asked when the elevated INR should have been reported to the NP or physician. Nurse #6 stated, "The 4.25 INR should have been called as soon as she [nurse] got the results..."</p> <p>The facility failed to follow physician orders for monitoring labs and/or reporting critical and subtherapeutic levels related to anticoagulant therapy, failed to ensure physician orders were signed and/or dated, and failed to clarify Coumadin orders which placed Resident #252 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>6. Review of "PharMerica 2012" specialized long-term care nursing drug handbook documented, "...Heparin [anticoagulant]... For SubQ [subcutaneous] injections, when used for treatment... a PTT [partial thromboplastin time] is measured 6 hours after injection..."</p> <p>Medical record review for Resident #299 documented an admission date of 8/4/14 and a readmission date of 8/20/14 with diagnoses of DVT, Cerebrovascular Accident, Chronic</p>	F 309		
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F 309	<p>Continued From page 53</p> <p>Hepatitis C, Diabetes Mellitus, Hypertension and Chronic Kidney Disease. There were no PT/INR or PTT levels on Resident #299's record, who was receiving Heparin 5,000 Units/ML (milliliter) every 8 hours for Deep Vein Thrombosis.</p> <p>Review of the hospital discharge education instruction form dated 8/20/14 documented, "...Heparin 5,000 Units/ [per] ML Subcutaneous every 8 hours for Deep Vein Thrombosis (DVT) prophylaxis (prevention)..."</p> <p>Review of a daily skilled nurses' note dated 8/18/14 documented, "...8:30 AM Upon arriving in Resident [#299's] room... Resident was noted bleeding from Right nasal cavity... 9:30 AM Resident nasal bleeding continued... Resident noted to have brown colored emesis [vomit]... B/P [blood pressure] 168/106..."</p> <p>During an interview at the 4th floor nurses' station on 1/22/15 at 4:20 PM, Nurse #1 stated, "I called the [named hospital] lab and [named staff] reported that they have not done any PTT or PT/INR on the resident [#299]."</p> <p>During an interview at the 4th floor nurses' station on 1/23/15 at 11:05 AM, Family Nurse Practitioner (FNP) #1 stated, "If someone were on Heparin, I would check a PTT to monitor it."</p> <p>During an interview at the 4th floor nurses' station on 2/2/15 at 5:00 PM, Nurse #2 was asked for physician or NP orders for Resident #299. Nurse #2 stated, "There are no signed orders on the chart or in the overflow chart for August, September, October and November 2014. Apparently, the nurses were giving medications to this resident without signed orders."</p>	F 309		
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F 309	Continued From page 54 The facility failed to ensure signed physician orders were obtained for significant medications (anticoagulants) prior to administering the medications, which placed Resident #299 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage. 7. Medical record review for Resident #410 documented an admission date of 12/3/14 with diagnoses of Atrial Fibrillation, Pain in Limb, History of Chronic Coumadin Anticoagulation, Right Hip Fracture, Personal History of Fall, Hypothyroidism, Hypertension and Osteoporosis. The resident was transferred to hospital on 12/6/14, underwent a thrombectomy, and returned with a new diagnoses of DVT of the right upper extremity. Review of a hospital discharge medication list dated 12/6/14 documented, "...warfarin [Coumadin] (warfarin 4 mg oral tablet) 1 tab oral, Daily..." Review of a PT/INR dated 12/11/14 printed at 7:06 AM documented, "...PT 16.4... INR 1.39..." a subtherapeutic blood level. There was no documentation the physician or NP was notified of the subtherapeutic level. Review of a NP's telephone order dated 1/16/15 at 12:20 PM documented, "Hold Coumadin today and tomorrow. Resume Coumadin 4 mg po q HS 1/18/14..." Review of Resident #410's January 2015 MAR documented the Coumadin 4 mg dose was not restarted until 1/19/15.	F 309			

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F 309	<p>Continued From page 55</p> <p>The facility failed to notify the physician or NP of subtherapeutic labs and failed to administer Coumadin as ordered, which placed Resident #410 at risk for serious injury, harm, impairment or death related to blood clotting.</p> <p>8. Medical record review for Resident #211 documented an admission date of 1/25/2013 with diagnoses of Cerebrovascular Accident (CVA), Anoxic Brain Injury, Hypertension, Myelopathy, Chronic Respiratory Failure and Tracheostomy.</p> <p>Review of lab results dated 4/7/14 documented, "...PT 49.1 INR 5.22..." Review of a NP's progress note dated 4/7/14 documented, "...Currently on Warfarin for CVA... Today's INR critical value 5.22. This value was not called to me..." Review of a physician order dated 4/7/14 documented, "...Hold Warfarin x 2 days. Give Vitamin K[vitamin used to help the blot clot] 1 mg IM/SQ now. Recheck INR in AM..."</p> <p>Review of a NP's progress note dated 4/10/14 and timed 11:38 AM documented, "...Patient [Resident #211] seen today f/u [follow up] INR... Last INR 5.22 on 4/7/14. Patient was given Vitamin K IM. Warfarin was held x 2 days. INR was supposed to be rechecked 4/8/14 but was not done..."</p> <p>Review of a physician's order dated 4/10/14 documented, "...STAT [immediately] PT/INR now..." Review of lab results dated 4/10/14 documented, "PT 15.9 INR 1.33..."</p> <p>Review of NP' progress note dated 4/11/14 documented, "...Patient seen today for anticoagulation management. [4/10/14] INR was not called to me as ordered. INR subtherapeutic</p>	F 309			

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F 309	<p>Continued From page 56 at 1.33. Last INR was 5.22. Patient received Vitamin K..."</p> <p>Review of Resident #211's lab results dated 6/28/14 documented, "...INR 1.49..." There was no documentation provided the NP was notified of the subtherapeutic results.</p> <p>Review of physician's order dated 8/22/14 documented, "...Hold Coumadin (8/23/14) Recheck PT/INR in AM (8/24/14)..." The facility was unable to provide PT/INR lab results for 8/24/14.</p> <p>Review of a NP's progress note dated 9/3/14 documented, "...Results of PT/INR not on chart for...8/24/14..."</p> <p>During an interview in the DON's office on 2/3/15 at 10:45 AM, the DON confirmed the clinical pathway for laboratory reporting was not followed on 4/7/14 and 4/11/14 and the PT/INR was not done as ordered on 4/8/14. The DON further stated, "I see what you are saying, just put it in the tag [deficiency]..."</p> <p>The facility failed to notify the physician or NP of critical lab results, failed to obtain PT/INR as ordered following critical values with medication intervention, failed to notify the physician or NP of subtherapeutic lab results and obtained labs without orders, which placed Resident #211 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>9. Medical record review for Resident #8 documented an admission date of 6/21/12 with diagnoses of CVA, Right Tibia/Fibula Fracture, Chronic Anticoagulation, Neuropathy and</p>	F 309			

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F 309	<p>Continued From page 57</p> <p>Diabetes.</p> <p>Review of a physician order dated 7/1/14 documented, "...Recheck INR monthly..." The facility was unable to provide PT/INR results for October 2014.</p> <p>During an interview in Resident #8's room on 1/22/15 at 8:30 AM, Resident #8 stated, "Been on blood thinner for a while."</p> <p>During an interview at the 5th floor nurse's station on 1/26/15 at 3:45 PM, Nurse #4 confirmed there were no PT/INR results for October 2014.</p> <p>During an interview at the 5th floor nurses' station on 2/3/15 at 3:45 PM, Nurse #5 confirmed there was an order written 7/1/14 for PT/INR monthly and stated, "No, there aren't any PT/INR for the month of October 2014 on the chart or overflow record..."</p> <p>The facility failed to follow orders for lab monitoring and/or giving significant medications as ordered by a physician, which placed Resident #8 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>10. Medical record review for Resident #84 documented an admission date of 8/4/14 with diagnoses of CVA with Left Side Hemiplegia, Hypertension, Peripheral Vascular Disease and Coumadin Therapy. Review of a physician order dated 4/15/14 documented, "...WARFARIN [Coumadin]... 2 MG TABLET... ALONG WITH 7.5 MG 10 MG = [amount to be administered] 19.5 MG... DAILY..."</p>	F 309			

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F 309	<p>Continued From page 58</p> <p>Review of a physician's order dated 10/30/14 documented, "...INR q [every] 2 weeks..." The facility was unable to provide INR results after 11/18/14.</p> <p>During an interview on the 4th floor on 1/13/15 at 9:45 AM, Nurse #7 confirmed the physician order for Warfarin was 19.5 mg daily.</p> <p>During an interview at the 4th floor nurses' station on 1/20/15 at 3:58 PM, Nurse #2 was asked about the order dated 10/30/14 to obtain an INR q 2 weeks and there were no labs results after 11/18/14. Nurse #2 stated she would call the hospital lab to check on any lab results after 11/18/14. At 4:30 PM Nurse #2 returned and stated, "Apparently, there hasn't been a PT/INR done since 11/18/14. That is unacceptable..."</p> <p>The failure of the facility to ensure labs were done as ordered placed Resident #84 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>11. Medical record review for Resident #116 documented an admission date of 11/21/14 with diagnoses of Acute Respiratory Failure, Congestive Heart Failure, Hypertension and Diabetes Mellitus. Review of a the post acute admission orders form dated 11/20/14 was not signed by a physician.</p> <p>Review of the November 2014 MAR documented Resident #116 received medications without a signed physician order as followed: a. Carvedilol (medication to control blood pressure), Potassium (medication to replace potassium), Benazapril (medication to control blood pressure), Aspirin (medication to prevent</p>	F 309			

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F 309	<p>Continued From page 59</p> <p>blood clotting), Atorvastatin (medication to reduce cholesterol) and Fenofibrate (medication to reduce triglycerides) given 11/22 through 11/30/14</p> <p>b. Albuterol (medication used to prevent bronchospasm) 0.083 percent (%) inhalation given 11/22 through 11/25/14.</p> <p>c. Heparin (medication used to prevent blood clotting) 5000 Units given 11/22, 11/23 and 11/24.</p> <p>d. Novolog (medication used to treat diabetes) sliding scale insulin given 11/24, 11/25, 11/26, 11/27, 11/28 and 11/29/14.</p> <p>e. Levemir (medication used to treat diabetes) Insulin given 11/22 through 11/30/14.</p> <p>There was no signed physician's order sheet (POS) until 1/8/15.</p> <p>During an interview at the 4th floor nurses' station on 1/22/15 at 10:28 AM, Nurse #1 was asked about Resident #116's admission orders. Nurse #1 confirmed there were no signed admission orders.</p> <p>During an interview at the 4th floor nurses' station on 2/3/15 at 2:00 PM, Nurse #2 was asked for signed and dated admission orders for Resident #116. Nurse #2 stated, "If you can't find it in the chart, it isn't there and they would have been giving meds [medications] without signed orders. This resident does not have an overflow record."</p> <p>The facility failed to ensure admission orders were signed and dated by the physician and the administration of significant medications for blood pressure, diabetes, cholesterol and blood thinner (anticoagulants) without a signed physician order placed Resident #116 at risk for serious injury, harm, impairment or death related to abnormal</p>	F 309			

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F 309	<p>Continued From page 60 bleeding or hemorrhage.</p> <p>12. Medical record review for Resident #192 documented an admission date of 10/31/14 with diagnoses of Long Term Anticoagulation Therapy, Cerebrovascular Accident, Atrial Fibrillation, and Weakness.</p> <p>Review of a physician order dated 11/1/14 documented, "...[increase] Coumadin to 3.5 mg QD [every day] PT/INR in AM..." There was no documentation provided the PT/INR was obtained on 11/2/14.</p> <p>Review of lab report dated 11/1/14 documented, "...PT 15.4...INR 1.28..."</p> <p>There was no documentation provided the Nurse Practitioner or Physician was notified of the subtherapeutic INR levels of less than 2 on 11/1/14 or 11/17/14.</p> <p>There was no order provided for the PT/INR that was obtained on 11/25/14 and 12/1/14.</p> <p>Review of a physician's order dated 1/12/15 documented, "...D/C [discharge] home on 1/27/15." This order was not signed or dated.</p> <p>During an interview at the 5th floor nurses' station on 1/12/15 at 5:26 PM, Nurse #4 was asked what Resident #192's current dose of Coumadin was. Nurse #4 stated, "I don't recall. I think it's 5 mg." Nurse #4 was asked what time does Resident #192 receive Coumadin. Nurse #4 stated, "I think she gets it about 9 or 9:30 [AM]." Nurse #4 was asked if the facility had a PT/INR protocol. Nurse #4 stated, "I'm not sure."</p>	F 309			

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F 309	<p>Continued From page 61</p> <p>During an interview at the 5th floor nurses' station on 1/14/15 at 12:55 PM, Nurse #8 was asked how long it usually takes to get STAT results and routine lab results. Nurse #8 replied, "STATS usually about 45 minutes to an hour. Routine sometimes the next day or two." Nurse #8 was asked who is responsible for making sure labs are logged and checked off in the lab book. Nurse #8 replied, "All of us; The assigned Nurse, ADON [Assistant Director of Nursing], the House Supervisor who is on 3-11 in the afternoon, and the night Supervisor who catches it all. They review the day."</p> <p>The facility failed to notify the physician or NP of subtherapeutic lab results and failed to obtain blood level labs for anticoagulant therapy as ordered, this placed Resident #192 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>13. Medical record review for Resident #403 documented an admission date of 1/9/15 with diagnoses of Multiple Myeloma, Deconditioning and Peripheral Neuropathy.</p> <p>Review of the hospital "Medication Reconciliation" from the transferring / referring hospital dated 1/8/14 was not signed and dated by a physician.</p> <p>The facility was unable to provide medication and treatment orders signed and dated by the facility's attending physician for January 2015.</p> <p>Review of the January MAR dated 1/1/15 through 1/31/15 documented Resident #403 received Coumadin (blood thinner) and Lovenox (blood thinner) on 1/10, 1/11 and 1/12/15 without signed physician orders.</p>	F 309			

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F 309	<p>Continued From page 62</p> <p>During an interview at the 4th floor nurses' station on 1/20/15 at 4:15 PM, Nurse #1 was asked about the process of admission to the facility. Nurse #1 stated, "I find the hospital medication sheet, call the Nurse Practitioner and see what she wants to continue. Then, when the resident is in the building, I enter those orders into the computer for a POS. I print it out and put it on the chart to be signed and give a copy to the resident's nurse."</p> <p>During an interview at the 3rd floor nurses' station on 1/22/15 at 2:29 PM, Nurse #6 confirmed the January 2015 POS was initiated by the Nurse Practitioner but was not dated. The physician did not sign the POS until 1/17/15.</p> <p>During an interview in the activity room on 1/27/15 at 4:15 PM, Nurse #6 was asked about the facility's admission process. Nurse #6 confirmed the reconciliation orders sent with the residents from the transferring / referring hospital must be signed by the transferring physician and if not signed the nurse would call the transferring hospital requesting a faxed signed copy of the orders.</p> <p>The facility failed to ensure admission reconciliation orders were signed and dated by the physician and the administration of anticoagulant medications without signed orders placed Resident #403 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>14. Medical record review for Resident #411 documented an admission date of 12/30/14 with diagnoses of Coronary Artery Disease, Upper</p>	F 309			

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F 309	<p>Continued From page 63</p> <p>Extremity DVT, Atrial Fibrillation, Aneurysm Repair, Hypoglycemia, Hypertension and Resolved Respiratory Failure.</p> <p>Review of the hospital "Medication Reconciliation - Transfer" form dated 12/29/14 documented, "...aspirin 325 mg oral tablet 1... daily... [checked to continue] aspirin 325 mg oral tablet 1... daily... [checked to stop]... Coumadin 1 mg 1 po Q HS... [check] INR Q 48 [sign for hours] to adjust Coumadin dose to reach goal INR 2.0 - 3.0... If INR > [greater than] 3.0... Hold Coumadin..."</p> <p>Review of the hospital transfer referral form dated 12/30/14 documented, "...[check] INR Q 48 [sign for hours] to adjust Coumadin to reach goal INR... 2.0-3.0... Hold Coumadin if INR > 3.0... Coumadin 1 mg po Q HS... [sign for change] to Coumadin 2 mg po Q HS..." The form was signed by a physician.</p> <p>There was no documentation provided for completed INRs for 1/1, 1/3, 1/5, 1/8, 1/10, 1/12, 1/16, 1/18, or 1/20/15. There was no clarification order obtained for the Aspirin or Coumadin.</p> <p>Review of the MAR dated 1/1/15 through 1/31/15 documented, Resident #411 received 2 mg of Coumadin on 1/1, 1/2, 1/3, 1/4, 1/5, 1/6, 1/9, 1/10, 1/11, 1/12, 1/13, 1/14, 1/15, 1/16, 1/17, 1/18, 1/19, 1/20, 1/21 and 1/22/15. There was no documentation the Coumadin was given on 1/7 or 1/8, as ordered.</p> <p>During an interview at the 2nd floor nurses' station on 1/22/15 at 10:30 AM, Nurse #3 was asked about the Q 48 hr INR results. Nurse #3 stated, "They aren't there." Nurse #3 was asked who would ensure labs were done. Nurse #3</p>	F 309			

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F 309	<p>Continued From page 64</p> <p>stated, "The ADON...11-7 fills out the lab sheets." Nurse #3 was shown the order of Coumadin 1 mg and transfer sheet with an order for Coumadin 2 mg and asked how the medication should be transcribed. Nurse #3 stated, "Call the doctor for clarification." Nurse #3 was asked if she could show where the doctor was called for clarification. Nurse #3 looked through chart and stated, "There is nothing there."</p> <p>During an interview in the DON's office on 1/22/15 at 4:25 PM, the DON was asked about the order process. The DON stated, "Reconciliation must come over with them [residents] or we do not have any orders to take care of them. The hospital faxes the reconciliation orders over." The DON was then told about the transfer form with the order to change the Coumadin dose to 2 mg. The DON stated, "We do not use the transfer sheet for an order, we have no way of knowing who wrote that note in. Don't know if that is a doctor's signature or not on the transfer form."</p> <p>During an interview in the activity room on 1/27/15 at 11:00 AM, the DON confirmed the reconciliation order is what the nurse goes by for orders and stated, "Do not use that transfer form to take off orders." The DON was asked what dose of Coumadin was Resident #411 on. The DON stated, "1 mg." The DON then pulled the MAR for the January 2015 and stated, "She got 2 mg. [Nurses] Should have clarified the order."</p> <p>The facility failed to ensure labs were done as ordered and failed to obtain clarification orders for significant anticoagulants medications, this placed Resident #411 at risk for serious injury, harm, impairment or death related to abnormal</p>	F 309		

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F 309	<p>Continued From page 65 bleeding or hemorrhage.</p> <p>15. Medical record review for Resident #412 was admitted on 7/10/14 with diagnoses of Stage IV Metastatic Colon Cancer, Right Lower Extremity DVT, Hypertension, Failure to Thrive, Pleural Effusion, Malnutrition and Post Hemicolectomy and Ileostomy.</p> <p>Review of a physician order dated 7/22/14 documented, "...Stat PT/INR ... PT/INR every Monday... Increase Coumadin to 5.5 mg every day..." Review of lab dated 7/22/14 documented, "...PT 16.7... INR 1.42..."</p> <p>Review of the POS generated on 7/25/14, reviewed by the nurse on 7/28/14 and signed by the physician on 8/10/14 documented, "...WARFARIN... 2.5 MG TABLET... 1 TABLET ORALLY DAILY (TAKE WITH 3 MG TABLET... TD [TOTAL DOSE] 5.5 MG..."</p> <p>Review of a lab report dated 7/28/14 documented, "...PT 16.9... INR 1.44..." There was no documentation provided that the NP or physician was notified of the subtherapeutic INR results.</p> <p>There was no documentation the PT/INR was done as ordered for 8/4/14 nor was there documentation provided that the physician or NP was notified the PT/INR was not done as ordered.</p> <p>During an interview in the activity room on 1/28/15 at 3:20 PM, the Medical Director was asked if laboratory tests were not done as ordered, if he expected the physician or NP to be notified. The Medical Director stated, "Yes, if it was not done." The Medical Director was asked if</p>	F 309		
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F 309	<p>Continued From page 66</p> <p>there was a protocol for monitoring Coumadin. The Medical Director stated, "The DON has a list of Coumadin recipients. I would expect to see an INR once a month." The Medical Director was asked if he was aware of any problems with anticoagulants in this facility. The Medical Director stated, "No."</p> <p>The facility failed to notify the physician or NP of subtherapeutic lab results and failed to obtain ordered PT/INRs, this placed Resident #412 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>16. Medical record review for Resident #222 documented an admission date of 6/26/13 with a readmission date of 12/22/14 with diagnoses of Seizures, Chronic Respiratory Failure, Traumatic Brain Injury, Diabetes Mellitus, Hypertension and Chronic Obstructive Pulmonary Disease. The resident was discharged to the hospital on 12/6/14 and returned to the facility on 12/22/14.</p> <p>Review of the hospital "...Transfer/Referral Form" from the transferring / referring hospital dated 12/22/14 documented, "... START taking these medications..." This form was not signed and dated by a physician.</p> <p>There were no medication and treatment recapitulation orders signed and dated by a physician until the facility's POS generated 1/27/15 was signed by the facility's attending physician on January 2015 (exact date is illegible).</p> <p>Review of Resident #222's December 2014 MAR documented the following significant medications were administered from 12/22/14 through</p>	F 309		
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F 309	<p>Continued From page 67</p> <p>12/31/14 without a physician's order:</p> <p>a. Vimpat 100 mg of solution twice daily - medication to control seizures.</p> <p>b. Duoneb inhalation respiratory bronchodialator 3 ml (milliliter) every 6 hours.</p> <p>c. Depakene 250 mg of solution twice daily - medication to control seizures.</p> <p>d. Humalog insulin subcutaneous injection 4 times daily - fast acting insulin given according to accucheck results to control high blood glucose levels.</p> <p>Review of Resident #222's January 2015 MAR documented the following significant medications were administered from 1/1/15 through 1/27/15 without a physician's order:</p> <p>a. Vimpat 100 mg of solution twice daily - medication to control seizures.</p> <p>b. Duoneb inhalation respiratory bronchodialator 3 ml every 6 hours.</p> <p>c. Depakene 250 mg of solution twice daily - medication to control seizures.</p> <p>d. Humalog insulin subcutaneous injection 4 times daily - fast acting insulin given according to accucheck results to control high blood glucose levels.</p> <p>During an interview at the 4th floor nurses' station on 1/17/15 at 9:45 AM, Nurse #2 was asked where the physician orders were for Resident #222. Nurse #2 stated, "They're in the computer. I've checked my box and don't have any signed orders there."</p> <p>The facility failed to ensure admission orders were signed by a physician and failed to ensure medications for seizures and diabetes were administered with a signed physician order.</p>	F 309			

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F 309	<p>Continued From page 68</p> <p>17. Medical record review for Resident #229 documented an admission date of 10/22/13 and a readmission date of 7/18/14 with diagnoses of Gun Shot Wound, Respiratory Failure with Mechanical Ventilation via Tracheostomy Tube, Vegetative State and Depression. The resident was discharged to the hospital on 7/14/14 and was readmitted to the facility on 7/18/14.</p> <p>Review of the hospital "...Medication Reconciliation by Therapeutic Class - Discharge" dated 7/17/14 from the transferring / referring hospital was not signed and dated by a physician.</p> <p>There were no medication and treatment orders signed and dated by a physician until the facility's POS generated 10/31/14 was signed by the facility's attending physician on October 2014 (exact date is illegible).</p> <p>Review of Resident #229's July 2014 MAR documented the following significant medications were administered via Percutaneous Endoscopic Gastrostomy (PEG) tube from 7/19/14 through 7/31/14 without a physician's order:</p> <ul style="list-style-type: none"> a. Oxycodone 5 mg tablet prior to wound care daily - narcotic pain medication. b. Propranolol 120 mg tablet twice daily - medication to control fast heart rate. <p>Albuterol a respiratory bronchodialator was administered per inhalation on 7/19/14 through 7/28/14.</p> <p>The facility failed to ensure readmission reconciliation orders were signed by a physician, resulting in Resident #229 receiving medications without signed physician orders.</p> <p>18. Medical record review for Resident #358</p>	F 309		
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F 309	<p>Continued From page 69</p> <p>documented an admission date of 10/3/14 and a readmission date of 11/9/14 with diagnoses of Hypertension, Parkinson's Disease, Depressive Disorder, Adult Failure to Thrive, System Lupus Erythematouos, Acute Pancreatitis, Gastrostomy and Malignant Neoplasm Parotid and Malignant Salivary Glands</p> <p>Review of Resident #358's POS dated 10/3/14 did not have a physician signature.</p> <p>Review of the October 2014 MAR documented Resident #358 received these medications without orders as followed:</p> <ul style="list-style-type: none"> a. Amlodopine (medication to control blood pressure) given 10/3/14 through (-)10/31/14. b. Hydroxychloroquine (medication to treat Lupus) given 10/4/14-10/31/14. c. Prednisone (medication to treat inflammation) given 10/4/14-10/12/14. d. Levothyroxine (medication used to replace thyroid hormone) given 10/4/14-10/31/14. <p>Review of a "Medication Reconciliation" form dated 11/9/14 did not document a physician signature.</p> <p>Review of the November 2014 MAR documented Resident #358 received these medications without orders as followed:</p> <ul style="list-style-type: none"> a. Amlodopine, Zyvox, Lisinopril and Levothyroxine were given 11/22/14-11/30/14. b. Remeron was given 11/19/14 through 11/30/14. <p>The facility failed to ensure admission and readmission reconciliation orders were signed by a physician resulting in Resident #358 receiving medications without signed physician orders.</p>	F 309			

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F 309	<p>Continued From page 70</p> <p>19. Medical record review for Resident #361 documented an admission date of 11/6/14 and a readmission date of 12/2/14 with diagnoses of Aspiration Pneumonia, Recent Intracranial Hemorrhage with Ventriculoperitoneal Shunt, Hydrocephalus, Anoxic Brain Injury, Acute and Chronic Respiratory Failure, Tracheostomy, Syndrome of Inappropriate Antidiuretic Hormone, Percutaneous Endoscopy Gastrostomy Tube and Hypertension.</p> <p>The facility was unable to provide signed POS for the resident's admission on 11/6/14 or for the readmission on 12/2/14.</p> <p>20. Medical record review for Resident #394 documented an admission date of 11/28/14 with diagnoses of Chronic Airway Obstruction, Chronic Respiratory Failure, Muscle Weakness, Lack of Coordination, Hypertension, Venous Thrombosis and Emphysema. Review of a POS generated on 11/29/14 was not signed by the physician or NP as of 1/21/15.</p> <p>Review of physician telephone orders dated 11/29/14, 12/2/14, 12/3/14, 12/4/14, 12/5/14, 12/7/14, 12/8/14, 12/16/14, 12/18/14, 12/24/14, 12/30/14 and 1/12/15 were not signed and dated..</p> <p>During an interview in the activity room on 1/26/15 at 5:05 PM, the DON was asked when telephone orders were to be signed. The DON stated, "Telephone orders must be signed within 10 days."</p> <p>The facility failed to ensure admission orders were signed by a physician.</p> <p>21. Medical record review for Resident #81</p>	F 309			

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F 309	<p>Continued From page 71</p> <p>documented an admission date of 7/1/09 with a readmission date of 12/22/14 with diagnoses of Alzheimer's Disease, Diabetes Mellitus, Hypertension, Seizures and Hyperlipidemia.</p> <p>Review of a physician's order dated 12/22/14 documented, "...Aspirin [medication used to thin blood] 81 mg... Daily... Lisinopril [medication to control blood pressure] 5 mg... 1... daily... Levetiracetam [medication for seizures] 500 mg... 1 tab... Once each shift... Namenda [medication for dementia] 10 mg... Daily... Therems H...[multivitamin with iron]... 1 Daily...Amlodopine [medication for blood pressure]10 mg... 1...Daily... Levemir [medication for diabetes]... 15 Units Injection Subcut [subcutaneous] Every 12 hours scheduled..."</p> <p>Review of Resident #81's MAR revealed medications were not administered as ordered as followed:</p> <ol style="list-style-type: none"> Resident #81 did not receive Levetiracetam, Namenda, Aspirin, Lisinopril, Therems H on 12/22 through 12/31/14. Resident #81 did not receive Levemir insulin on 12/22/14. Resident #81 did not receive Amlodopine on 12/23 or 12/24/14. <p>During an interview in the activity room on 1/29/15 at 3:54 PM, Nurse #8 confirmed the hospital reconciliation orders were the orders to be used for December 2014 and the MAR was for the month of December 2014. Nurse #8 was asked if Resident #81 received the Lisinopril, Namenda, Multivitamin and Aspirin as ordered. Nurse #8 shook her head no after reviewing the MAR. Nurse #8 was asked where would it be documented if the nurse spoke with the NP or</p>	F 309		
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F 309	<p>Continued From page 72</p> <p>physician for reconciliation of medications. Nurse #8 shook her head in a no response and stated, "No [not documented]..."</p> <p>The facility failed to ensure nurses administered significant medications as ordered for seizures, blood pressure and/or diabetes from 12/22/14 to 12/31/14.</p> <p>22. Medical record review for Resident #151 documented an admission date of 10/7/14 and a readmission date of 12/1/14 with diagnoses of Chronic Obstructive Pulmonary Disease, Personal History of Fall, Chronic Kidney Disease, Bipolar Disorder Disease, Hypertension, Diabetes Mellitus Type 2, Congestive Heart Failure, Hypothyroidism, Dementia and Anemia. Resident #151 was discharged home on 11/12/14 with home health and returned to the facility from the hospital on 12/1/14 following multiple falls at home.</p> <p>Review of the active medication list from the transferring / referring hospital on 12/1/14 was not signed and dated by a physician. There were no medication and treatment orders signed and dated by a physician until the facility's POS generated 12/30/14 was signed by the attending physician in January 2015 - exact date illegible.</p> <p>Review of the December MAR dated 12/1/14 through 12/31/14 and the January MAR dated 1/1/15 through 1/31/15 documented Resident #151 received medications including Atorvastatin [medication for cholesterol], Buspirone [medication for anxiety], Carvedilol [medication for blood pressure], Gabapentin medication for nerve pain], Levothyroxine [medication for thyroid hormone replacement], Lisinopril [medication for</p>	F 309			

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F 309	<p>Continued From page 73</p> <p>blood pressure), Mirtazapine [medication for depression], Venlafaxine [medication for depression and/or anxiety], Clonidine [medication for blood pressure] and Insulin [medication for diabetes] without signed physician orders.</p> <p>The facility failed to ensure physician orders were signed on admission and failed to ensure blood pressure, thyroid, diabetes and any other medications were not administered without an order.</p> <p>23. Medical record review for Resident #131 documented an admission date of 12/2/14 with diagnoses of Brain Tumor, Seizures, Hearing Loss, Hyponatremia, Dementia and Inappropriate Antidiuretic Hormone.</p> <p>Review of a POS generated on 11/27/14 for the month of December 2014 was not dated or signed. There were no signed orders on the chart for December 2014.</p> <p>Review of "Medication Reconciliation" orders from the hospital dated 12/2/14 did not have a physician signature. The order was written by a Registered Nurse.</p> <p>Reviews of the December MAR dated 12/1/14 to 12/31/14 documented Resident #131 received medications including Sodium Chloride [sodium replacement], Topiramate [medication for seizures] and Prednisone [medication for inflammation] from 12/3/14 through 12/31/14 without signed physician orders.</p> <p>Review of a POS generated 1/27/15 with a physician signature date of 1/27/15 documented there were no signed orders for January from</p>	F 309		

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F 309	<p>Continued From page 74 1/1/15 until 1/27/15.</p> <p>Review of the January MAR dated 1/1/15 through 1/31/15 documented Resident #131 received medications including Sodium Chloride, Topiramate, and Prednisone from 1/1/15 through 1/27/15 without signed physician order.</p> <p>During an interview at the 5th floor nurses' station on 2/2/15 at 6:10 PM, Nurse #10 confirmed the medications had been given in December 2014 and January 2015 without signed orders. Nurse #10 stated, "We would have used the reconciliation orders sent from the hospital [12/2/14] for December [2014] orders." Nurse #10 confirmed these orders were not signed.</p> <p>The facility failed to ensure their policy was followed for physician visits within 72 hours after admission when there was no physician visit until the physician signed the 1/27/15 orders, failed to ensure admission orders were signed by a physician and failed to ensure medications including Prednisone were given with a signed physician order from 12/3/14 through 1/27/15.</p> <p>24. Medical record review for Resident #29 documented an admission date of 1/16/12 with diagnoses of Cerebrovascular Accident, End Stage Dementia, Hypertension, Arthritis, Dysphasia, Hyperlipidemia, Mental Disorder and Depression.</p> <p>Review of the care plan dated 7/22/14 documented, "...Resident is diagnosed with terminal condition and is at risk for loss of dignity, depression, feeling uncomfortable, and unavoidable significant declines. palliative care... Resident has Advanced Directives on record:</p>	F 309			

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F 309	Continued From page 75 DNR [Do Not Resuscitate], Palliative Care..." Review of the hospice Registered Nurse admission assessment dated 10/27/14 documented Resident #29 received an admission assessment for hospice on 10/27/14. There is no documentation in the chart when hospice assumed care as there is no order in the chart for admission to hospice. During an interview in the Minimum Data Set (MDS) office on 1/16/2015 11:35 AM, MDS Nurse #2 was asked about hospice care for Resident #29. MDS Nurse #2 stated, "I recall doing [a MDS] one in December regarding hospice and declining condition."	F 309			
F 314 SS=H	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on review of the "National Pressure Ulcer Advisory Panel (NAUAP) Pressure Ulcer Prevention" quick reference guide, policy review, medical record review, observation and interview, it was determined the facility failed to ensure	F 314	1. Resident #'s 62, 81, 252, 294 and 410 are discharged. Resident #'s 222 and #394 are receiving weekly skin checks by a licensed nurse with treatments being performed according to physician order. WOCN (Wound Care Nurse Consultant) participated in wound rounds on April 17, 2015.	5/28/2015	

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F 314	<p>Continued From page 76</p> <p>nurses completed weekly skin assessments and identified pressure sores timely, and provided treatment per order and preventative measures for 7 of 11 (Residents #294, 222, 81, 62, 252, 394 and 410) sampled residents reviewed with a pressure ulcer. The failure of the nurses to complete weekly skin assessments on residents, who are a high risk for developing pressure ulcers, the failure to identify a pressure ulcers before residents develop Stage II to suspected deep tissue injury (SDTI), failure to complete weekly skin assessments and treatment as ordered resulted in actual harm for Resident #294, #222 and #81 which resulted in substandard quality of care.</p> <p>An extended survey was conducted on 2/4/15 through 2/11/15.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the "NAUAP Pressure Ulcer Prevention" quick reference guide documented, "...Ongoing assessment of the skin is necessary to detect early signs of pressure damage... Skin inspection should include assessment for localized heat, edema, or induration (hardness)... Accurate documentation is essential for monitoring the progress of the individual and to aiding communication between professionals..." 2. Review of the facility's "Skin Management and Prevention" policy documented, "...The "weekly skin rounds sheet" will be utilized to determine if any new skin alterations have developed... Any new skin condition(s) found during the weekly skin rounds will be documented... On shower/bath days, CNA's [Certified Nursing Assistant] will complete total body skin 	F 314	<p>Resident #'s 222 and #394 treatments and care plans are updated to reflect current treatment and preventative measures related to potential for skin breakdown</p> <p>2. A baseline skin sweep was conducted on 1/15/2015, 1/22/2015 and 1/23/2015. Any new skin alterations noted were reported to the physician, family was notified and treatment initiated. A baseline review of weekly skin checks was completed by licensed nurses. Newly identified issues were corrected. A new schedule for weekly skin checks was created for licensed nurses to easily identify skin assessments to be completed. A baseline audit of ordered wound treatments was completed by WOCN Consultant and recommendations made. Any newly identified issues were corrected. A baseline audit of residents at high risk for skin impairment will be completed by DON, ADON/ designee to assess for presence of care planning and implementation of proper preventive measures as indicated.</p>		

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F 314	<p>Continued From page 77 observations..."</p> <p>Review of the facility's "Pressure Ulcers Skin Breakdown - Clinical Protocol" policy documented, "...The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive, absorptive...) and application of topical agents if indicated for type of skin alteration..."</p> <p>3. Closed medical record review for Resident #294 documented an admission date of 9/9/14 with diagnoses of Acute and Chronic Respiratory Failure, Ventilator Dependence via Tracheostomy, Percutaneous Endoscopy Gastrostomy Tube, History of Drug and Alcohol Abuse, Pulmonary Embolus, Acute and Chronic Renal Failure, Anemia and Cerebrovascular Accident - Main Brainstem Infarction.</p> <p>Review of the nursing admission information dated 9/9/14 documented, on the picture of the human body, a large reddened area on the resident's buttocks and perineal area and calloused and scaly skin on the bottom of both feet and both heels.</p> <p>The Braden Scale was completed 9/9/14 and documented the resident was a high risk for developing pressure ulcers.</p> <p>Review of the comprehensive admission MDS assessment with an assessment reference date of 9/16/14 documented the resident was in a persistent vegetative state with no discernible consciousness, dependent on staff for activities of daily living (ADL) performance and at risk for developing pressure ulcers.</p>	F 314	<p>3. In-services for licensed nurses and CNAs were completed 2/15/15 by the SDC that included performing skin assessment, positioning, and documentation of skin assessment. The treatment nurses will be proficient in Braden Scale scoring following in-servicing and validation of skills by WOCN (Wound Care Nurse Consultant). The Braden will be completed for all newly admitted residents and quarterly for current residents. Those residents identified at high risk will have preventative measures put in place and documented on care plan. Additional in-servicing was completed on 3/31/15 for licensed nurses regarding providing wound care treatments according to physicians orders as well as identifying residents at risk according to the Braden scale with preventative measures implemented based upon scoring. The Braden Scale for residents with a pressure ulcer will be completed monthly until pressure area resolves, at which time will resume to quarterly.</p>	

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F 314	<p>Continued From page 78</p> <p>Review of the "PRESSURE ULCER RECORD", completed by the treatment nurse, dated 9/24/14 documented a stage 2 pressure ulcer (loss of the skin presenting as a shallow open ulcer with a red pink wound bed) measuring "L (cm) 3.5 x W (cm) 3.0 x D (cm) < 0.1... WOUND BED Dark pink/red tissue 100% [percent]..." was present on the resident's sacrum/coccyx. The date of origin was 9/24/14. There was no corresponding nursing documentation. The resident's medical record had no skilled nursing notes from 9/19/14 through 9/29/14 or generic nurse's notes documenting the identification of the pressure ulcer; however the resident had remained in the facility. The next pressure ulcer record documentation was due on 10/8/14; it was not completed.</p> <p>Review of the physician and/or NP orders documented no orders for wound treatment until the "Physician's Order Sheet" (POS) was signed by the physician on 10/6/14; however review of the resident's September 2014 MAR documented the treatment being performed was - cleansing the sacrum with soap and water, patting dry and applying Skin Barrier to the sacrum three times daily and as needed. On 9/26/14, 9/27/14 and 9/28/14 the treatment was only done once daily and on 9/29/14 the treatment was only done twice.</p> <p>Review of Resident #294's October 2014 treatment record documented the treatments were done as follows:</p> <ol style="list-style-type: none"> 10/2/14 twice daily. 10/4/14 none. 10/5/14, 10/11/14 and 10/12/14 twice daily. 10/13/14 once daily. 10/14/14, 10/15/14, 10/19/14, 10/20/14 and 	F 314	<p>A partnership with the Quality Improvement Organization has been established with a focus on pressure ulcers. Residents with wounds will be discussed weekly at the weekly clinical meeting which includes the Interdisciplinary Team Members (IDT) members being, DON, ADON, Wound Care Nurse, Registered Dietitian, Social Service Director and Quality of Life Director (QOLD). The IDT will validate the treatment is appropriate and wound is showing improvement. If no improvement is noted, physician and family will be notified with care plan updated to reflect status.</p> <p>4. If audits demonstrate substantial compliance and QAPI committee approves, the frequency will be reduced periodically, over time, as indicated.</p> <p>An audit will be conducted for completion of weekly skin checks and wound treatments performed by licensed nurse as ordered five times per week for 8 weeks, then three times per week for 4 week until substantial compliance is maintained. Newly identified issues will be corrected.</p> <p>If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of audit.</p>	
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F 314	<p>Continued From page 79</p> <p>10/25 twice daily. f. 10/27/14 once daily.</p> <p>There was not documentation in the nurse's notes explaining why the treatments were not done as ordered.</p> <p>Review of the pressure ulcer record dated 10/31/14 documented a deterioration of the resident's sacral pressure ulcer to a stage 3 (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss) measuring "...l (cm) 3.0 X w (cm) 2.0 X D (cm) 1.0...WOUND BED Dark pink/red tissue 50%...Slough - moist yellow or gray necrotic [dead] tissue 50%..."</p> <p>Review of the physician and/or NP orders documented no order for wound treatment until the POS was signed by the NP on 11/3/14; however review of the resident's October 2014 MAR documented the treatment being performed beginning 10/25/14 was - cleansing the sacrum with soap and water, patting dry, applying skin prep to the skin surrounding the wound, applying Vasolex ointment (a topical ointment that removes dead tissue from a wound - prescription only), covering the wound with a 4 by 4 gauze and securing daily. The wound treatment was administered without a physician's order on 10/25/14, 10/26/14, 10/27/14 and 10/31/14.</p> <p>Review of the November 2014 treatment record for the sacral wound revealed a treatment done without an order on 11/1/14 and 11/2/14. There was no sacral wound treatment documented on 11/8/14, 11/9/14, 11/10/14, 11/12/14, 11/13/14, 11/19/14 and 11/20/14. There was no documentation in the nurse's notes</p>	F 314			

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F 314	<p>Continued From page 80 explaining why the treatments were not done.</p> <p>Review of the pressure ulcer record dated 11/20/14 documented the sacral wound measured "L (cm) 3.0 x W (cm) 2.0... WOUND BED... Slough... 100%..."</p> <p>Review of the pressure ulcer record dated 11/27/14 documented a deterioration of the resident's sacral wound to unstageable (full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined; but it will be either a stage 3 or 4) and measured the same as on 11/20/14 with 100% slough covering the wound bed.</p> <p>Review of a NP's order dated 11/20/14 documented, "Physical therapy to consult for wound care..." Review of a physician's order dated 11/21/14 documented, "PT [physical therapy] wound clarification order: to see pt [patient] 3d [days] / [per] wk [week] for skilled PT wound care (cleanse, irrigate, debride & [and] drsg [dressing change with] Santyl [ointment removes dead tissue] & use of modal [modalities] to aid in healing a sacral wound..."</p> <p>Review of a "PT Evaluation & Plan of Treatment" dated 11/21/14 documented, "...Wound Analysis... Location = Sacrum & Coccyx... Length = [size] 6.1 centimeters; Width = 10.5 centimeters; Depth/Exposure = Subcutaneous tissue (May be further depth as wound is w/ [with] necrosis...75-100% of wound bed covered..." PT would treat Monday, Wednesday and Friday and nursing to provide daily wound treatments with Santyl otherwise.</p>	F 314			

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F 314	<p>Continued From page 81</p> <p>Review of the November 2014 MAR documented Resident #292 continued to receive the previous treatment with Vasolex on 11/22/14, 11/23/14, 11/25/14, 11/26/14 and 11/29/14. The MAR documented the wound treatment with Santyl, documented to be administered daily, was done prior to the order date of 11/21/14 on - 11/11/14, 11/13/14, 11/14/14, 11/15/14, 11/16/14, 11/17/14 and 11/18/14. The Santyl wound treatment was not administered on 11/24/14 or 11/28/14. There was no documentation in the nurse's notes explaining why the treatments of the sacral wound were not done.</p> <p>Review of the December 2014 treatment record for the sacral wound documented wound treatment with Vasolex was administered on 12/1/14, 12/2/14, 12/4/14, 12/5/14, 12/6/14, 12/8/14 through 12/14/14, 12/16/14, 12/18/14, 12/19/14, 12/23/14 and 12/30/14. The treatment record documented wound treatment with Santyl was administered on 12/1/14, 12/2/14, 12/4/14 through 12/6/14, 12/8/14 through 12/10/14, 12/12/14, 12/13/14, 12/16/14 through 12/19/14, 12/23/14, 12/27/14, 12/28/14 and 12/30/14.</p> <p>Review of a PT note dated 12/31/14 documented a wound vac (vacuum for negative pressure wound therapy) device was applied and PT would change Monday, Wednesday and Fridays.</p> <p>Review of the resident's MARs for September, October, November, and December 2014 documented, "...TREATMENT / PROCEDURE...S KIN ASSESSMENT: PERFORM WEEKLY... ASSESS SKIN FROM HEAD TO TOE, DOCUMENT ALL FINDINGS..." The skin assessments on the MAR were all blank.</p>	F 314			

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F 314	<p>Continued From page 82</p> <p>During an interview in the activity room on 1/22/15 at 4:30 PM, Nurse #11 was asked about Resident #294's wound treatments. Nurse #11 stated, "[Named Resident #294] had issues on her sacrum on admission [redness]. The nurse brought it [open wound on 9/24/14] to my attention. Initially used barrier cream three times daily." Nurse #11 confirmed the wound treatment had changed to Vasolex daily on 10/24/14 due to slough on the wound bed and then changed to Santyl daily on 11/7/14. Nurse #11 confirmed there were no written physician or NP orders in the resident's medical record for the treatment changes on 10/25/14 and 11/7/14 and the documentation on the resident's treatment records of wound care administered, should correspond to the change in treatments.</p> <p>During an interview in the 4th floor Assistant Director of Nursing/Respiratory's office on 1/23/15 at 10:10 AM, Nurse #2 was asked if the resident's skin assessments had been completed. Nurse #2 stated, "The weekly skin assessment - if the nurse didn't write a note. The skin assessment will not show up in the computer." The facility was unable to provide documentation of weekly skin assessments for Resident #294.</p> <p>The failure of the nurses to complete weekly skin assessments on a resident, who is at high risk for developing pressure ulcers, and the failure to provide treatments as ordered when a Stage 2 pressure ulcer deteriorated to a Stage 3 pressure ulcer, resulted in actual harm for Resident #294.</p> <p>4. Medical record review for Resident #222 documented an admission date of 6/26/13 and a</p>	F 314			

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F 314	<p>Continued From page 83</p> <p>readmission date of 12/22/14 with diagnoses of Seizure Disorder, Chronic Respiratory Failure on Mechanical Ventilation via Tracheostomy, Pneumonia, Cardiac Dysrhythmias, Percutaneous Endoscopy Gastrostomy (PEG), Traumatic Brain Injury, Hypertension (HTN), Diabetes and Vegetative State.</p> <p>Review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/29/14 documented, "...Cognition is Severely impaired... Total dependence for all ADL's [activities of daily living]... Indwelling catheter... Always incontinent of bowel... Feeding tube... Does the resident have one or more unhealed pressure ulcers at Stage 1 or higher... 0 ... Pressure reducing device for bed... Medications... Antianxiety... Oxygen therapy... Suctioning... Tracheostomy care..."</p> <p>Review of the nursing admission skin evaluation dated 12/22/14 documented, "...[circle in the sacral area] excoriation... [circle around the heels]... dry skin... No open areas..."</p> <p>Review of the Braden scale for predicting pressure sore risk dated 12/22/14 documented, Resident #22's "...Total Score... 11 [10 to 12 indicates resident at a high risk for pressure ulcer development]..."</p> <p>Review of the care plan dated 9/9/14 documented, "...Problem... Resident is at risk for developing skin breakdown r/t [related to] decreased mobility, Incontinence... Goal... Resident will have intact skin, free of redness, blisters, or discoloration over a bony prominence through next review date... Approach... Provide pressure relieving or reduction mattress... Turn</p>	F 314			

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F 314	<p>Continued From page 84 and reposition every 2 hours and as needed... Provide incontinence care after incontinence episodes, apply barrier cream PRN [as needed]... Avoid prolonged skin to skin contact... Minimize pressure over bony prominence... Use lift devices, draw sheet to reduce friction as needed... Complete Skin check weekly and prn... Provide pressure relieving or reduction Chair cushion..."</p> <p>Review of the care plan dated 1/14/15 documented, "...Problem... Resident has SDTI to right and left feet & [and] Stage II pressure ulcer to sacrum... Goal... SDTI to right and left feet will exhibit signs of healing evidenced by decrease in size, improved appearance, and be free from s/s [signs and symptoms] of infection thru [through] next review... Stage II to sacrum will exhibit signs of healing aeb [as evidenced by] decrease in size, improved appearance & be free from s/s infection thru next review period... Approach... Report changes in skin status (...s/s infection, non-healing, new areas) to physician... Assist to turn and reposition q2hrs [every 2 hours] and prn [as needed]... Provide pressure relieving relieving or reduction mattress... Provide incontinence care after incontinence episodes; apply barrier cream PRN... Avoid prolonged skin to skin contact... Provide preventative measures, dietary intervention, use of pressure relieving devices as needed to prevent further skin breakdown... Refer to RD [Registered Dietician]... Provide diet as ordered... Provide Tx [treatment] as ordered..."</p> <p>Review of the physician's telephone orders dated 1/14/15 documented, "...1. Apply skin prep to right & left feet. 2. Prevalon Boots 3. Cleanse sacrum c [with] soap & water pat dry. Apply Barrier cream to open area cover with foam</p>	F 314		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT SAINT FRANCIS	STREET ADDRESS, CITY, STATE, ZIP CODE 6007 PARK AVE MEMPHIS, TN 38119
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F 314	<p>Continued From page 85 dressing Daily/prn [as needed]..."</p> <p>The facility was unable to provide weekly skin assessments for Resident #222, prior to the 1/14/15 date.</p> <p>Review of the pressure sore record dated 1/14/15 documented the following:</p> <p>a. "...(Rt) [right] Foot... Date of Origin: 1/14/15... SDTI... Length [L] (cm) [centimeter] 2.0... x [by] Width [W] (cm) 3.0... Depth [D] (cm) < [less than] 0.1..."</p> <p>b. Left Foot... Date of Origin: 1/14/15... SDTI... [L] (cm) 1.5... x [W] (cm) 1.0... [D] (cm) <0.1..."</p> <p>c. Sacrum... Date of Origin: 1/14/15... Stage II... [L] (cm) 0.5... x [W] (cm) 0.5... [D] (cm) <0.1..."</p> <p>Observations in Resident #222's room on 1/14/15 at 1:20 PM and 1/15/15 at 11:10 AM, revealed Resident #222 lying on his back with feet in boots. There was a quarter size purple/red area on right inner ankle/bony prominence, a nickel size purple/red area on the left heel and the sacrum was excoriated with a 1 cm opening at the coccyx area that was pink. There was no odor or drainage present.</p> <p>Observations in Resident #222's room on 1/22/15 at 10:10 AM, revealed Resident #222 lying on his back with his feet in boots. Resident #222's right inner foot next to the heel had a purplish blister and the left outer ankle had a purplish area and the left heel had a purplish blister. The sacrum stage II wound had closed.</p> <p>During an interview in Resident #222's room at 1/14/15 at 1:20 PM, Resident #222's family member stated the resident had breakdown on his right inner ankle and left heel and he had</p>	F 314		
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F 314	<p>Continued From page 86</p> <p>been in the same position from 10:15 AM until 1:15 PM today. Resident #222's family member also stated she had reported the problem with the staff not turning Resident #222 to the floor assistant director of nursing (ADON) today and that she had already told the treatment nurse about the pressure areas on his feet.</p> <p>During an interview in the 4th floor ADON's office on 1/15/15 at 4:35 PM, Nurse #2 was asked for the weekly skin assessments for Resident #222. Nurse #2 stated, "If there's not a skin assessment on the chart, then assessments were not done... weekly skin assessments have not been ordered." Nurse #2 was asked would his nursing staff complete a weekly skin assessment if it wasn't on the orders. Nurse #2 stated, "Some [nurses] do more than others."</p> <p>During an interview in the Director of Nursing's (DON) office on 1/20/15 at 11:55 AM, the DON was asked when did she expect her nursing staff to complete skin assessments on the residents. The DON stated, "They [nurses] are supposed to be doing skin assessments on their patients weekly." The DON was asked if the nursing staff had been following the facility's policy on skin assessments for Resident #222. The DON stated, "It fell through the cracks. Upon our investigation, we did not find the skin assessments documented [prior to 1/14/15]."</p> <p>During an interview outside Resident #222's room on 1/22/15 at 9:02 AM, Nurse #11 was asked when Resident #222's SDTI was identified. Nurse #11 stated, "The CNA and the resident's wife brought it to my attention on 1/14/15."</p> <p>During an interview in the activity room on</p>	F 314			

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F 314	<p>Continued From page 87</p> <p>1/22/15 at 1:30 PM, the Administrator was asked what she expected for follow up on issues such as failure to perform skin assessments. The Administrator stated, "Nursing administration should be on it. I expect weekly skin assessments."</p> <p>During an interview in the activity room on 1/29/15 at 10:35 AM, Resident #222's family member stated, "They [the staff] tell me they don't have time to turn him...[The staff] have too many patients. I try to look all over him cause if I don't report it nobody will."</p> <p>The failure of the nurses to complete weekly skin assessments on a resident, who was a high risk for developing pressure ulcers, and the failure to identify a right heel pressure ulcer before it became a suspected deep tissue injury, resulted in actual harm for Resident #222.</p> <p>5. Medical record review for Resident #81 documented an admission date of 7/1/09 with a readmission date of 12/22/14 with diagnoses of Alzheimer's Disease, Diabetes Mellitus, Stage 3 Pressure Ulcer, Hypertension, Hyperlipidemia and Seizures.</p> <p>Review of the interim care plan dated 12/23/14 documented, "...Alteration in skin integrity... Potential [checked]... skin assessment weekly [checked]..." Resident #81 did have an actual Stage 3 pressure ulcer on 12/22/14 when the resident was admitted.</p> <p>Review of a "PRESSURE ULCER RECORD" dated 12/23/14 documented, "...Sacrum ...Stage III ...Length 4.0 [cm] x Width 4.0 [cm] x Depth 2.0 [cm] ..."</p>	F 314			

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F 314	<p>Continued From page 88</p> <p>Review of the care plan dated 1/3/15 documented, "...Resident has Pressure Ulcer... Sacrum wound... Area behind R [right] ear... Treatments as ordered... Provide pressure relieving or reduction mattress... Complete Weekly Skin Check..."</p> <p>Review of a "PRESSURE ULCER RECORD" dated 1/3/14 documented, "...Rt [right] ear... Stage II... Length 1.0 [cm] x 1.0 [cm] x Depth < 0.1 [cm]..."</p> <p>Review of Resident #81's treatment records revealed the following: a. December 2014 - "...Cleanse Sacral wound with wound cleanser, pat dry. Apply skin prep to peri wound. Apply calcium alginate to wound bed, cover with hydrocolloid, change every 2 days... Sacral Wound... O [order onset]:12/23/14..." This treatment was not documented as being done on 12/23, 12/25 or 12/29/14.</p> <p>December 2014 - "...SANTYL OINTMENT COLLAGENASE CLOSTRIDIUM... APPLY TO WOUND DAILY... Sacral Wound... O: 12/30/14..." This treatment was not documented as being done on 12/30 or 12/31/14.</p> <p>b. January 2015 - "...SANTYL OINTMENT COLLAGENASE CLOSTRIDIUM... Irrigate wound to Sacrum with daskin's [Dakin's] solution, pat dry. Skin prep to periwound. Apply Santyl to wound bed. Pack lightly with gauze. Cover with foam dressing. Change daily/PRN... O: 1/13/15..." This treatment was not documented as being done on 1/13, 1/14, 1/15, 1/16, 1/19, 1/20, 1/21, 1/22, 1/26, 1/27, 1/28, 129, 1/30 or 1/31/15.</p> <p>January 1/15 to 1/31/15 - documented</p>	F 314			

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F 314	<p>Continued From page 89</p> <p>"...SANTYL OINTMENT COLLAGENASE CLOSTRIDIUM... APPLY TO WOUND DAILY... O: 12/30/14..." This treatment was not documented as being done on 1/2, 1/5, 1/6, 1/7, 1/8, 1/9, 1/12, 1/13, 1/14, 1/15, 1/16, 1/20, 1/21, 1/22, 1/23, 1/26, 1/27, 1/28, 1/29, 1/30 or 1/31/15.</p> <p>Review of a physician's order dated 1/3/15 for Resident #81 documented, "...Cleanse ulcer noted to R [right] ear [sign for with] wound cleanser pat dry, apply alginate, cover [sign for with] cover dressing daily..." Review of the treatment record for January 2015 revealed these treatments were not done on 1/3, 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, 1/12 or 1/13/15.</p> <p>The facility was unable to provide documentation of weekly skin assessments or of treatments being done as ordered.</p> <p>Observations in Resident #81's room on 1/29/15 at 1:15 PM, revealed Resident #81 in bed receiving oxygen per nasal cannula. The nasal cannula tubing was over both ears. Resident #81's right ear had a rubber strip on the tubing; the left ear did not have a rubber strip on the tubing or any gauze padding on the ear.</p> <p>During an interview on the 5th floor on 1/26/15 at 4:15 PM, Nurse #4 was asked if he could print the weekly skin assessments for Resident #81. Nurse #4 stated, "I am not familiar with that. You mean that thing with the picture [picture of a person's body for marking skin impairments]." The surveyor told Nurse #4, "Yes, that was what was needed." After looking in the computer, Nurse #4 stated, "No, not there."</p> <p>During an interview in the activity room on</p>	F 314			

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F 314	<p>Continued From page 90</p> <p>1/27/15 at 9:30 AM, Nurse #11 stated, "She [Resident #81] wears oxygen. The tubing caused the open area on her ear. It is scabbed over now she has protectors in place now but there was nothing in place prior to noticing the wound."</p> <p>During an interview in the ADON's office on 1/27/15 at 2:00 PM, Nurse #2 was asked if there would be a written order for every treatment change for pressure ulcers for Resident #81. Nurse #2 stated, "The new orders should be on a telephone order and on the chart. If it's not on the chart then it is not. The Pos [Physician's Order Sheet] for December should be in the chart if it's not it's not."</p> <p>During an interview in Resident #81's room on 1/28/15 at 8:50 AM, Nurse #11 was asked if Resident #81 had any preventative pressure relief measures in place for the left ear. Nurse #11 stated, "Yes she does, and there it is laying on the bed [referring to a piece of soft rubber that should have been between the skin and tubing]."</p> <p>During an interview in the activity room on 1/28/15 at 4:20 PM, Nurse #11 was asked to provide the treatment orders for 12/23/14 and 12/30/14. After looking through the medical record, Nurse #11 stated, "I don't see it, doesn't make sense."</p> <p>During an interview in Resident #81's room on 1/29/15 at 1:15 PM, CNA #1 confirmed there was no gauze padding or rubber cushion on the tubing over Resident #81's left ear.</p> <p>The failure of the facility to ensure preventative measures were in place prior to developing a pressure ulcer that was a Stage 2 when found,</p>	F 314			

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F 314	<p>Continued From page 91</p> <p>failure to ensure treatments and assessments were done as ordered and preventative measures not implemented and maintained for Resident #81's left ear resulted in actual harm for Resident #81.</p> <p>6. Medical record review for Resident #62 documented an admission date of 8/28/13 and a readmission date of 12/9/14 and 3/4/14 with diagnoses of Chronic Respiratory Failure, Anemia, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), HTN, Cerebrovascular accident (CVA), Seizures and Reflux Disease.</p> <p>Review of the interim care plan dated 3/4/14 documented, "...Alteration in skin integrity... Actual [marked]... Skin assessment weekly..."</p> <p>Review of a nurses' note dated 3/5/14 documented, " ...Pt [patient] is high risk for skin breakdown Braden score 10 ...Stage II R [right] trochanter 3. [0] [centimeters [cm] x 2. [0] [cm]. Scattered scab D [dry] / I [intact] on L [left] lateral knee 2.5 [cm] x 1.3 [cm]. R Anterior knee 1.0 [cm] x 1.5 [cm] . L Anterior knee 0.8 [cm] x 0.8 [cm] L foot proximal lateral 0.7 [cm] x 0.7 [cm] L foot Distal lateral 1.5 [cm] x 3.0 [cm] & 5th digit L foot dorsal & lateral 2.5 [cm x 2 [cm ...]</p> <p>Review of the care plan dated 3/11/14 documented, "...Resident has impaired skin integrity r/t [related to] wounds... Report changes in skin status (...s/s [signs and symptoms] infection, non healing, new areas) to physician... Weekly skin checks..."</p> <p>Review of a weekly skin integrity review form for Resident #62 revealed the form was not dated</p>	F 314		
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F 314	<p>Continued From page 92 and there was no assessments documented.</p> <p>Review of a physician order dated 3/21/14 documented, "...Clean R [right] elbow c [with] NS [normal saline] Pat Dry. Apply skin prep Stg [stage] II PU [pressure ulcer] to peri wound. Cover c hydrocolloid [change] Q [every] 3 Days PRN..."</p> <p>The facility was unable to provide documentation of weekly skin assessments or treatment records for March 2014.</p> <p>During an interview in the activity room on 2/9/15 at 4:33 PM, Nurse #3 was asked for the March 2014 treatment records and weekly skin assessments. Nurse #3 stated, "No ma'am I don't see it. No they are not in here."</p> <p>Review of a physician order dated 4/2/14 documented, "...Clean R elbow c NS Pat Dry, Apply skin prep to periwound. Cover c hydrocolloid [sign for change] Q 3 days /PRN Clean hip c NS. Pat Dry Apply skin prep to periwound Cover c hydrocolloid [sign for change] Q 3 days/PRN..."</p> <p>Review of the treatment record dated April 1 through April 30, 2014 documented the following: a. "...Clean R Elbow c N.S Pat Dry. Apply Skin prep to periwound. Cover c hydrocolloid [change] Q 3 Days/PRN..." Review of the treatment record for the right elbow documented treatments were not done on 4/2, 4/6, 4/8, 4/12, 4/13, 4/15, 4/18, 4/21, 4/24 and 4/26/14. The treatments were not provided as ordered. b. "...Clean hip c NS, Pat Dry Apply skin prep to periwound Cover c hydrocolloid [change] Q 3 Day/PRN..." Review of the treatment record for</p>	F 314			

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F 314	<p>Continued From page 93</p> <p>the hip wound documented the treatments were not done on 4/2, 4/6, 4/8, 4/12, 4/15, 4/18, 4/21, 4/24 and 4/26/14. The treatments were not provided as ordered by the doctor. There was no date of origin of the wound.</p> <p>Review of the treatment record dated 6/1/14 through 6/30/14 documented, "...Clean R elbow c NS Apply skin prep to periwound. Cover c hydrocolloid [change] Q3 D [days] /PRN O [order date] 5/23/14..." Review of the treatment record documented treatment was not done on 6/1/14, 6/2/14, 6/5/14, 6/8/14, 6/11/14, 6/14, 6/17/14, 6/20 and 6/28/14.</p> <p>Review of a "PRESSURE ULCER RECORD" for Resident #62 documented the following:</p> <p>a. Left lateral distal foot dated 6/2/14 did not document the date of origin for the wound, a description of the wound for drainage, surrounding skin, response to treatment or physician and/or responsible party notification. The weekly note was incomplete.</p> <p>b. Right hip dated 6/2/14 was incomplete. There was no stage of the wound marked and no date of origin for the wound.</p> <p>c. Left lateral mid foot dated 7/2/14 and 7/8/14 were incomplete.</p> <p>Review of a "PRESSURE ULCER RECORD" dated 6/2/14 documented, "...Lt [left] Mid Foot -lateral ...unstageable [marked] ...length 1.5 [cm.] x Width 2.0 [cm] Depth UTD [unable to determine]..."</p> <p>Review of a "PRESSURE ULCER RECORD" dated 6/2/14 documented, "...R hip Length 0.4 [cm] x Width 0.5 [cm] Depth < [less than] 0.1 [cm]..."</p>	F 314			

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F 314	Continued From page 94 Review of a "PRESSURE ULCER RECORD" dated 6/2/14 documented, "...Lt [left] Distal Foot-lateral ...Length 1.0[cm] x Width 1.4 [cm] x Depth UTD [cm]..." Review of a weekly skin integrity review dated 6/6/14 revealed the review was left blank. The skin assessment was incomplete. Review of a weekly skin integrity review dated 8/26/14 documented, "...[checked] Skin Intact... [checked] Open Area... The assessment was inaccurate. Resident #62 had an unstageable wound on his left elbow. Review of a pressure ulcer record dated 12/23/14 of Resident #62's right lateral foot documented a suspected deep tissue injury and notification of dietary, physician and family on 12/1/14. Resident #62 was transferred to the hospital on 11/25/14 and was readmitted on 12/9/14. During an interview on the 4th floor on 2/6/15 at 12:00 PM, Nurse #11 confirmed Resident #62 currently had a wound and stated, "Now he [Resident #62] has a stage 3 on his left elbow... only the stage 3 is open now... around July or August [2014] he had wounds on his bilateral elbows stage 3 or unstageable I believe. His left foot was a DTI [deep tissue injury]. It healed one time and reoccurred. I believe his left ischial was a stage 2 it's resolved but it was acquired here. He is so bony and contracted. The one on his left foot is a scab but if I take the dressing off it will come off with it." Nurse #11 was asked how she staged a scab or if she would stage a scab. Nurse #11 stated, "That would be an eschar, but in his case he is stable. I've skin prepped it	F 314			

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F 314	<p>Continued From page 95</p> <p>already. I don't believe it is going to change. It is what it is for him. The foam dressing and Prevalon boots is best for him, because I would write that up as resolved."</p> <p>7. Medical record review for Resident #252 documented an admission date of 8/28/14 with diagnoses of Deep Vein Thrombosis of the Left Lower Extremity, Atrial Fibrillation, Chronic Renal Insufficiency, Hypertension, Peripheral Neuropathy, Type 2 Diabetes Mellitus, Anemia and Mixed Hyperlipidemia.</p> <p>Review of pressure ulcer records documented the following:</p> <p>a. 10/3/14 - resident had developed a Stage 2 pressure ulcer on the coccyx. Review of a " PRESSURE ULCER RECORD" dated 10/3/14 documented, "...Coccyx...Stage II...Length 3.5 [cm] x Width 3.0 [cm] x Depth 0..."</p> <p>b. 10/7/14 - resident had developed a suspected deep tissue injury to the left heel. Review of a " PRESSURE ULCER RECORD " dated 10/7/14 documented, "...L [left] heel..."Stage...SDTI [suspected deep tissue injury] Length 2.0 [cm] x Width 3.8 [cm] x Depth 0..."</p> <p>Review of the electronic medication and treatment record (EZMAR) dated beginning 8/28/14 through discharge on 11/5/14 documented the treatment was to be completed by the nurse. However, the space provided on the EZMAR for documentation of the weekly skin checks and skin monitoring was left blank.</p> <p>During an interview in the activity room on 2/3/14 at 4:20 PM, Nurse #6 was asked where nursing documented the weekly skin assessments. Nurse</p>	F 314		
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F 314	<p>Continued From page 96</p> <p>#6 looked in the EZ MAR and stated, "Clicking on it [treatment procedure] say you saw and acknowledged the order. If they don't have any skin issues, they [nurse] will have to go in and open the body man [picture of the body nurses are to document findings of any skin impairments] to write a note. When a resident is admitted, the skin assessment has to be checked just like pain, it's non-negotiable, a standard of practice. If they do not click on the skin note, for the body to pop up and become a part of the record, you do not have the body to validate the assessment was done..."</p> <p>8. Medical record review for Resident #394 documented an admission date of 11/28/14 with diagnoses of COPD, Hypertension, DVT, HTN, Degenerative Joint Disease, Tracheostomy, Osteoarthritis, Morbid Obesity and Respiratory Failure.</p> <p>Review of the interim care plan dated 11/29/14 documented, "...[checked] Alteration in skin integrity [actual]... Skin assessment weekly..."</p> <p>The facility was unable to provide documentation of weekly skin assessments for the month of December 2014.</p> <p>9. Medical record review for Resident #410 documented an admission date of 12/3/14 with diagnosis of Hypertension, Pain in Limb, Right Hip Fracture, Personal History of Fall, Hypothyroidism, Atrial Fibrillation and a history of Chronic Coumadin therapy. The diagnosis of DVT of the right arm was added on 12/6/14.</p> <p>Review of the pressure ulcer record dated 12/19/14 documented the following:</p>	F 314			

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F 314	Continued From page 97 a. Center Back #1 (spine) stage II, L 1.3 cm x w 1.3 cm x D 0 cm. The wound was healed on 1/14/15. b. Center Back #2 (spine) Stage II, measurements as L 1.0 cm x w 1.0 cm x no depth. As of 1/16/15 Center Back #2 wound measurements were L 0.5 cm x W 0.4 cm x 0 depth. Review of the care plan dated 12/19/14 documented, "...[Named Resident #410] is at risk for developing skin breakdown related to episodes of incontinence, decreased mobility... Approach... Complete Weekly Skin Check..." The facility was unable to provide documentation of weekly skin assessments for Resident #410 for December 2014 and January 2015. During an interview at the 2nd floor nurses' station on 1/21/15 3:00 PM, Nurse #13 was asked if weekly skin assessments had been completed for Resident #410. Nurse #13 stated, "We do it in the computer now. There are none [skin assessments] in the computer. The surveyor clarified by asking, "There have not been any skin assessments done?" Nurse #13 stated, "No Ma'am."	F 314			
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate	F 315		5/28/2015	

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F 315	<p>Continued From page 98</p> <p>treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review observation and interview, it was determined the facility failed to have physician's orders and documented justification for indwelling urinary catheters and/or provide foley catheter care for 3 of 3 (Resident #222, 252 and 294) residents reviewed for catheters of the 53 residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's catheter care policy documented, "...Foley catheter care will be done as per physician's orders... Chart procedure and any pertinent information..." 2. Medical record review for Resident #222 documented an admission date of 6/26/13 and a readmission date of 12/22/14 with diagnoses of History of Seizure Disorder, History of Chronic Respiratory Failure on Mechanical Ventilation via Tracheostomy, History of Pneumonia, Cardiac Dysrhythmias, Traumatic Brain Injury, Hypertension, Diabetes and Vegetative State. <p>Review of the quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/29/14 documented staff assessment for mental status was a score of 3, indicating the resident was severely cognitively impaired and was dependent on staff for activities of daily living (ADL) care and had an indwelling urinary</p>	F 315	<ol style="list-style-type: none"> 1. Resident #'s 252 and #294 were discharged. Resident #222 has a physician order for use of a catheter that includes justification and frequency of catheter care of which is care planned. Resident is receiving catheter care as ordered. 2. A baseline audit of residents with indwelling catheters was completed to validate there is a physician's order for use of the catheter that includes justification and frequency of catheter care of which is care planned. Any newly identified issues were corrected. 3. A log will be maintained to identify all existing and new Foley catheters to ensure appropriate justification for catheter with orders for care are in place and care planned by the DON / Designee. Education was completed by the Staff Development Department on 3/31/15 for all licensed nurses regarding completion of physician orders for catheters to include catheter care and justification for the use of the catheter. New admissions will be reviewed during the next clinical morning meeting to ensure any residents admitted with a catheter have a physician's order for use of the catheter that includes justification and frequency of catheter care of which is care planned by the DON / Designee. 		

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F 315	<p>Continued From page 99 catheter.</p> <p>Review of the comprehensive care plan dated 9/9/14 documented, "...Problem... Resident has potential risk for complications related to altered elimination device for bladder elimination. Resident has an indwelling foley catheter... Approach... Provide catheter care per policy..."</p> <p>Observations in Resident #222's room on 1/29/15 at 10:21 AM, 1/30/15 8:05 AM, 2/2/15 10:20 AM and 2/4/15 at 5:35 PM, revealed Resident #222 had an indwelling urinary catheter.</p> <p>During an interview at the 4th floor nurses' station on 2/3/15 at 3:35 PM, Nurse #1 was asked to access the December 2014 and January 2015 MAR for Resident #222's catheter care. Nurse #1 stated, "It [catheter care] is not there." Nurse #1 was asked if the MAR was blank did that mean the catheter care was not done. Nurse #1 stated, "I would think so. Nurse #1 was looking at the January 2015 MAR and stated, "I don't know why it is blank until the end. I'll tell you why because it was not picked up for the orders until 1/30/15." Nurse #1 stated, "It looks like it was not entered until 1/30/15 and that means someone picked up the template for catheter. It must not have been done when the nurse entered the admission orders. Someone picked up the template later."</p> <p>3. Closed medical record review for Resident #252 documented an admission date of 8/28/14 with diagnoses of Atrial Fibrillation, Deep Vein Thrombosis (DVT) of the Left Lower Extremity, Anemia, Type 2 Diabetes Mellitus, Chronic Renal Insufficiency, Hypertension, Peripheral Neuropathy and Mixed Hyperlipidemia.</p>	F 315	<p>4. If audits demonstrate substantial compliance and QAPI committee approves, the frequency will be reduced periodically, over time, as indicated.</p> <p>Foley catheter log will be reviewed weekly by the DON times 12 weeks then monthly thereafter.</p> <p>Trends will be reported to the QAPI committee by the ADON / Designee for review and further recommendation of continued auditing.</p> <p>If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of audit.</p>	

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F 315	<p>Continued From page 100</p> <p>Review of the comprehensive MDS assessment with an ARD of 9/4/14 documented a cognitive summary score of 15 out of a possible 15, indicating the resident was cognitively intact, required extensive physical assistance of one person for toilet use, and was frequently incontinent of urine.</p> <p>Review of the comprehensive care plan dated 9/10/14 documented, "Resident has a potential for complications associated with incontinence of bowel and/or bladder... Assist to b/r [bathroom] as needed... 10/6/14 Foley cath [catheter] Add for wound care... catheter care q [every] shift..."</p> <p>Review of a NP's telephone order dated 10/6/14 documented, "...Foley cath placement..."</p> <p>Review of a pressure ulcer record dated 10/10/14 related to the stage II pressure ulcer identified on the resident's coccyx on 10/3/14 documented, "...STAGE II... Area increased in size. Resident is a heavy wetter. Foley cath [catheter] in place R/T [related to] wound..." Review of the pressure ulcer record dated 10/17/14, 10/21/14 and 10/28/14 documented the wound remained a stage II.</p> <p>The facility was unable to provide adequate justification for placement of an indwelling catheter or documentation Resident #252 was provided with catheter care from the time of placement on 10/7/14 until the resident was discharged home on 11/5/14.</p> <p>During an interview at the 3rd floor nurses' station on 2/9/14 at 4:00 PM, Nurse #6 confirmed the catheter care was not documented on the resident's electronic medication and treatment record (EZMAR). The nurse was asked if a stage</p>	F 315		

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F 315	<p>Continued From page 101</p> <p>Il wound was appropriate justification for placement of an indwelling catheter. Nurse #6 stated, "If getting worse."</p> <p>4. Closed medical record review for Resident #294 documented an admission date of 9/9/14 with diagnoses of Acute and Chronic Respiratory Failure, Ventilator Dependence via Tracheostomy, Percutaneous Endoscopy Gastrostomy Tube, History of Drug and Alcohol Abuse, Pulmonary Embolus, Acute and Chronic Renal Failure, Anemia and CVA - Main Brainstem Infarction.</p> <p>Review of the nursing admission dated 9/9/14 documented, "...Foley Y [yes]..."</p> <p>Review of the physician's orders dated 9/9/14 revealed the orders had no justification for the resident's catheter. There were no physician or NP orders for insertion, maintenance or care of the catheter.</p> <p>Review of the comprehensive admission MDS assessment with an ARD of 9/16/14 documented the resident was in a persistent vegetative state with no discernible consciousness, dependent on staff for ADL performance, and had an indwelling foley catheter.</p> <p>Review of the nurses' notes and MARs for September, October, November and December 2014 documented a foley catheter change on 9/30/14 and 12/31/14. There were no physician or NP orders documented for the catheter change. The facility was unable to provide documentation of catheter care for September, October, November or December 2014.</p>	F 315		
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F 315	Continued From page 102 5. During an interview at the 3rd floor nurses' station on 2/4/15 at 12:10 PM, Nurse #6 was asked about the facility's protocol for catheter care and where the nurse would document the care provided. Nurse #6 stated, "First, if the resident has a foley catheter, it goes in the EZMAR by selecting the template for the foley. Catheter care is done every shift and as needed. Change the bag as needed. We will change it [catheter] every 30 days. You [nurses] know the patient has the foley, you have the order template, it has to be addressed. If not addressed, you risk missing it, not providing the care."	F 315			
F 317 SS=G	483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to provide range of motion (ROM) exercises for 1 of 3 (Resident #294) residents reviewed for ROM of the 53 residents included in the stage 2 review. The facility failed to provide ROM which resulted in actual harm when Resident #294 developed limitations in functional ROM of the upper extremities.	F 317	1: Resident #294 is discharged 2: On 2/13/15, an audit was performed on all residents that were referred from therapy to restorative in January 2015 by the RSM to determine if a restorative program was established with record of restorative training dates. Audit results indicate 100% of residents referred to restorative program in January had established plans and training dates. Currently all residents referred to restorative programming from therapy are currently receiving services.	5/28/2015	

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The findings included:

Closed medical record review for Resident #294 documented an admission date of 9/9/14 with diagnoses of Acute and Chronic Respiratory Failure, Ventilator Dependence via Tracheostomy, Percutaneous Endoscopy Gastrostomy Tube, History of Drug and Alcohol Abuse, Pulmonary Embolus, Acute and Chronic Renal Failure, Anemia and Cerebrovascular Accident - Main Brainstem Infarction.

Review of the comprehensive admission Minimum Data Set (MDS) dated 9/16/14 documented the resident was in a persistent vegetative state with no discernible consciousness requiring extensive assistance with activities of daily living (ADLs), and had no impairment of the upper extremity (UE) in functional limitation of ROM. Review of the quarterly MDS dated 12/7/14 documented the resident was no longer in a persistent vegetative state, continued to require extensive assistance with ADLs, and had impairment on both sides of the UE in functional ROM.

Review of a rehab therapy "Discharge Communication Form" dated 10/21/14 documented, "...Discharge Plan D/C [discharge] to facility w [with] / Restorative... Discharge Date 10/30/14... Restorative Nursing Program for ROM... Active Assistive Range of Motion [AAROM] Passive Range of Motion [PROM]... PROGRAM GOALS: Maintain normal ROM, Maintain muscle strength, Prevent deformity..." The "Restorative Nursing Program" for ROM dated 10/21/14 documented PROM the resident's shoulders and AAROM for the resident's elbows and hands.

F 317

3:
In-service all full time therapy staff by 3/31/15 on the protocol outlined below for discharging any resident from therapy by Rehab Service Manager (RSM)
All residents (except those discharged to hospital, AMA, unplanned, or expired) being discharged from therapy services will have an established restorative, Home Exercise program, or functional maintenance program established prior to the last day of therapy services.
Appropriate program will be determined by the evaluating therapist. Form used will be the Discharge Communication Form.
Residents being discharged to restorative nursing will have training completed prior to discharge with signatures and dates of person's trained on resident specific programs done by RSM.

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F 317	<p>Continued From page 104</p> <p>Review of a physician's order dated 11/3/14 documented, "D/C [discontinue] PT [physical therapy] services [after] tx [treatment] this date (eff. [effective] 10/28/14) [secondary] max [maximum] benefit. Restorative program for ROM of UE/LE [lower extremity] & [and] positioning 5d [days] / [per] wk [week] x [for] 6 wks..."</p> <p>Review of the restorative service delivery record for November 2014, December 2014 and January 2015 revealed no exercises were documented as being performed with Resident #294 for the upper extremities.</p> <p>Review of a Nurse Practitioner's (NP) order dated 12/11/14 documented, "PT to eval [evaluate] / [and] tx [treat] as indicated - pt [patient] more responsive..."</p> <p>Review of an "OT [Occupational therapy] Evaluation & Plan of Treatment" dated 12/18/14 documented, "...ROM... Right Shoulder = Impaired... Pt's digits [fingers of both hands] remain in a flexed potion [contracted]... Left Shoulder = Impaired... Left Elbow/ Forearm = Impaired... Left Wrist Impaired..."</p> <p>During an interview at the 4th floor nurses' station on 1/29/15 at 11:10 AM, Certified Nursing Assistant (CNA) #10, Resident #294's direct care CNA, was asked if she had performed ROM exercises with Resident #294. CNA #10 stated, "When bathing I would raise her arms to wash. Restorative was going in there and straightening her arms out, [arms] were beginning to draw up toward her chest."</p> <p>During an interview in the activity room on</p>	F 317	<p>Residents being discharged to restorative will be seen by an evaluating therapist on the date of discharge and order will be written for restorative care.</p> <p>Restorative aids to receive annual competency training on Signature P&P established restorative programs by 3/26/15 by RSM.</p> <p>Once orders for restorative care are obtained by therapy, restorative nursing will ensure programs are followed according to physicians order and care plan.</p> <p>Certified Nursing Assistants will be in-serviced by 3/31/15 on how to perform range of motion by Staff Development department.</p> <p>4:</p> <p>Results of the restorative audits will be reported by the ADON/designee to the Quality Assurance Committee for review.</p> <p>If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of audit.</p>	

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F 317	Continued From page 105 1/30/15 at 9:15 AM, the Therapy Director was asked about ROM exercises for Resident #294's upper body, The Therapy Director stated, "We extended her a week past the original discharge date from occupational therapy and did not do an updated restorative plan. We just flat out missed it." During an interview in the 4th floor employee breakroom on 2/3/15 at 10:10 AM, CNA #9, a Restorative CNA, was asked if she had performed ROM exercises with Resident #294. CNA #9 stated, "She was passive range of motion. It was lower. The program was for lower body exercises." CNA #9 was not performing ROM exercises for the upper body. The facility failed to provide ROM exercises for Resident #294's upper body resulted in actual harm when Resident #294 developed contractures, fixed high resistance to passive stretch of a muscle and limiting functional ROM of the upper extremities.	F 317			
F 329 SS=K	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329	1. Resident #'s 192, 211, 252, 410, 411 and 412 Have been Discharged. Resident #'s 8, 43, 84 and 299 are receiving medications per physicians order. 2 A baseline laboratory audit was completed by nursing on 1/28/15 to validate labs were performed according to physician order and care plan. If results were abnormal, validation of the physician being notified and a telephone order written if change in treatment was required.	5/28/2015	

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F 329	Continued From page 106 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on policy review, review of a posted note, review of "PharMerica 2012" specialized long-term care nursing drug handbook, medical record review and interview, it was determined the facility failed to demonstrate a process that monitored and addressed the potential for adverse consequences related to anticoagulant therapy when the facility failed to ensure physician / nurse practitioner (NP) orders were obtained for anticoagulant medications prior to administering the medications, failed to ensure medication orders were signed and dated, failed to ensure anticoagulant medications were administered as ordered, failed to perform ordered lab monitoring tests, failed to obtain a clarification order for correct doses of anticoagulant medications to be given and failed to notify the physician or Nurse Practitioner (NP) of critical and subtherapeutic lab results for 10 of 16 (Residents #43, 252, 299, 410, 211, 8, 84, 192, 411 and 412) sampled residents of the 53 residents included in the stage 2 review. The facility failed to ensure orders were obtained for	F 329	A baseline audit of resident receiving Coumadin therapy was completed by DON, ADON or designee on 1/27/15 validating the physician/nurse practitioner were notified of any abnormal lab values and telephone order was written if change in treatment was required. A baseline audit will be conducted to validate that medications are administered according to physician order. A baseline audit was conducted by MDSC 2/19/2015 of residents receiving hospice services to validate a physician order is present, a progress note indicating initiation date of hospice services and care plan reflects hospice service and coordination of care. 3. Education and training initiated on 1/28/15 and completed on 1/30/15 with all licensed nursing staff by the Staff Development Coordinator (SDC) or RN Supervisor regarding the procedure of printing monthly physician order statements and obtaining physician signature. Licensed nurses also received education and training on 1/29/15 and completed on 1/30/15 regarding processing of physicians orders related to obtaining, transcribing and obtaining signature by the SDC. Education and training also provided to licensed nurses on 1/29/15 and completed on 1/30/15 regarding medication reconciliation of physician orders and completion of twenty-four chart checks for current residents by SDC. Education and training also provided to licensed nurses regarding writing Physician orders will be written at the time of admission indicating admission to the facility, physician assigned and that physician orders were verified with a physician documented on a physician telephone order by SDC. An audit of the medical record will be completed monthly by Medical Records and/or designee to ensure all monthly physician order statements are printed and signed.		

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F 329	<p>Continued From page 107</p> <p>anticoagulant medications prior to administering the medications, ensure medication orders were signed and dated, ensure anticoagulant medications were administered as ordered, perform ordered lab monitoring tests, obtained a clarification order for correct doses of anticoagulant medications to be given and to notify the physician or NP of critical and subtherapeutic labs which resulted in an immediate jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident.</p> <p>A meeting was conducted in the activity room on 1/27/15 at 3:15 PM with the Administrator and she was informed of the IJ.</p> <p>The survey team received an acceptable Allegation of Compliance (AOC) from the Administrator on 1/30/15 at 12:05 PM. The AOC was validated by team members on 2/2/15 through 2/6/15 which removed the immediacy of the jeopardy as of 1/30/15.</p> <p>The AOC documented the following: It is the policy of this facility to ensure all resident's lab results are obtained only when ordered by the physician and abnormal results are reported to the physician/NP timely. It is also the policy of this facility to ensure that all physician orders are signed and dated. As well as orders for medications and treatments will be consistent with principles of safe and effective order writing.</p> <p>Validation of the Credible Allegation of Compliance was accomplished on site 2/2/15 through 2/6/15 through record review, review of</p>	F 329	<p>4. An audit of the medical record will be completed daily by DON/ ADON and/or RN Supervisor to ensure physician orders are obtained and transcribed correctly as well as signed.</p> <p>An audit of the medical record will be completed daily by DON/ADON and/or RN Supervisor to ensure that twenty-four hour chart checks are completed on all current residents and medication reconciliation was completed on all newly admitted residents. Results of the audits will be reported to QAPI by the ADON / Designee.</p> <p>If audits demonstrate substantial compliance and QAPI committee approves, the frequency will be reduced periodically, over time, as indicated. If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of the Medical record audit.</p>		

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F 329	<p>Continued From page 108</p> <p>facility documents, observation and interviews with nursing, administration and corporate staff.</p> <p>The facility provided evidence of in-service training with sign in sheets for all licensed nursing staff dated 1/28/15 through 1/30/15 related to 24 hour chart checks, physician orders, admission orders, telephone orders, physician order sheets, reconciliation of medications with physician orders, lab ordering and tracking and reporting abnormal labs.</p> <p>The facility provided evidence of auditing tools utilized for 24 hour chart checks, physician orders, admission orders, telephone orders, physician order sheets, reconciliation of medications with physician orders, lab ordering and tracking and reporting abnormal labs.</p> <p>Medical record review on 2/5/15 documented 9 of 9 new admission charts admitted on or after 1/30/15 included the admission to the facility order, reconciliation of admission medication and treatment orders, physician order sheets (POS), labs, admission nurses notes documenting verification of orders to ensure the process of chart checks was being done and any follow up was occurring.</p> <p>The licensed staff currently on leave of absence, vacation or per diem was sent a certified letter on 1/30/15 informing staff of the in-service and training and that the training must be completed prior to returning for their next scheduled shift.</p> <p>Observations were conducted on 2/2/15 of licensed staff's shift change reporting methods to validate pertinent resident information including anticoagulant medications and resulted and/or</p>	F 329			

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F 329	<p>Continued From page 109</p> <p>pending lab testing was reported to the oncoming shift with utilization of the lab tracking tool.</p> <p>Interviews with facility licensed nursing staff were conducted on 2/4/15 through 2/5/15 with staff from all floors and all shifts validating 24 hour chart checks, physician orders, lab ordering and tracking, reconciliation of medications with physician orders and clinical pathway for lab reporting and monitoring.</p> <p>The facility provided documentation of a complete laboratory audit completed on 1/28/15 on all active residents to ensure labs were performed according to physician orders as indicated on the care plan and the physician being notified when abnormal results are obtained and documented on a telephone order if change and treatment is required. The audits were reviewed and current to date and are ongoing.</p> <p>Interviews with the Administrator and Corporate Staff (Health Information Management) on 2/4/15 revealed the facility would continue monitoring by a Quality Assurance (QA) meeting to be held weekly for four weeks beginning 2/5/15 and then monthly for findings, recommendations and follow up regarding the plan. The frequency of the audits to be maintained will be decided by the QA committee based on the findings of the audits.</p> <p>The survey team validated the AOC on 2/2/15 through 2/6/14. The IJ was removed as of 1/30/15.</p> <p>The IJ for F329-K constitutes substandard quality of care.</p> <p>An extended survey was conducted on 2/4/15</p>	F 329			

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F 329	Continued From page 110 through 2/11/15. Non-compliance of the IJ continues at a scope and severity of an "E" level for F329 for monitoring of corrective actions. The facility is required to submit a plan of correction for all tags. The findings included: 1. Review of the facility's "Anticoagulation - Clinical Protocol" policy documented, "...As part of the initial assessment, the physician will help identify individuals who are currently anticoagulated... Assess for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to that particular drug (for example, a resident with an above therapeutic level of an anticoagulation medication should be assessed for bleeding)... In addition, the nurse shall assess and document/report the following: a. Current anticoagulation therapy, including drug and current dosage; b. Recent labs, including therapeutic dose monitoring; c. Other current medications; and d. All active diagnoses... The staff and physician will identify situations where an individual is not anticoagulated but where anticoagulation may be indicated... The physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications; for example... periodically checking... PT [Prothrombin Time - a blood test that measures how long it takes blood to clot] / INR [International Normalized Ratio]... The staff should use a warfarin [Coumadin] sheet or comparable monitoring tool to follow trends in anticoagulant dosage response... The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems... If an individual on	F 329			

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F 329	<p>Continued From page 111</p> <p>anticoagulation therapy shows signs of excessive bruising... or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant..."</p> <p>Review of the facility's "Clinical Pathway for Laboratory Reporting" policy documented, "...The facility is expected to follow notification from AMDA [American Medical Directors Association]. In addition, the clinicians practicing in this facility would appreciate it if these guidelines were followed for notification... INR greater than 3.0 or less than 2.0..."</p> <p>2. Review of a note posted at the 5th floor nurses' station (not dated) documented, "...ATTENTION 11- [to] 7 [staff] PLEASE MAKE SURE THAT ALL LAB REQUISITIONS ARE COMPLETED AND SENT OVER TO LAB NO LATER THAN 2:30 AM..."</p> <p>3. Review of "PharMerica 2012" specialized long-term care nursing drug handbook documented, "...Heparin... For SubQ [subcutaneous] injections, when used for treatment... a PTT [Partial Thromboplastin time] is measured 6 hours after injection..."</p> <p>4. Medical record review for Resident #43 documented an admission date of 9/23/14 with diagnoses of Heart Failure, Hypertension, Urinary Tract Infection, Diabetes Mellitus, Coronary Artery Disease, Congestive Heart Failure, Cardiac Arrhythmia, Atrial Fibrillation, Diabetes Mellitus, Pulmonary Disease, Anxiety and Depression.</p> <p>Review of a signed physician order dated 9/23/14 documented, "...COUMADIN 10 MG [milligram]..."</p>	F 329		
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F 329	<p>Continued From page 112</p> <p>DAILY... INR in 3 days..." There was no PT/INR done as ordered on 9/26/14.</p> <p>Review of a lab report dated 9/24/14 documented, "...PT 18.2 sec. [seconds] Ref [reference] range 11.7-14.9... INR 1.59 Ref Range 0.00-1.13..." There was no order for the PT/INR to be done on 9/24/14.</p> <p>Review of a physician order dated 9/24/14 documented, "...PT/INR in AM..." There was no PT/INR done on 9/25/14 as ordered.</p> <p>Review of a physician order dated 10/6/14 documented, "...Contact [named Doctor] to get Coumadin dose... Increase Coumadin to 11 mg [milligrams]... PT/INR in AM. Review of a lab report dated 10/7/14 documented, "...PT 15.0... INR... 1.23..." There was no documentation provided of the physician or NP being notified of the elevated lab results.</p> <p>Review of a physician's order dated 10/23/14 documented, "...PT/INR... 10/27/14..." Review of the lab result dated 10/27/14 documented, "PT 21.3... INR... 1.96..." There was no documentation provided of the physician or NP being notified of the elevated lab results.</p> <p>Review of a telephone order for Resident #43 dated 11/18/14 documented, "INR q [every] week (next due 11/25/14)."</p> <p>Review of a physician order dated 11/26/14 documented, "...Hold Coumadin today INR in AM & [and] call results to [Named Nurse Practitioner]..." Review of a lab report dated 11/27/14 documented, "...PT 19.6... INR 1.75..." There was no documentation the NP was notified</p>	F 329		
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F 329	<p>Continued From page 113 of the elevated lab results as ordered.</p> <p>The facility was unable to provide documentation the weekly PT/ INR was done on 12/16/14, 12/23/14 or 12/30/14 as ordered on 11/1/14.</p> <p>Review of a physician order dated 1/1/15 documented, "...Transfer resident to [Named Hospital] ER [emergency room] d/t [due to] nosebleed out of control..."</p> <p>Review of a hospital lab report dated 1/1/15 documented, "PT 27.7... INR... 2.77..."</p> <p>Review of a telephone order dated 1/1/15 documented, "...Hold Coumadin until seen by ENT [Ear Nose Throat Specialist]..."</p> <p>Review of a physician's order for Resident #43 dated 1/5/15 documented, "...Restart Coumadin after observation and [symbol for no] sign of cont. [continued] bleeding..." There was no clarification order for the dose of Coumadin to be administered. The order was not signed by the physician or NP.</p> <p>During an interview in the Director of Nursing's (DON) office on 1/20/15 at 12:00 PM, the DON was asked if Resident #43's telephone order dated 1/5/15 was complete. The DON stated, "I see where you are going cause [because] it doesn't say the dose of the Coumadin." The DON was asked how she expected her nursing staff to write a medication order. The DON stated, "I would want to make it totally clear to state the dose of the Coumadin."</p> <p>The facility failed to follow orders for monitoring labs and failed to obtain a clarification order for</p>	F 329		

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F 329	<p>Continued From page 114</p> <p>correct dosage of a significant medication (anticoagulant) to be given, which placed Resident #43 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>5. Medical record review for Resident #252 documented an admission date of 8/28/14 with diagnoses of Deep Vein Thrombosis, Chronic Renal Insufficiency, Diabetes Mellitus Type 2, Hypertension, Peripheral Neuropathy, Atrial Fibrillation, Anemia, Hyperlipidemia and Osteoarthritis.</p> <p>There were no signed physician orders for Resident #252's medications from 8/28/14 to September 2014 - exact date illegible. Review of the August 2014 MAR documented Coumadin 5 milligram (mg) was administered on 8/29/14 with no physician order. The following medications were also administered without a signed physician order:</p> <p>a. Amlodipine 5 milligram (mg) tablet daily - medication for HTN.</p> <p>b. Carvedilol 25 mg tablet twice daily - medication for HTN.</p> <p>c. Clonidine 0.3 mg tablet three times daily - medication for HTN.</p> <p>d. Hydralazine 100 mg tablet three times daily - medication for HTN.</p> <p>e. Isosorbide extended release 40 mg tablet twice daily - medication for HTN.</p> <p>f. Simvastatin 40 mg tablet daily - medication for high cholesterol levels.</p> <p>g. Lispro/Humalog mix insulin subcutaneous injection of 20 units twice daily - intermediate acting insulin to control high blood glucose levels.</p> <p>h. Humulin Regular insulin subcutaneous injection - fast acting insulin given according to</p>	F 329			

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F 329	<p>Continued From page 115</p> <p>accucheck results to control high blood glucose levels.</p> <p>i. Docusate Sodium 100 mg twice daily - medication for Constipation</p> <p>j. Gabapentin 300 mg tablet daily - medication for nerve pain</p> <p>k. Lactulose 30 milliliters (ml) three times daily - medication for Constipation</p> <p>l. Sodium Bicarbonate 325 mg tablet three times daily - medication for supplement</p> <p>Review of a NP telephone order for Resident #252 dated 8/29/14 at 10:30 AM documented, "...stat [immediately] PT/INR..." Review of a lab report dated 8/29/14 documented, "...PT 38.3... INR 4.25..." The 4.25 INR was above the therapeutic range of 2 to 3. There is no documentation the NP was notified of the elevated INR until 8/30/14.</p> <p>Review of a NP's telephone order dated 8/30/14 at 1:00 PM documented, "Hold Coumadin x [times] 2 days, recheck PT/INR on Monday 9/1/14..." The facility was unable to provide documentation the PT/INR was done on 9/1/14 as ordered. A lab report dated 9/2/14 documented, "...PT 14.2... INR 1.15..." There was no documentation the subtherapeutic lab results was called to the NP or physician.</p> <p>Review of a NP's telephone order dated 9/3/14 at 2:00 PM, documented, "Coumadin 3 mg 1 tab [tablet] po [by mouth] q HS [hour of sleep or bedtime]. PT/INR 9/8/14 AM..." Resident #252's September 2014 MAR documented the Coumadin 3 mg dose was not started until 9/4/14.</p> <p>Review of a NP's telephone order dated 9/8/14 at 11:30 AM documented, "[symbol for increase]</p>	F 329			

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F 329	<p>Continued From page 116</p> <p>Coumadin to 3.5 mg po q HS. PT/INR in [one] wk..." Review of a lab report dated 9/15/14 documented, "...PT 17.8... INR 1.55..." There was no documentation the subtherapeutic lab result was called to the NP or physician.</p> <p>Review of a NP's telephone order for Resident #252 dated 9/16/14 documented, "[symbol for increase] Coumadin to 4 mg po q HS. PT/INR 9/22/14 AM..." Review of a lab report dated 9/22/14 documented, "...PT 17.9... INR 1.56..." There was no documentation the subtherapeutic lab result was called to the NP or physician.</p> <p>Review of a NP's telephone order dated 9/19/14 at 10:10 AM documented, "...PT/INR NOW..." There was no documentation this PT/INR was done as ordered.</p> <p>Review of a NP's telephone order dated 9/19/14 at 1:30 PM for Resident #252 documented, "...Transfer to [Named Hospital] (Per Family Request) Facial Drooping..."</p> <p>The hospital Emergency Department (ED) form documented, "...9/19/14 Hospital Encounter... Your Plan... ASK your doctor about these medications..." and listed 2 different doses of Coumadin, a 7.5 mg dose to be taken every evening and a 10 mg dose to be taken once daily for 3 days. The form documented the resident was to "...ask about: Which instructions should I use..."</p> <p>There was no documentation in Resident #252's medical record where the nurses contacted the NP or physician to clarify the correct dose of Coumadin to be given. Prior to the hospital ED visit, Resident #252 had received 4 mgs of</p>	F 329			

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F 329	<p>Continued From page 117</p> <p>Coumadin by mouth every evening, since 9/16/14.</p> <p>Review of Resident #252's MAR for September 2014 documented the resident was given 10 mg of Coumadin on 9/20/14, 9/21/14 and 9/22/14. There was no order for this Coumadin 10 mg dose.</p> <p>Review of a laboratory report dated 9/23/14 for Resident #252 documented, "...PT 20.2... INR 1.83..." There was no documentation of a NP or physician order for this lab to be completed on this date.</p> <p>Review of a NP's telephone order dated 9/23/14 documented, "...[symbol for increase] Coumadin to 4 mg tab [tablet] po [by mouth] q [every] HS. PT/INR 9/29/14 AM..."</p> <p>Review of a lab report dated 9/29/14 printed at 12:09 PM documented, "PT 31.6... INR 3.30..." There was no documentation the NP or physician was notified of the elevated lab results. Resident #252's September 2014 MAR documented the nurse continued to give the resident Coumadin 4 mg every evening 9/29/14, 9/30/14, 10/1/14, 10/2/14 and 10/3/14 although the lab results was elevated above therapeutic blood levels.</p> <p>Review of a NP's telephone order dated 10/3/14 at 3:00 PM documented, "PT/INR 10/6/14. [symbol for decrease] 4.5 mg Coumadin po q HS..." The 4.5 mg dose of Coumadin was actually an increase in Resident #252's Coumadin. The MAR documented on 10/4/14, 10/5/14 and 10/6/14 the resident received the higher dose (4.5 mg) of Coumadin although the most recent INR was elevated above therapeutic blood levels.</p>	F 329		
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F 329	<p>Continued From page 118</p> <p>There was no documentation the nurse identified, or clarified the Coumadin order. Review of a lab report dated 10/6/14 printed at 8:38 AM documented, "...PT 34.4... INR 3.69..."</p> <p>Review of a NP's telephone order dated 10/6/14 at 1:20 PM documented, "...Hold Coumadin today. PT/INR in A.M. [symbol for decrease] to 3.5 mg po q HS..." The MAR documented on 10/6/14 Resident #252 continued to receive the higher dose, of 4.5 mg of Coumadin, and did not receive any Coumadin on 10/7/14 or 10/8/14.</p> <p>Review of a lab report dated 10/7/14 documented, "...PT 31.2... INR 3.24..." There was no documentation the NP or the physician was notified of the elevated lab results.</p> <p>There was no documentation of a PT/INR having been completed following the elevated results on 10/7/14 until 10/27/14. Review of lab report dated 10/27/14 printed at 7:21 AM documented, "...PT 14.3... INR 1.16..." There was no documentation the NP or the physician was notified of the subtherapeutic level lab results.</p> <p>Review of a NP's telephone order dated 10/28/14 at 3:00 PM documented, "[symbol for increase] Coumadin to 4 mg po q HS. PT/INR 11/3/14 AM..." There was no documentation on the MAR the resident received any Coumadin on 10/28/14. The 4 mg dose of Coumadin was not documented as given until 10/29/14.</p> <p>Review of a lab report dated 11/1/14 documented, "...PT 15.2... INR 1.25..." There was no documentation the NP or physician order for this lab, however, a corresponding NP's telephone order dated 11/1/14 at 1:35 PM</p>	F 329		
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F 329	<p>Continued From page 119</p> <p>documented, "increase Coumadin to 4.5 mg and recheck PT/INR in the AM..." There was no documentation the lab was done on 11/2/14 as ordered.</p> <p>Review of a lab report dated 11/3/14 printed at 7:28 AM documented, "...PT 15.2... INR 1.25..." There was no documentation the NP or physician was notified of the subtherapeutic lab results.</p> <p>Resident #252, who was initially admitted to the facility with Atrial Fibrillation (an irregular heart rhythm), history of Deep Vein Thrombosis (DVT) and currently with a DVT in her left lower extremity, was discharged home on 11/5/14. The last PT/INR completed at the facility was subtherapeutic at 1.25. The standard recommended level for DVT prevention is an INR of 2-3.</p> <p>During an interview in the activity room on 1/27/15 at 11:00 AM, the Director of Nursing (DON) was asked about the facility's protocol for performing PT/INR labs. The DON stated, "Protocol is to do weekly PT/INR if on Coumadin."</p> <p>During an interview at the 3rd floor nurses' station on 2/9/15 at 4:00 PM, Nurse #6 confirmed the nurse had given Resident #252 the higher dose of Coumadin even though the blood level was above the therapeutic range. Nurse #6 stated, "The order needed clarification."</p> <p>During a interview at the 3rd floor nurses' station on 2/9/15 at 4:50 PM, Nurse #6 was asked when Resident #252's elevated INR should have been reported to the NP or physician. Nurse #6 stated, "The 4.25 INR should have been called as soon as she [nurse] got the results..."</p>	F 329		
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F 329	Continued From page 120 The facility failed to follow physician orders for monitoring labs and reporting the results related to anticoagulant therapy, failed to administer Coumadin as ordered and failed to clarify Coumadin orders when there was no dose documented, which placed Resident #252 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage. 6. Medical record review for Resident #299 documented an admission date of 8/4/14 and a readmission date of 8/20/14 with diagnoses of DVT, Cerebrovascular Accident (CVA), Chronic Hepatitis C, Diabetes Mellitus, Hypertension and Chronic Kidney Disease. Review of the hospital discharge instructions / education form dated 8/20/14 documented, "...Heparin 5,000 Units/ [per] ML [milliliter] Subcutaneous every 8 hours for Deep Vein Thrombosis (DVT) prophylaxis (prevention)..." Review of Resident #299's August 2014 MAR documented the following medications were administered from 8/4/14 through 8/17/14 without a physician's order: a. Aspirin enteric coated 81 mg tablet at bedtime - medication for anticoagulant therapy related to history of a stroke. b. Atorvastatin 80 mg tablet at bedtime - medication given related to history of a stroke and HTN. c. Clopidogrel 75 mg tablet daily - medication for anticoagulation therapy related to history of a stroke. d. Heparin 5,000 units subcutaneous injection every 8 hours - medication for anticoagulation therapy deep vein thrombosis prevention.	F 329			

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F 329	<p>Continued From page 121</p> <p>e. Lantus insulin 5 units subcutaneous injection at bedtime - medication for control of high blood glucose levels.</p> <p>f. Lisinopril 5 mg tablet daily - medication for HTN.</p> <p>g. Insulin Aspart subcutaneous injection 4 times daily - fact acting insulin given according to accucheck results to control high blood glucose levels.</p> <p>h. Multivitamins 1 tablet daily - medication for vitamin supplement</p> <p>i. Omeprazole 40 mg tablet daily - medication for Esophageal Reflux</p> <p>j. Thiamine 100 mg 1 tablet daily -medication for vitamin supplement</p> <p>k. Docusate Sodium 250 mg 1 tablet daily - medication for Constipation</p> <p>l. Remeron 15 mg 1 tablet daily - medication for appetite</p> <p>Review of a skilled nurses' note dated 8/18/14 documented, "...8:30 AM Upon arriving in Resident [#299's] room... Resident was noted bleeding from Right nasal cavity... 9:30 AM Resident nasal bleeding continued... Resident noted to have brown colored emesis [vomit]... B/P [blood pressure] 168/106..."</p> <p>There were no PT/INR or PTT levels on Resident #299's record, who was receiving Heparin 5,000 Units/ML every 8 hours for DVT.</p> <p>During an interview at the 4th floor nurses' station on 1/22/15 at 4:20 PM, Nurse #1 stated, "I called the [named hospital] lab and [named staff] reported that they have not done any PTT or PT/INR on the resident [#299]."</p> <p>During an interview at the 4th floor nurses' station</p>	F 329			

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F 329	<p>Continued From page 122</p> <p>on 1/23/15 at 11:05 AM, Nurse Practitioner (NP) #1 stated, "If someone were on Heparin, I would check a PTT to monitor it."</p> <p>During an interview at the 4th floor nurses' station on 2/2/15 at 5:00 PM, Nurse #2 was asked for physician or NP orders for resident #299. Nurse #2 stated, "There are no signed orders on the chart or in the overflow chart for August, September, October and November 2014. Apparently, the nurses were giving medications to this resident without signed orders."</p> <p>The facility failed to ensure signed physician orders were obtained for significant medications (anticoagulants) prior to administering the medications, and failed to obtain lab work as ordered. This placed Resident #299 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>7. Medical record review for Resident #410 documented an admission date of 12/3/14 with diagnoses of Pain in Limb, Right Hip Fracture, Atrial Fibrillation, Chronic Coumadin Anticoagulation, Hypertension, History of Fall, Hypothyroidism and Osteoporosis. The resident was transferred to hospital on 12/6/14, underwent a thrombectomy, and returned with a new diagnoses of DVT of the right upper extremity.</p> <p>Review of a hospital discharge medication list dated 12/6/14 documented, "...warfarin [Coumadin] [warfarin 4 mg oral tablet] 1 tab oral, Daily..."</p> <p>Review of a PT/INR dated 12/11/14 printed at 7:06 AM documented, "...PT 16.4... INR 1.39..." a subtherapeutic blood level. There was no</p>	F 329		
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F 329	<p>Continued From page 123</p> <p>documentation of the physician or NP was notified of the subtherapeutic lab results.</p> <p>Review of a NP telephone order dated 1/16/15 at 12:20 PM documented, "Hold Coumadin today and tomorrow. Resume Coumadin 4 mg po q HS 1/18/14..."</p> <p>Review of Resident #410's January 2015 MAR documented the Coumadin 4 mg dose was not restarted until 1/19/15.</p> <p>The facility failed to notify the physician or NP of subtherapeutic labs and failed to administer Coumadin as ordered, this placed Resident #410 at risk for serious injury, harm, impairment or death related to blood clotting.</p> <p>8. Medical record review for Resident #211 documented an admission date of 1/25/13 with diagnoses of CVA, Anoxic Brain Injury, Hypertension, Myelopathy, Tracheostomy and Chronic Respiratory Failure.</p> <p>Review of lab results dated 4/7/14 documented, "...PT 49.1 INR 5.22..." Review of a NP progress note dated 4/7/14 and timed 1:33 PM documented, "...Currently on Warfarin [Coumadin] for CVA... Today's INR critical value 5.22. This value was not called to me..."</p> <p>Review of a physician order dated 4/7/14 documented, "...Hold Warfarin x [times] 2 days. Give Vitamin K 1 mg IM [intramuscular] /SQ [subcutaneous] now. Recheck INR in AM..."</p> <p>Review of a NP progress note dated 4/10/14 and timed 11:38 AM documented, "...Patient seen today f/u [follow up] INR... Last INR 5.22 on 4/7/14. Patient was given Vitamin K IM. Warfarin</p>	F 329		
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F 329	<p>Continued From page 124 was held x 2 days. INR was supposed to be rechecked 4/8/14 but was not done..."</p> <p>Review of a physician order dated 4/10/14 documented, "...STAT [immediately obtain] PT/INR now..." Review of lab results dated 4/10/14 and timed 17:00 PM documented, "PT 15.9 INR 1.33..." Review of a nurse practitioner progress note dated 4/11/14 documented, "...Patient seen today for anticoagulation management. INR was not called to me as ordered. INR subtherapeutic at 1.33. Last INR was 5.22. Patient received Vitamin K..."</p> <p>Review of lab results dated 5/22/14 for Resident #211 documented, "...PT 41.8 INR 4.77..." Review of a NP progress note dated 5/22/14 documented, "...F/U INR Patient continues to have abnormally high INR. Warfarin has been on hold x 2 days... also received Vitamin K 10 mg x 1. Today's INR remains suprathapeutic [critical high]..."</p> <p>Review of a physician order dated 6/24/14 documented, "...Stat PT/INR..." Review of lab results dated 6/24/14 documented, "...PT 63.1 INR 8.21..." Review of a physician order dated 6/25/14 documented, "...Give Vitamin K 5 mg IM x [times] 1 dose now Continue to hold Coumadin Repeat PT/INR in AM..." Review of a NP note dated 6/25/14 documented, "...Patient with suprathapeutic [lab result] Repeat INR remains critical @ [at] 5.71... Goal 2 - 3..."</p> <p>Review of lab results dated 6/28/14 documented, "...INR 1.49..." There was no documentation provided that the physician or NP was notified of the subtherapeutic lab results.</p>	F 329		
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F 329	<p>Continued From page 125</p> <p>Review of physician order dated 8/22/14 documented, "...Hold Coumadin (8/23/14) Recheck PT/INR in AM (8/24/14)..." Review of a NP progress note dated 9/3/14 documented, "...Results of PT/INR not on chart for...8/24/14..." The facility was unable to provide results for the ordered PT/INR to be done on 8/24/14.</p> <p>During an interview in the DON's office on 2/3/15 at 10:45 AM, the DON confirmed the Clinical Pathway for Laboratory Reporting was not followed on 4/7/14 and 4/11/14 and the PT/INR was not done as ordered on 4/8/14. The DON also stated, "I see what you are saying, just put it in the tag [deficiency]..."</p> <p>The facility failed to call critical lab results to the physician/NP, failed to follow orders for rechecking labs after critical values with medication intervention and failed to notify the physician/NP of subtherapeutic lab results, which placed Resident #211 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>9. Medical record review for Resident #8 documented an admission date of 6/21/12 with diagnoses of Cerebrovascular Accident, Right Tibia/Fibula Fracture, Chronic Anticoagulation, Diabetes and Neuropathy. Review of a physician order dated 7/1/14 documented, "...Recheck INR monthly..." The facility was unable to provide PT/INR results for October 2014.</p> <p>Review of a lab report dated 9/2/14 documented, "...PT 17.5...INR 1.51...Suggested Therapeutic Range[s]: Low Risk = 2.0 - [to] 3.0..."</p> <p>During an interview in Resident #8's room on</p>	F 329		
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F 329	<p>Continued From page 126</p> <p>1/22/15 at 8:30 AM, Resident #8 stated, "Been on blood thinner for a while."</p> <p>During an interview at the 5th floor nurses' station on 1/26/15 at 3:45 PM, Nurse #4 confirmed there were no PT/INR results For Resident #8 on the chart for October 2014.</p> <p>During an interview at the 5th floor nurses' station on 2/3/15 at 3:45 PM, Nurse #5 confirmed there was an order written on 7/1/14 for PT/INR to be done monthly. Nurse #5 stated, "No, there aren't any PT/INR for the month of October 2014 on the chart or [in the] overflow record."</p> <p>The facility failed to ensure labs were monitored as ordered by the physician/NP, which placed Resident #8 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>10. Medical record review for Resident #84 documented a readmission date of 8/4/14 with diagnoses of Cerebrovascular Accident with Left Side Hemiplegia, Hypertension, Peripheral Vascular Disease and Coumadin Therapy.</p> <p>Review of a physician order dated 4/15/14 documented, "...WARFARIN [Coumadin]... 2 MG TABLET... ALONG WITH 7.5 MG [and] 10 MG = [amount to be given] 19.5 MG... DAILY..." Review of a physician order dated 10/30/14 documented, "...INR q 2 weeks..." The facility was unable to provide results of a PT/INR after 11/18/14.</p> <p>During an interview on the 4th floor on 1/13/15 at 9:45 AM, Nurse #7 confirmed the physician order was for Warfarin 19.5 mg daily.</p>	F 329		

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F 329	<p>Continued From page 127</p> <p>During an interview at the 4th floor nurses' station on 1/20/15 at 3:58 PM, Nurse #2 was asked about the order dated 10/30/14 for a PT/INR to be done q 2 weeks and there were no PT/INRs done after 11/18/14. Nurse #2 state would call to check on lab results after 11/18/14. At 4:30 PM, Nurse #2 returned and stated, "Apparently, there hasn't been a PT/INR done since 11/18/14. That is unacceptable."</p> <p>The facility failed to follow physician orders for monitoring labs, this placed Resident #84 at a risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage. Resident #84 had not received a PT / INR from 11/18/14 until 1/20/15 when the surveyor requested the information.</p> <p>11. Medical record review for Resident #192 documented an admission date of 10/31/14 with diagnoses of Atrial Fibrillation, CVA, Long Term Anticoagulation Therapy and Weakness.</p> <p>Review of a physician order dated 11/1/14 documented, "...[increase] Coumadin to 3.5 mg QD [every day] PT/INR in AM..." There was no documentation provided the PT/INR was obtained on 11/2/14.</p> <p>Review of a lab report dated 11/3/14 documented an INR of 1.14. There was no documentation provided the NP was notified of the subtherapeutic level.</p> <p>Review of a telephone order dated 11/13/14 documented, "PT INR 11/17/14 AM..." Review of a lab report dated 11/17/14 documented, "...PT 13.0 INR 1.02..." There was no documentation provided the NP or Physician was notified of the</p>	F 329			

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F 329	<p>Continued From page 128 subtherapeutic level on 11/17/14.</p> <p>Review of a lab report dated 11/25/14 documented, "...PT 15.0 INR 1.23..." There was no order for this PT/INR to be done on 11/25/14.</p> <p>The facility failed to ensure the physician/NP was notified of subtherapeutic lab reports and failed to obtain labs for a resident receiving significant medications (anticoagulants), this placed Resident #192 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>12. Medical record review for Resident #411 documented an admission date of 12/30/14 with diagnoses of Hypoglycemia, Hypertension, Coronary Artery Disease, Atrial Fibrillation, Upper Extremity DVT, Aneurysm Repair and Resolved Respiratory Failure.</p> <p>Review of the hospital "Medication Reconciliation" form dated 12/29/14 documented Aspirin 325 mg 1 tablet daily, Coumadin 1 mg tablet daily at bedtime and to check the INR every 48 hours.</p> <p>Review of the hospital transfer and referral form dated 12/30/14, signed by the same physician on the medication reconciliation form, documented a change in the dose of Coumadin from 1 mg tablet daily at bedtime to Coumadin 2 mg tablet daily at bedtime.</p> <p>The facility was unable to provide documentation of INR results every 48 hours as ordered for 1/1/15, 1/3/15, 1/5/15, 1/8/15, 1/10/15, 1/12/15, 1/16/15, 1/18/15 and 1/20/15.</p> <p>Review of the January 2015 MAR documented</p>	F 329		

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F 329	<p>Continued From page 129</p> <p>Resident #411 received 2 mg of Coumadin on 1/1/15 through 1/6/15 and 1/9/15 through 1/22/15. Resident #411 received no Coumadin on 1/7/15 or 1/8/15.</p> <p>During an interview in the activity room on 1/27/15 at 11:00 AM, the DON confirmed the reconciliation order is what the nurse goes by for orders and stated, "Do not use that transfer form to take off orders." The DON was asked what dose of Coumadin was Resident #411 to receive. The DON stated, "1 mg." The DON then pulled the January 2015 MAR and stated, "She got 2 mg. [Nurse] Should have clarified the [Coumadin] order..."</p> <p>The facility failed to follow physician orders for monitoring labs and administering the significant medication of Coumadin, which placed Resident #411 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>13. Medical record review for Resident #412 documented an admission date of 7/10/14 with diagnoses of Stage IV Metastatic Colon Cancer, Hypertension, Right Lower Extremity DVT, Failure to Thrive, Malnutrition, Pleural Effusion and Post Hemicolectomy and Ileostomy.</p> <p>Review of a NP's order dated 7/22/14 documented, "...Stat PT/INR... PT/INR every Monday... Increase Coumadin to 5.5 mg every day..." Review of lab report dated 7/28/14 documented, "...PT 16.7... INR 1.44..." The facility was unable to provide documentation of the NP or physician being notified of this subtherapeutic INR results. The facility was unable to provide results for the PT/INR due Monday 8/4/14 nor</p>	F 329		
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F 329	<p>Continued From page 130</p> <p>was there documentation the physician or NP was notified the lab was not done as ordered.</p> <p>During an interview in the activity room on 1/28/15 at 3:20 PM, the Medical Director was asked if the laboratory tests were not done as ordered, if he expected the physician or NP to be notified. The Medical Director stated, "Yes, if it was not done."</p> <p>The facility failed to follow physician orders for monitoring labs and failed to notify the physician of subtherapeutic blood levels for anticoagulant therapy, which placed Resident #412 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>14. The facility failed to ensure physician orders were obtained for anticoagulant medications prior to administering the medications, failed to ensure medication orders were signed and dated, failed to ensure anticoagulant medications were administered as ordered, failed to perform ordered lab monitoring tests, failed to obtain a clarification order for correct doses of anticoagulant medications to be given and failed to notify the physician of critical and subtherapeutic lab results, which placed Residents #43, 252, 299, 410, 211, 8, 84, 192, 411 and 412 in IJ.</p>	F 329		
F 333 SS=L	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 333		5/28/2015

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F 333	<p>Continued From page 131</p> <p>by:</p> <p>Based on policy review, medical record review and interview, it was determined the facility failed to ensure 12 of 16 (Residents #252, 299, 116, 403, 411, 229, 222, 81, 151, 131, 358 and 394) sampled residents were free of significant medication errors of the 53 residents included in the stage 2 review. The facility failed to consistently follow a systemic process to ensure medications administered were ordered by the physician or nurse practitioner (NP); failed to ensure medication orders were transcribed accurately on the Medication Administration Record (MAR); failed to ensure medications were given as ordered and/or admission orders were verified with the physician for accuracy which resulted in Immediate Jeopardy (IJ), a situation in which the facility's noncompliance has caused or is likely to cause serious injury, harm, impairment or death and is also Substandard Quality of Care</p> <p>A meeting was conducted in the activity room on 1/27/15 at 3:15 PM, and the Administrator was informed of the IJ.</p> <p>The survey team received an acceptable Allegation of Compliance (AOC) from the Administrator on 1/30/15 at 12:05 PM.</p> <p>The AOC documented the following: It is the policy of this facility to ensure that all physician orders are signed and dated. As well as orders for medications and treatments will be consistent with principles of safe and effective order writing. Validation of the Credible Allegation of Compliance was accomplished on site 2/2/15 through 2/6/15, through record review, review of facility documents and interviews with nursing,</p>	F 333	<p>1. Resident #'s 252, 411, 222, 81, 151 Have been Discharged.</p> <p>Resident #'s 299, 116, 403, 229, 131, 358, 394 are receiving medications per physicians order.</p> <p>2 A baseline laboratory audit was completed by nursing on 1/28/15 to validate labs were performed according to physician order and care plan. If results were abnormal, validation of the physician being notified and a telephone order written if change in treatment was required.</p> <p>A baseline audit of resident receiving Coumadin therapy was completed by DON, ADON or designee on 1/27/15 validating the physician/nurse practitioner were notified of any abnormal lab values and telephone order was written if change in treatment was required. A baseline audit will be conducted to validate that medications are administered according to physician order.</p> <p>A baseline audit was conducted by MDSC 2/19/2015 of residents receiving hospice services to validate a physician order is present, a progress note indicating initiation date of hospice services and care plan reflects hospice service and coordination of care.</p>	
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F 333	<p>Continued From page 132 administration and corporate staff.</p> <p>The facility provided evidence of in-service training with sign in sheets for all licensed nursing staff dated 1/28/15 through 1/30/15 related to 24 hour chart checks, physician orders, admission orders, telephone orders, physician order sheets and reconciliation of medications with physician orders.</p> <p>The facility provided evidence of auditing tools utilized for 24 hour chart checks, physician orders, admission orders, telephone orders, physician order sheets and reconciliation of medications with physician orders.</p> <p>Medical record review conducted on 2/5/15 documented 9 of 9 new admission charts admitted on or after 1/30/15 included the Admission to the facility order, Reconciliation of admission medication and treatment orders, Physician Order Sheets (POS), Admission nurses notes documenting verification of orders to ensure the process of chart checks were being done and any follow up was occurring.</p> <p>The licensed staff currently on leave of absence, vacation or per diem was sent certified letter on 1/30/15 informing staff of the in-service and training and that the training must be completed prior to returning for their next scheduled shift.</p> <p>Observations were conducted on 2/2/15 of licensed staff's shift change reporting methods to validate pertinent resident information including anticoagulant medications, resulted and/or pending lab testing with utilization of the lab tracking tool, and new admissions with documented reconciliation of medications</p>	F 333	<p>3. Education and training initiated on 1/28/15 and completed on 1/30/15 with all licensed nursing staff by the Staff Development Coordinator (SDC) or RN Supervisor regarding the procedure of printing monthly physician order statements and obtaining physician signature. Licensed nurses also received education and training on 1/29/15 and completed on 1/30/15 regarding processing of physicians orders related to obtaining, transcribing and obtaining signature by the SDC. Education and training also provided to licensed nurses on 1/29/15 and completed on 1/30/15 regarding medication reconciliation of physician orders and completion of twenty-four chart checks for current residents by SDC.</p> <p>Education and training also provided to licensed nurses regarding writing Physician orders will be written at the time of admission indicating admission to the facility, physician assigned and that physician orders were verified with a physician documented on a physician telephone order. An audit of the medical record will be completed monthly by Medical Records and/or designee to ensure all monthly physician order statements are printed and signed.</p>		

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F 333	<p>Continued From page 133</p> <p>ordered by a physician was reported to the oncoming shift.</p> <p>Interview with facility licensed nursing staff were conducted on 2/4/15 through 2/5/15 with staff from all floors and all shifts validating 24 hour chart checks, physician orders and reconciliation of medications with physician orders.</p> <p>Interview with the Administrator and Corporate Staff (Health Information Management) on 2/4/15 revealed the facility would continue monitoring by: Quality Assurance (QA) meeting to be held weekly for four weeks beginning 2/5/15 and then monthly for findings, recommendations and follow up regarding the plan. The frequency of the audits to be maintained will be decided by the QA committee based on the findings of the audits.</p> <p>The survey team validated the AOC on 2/2/15 through 2/6/14. The IJ was removed as of 1/30/15.</p> <p>The IJ for F333-L constitutes substandard quality of care.</p> <p>An extended survey was conducted 2/4/15 through 2/11/15.</p> <p>Non-ompliance of the IJ continues at a scope and severity of a "F" level for F333 for monitoring of corrective actions. The facility is required to submit a plan of correction for all tags.</p> <p>The findings included:</p> <p>1. Review of the facility's medication administration policy documented, "...Medications are administered only as ordered by the</p>	F 333	<p>4. An audit of the medical record will be completed daily by DON/ ADON and/or RN Supervisor to ensure physician orders are obtained and transcribed correctly as well as signed.</p> <p>An audit of the medical record will be completed daily by DON/ADON and/or RN Supervisor to ensure that twenty-four hour chart checks are completed on all current residents and medication reconciliation was completed on all newly admitted residents. Trends will be reported to QAPI by ADON/ Designee.</p> <p>If audits demonstrate substantial compliance and QAPI committee approves, the frequency will be reduced periodically, over time, as indicated.</p> <p>If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of audit.</p>		

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F 333	<p>Continued From page 134</p> <p>physician... Chart Failure to Administer Chart on medication sheet and/or nurse's notes any failure to administer medication, regardless of the reason. Include the reason..."</p> <p>2. Medical record review for Resident #252 documented an admission date of 8/28/14 with diagnoses of Deep Vein Thrombosis (DVT), Hypertension (HTN), Chronic Renal Insufficiency, Diabetes Mellitus (DM) Type 2, Atrial Fibrillation (AFib), Peripheral Neuropathy, Anemia, Hyperlipidemia and Osteoarthritis.</p> <p>Review of a hospital "...Medications" discharge information form dated 8/28/14 documented, "...Your medication list... CHANGE how you take these medications..." that was not signed and dated by a physician.</p> <p>There were no medication and treatment recapitulation (recap) orders signed and dated by a physician or NP until the facility's POS generated 8/31/14 was signed by the facility's attending physician on September 2014 (exact date is illegible).</p> <p>Review of Resident #252's August 2014 MAR documented the following significant medications were administered from 8/29/14 through 8/31/14 without a physician's order:</p> <ul style="list-style-type: none"> a. Amlodipine 5 milligram (mg) tablet daily - medication for HTN. b. Carvedilol 25 mg tablet twice daily - medication for HTN. c. Clonidine 0.3 mg tablet three times daily - medication for HTN. d. Hydralazine 100 mg tablet three times daily - medication for HTN. e. Isosorbide extended release 40 mg tablet twice 	F 333			

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F 333	<p>Continued From page 135</p> <p>daily - medication for HTN.</p> <p>f. Simvastatin 40 mg tablet daily - medication for high cholesterol levels.</p> <p>g. Lispro/Humalog mix insulin subcutaneous injection of 20 units twice daily - intermediate acting insulin to control high blood glucose levels.</p> <p>h. Humulin Regular insulin subcutaneous injection - fast acting insulin given according to accucheck results to control high blood glucose levels. Resident #252 received 2 to 4 units of insulin.</p> <p>i. Coumadin 5 mg tablet - anticoagulant therapy related to DVT and AFib - given 8/29/14.</p> <p>Review of a NP telephone order dated 9/19/14 at 1:30 PM documented, "... Transfer to [Named Hospital] (Per Family Request) Facial Drooping..."</p> <p>The hospital emergency department (ED) form dated 9/19/14 documented, "...9/19/14 Hospital Encounter... Your Plan... ASK your doctor about these medications..." and listed 2 different doses of Coumadin, a 7.5 mg dose to be taken every evening and a 10 mg dose to be taken once daily for 3 days. The form documented the resident was to "...ask about: Which instructions should I use..."</p> <p>There was no documentation the NP or Physician was called to clarify Resident #252's correct dose of Coumadin.</p> <p>Review of Resident #252's September 2014 MAR documented the resident was given 10 mg of Coumadin on 9/20/14, 9/21/14 and 9/22/14.</p> <p>Review of a NP's telephone order dated 9/23/14 documented, "... [symbol for increase] Coumadin</p>	F 333			

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F 333	<p>Continued From page 136</p> <p>to 4 mg tab [tablet] po [by mouth] q [every] HS [hour of sleep]. PT [Protime - measures the ability of blood to form a clot - reference range 11.7 to (-) 14.9] / [and] INR [International Normalized Ratio - reference ranges 0.00-1.13] 9/29/14 AM..."</p> <p>Review of a laboratory (lab) report dated 9/29/14 printed at 12:09 PM documented, "...PT... 31.6... INR... 3.30... Therapeutic Ranges: (2.0-3.0)..." Resident #252's MAR documented the nurse continued to give the resident Coumadin 4 mg every evening on 9/29/14, 9/30/14, 10/1/14, 10/2/14 and 10/3/14 although the INR was elevated above therapeutic blood levels.</p> <p>Review of a NP's telephone order dated 10/3/14 at 3:00 PM documented, "...[symbol for decrease] 4.5 mg Coumadin po q HS..." The 4.5 mg dose of Coumadin was actually an increase in Resident #252's Coumadin. The MAR documented on 10/4/14, 10/5/14 and 10/6/14 the resident received the higher dose of Coumadin although the most recent INR was elevated above therapeutic blood levels. There was no documentation the nurse identified, or clarified the Coumadin order.</p> <p>During an interview at the 3rd floor nurses' station on 2/9/14 at 4:00 PM, Nurse #6 confirmed the nurse had given Resident #252 the higher dose of Coumadin even though the blood level was above the therapeutic range. Nurse #6 stated, "The [Coumadin] order needed clarification."</p> <p>The administration of medications for HTN, DM, DVT and high cholesterol without a physician's order and without verification of anticoagulant medications resulted in significant medication</p>	F 333			

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F 333	<p>Continued From page 137 errors for Resident #252 and placed Resident #252 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>3. Medical record review for Resident #299 documented an admission date of 8/4/14 and a readmission date of 8/20/14 with diagnoses of Cerebrovascular Accident (CVA), Chronic Hepatitis C, DM, HTN and Chronic Kidney Disease (CKD).</p> <p>The facility was unable to provide transferring / referring hospital orders, physician documentation of medication and treatment reconciliation orders or a POS signed by the facility's attending physician for Resident #299's initial admission on 8/4/14.</p> <p>Review of Resident #299's August 2014 MAR documented the following significant medications were administered from 8/4/14 through 8/17/14 without a physician's order:</p> <ul style="list-style-type: none"> a. Aspirin enteric coated 81 mg tablet at bedtime - medication for anticoagulant therapy related to history of a stroke. b. Atorvastatin 80 mg tablet at bedtime - medication given related to history of a stroke and HTN. c. Clopidogrel 75 mg tablet daily - medication for anticoagulation therapy related to history of a stroke. d. Heparin 5,000 units subcutaneous injection every 8 hours - medication for anticoagulation therapy deep vein thrombosis prevention. e. Lantus insulin 5 units subcutaneous injection at bedtime - medication for control of high blood glucose levels. f. Lisinopril 5 mg tablet daily - medication for 	F 333			

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F 333	<p>Continued From page 138</p> <p>HTN.</p> <p>g. Insulin Aspart subcutaneous injection 4 times daily - fast acting insulin given according to accucheck results to control high blood glucose levels. The amount of insulin given without a physician order based on the accucheck result ranged from 2 to 8 units.</p> <p>Review of a physician's telephone order dated 8/18/14 documented Resident #299 was sent to the hospital emergency room on 8/18/14 for an uncontrolled nose bleed, elevated blood pressure, elevated heart rate, status post fall and was readmitted to the facility on 8/20/14.</p> <p>Review of the hospital "...NURSING HOME DISCHARGE INSTRUCTIONS..." from the transferring / referring hospital dated 8/20/14 documented, "...Signed by: [Named Physician]... RESIDENT PHYSICIAN 08/20/2014 13:33 [1:30 pm]... REQUIRES COSIGNATURE..." The discharge instructions form was not cosigned and dated by a physician.</p> <p>There were no medication and treatment orders signed and dated by a physician until the facility's POS generated 12/1/14 was signed by the facility's attending physician on January 2015 (exact date is illegible).</p> <p>Review of Resident #299's August 2014 MAR documented the following significant medications were administered from 8/20/14 through 8/31/14 without a physician's order:</p> <p>a. Aspirin enteric coated 81 mg tablet at bedtime - medication for anticoagulant therapy related to history of a stroke.</p> <p>b. Atorvastatin 80 mg tablet at bedtime - medication given related to history of a stroke and</p>	F 333			

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F 333	<p>Continued From page 139</p> <p>HTN.</p> <p>c. Clopidogrel 75 mg tablet daily - medication for anticoagulation therapy related to history of a stroke.</p> <p>d. Heparin 5,000 units subcutaneous injection every 8 hours - medication for anticoagulation therapy deep vein thrombosis prevention.</p> <p>e. Lisinopril 5 mg tablet daily - medication for HTN.</p> <p>f. Insulin Aspart subcutaneous injection 4 times daily - fast acting insulin given according to accucheck results to control high blood glucose levels. The amount of insulin given without a physician order based on the accucheck result ranged from 2 to 6 units.</p> <p>g. Lantus insulin 5 units subcutaneous injection at bedtime - medication for control of high blood glucose levels given 8/20/14 through 8/25/14.</p> <p>Review of Resident #299's September 2014 MAR documented the following significant medications were administered from 9/1/14 to 9/30/14 without a physician's order:</p> <p>a. Aspirin enteric coated 81 mg tablet at bedtime - medication for anticoagulant therapy related to history of a stroke.</p> <p>b. Atorvastatin 80 mg tablet at bedtime - medication given related to history of a stroke and HTN.</p> <p>c. Clopidogrel 75 mg tablet daily - medication for anticoagulation therapy related to history of a stroke.</p> <p>d. Heparin 5,000 units subcutaneous injection every 8 hours - medication for anticoagulation therapy deep vein thrombosis prevention.</p> <p>e. Lisinopril 5 mg tablet daily - medication for HTN.</p> <p>f. Insulin Aspart subcutaneous injection 4 times daily - fast acting insulin given according to</p>	F 333			

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F 333	<p>Continued From page 140</p> <p>accucheck results to control high blood glucose levels. The amount of insulin given without a physician order based on the accucheck result ranged from 2 to 10 units.</p> <p>Review of Resident #299's October 2014 MAR documented the following significant medications were administered from 10/1/14 through 10/31/14 without a physician's order:</p> <ul style="list-style-type: none"> a. Aspirin enteric coated 81 mg tablet at bedtime - medication for anticoagulant therapy related to history of a stroke. b. Clopidogrel 75 mg tablet daily - medication for anticoagulation therapy related to history of a stroke. c. Lisinopril 5 mg tablet daily - medication for HTN. d. Insulin Aspart subcutaneous injection 4 times daily - fast acting insulin given according to accucheck results to control high blood glucose levels. The amount of insulin given without a physician order based on the accucheck result ranged from 2 to 12 units. e. Heparin 5,000 units subcutaneous injection every 8 hours - medication for anticoagulation therapy deep vein thrombosis prevention - given 10/1/14 through 10/8/14. f. Atorvastatin 80 mg tablet at bedtime - medication given related to history of a stroke and HTN - given 10/1/14 through 10/8/14. <p>During an interview at the 4th floor nurses' station on 2/2/15 at 5:00 PM, Nurse #2 was asked for signed and dated physician orders for Resident #299. Nurse #2 was unable to provide the documentation. Nurse #2 stated, "Apparently, the nurses were giving medications to this resident without signed orders."</p>	F 333			

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F 333	<p>Continued From page 141</p> <p>The administration of medications for CVA, DM, Hyperlipidemia and HTN without a physician's order resulted in significant medication errors for Resident #299 and placed Resident #299 at risk for serious injury, harm, impairment or death related to abnormal bleeding or hemorrhage.</p> <p>4. Medical record review for Resident #116 documented an admission date of 11/21/14 with diagnoses of Acute Respiratory Failure, Coronary Artery Disease (CAD) with Bypass Graft, Internal Defibrillator, DM Type 2, HTN, Congestive Heart Failure (CHF), Hyperlipidemia and CKD.</p> <p>Review of the hospital "...POST ACUTE ADMISSION ORDERS" dated 11/20/14 from the transferring / referring hospital was not signed and dated by a physician.</p> <p>There were no signed and dated physician orders until the facility's POS generated on 11/30/14 was signed by the facility's attending physician on January 2015 (exact date is illegible).</p> <p>Review of Resident #116's November 2014 MAR documented the following significant medications were administered from 11/22/14 through 11/30/14 without a physician's order:</p> <ul style="list-style-type: none"> a. Carvedilol 6.25 mg tablet twice daily - medication for HTN and CHF. b. Potassium Chloride 10 milliequivalents (mEq) daily - potassium supplement. c. Benazepril 10 mg tablet daily - medication for HTN. d. Orvastatin 40 mg tablet at bedtime - medication for high lipids. e. Fenofibrate 145 mg tablet daily - medication for high cholesterol, lipids, and triglycerides. f. Levimir insulin 10 units subcutaneous injection 	F 333			

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F 333	<p>Continued From page 142</p> <p>twice daily - long acting medication for control of high blood glucose levels.</p> <p>g. Novolog insulin subcutaneous injection 4 times daily - fast acting insulin given according to accucheck results. The amount of insulin given without a physician order based on the accucheck result ranged from 2 to 4 units.</p> <p>h. Aspirin 81 mg tablet daily - medication for anticoagulant therapy.</p> <p>i. Heparin 5,000 units subcutaneous injection twice daily - anticoagulant therapy - given on 11/22/14, 11/23/14 and 11/24/14.</p> <p>j. Norco 7.5 mg tablet - narcotic pain medication - given on 11/22/14, 11/25/14, 11/26/14, 11/28/14 and 11/29/14.</p> <p>k. Albuterol inhalation respiratory bronchodialator - given on 11/22/14, 11/23/14, 11/24/14 and 11/25/14.</p> <p>During an interview at the 4th floor nurses' station on 1/22/15 at 10:28 AM, Nurse #1 was asked about Resident #116's admission orders. Nurse #1 confirmed there were no signed admission orders for Resident #116.</p> <p>During an interview at the 4th floor nurses' station on 2/3/15 at 2:00 PM, Nurse #2 when asked for signed and dated admission orders for Resident #116. Nurse #2 stated, "If you can't find it in the chart, it isn't there and they would have been giving meds [medications] without signed orders. This resident does not have an overflow record."</p> <p>The administration of medications for Respiratory Failure, CAD, DM, HTN, CHF, Potassium supplementation, Hyperlipidemia and Narcotic pain medications without a physician's order resulted in significant medication errors for Resident #116.</p>	F 333			

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F 333	<p>Continued From page 143</p> <p>5. Medical record review for Resident #403 documented an admission date of 1/9/15 with diagnoses of Multiple Myeloma, Deconditioning and Peripheral Neuropathy.</p> <p>Review of the hospital "...Medication Reconciliation by Therapeutic Class - Discharge" from the transferring / referring hospital dated 1/8/14 was not signed and dated by a physician.</p> <p>The facility was unable to provide medication orders signed and dated by the facility's attending physician for January 2015.</p> <p>Review of Resident #403's January 2015 MAR documented the following significant medications were administered from 1/10/15 through 1/12/15 without a physician's order:</p> <ul style="list-style-type: none"> a. Coumadin 13.5 mg tablet daily - anticoagulant therapy for deep vein DVT. b. Lovenox 80 mg subcutaneous injection twice daily - anticoagulant therapy for DVT. <p>The administration of medications for DVT without a physician's order resulted in significant medication errors for Resident #403.</p> <p>6. Medical record review for Resident #411 documented an admission date of 12/30/14 with diagnoses of Hypoglycemia, HTN, Coronary Artery Disease (CAD), Atrial Fibrillation (AFib), Upper Extremity Deep Vein Thrombosis (DVT), Aneurysm Repair and Resolved Respiratory Failure.</p> <p>Review of the hospital "Medication Reconciliation" form dated 12/29/14 documented Aspirin 325 mg 1 tablet daily, Coumadin 1 mg tablet daily at</p>	F 333			

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F 333	<p>Continued From page 144 bedtime.</p> <p>Review of the hospital transfer and referral form dated 12/30/14, signed by the same physician documented a change in the dose of Coumadin from 1 mg tablet daily at bedtime to Coumadin 2 mg tablet daily at bedtime.</p> <p>Review of the January 2015 MAR documented Resident #411 received 2 mg of Coumadin on 1/1/15 through 1/6/15 and 1/9/15 through 1/22/15. The resident received no Coumadin on 1/7/15 or 1/8/15.</p> <p>During an interview in the activity room on 1/27/15 at 11:00 AM, the Director of Nursing (DON) confirmed the reconciliation order is what the nurse goes by for orders and stated, "...Do not use that transfer form to take off orders..." The DON was then asked what dose of Coumadin was the resident on. The DON stated, "...1 mg..." The DON then pulled the MAR for the month and stated, "...She got 2 mg [without a physician order]... [the nurse] should have clarified the order..."</p> <p>The administration of medications for HTN, CAD, AFib and DVT without a physician's order resulted in significant medication errors for Resident #411 and placed Resident #411 at risk for serious injury, harm, impairment or death.</p> <p>7. Medical record review for Resident #229 documented an admission date of 10/22/13 and a readmission date of 7/18/14 with diagnoses of Gun Shot Wound, Respiratory Failure with Mechanical Ventilation via Tracheostomy Tube, Vegetative State and Depression. The resident was discharged to the hospital on 7/14/14 and</p>	F 333			

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F 333	<p>Continued From page 145 was readmitted to the facility on 7/18/14.</p> <p>Review of the hospital "...Medication Reconciliation by Therapeutic Class - Discharge" dated 7/17/14 from the transferring / referring hospital was not signed and dated by a physician.</p> <p>There were no medication and treatment orders signed and dated by a physician until the facility's POS generated 10/31/14 was signed by the facility's attending physician on October 2014 (exact date is illegible).</p> <p>Review of Resident #229's July 2014 MAR documented the following significant medications were administered via PEG tube from 7/19/14 through 7/31/14 without a physician's order:</p> <ul style="list-style-type: none"> a. Oxycodone 5 mg tablet prior to wound care daily - narcotic pain medication. b. Propranolol 120 mg tablet twice daily - medication to control fast heart rate. c. Albuterol inhalation respiratory bronchodialator - given on 7/19/14 through 7/28/14. <p>The administration of medication for HTN, Respiratory failure and Narcotic pain medication without a physician's order resulted in significant medication errors for Resident #229 and placed Resident #229 at risk for serious injury, harm, impairment or death.</p> <p>8. Medical record review for Resident #222 documented an admission date of 6/26/13 and a readmission date of 12/22/14 with diagnoses of Traumatic Brain Injury, DM Type 2, COPD, HTN, Seizure Disorder, Tracheostomy, Ventilator, Suprapubic Catheter, Percutaneous Endoscopy Gastrostomy (PEG) Tube, and Chronic Respiratory Failure. The resident was discharged</p>	F 333			

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F 333	<p>Continued From page 146 to the hospital on 12/6/14 and returned to the facility on 12/22/14.</p> <p>Review of the hospital "... Transfer/Referral Form" from the transferring / referring hospital dated 12/22/14 documented, "... START taking these medications..." This form was not signed and dated by a physician.</p> <p>There were no medication and treatment recap orders signed and dated by a physician until the facility's POS generated 1/27/15 was signed by the facility's attending physician on January 2015 (exact date is illegible).</p> <p>Review of Resident #222's December 2014 MAR documented the following significant medications were administered via PEG tube from 12/22/14 through 12/31/14 without a physician's order:</p> <ul style="list-style-type: none"> a. Vimpat 100 mg of solution twice daily - medication to control seizures. b. Duoneb inhalation respiratory bronchodialator 3 ml (milliliter) every 6 hours. c. Depakene 250 mg of solution twice daily - medication to control seizures. d. Humalog insulin subcutaneous injection 4 times daily - fast acting insulin given according to accucheck results to control high blood glucose levels. The amount of insulin given without a physician order based on the accucheck result ranged from 3 to 4 units. <p>Review of Resident #222's January 2015 MAR documented the following significant medications were administered via PEG tube from 1/1/15 through 1/27/15 without a physician's order:</p> <ul style="list-style-type: none"> a. Vimpat 100 mg of solution twice daily - medication to control seizures. b. Duoneb inhalation respiratory bronchodialator 	F 333			

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F 333	<p>Continued From page 147</p> <p>3 ml every 6 hours.</p> <p>c. Depakene 250 mg of solution twice daily - medication to control seizures.</p> <p>d. Humalog insulin subcutaneous injection 4 times daily - fast acting insulin given according to accucheck results to control high blood glucose levels. The amount of insulin given without a physician order based on the accucheck reult was 2 units.</p> <p>The administration of medications for Seizures, DM and Respiratory failure without a physician's order resulted in significant medication errors for Resident #222 and placed Resident #222at risk for serious injury, harm, impairment or death.</p> <p>9. Medical record review for Resident #81 documented an admission date of 7/1/09 with a readmission date of 12/22/14 with diagnoses of Alzheimer's Disease, Senile Dementia, Dysphagia, DM, HTN, Hyperlipidemia and Adult Failure to Thrive (FTT).</p> <p>Review of the hospital "...Medication Reconciliation by Therapeutic Class - Discharge" physician's orders dated 12/22/14 documented, "...lisinopril [medication to treat elevated blood pressure]... 5 mg [milligram]... 1 tab... oral... Additional Discharge Meds [medications]... ASPIRIN (CHEWABLE) 81 mg P [per] Tube DAILY..."</p> <p>Review of Resident #81's MAR dated 12/1/14 through 12/31/14 documented the Lisinopril and the Aspirin were not given as ordered.</p> <p>The facility was unable to provide documentation of the facility's POS generated upon Resident #81's readmission to the facility on 12/22/14.</p>	F 333			

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F 333	Continued From page 148 During an interview in the activity room on 1/29/15 at 3:54 PM, Nurse #8 was asked if the Lisinopril was on the December 2014 MAR. Nurse #8 verified the Lisinopril and the Aspirin were not on the MAR and Resident #81 did not receive the medications as ordered by the physician. Nurse #8 was asked if the hospital medication reconciliation orders dated 12/22/14 should have been transcribed as active physician orders. Nurse #8 stated, "Yes Ma'am. We are suppose to use those. They should have put these [hospital discharge medication reconciliation orders] in [the computerized order system]. The reconciliation overrides these [POS generated 11/28/14 prior to the resident's discharge to the hospital 12/10/14 for mental status changes]." The failure to administer medications for HTN resulted in significant medication errors for Resident #81. 10. Medical record review for Resident #151 documented an admission date of 10/7/14 and a readmission date of 12/1/14 with diagnoses of COPD, Personal History of Fall, CKD, HTN, DM Type 2, CHF, Hypothyroidism, Bipolar Disorder Disease, Dementia, Hypercholesterol and Anemia. A discharge summary dated 11/12/14 documented the resident was discharged home on 11/12/14 with home health and returned to the facility from the hospital on 12/1/14 following multiple falls at home. Review of the hospital "...Final Active Medication List" dated 12/1/14 from the transferring / referring hospital was not signed and dated by a physician.	F 333			

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F 333	<p>Continued From page 149</p> <p>There were no medication and treatment recapitulation (recap) orders signed and dated by a physician until the facility's POS generated 12/30/14 was signed by the facility's attending physician on January 2015 (exact date illegible).</p> <p>Review of Resident #151's December 2014 MAR documented the following significant medications were administered from 12/2/14 through 12/31/14 without a physician's order:</p> <ul style="list-style-type: none"> a. Atorvastatin 10 mg tablet daily - medication for elevated cholesterol. b. Carvedilol 6.25 mg tablet twice daily - medication for high blood pressure. c. Levothyroxine 100 mcg tablet daily - medication for under active thyroid gland. d. Lisinopril 5 mg tablet daily - medication for high blood pressure. <p>The administration of medication for Hypercholesterol, HTN and Hypothyroidism without a physician's order resulted in significant medication errors for Resident #151 and placed Resident #151 at risk for serious injury, harm, impairment or death.</p> <p>11. Medical record review for Resident #131 documented an admission date of 3/26/10 and a readmission dated of 12/2/14 with diagnoses of Hyponatremia, Brain Tumor, Seizures, Dementia, Hearing Loss, Hypothyroidism and Syndrome of Inappropriate Antidiuretic Hormone.</p> <p>Review of the hospital "...Medication Reconciliation by Therapeutic Class - Discharge" dated 12/2/14 from the transferring / referring hospital was not signed and dated by a physician.</p>	F 333			

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F 333	<p>Continued From page 150</p> <p>There were no medication and treatment orders signed and dated by a physician until the facility's POS generated 1/27/15 was signed by the facility's attending physician on January 2015 (exact date is illegible).</p> <p>Review of Resident #131's December 2014 MAR documented the following significant medications were administered from 12/1/14 through 12/31/14 without a physician's order:</p> <ul style="list-style-type: none"> a. Sodium Chloride tablet 2 grams 4 times daily - medication given for sodium supplementation. b. Topiramate 50 mg tablet daily - medication for control of seizures. c. Levothyroxine 50 microgram (mcg) tablet daily - medication for under active thyroid gland. d. Prednisone 40 mg tablet daily - steroid medication for severe inflammation was given on 12/3/14 through 12/7/14. <p>Review of the resident's January 2015 MAR documented the following significant medications were administered from 1/1/15 through 1/27/15 without a physician's order:</p> <ul style="list-style-type: none"> a. Sodium Chloride tablet 2 grams 4 times daily - medication given for sodium supplementation. b. Topiramate 50 mg tablet daily - medication for control of seizures. c. Levothyroxine 50 mcg tablet daily - medication for under active thyroid gland. <p>During an interview at the 5th floor nurses' station on 2/2/15 at 6:10 PM, Nurse #2 confirmed Sodium Chloride, Topiramate, Levothyroxine and Prednisone had been given in December 2014 and January 2015.</p> <p>The administration of medications for Hyponatremia, Seizures and Hypothyroidism</p>	F 333			

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F 333	<p>Continued From page 151</p> <p>without a physician's order resulted in significant medication errors for Resident #131 and placed Resident #131 at risk for serious injury, harm, impairment or death.</p> <p>12. Medical record review for Resident #358 documented an admission date of 10/3/14 and readmission date of 11/10/14 with diagnoses of HTN, Parkinson's Disease, Depressive Disorder, Adult FTT, Systemic Lupus Erythematosus, Acute Pancreatitis, Gastrostomy, Malignant Neoplasm of the Parotid Gland and Malignant Salivary Glands. The resident was discharged to the hospital on 11/2/14 and readmitted to the facility on 11/10/14.</p> <p>Review of the hospital "...Medication Reconciliation by Therapeutic Class - Discharge" dated 11/9/14 from the transferring / referring hospital was not signed or dated by a physician.</p> <p>The facility was unable to provide medication orders signed and dated by the facility's attending physician for the resident's original admission on 10/3/14 or the readmission on 11/10/14.</p> <p>Review of Resident #358's October 2014 MAR documented the following significant medications were administered 10/4/14 through 10/31/14 without a physician's order:</p> <ul style="list-style-type: none"> a. Amlodipine 5 mg tablet daily - medication for HTN. b. Plaquenil 200 mg tablet daily - medication for treatment of Lupus. c. Lisinopril 10 mg tab daily - medication for HTN. d. Levothyroxine 150 mcg daily - medication for under active thyroid gland. e. Prednisone 10 mg tablet - medication for severe inflammation - given 10/4/14 through 	F 333			

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F 333	<p>Continued From page 152 10/13/14.</p> <p>Review of Resident #358's November 2014 MAR documented the following significant medications were administered 11/1/14 without a physician's order:</p> <ul style="list-style-type: none"> a. Amlodipine 5 mg tablet daily - medication for HTN. b. Plaquenil 200 mg tablet daily - medication for treatment of Lupus. c. Lisinopril 10 mg tab daily - medication for HTN. d. Levothyroxine 150 mcg daily - medication for under active thyroid gland. <p>Review of Resident #358's November 2014 MAR documented the following significant medications were administered 11/12/14 through 11/30/14 without a physician's order:</p> <ul style="list-style-type: none"> a. Amlodipine 5 mg tablet daily - medication for HTN. b. Plaquenil 200 mg tablet daily - medication for treatment of Lupus. c. Lisinopril 10 mg tab daily - medication for HTN. d. Levothyroxine 150 mcg daily - medication for under active thyroid gland. <p>The administration of medications for HTN, Lupus and Hypothyroidism without a physician's order resulted in significant medication errors for Resident #358 and placed Resident #358 at risk for serious injury, harm, impairment or death.</p> <p>13. Medical record review for Resident #394 documented an admission date of 11/28/14 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), HTN, DVT, Degenerative Joint Disease, Tracheostomy, Morbid Obesity, Respiratory Failure, Osteoarthritis and Motor Vehicle Accident - status post multiple surgeries</p>	F 333			

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F 333	<p>Continued From page 153 related to traumatic injuries.</p> <p>Review of a NP's telephone order dated 11/29/14 documented, "...Give 40 mEq [milliequivalents] K+ [potassium] now and 40 mEq in the AM..."</p> <p>Review of Resident #394's November 2014 MAR did not document the potassium as being given as ordered. There was no documentation of why the medication was not given or of the NP being notified the potassium was not given as ordered.</p> <p>Review of a NP's telephone order dated 12/5/14 documented, "...80 mEq of Potassium tonight 12/5/14..."</p> <p>Review of a NP's telephone order dated 12/7/14 documented, "...Give additional Potassium Chloride 60 mEq elixir... now..."</p> <p>Review of a NP's telephone order dated 12/8/14 documented, "...Administer 60 mEq of Potassium...now..."</p> <p>Review of Resident #394's December 2014 MAR did not document the potassium was given as ordered. There was no documentation of why the potassium was not given or that the NP or physician was notified the potassium was not given.</p> <p>Review of a NP's progress note dated 12/8/14 documented, "...Patient's potassium has been running low over the last few days she has been given multiple doses of potassium chloride 80 mEq to try and raise this. Her potassium this morning is 2.5 [normal range 3.5 to 5]..." There was no documentation the NP was aware the resident had not been administered the 5 doses</p>	F 333			

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F 333	<p>Continued From page 154 of potassium as ordered.</p> <p>The failure to administer medication for Hypokalemia resulted in significant medication errors for Resident #394 and placed Resident #394 at risk for serious injury, harm, impairment or death.</p> <p>14. During an interview in the activity room on 1/26/14 at 5:05 PM, the Director of Nursing (DON) was asked about the missing POS documentation in the residents' medical records. The DON stated, "If everybody looks and can not find a signed copy, then we don't have a signed copy." The DON was asked when should telephone orders be signed. The DON stated, "Telephone orders must be signed within 10 days."</p> <p>During an interview in the activity room on 1/27/15 at 4:15 PM, Nurse #6 was asked about the facility's admission process. Nurse #6 confirmed the reconciliation orders sent with the residents from the transferring / referring hospital must be signed by the transferring physician and if not signed, the nurse would call the transferring hospital requesting a faxed signed copy of the orders.</p> <p>During an interview in the activity room on 1/27/15 at 4:15 PM, the DON was asked if the POS in the residents' medical records were physician orders. The DON stated, "The POS is the physician's orders. They have to be printed out and signed."</p> <p>The facility failed to ensure medications were not administered without signed physician orders, failed to ensure medication orders were</p>	F 333			

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F 333	Continued From page 155 transcribed accurately on the MAR, failed to ensure medications were given as ordered and/or admission orders were verified with the physician for accuracy, this resulted in a system failure that placed all residents receiving medications in IJ.	F 333			
F 386 SS=K	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on policy review, reference review of "Sorensen and Luckmann's Basic Nursing", medical record review and interview, it was determined the facility failed to ensure the physician reviewed the residents total program of care, including medications and treatments and all orders are signed and dated for 11 of 37 (Residents #43, 252, 299, 116, 403, 222, 229, 358, 394, 151 and 131) sampled residents of the 53 residents included in the stage 2 review. The facility's failure to ensure residents who were admitted to the facility had physician prescribed, signed and dated orders resulted in an immediate jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a	F 386	1. Resident # 252, 222, 151 have been discharged.# 43,299, 116, 403, 229, 358, 394 and 131, currently have physician orders that are signed and dated. 2: Facility wide audit to determine if all current residents will have physician orders that are signed and dated by DON, ADON and will be done monthly. 3: Education and training initiated on 1/28/15 and completed on 1/30/15 with all licensed nursing staff by the Staff Development Coordinator or RN Supervisor regarding the procedure of printing monthly physician order statements and obtaining physician signature.	5/28/2015	

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F 386	<p>Continued From page 156 resident.</p> <p>A meeting was conducted in the activity room on 1/27/15 at 3:15 PM, and the Administrator was informed of the IJ.</p> <p>The survey team received an acceptable Allegation of Compliance (AOC) from the Administrator on 1/30/15 at 12:05 PM.</p> <p>The AOC documented the following: It is also the policy of this facility to ensure that all physician orders are signed and dated. As well as orders for medications and treatments will be consistent with principles of safe and effective order writing. It is also the policy of this facility to maintain clinical records on each resident that are complete, accurately documented, readily accessible and systematically organized.</p> <p>Validation of the Credible Allegation of Compliance was accomplished on site 2/2/15 through 2/6/15 through record review, review of facility documents, observation and interviews with nursing, administration and corporate staff.</p> <p>The facility provided evidence of in-service training with sign in sheets for all licensed nursing staff dated 1/28/15 through 1/30/15 related to 24 hour chart checks, physician orders, admission orders, telephone orders, physician order sheets, reconciliation of medications with physician orders, lab ordering and tracking and reporting abnormal labs.</p> <p>The facility provided evidence of auditing tools utilized for 24 hour chart checks, physician orders, admission orders, telephone orders, physician order sheets, reconciliation of</p>	F 386	<p>Licensed nurses also received education and training on 1/29/15 and completed on 1/30/15 regarding processing of physicians orders related to obtaining, transcribing and obtaining signature SDC. Education and training also provided to licensed nurses on 1/29/15 and completed on 1/30/15 regarding medication reconciliation of physician orders and completion of twenty-four chart checks for current residents by SDC. Education and training also provided to licensed nurses on 1/29/15 and completed on 1/30/15 regarding medication reconciliation of physician orders and completion of twenty-four chart checks for current residents by SDC. Education and training also provided to licensed nurses regarding writing Physician orders will be written at the time of admission indicating admission to the facility by SDC.</p>		

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F 386	<p>Continued From page 157</p> <p>medications with physician orders, lab ordering and tracking and reporting abnormal labs.</p> <p>Medical record review on 2/5/15 documented 9 of 9 new admission charts admitted on or after 1/30/15 included the admission to the facility order, reconciliation of admission medication and treatment orders, Physician Order Sheets (POS), labs, admission nurses notes documenting verification of orders and admission skin assessments to ensure the process of chart checks was being done and any follow up was occurring.</p> <p>The licensed staff currently on leave of absence, vacation or per diem was sent a certified letter on 1/30/15 informing staff of the in-service and training and that the training must be completed prior to returning for their next scheduled shift.</p> <p>Observations were conducted on 2/2/15 of licensed staff's shift change reporting methods to validate pertinent resident information including anticoagulant medications, resulted and/or pending lab testing with utilization of the lab tracking tool, and new admissions with documented reconciliation of medications ordered by a physician was reported to the oncoming shift.</p> <p>Interviews with facility licensed nursing staff were conducted on 2/4/15 through 2/5/15 with staff from all floors and all shifts validating 24 hour chart checks, physician orders, lab ordering and tracking, reconciliation of medications with physician orders and clinical pathway for lab reporting and monitoring.</p> <p>The facility provided documentation of a complete</p>	F 386	<p>4:</p> <p>An audit of the medical record will be completed monthly by Medical Records and/or designee to ensure all monthly physician order statements are printed and signed.</p> <p>An audit of the medical record will be completed daily by DON/ ADON and/or RN Supervisor to ensure physician orders are obtained and transcribed correctly as well as signed.</p> <p>An audit of the medical record will be completed daily by DON/ADON and/or RN Supervisor to ensure that twenty-four hour chart checks are completed on all current residents and medication reconciliation was completed on all newly admitted residents.</p> <p>Results of audits will be reviewed with QAPI Committee by ADON / Designee. If audits demonstrate substantial compliance and QAPI committee approves, the frequency will be reduced periodically, over time, as indicated.</p> <p>If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of audit.</p>		

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F 386	<p>Continued From page 158</p> <p>laboratory audit completed on 1/28/15 on all active residents to ensure labs were performed according to physician orders as indicated on the care plan and the physician being notified when abnormal results are obtained and documented on a telephone order if change and treatment is required. The audits were reviewed and current to date and are ongoing.</p> <p>Interviews with the Administrator and Corporate Staff (Health Information Management) on 2/4/15 revealed the facility would continue monitoring by: A Quality Assurance (QA) meeting to be held weekly for four weeks beginning 2/5/15 and then monthly for findings, recommendations and follow up regarding the plan. The frequency of the audits to be maintained will be decided by the QA committee based on the findings of the audits.</p> <p>The survey team validated the AOC on 2/2/15 through 2/6/14. The IJ was removed as of 1/30/15.</p> <p>Non-compliance of the IJ continues at a scope and severity of an "E" level for F386 for monitoring of corrective actions. The facility is required to submit a plan of correction for all tags.</p> <p>The findings included:</p> <p>1. Review of the facility's "Admission Criteria" policy documented, "...The objectives of our admissions policies are to... Provide uniform criteria for admitting residents to the facility... Assure that the facility receives appropriate medical... records prior to or upon the resident's admission... Prior to or at the time of admission, the resident's Attending Physician must provide the facility with information needed for the</p>	F 386		
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F 386	<p>Continued From page 159</p> <p>immediate care of the resident, including orders covering at least: Type of diet... Medication orders, including (as necessary) a medical condition or problem associated with each medication; and Routine care orders to maintain or improve the resident's function... The Administrator, through the Admissions Department, shall assure that the resident and the facility follow applicable admission policies..."</p> <p>Review of the facility's physician visits and medical orders policy documented, "...All residents admitted to this facility must be under the direct supervision of a member of the active staff. Only those physicians with delineated clinical privileges to admit residents are allowed to do so. The attending physician must directly supervise the activities leading to the treatment of the resident... Medical orders are written by physicians to meet the needs of the resident..."</p> <p>2. Review of Sorensen and Luckmann's Basic Nursing A Psychophysiologic Approach, Third Edition, Chapter 46 documented, "[page] 1257... In relation to medication, physicians are... responsible for... (c) prescribing medications... monitoring the response to therapy... (e) modifying medication orders as necessary... [page] 1258... Medication prescriptions and orders are written by physicians..."</p> <p>3. Medical record review for Resident #43 documented an admission date of 9/23/14 with diagnoses of Heart Failure, Hypertension (HTN), Urinary Tract Infection, Diabetes Mellitus (DM), Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Cardiac Arrhythmia, Atrial Fibrillation (AFib), Pulmonary Disease, Anxiety and Depression.</p>	F 386		
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F 386	<p>Continued From page 160</p> <p>Review of a Nurse Practitioner's (NP) order dated 1/5/15 documented, "Remove nasal packing & [and] Restart Coumadin after observation and [symbol for no] sign of cont. [continued] bleeding..." This order was not signed and dated by the NP or physician.</p> <p>4. Medical record review for Resident #252 documented an admission date of 8/28/14 with diagnoses of Deep Vein Thrombosis (DVT), Hypertension (HTN), Chronic Renal Insufficiency, Diabetes Mellitus (DM) Type 2, Peripheral Neuropathy, Atrial Fibrillation, Anemia, Hyperlipidemia and Osteoarthritis.</p> <p>Review of a hospital "...Medications" discharge information form dated 8/28/14 documented, "...Your medication list... CHANGE how you take these medications..." that was not signed and dated by a physician.</p> <p>There were no medication and treatment recap orders signed and dated by a physician until the facility's POS generated 8/31/14 was signed by the facility's attending physician on September 2014 (exact date is illegible).</p> <p>5. Medical record review for Resident #299 documented an admission date of 8/4/14 and a readmission date of 8/20/14 with diagnoses of Cerebrovascular Accident (CVA), Chronic Hepatitis C, DM, HTN and Chronic Kidney Disease (CKD). The resident was discharged to the hospital on 8/18/14 and was readmitted to the facility on 8/20/14.</p> <p>The facility was unable to provide transferring / referring hospital orders, physician</p>	F 386			

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F 386	<p>Continued From page 161</p> <p>documentation of medication and treatment reconciliation orders or a POS signed by the facility's attending physician for Resident #299's initial admission on 8/4/14.</p> <p>Review of the hospital "...NURSING HOME DISCHARGE INSTRUCTIONS..." dated 8/20/14 from the transferring / referring hospital documented, "...Signed by: [Named Physician]... RESIDENT PHYSICIAN 08/20/2014 13:33 [1:30 pm] ...REQUIRES COSIGNATURE..." The discharge instructions form was not cosigned and dated by a physician.</p> <p>There were no medication and treatment recap orders signed and dated by the attending physician until the facility's POS generated 12/1/14 was signed by the physician on January 2(exact date illegible).</p> <p>During an interview at the 4th floor nurses' station on 2/2/15 at 5:00 PM, Nurse #2 was asked for signed and dated physician orders for Resident #299. Nurse #2 was unable to provide the documentation. Nurse #2 stated, "Apparently, the nurses were giving medications to this resident without signed orders."</p> <p>6. Medical record review for Resident #116 documented an admission date of 11/21/14 with diagnoses of Respiratory Failure, Coronary Artery Disease with Bypass Graft, Internal Defibrillator, DM, CHF and Chronic Kidney Disease (CKD).</p> <p>Review of the hospital "... POST ACUTE ADMISSION ORDERS" dated 11/20/14 from the transferring / referring hospital was not signed and dated by a physician.</p>	F 386			

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F 386	<p>Continued From page 162</p> <p>There were no signed and dated physician orders until the facility's Physician's order sheet (POS) generated on 11/30/14 was signed by the facility's attending physician on January 2015 (exact date is illegible).</p> <p>During an interview at the 4th floor nurses' station on 1/22/15 at 10:28 AM, Nurse #1 was asked about Resident #116's admission orders. Nurse #1 confirmed there were no signed admission orders for Resident #116 until January 2015.</p> <p>During an interview at the 4th floor nurses' station on 2/3/15 at 2:00 PM, Nurse #2 when asked for signed and dated admission orders for Resident #116. Nurse #2 stated, "If you can't find it in the chart, it isn't there and they would have been giving meds [medications] without signed orders. This resident does not have an overflow record."</p> <p>7. Medical record review for Resident #403 documented an admission date of 1/9/15 with diagnoses of Multiple Myeloma, Deconditioning and Peripheral Neuropathy.</p> <p>Review of the hospital "...Medication Reconciliation by Therapeutic Class - Discharge" from the transferring / referring hospital dated 1/8/14 was not signed and dated by a physician.</p> <p>The facility was unable to provide documentation of medication and treatment orders signed and dated by the facility's attending physician for January 2015.</p> <p>8. Medical record review for Resident #222 documented an admission date of 6/26/13 and a readmission date of 12/22/14 with diagnoses of Traumatic Brain Injury, DM Type 2, COPD, HTN,</p>	F 386		
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F 386	<p>Continued From page 163</p> <p>Seizure Disorder, Tracheostomy, Ventilator, Suprapubic Catheter, Percutaneous Endoscopy Gastrostomy (PEG) Tube, and Chronic Respiratory Failure. The resident was discharged to the hospital on 12/6/14 and returned to the facility on 12/22/14.</p> <p>Review of the hospital "... Transfer/Referral Form" from the transferring / referring hospital dated 12/22/14 documented, "... START taking these medications..." This form was not signed and dated by a physician.</p> <p>There were no medication and treatment recap orders signed and dated by a physician until the facility's POS generated 1/27/15 was signed by the facility's attending physician on January 2015 (exact date is illegible).</p> <p>9. Medical record review for Resident #229 documented an admission date of 10/22/13 and a readmission date of 7/18/14 with diagnoses of Gun Shot Wound, Respiratory Failure with Mechanical Ventilation via Tracheostomy Tube, Vegetative State and Depression. The resident was discharged to the hospital on 7/14/14 and was readmitted to the facility on 7/18/14.</p> <p>Review of the hospital "...Medication Reconciliation by Therapeutic Class - Discharge" dated 7/17/14 from the transferring / referring hospital was not signed and dated by a physician.</p> <p>There were no medication and treatment orders signed and dated by a physician until the facility's POS generated 10/31/14 was signed by the facility's attending physician on October 2014 (exact date is illegible).</p>	F 386			

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F 386	<p>Continued From page 164</p> <p>10. Medical record review for Resident #358 documented an admission date of 10/3/14 and readmission date of 11/10/14 with diagnoses of HTN, Parkinson's Disease, Depressive Disorder, Adult FTT, Systemic Lupus Erythematosus, Acute Pancreatitis, Gastrostomy and Malignant Neoplasm of the Parotid Gland and the Salivary Glands. The resident was discharged to the hospital on 11/2/14 and readmitted to the facility on 11/10/14.</p> <p>Review of the hospital "...Medications" discharge information form dated 10/3/14 from the transferring / referring hospital documented, "...Your medication list START taking these medications..." This form was not signed and dated by a physician.</p> <p>Review of the hospital "...Medication Reconciliation by Therapeutic Class - Discharge" dated 11/9/14 from the transferring / referring hospital was not signed or dated by a physician.</p> <p>The facility was unable to provide documentation of medication and treatment orders signed and dated by the facility's attending physician for admission of 10/3/14 or the readmission of 11/10/14.</p> <p>11. Medical record review for Resident #394 documented an admission date of 11/28/14 with diagnoses of COPD, HTN, DVT, Degenerative Joint Disease, Tracheostomy, Morbid Obesity, Respiratory Failure, Osteoarthritis and Motor Vehicle Accident - status post multiple surgeries related to traumatic injuries.</p> <p>Review of a physician's telephone order dated 11/29/14 documented, "...PT [physical therapy]</p>	F 386		
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F 386	<p>Continued From page 165</p> <p>Clarification Order..." was not signed and dated by the physician.</p> <p>Review of a NP telephone order dated 11/29/14 documented, "...Give 40 mEq [millequivalents] K+ [potassium] and 40 mEq in the AM, then start 20 mEq K+ PO [by mouth] q [every] day..." This telephone order was not signed and dated by the NP or physician.</p> <p>Review of a physician's telephone order dated 11/29/14 documented, "...OT [occupational therapy] Clarification..." was not signed or dated by the physician.</p> <p>Review of a NP telephone order dated 11/29/14 documented, "...Fiber Source 1 can q 4 [hours]..." This order was not signed or dated by the physician.</p> <p>Review of a NP telephone order dated 12/2/14 documented, "...Phenergan 12.5 mg IM [intramuscular] q 6 hrs [hours] prn [as needed]..." This order was not signed or dated by the NP or physician.</p> <p>Review of a telephone order dated 12/3/14 documented, "...Clarification Order: KUB [kidneys, ureters and bladder x-ray] today..." This order was not signed or dated by the physician or NP.</p> <p>Review of physician telephone order dated 12/5/14 documented, "Puree texture diet c [with] regular/thin liquids - no straws..." This order was not signed or dated by the physician.</p> <p>Review of a NP telephone order dated 12/5/14 documented, "...80 mEq of Potassium tonight</p>	F 386		
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F 386	<p>Continued From page 166</p> <p>12/5/14 then start 20 mEq q day 12/6/14..." This order was not signed or dated by the NP.</p> <p>Review of a NP telephone order dated 12/7/14 documented, "...Give additional Potassium Chloride 60 mEq elixir via peg [Percutaneous Endoscopy Gastrostomy tube] now..." This order was not signed or dated by the NP.</p> <p>Review of a physician telephone order dated 12/7/14 documented, "...Please hold po when pt [patient] on vent [ventilator] resume po when able to wean off again..." This order was not signed or dated by the physician.</p> <p>Review of a telephone order dated 12/16/14 documented, "...[symbol for change] TF [tube feeding]..." This order was not signed or dated by the physician or NP.</p> <p>Review of a NP telephone order dated 12/8/14 documented, "...Administer 60 mEq of Potassium by peg now and then give 80 mEq of Potassium by peg tonight at bedtime..." This order was not signed or dated by the NP.</p> <p>Review of a NP telephone order dated 12/18/14 documented, "...Place new midline [intravenous access] as soon as possible..." This order was not signed or dated by the NP.</p> <p>Review of a physician telephone order dated 12/29/14 documented, "...D/C [discontinue] current OT orders eff [effective] this date..." This order was not signed or dated by the physician.</p> <p>Review of a NP telephone order dated 12/30/14 documented, "...NOW portable CXR [chest x-ray] d/t [due to] coughing up old blood from Trach</p>	F 386		
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F 386	<p>Continued From page 167</p> <p>[tracheostomy] site..." This order was not signed or dated by the NP.</p> <p>Review of a NP telephone order dated 12/30/14 documented, "...Order clarification: Portable CXR NOW..." This order was not signed or dated by the NP.</p> <p>Review of a NP telephone order dated 1/12/15 documented, "...CMP [comprehensive metabolic panel] & CT [computerized tomography] of chest w [with] / contrast..." This order was not signed or dated by the NP.</p> <p>12. Medical record review for Resident #151 documented an admission date of 10/7/14 and a readmission date of 12/1/14 with diagnoses of COPD, Personal History of Fall, CKD, HTN, DM Type 2, CHF, Hypothyroidism, Bipolar Disorder Disease, Dementia and Anemia. A discharge summary documented the resident was discharged home on 11/12/14 with home health and returned to the facility from the hospital on 12/1/14 following multiple falls at home.</p> <p>Review of the hospital "...Final Active Medication List" dated 12/1/14 from the transferring / referring hospital was not signed and dated by a physician.</p> <p>There were no medication and treatment recapitulation (recap) orders signed and dated by a physician until the facility's POS generated 12/30/14 was signed by the facility's attending physician on January 2015 (exact date illegible).</p> <p>13. Medical record review for Resident #131 documented an admission date of 3/26/10 and a readmission dated of 12/2/14 with diagnoses of</p>	F 386			

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F 386	<p>Continued From page 168</p> <p>Hyponatremia, Brain Tumor, Seizures, Dementia, Hearing Loss and Syndrome of Inappropriate Antidiuretic Hormone.</p> <p>Review of the hospital "...Medication Reconciliation by Therapeutic Class - Discharge" dated 12/2/14 from the transferring / referring hospital was not signed and dated by a physician.</p> <p>There were no medication and treatment orders signed and dated by a physician until the facility's POS generated 1/27/15 was signed by the facility's attending physician on January 2015 (exact date is illegible).</p> <p>14. During an interview in the activity room on 1/26/14 at 5:05 PM, the Director of Nursing (DON) was asked about the missing POS documentation in the residents' medical records. The DON stated, "If everybody looks and can not find a signed copy, then we don't have a signed copy." The DON was asked when telephone orders should be signed. The DON stated, "Telephone orders must be signed within 10 days."</p> <p>During an interview in the activity room on 1/27/15 at 4:15 PM, Nurse #6 was asked about the facility's admission process. Nurse #6 confirmed the reconciliation orders sent with the residents from the transferring / referring hospital must be signed by the transferring physician and if not signed, the nurse would call the transferring hospital requesting a faxed signed copy of the orders.</p> <p>During an interview in the activity room on 1/27/15 at 4:15 PM, the DON was asked if the POS in the residents' medical records were</p>	F 386		
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F 386	Continued From page 169 physician orders. The DON stated, "The POS is the physician's orders. They have to be printed out and signed."	F 386			
F 387 SS=F	<p>The facility failed to ensure medication and treatment orders for residents admitted to the facility were signed and dated by a physician, which placed Residents #43, 252, 299, 116, 403, 222, 229, 358, 394, 151 and 131 in IJ.</p> <p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to ensure the physicians followed the facility's policy for completing a medical assessment within 72 hours of admission and/or a readmission to the facility for 25 of 37 (Residents #1, 19, 43, 62, 81, 116, 131, 151, 192, 222, 229, 239, 252, 294, 299, 358, 361, 394, 399, 400, 403, 405, 409, 410 and 412) sampled residents of the 53 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>1. Review of the facility's physician visits and</p>	F 387	<p>1. Resident #'s 81, 151, 192, 222, 252, 294, 399, 400, 405, 409, 410, 412 have been discharged.</p> <p>Resident #'s 1, 19, 43, 62, 116, 131, 229, 239, 299, 358, 361, 394, 403 are being followed by the physician with a medical assessment completed according facility policy.</p> <p>2. Facility wide audit completed to determine if physician visits are completed according to regulation on 4/28/2015 by Health Information Manager.</p>	5/28/2015	

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F 387	<p>Continued From page 170</p> <p>medical orders policy, effective date 12/2010, copied by the facility and given to the survey team upon request on 1/16/15 documented, "...A medical assessment is completed by a physician within 72 hours of admission..."</p> <p>During an interview in the activity room on 2/5/15 at 8:05 AM, the Administrator was asked if she was aware of the facility's policy documenting the initial visit by a physician must be done within 72 hours. The Corporate Consultant, also present during the interview, stated, "...Corporate did that for a reason..."</p> <p>On 2/5/15 at 8:55 AM, the Administrator returned to the activity room and presented a copy of a different policy to the survey team and stated this was the policy which should have been given to the survey team when the facility's policy for physician visits and/or orders was initially requested.</p> <p>Review of the facility's new "Physician Services" policy, with no documented effective date, documented, "...The resident must be seen by a physician at least every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The Initial comprehensive history and physical is to be completed by the physician, and then every other subsequent required visit can be completed by a NP [Nurse Practitioner] or PA [Physician Assistant]..."</p> <p>2. Medical record review for Resident #1 documented an admission date of 7/1/09 and readmission date of 12/24/14 with diagnoses of Cerebral Palsy, Psychosis, Diabetes Mellitus Type 2, Osteoporosis, Chronic Peptic Ulcer with Hemorrhage, Chronic Pancreatitis, Esophageal</p>	F 387	<p>3.</p> <p>Medical Records Director has received orientation on facility policy on timeliness of physician visits by Corporate Health Information Director on 3/10 - 3/20/2015. Medical Director and other attending physicians and collaborating NPs educated in regulation regarding frequency of physician visits by the Chief Nursing Executive (CNE) on 5/7/2015.</p> <p>4. Medical Records Director/designee will audit medical records for compliance of physician timeliness. Audits will be completed at 48 hours post admission and monthly. New Medical Director is in place and a new Director of Medical Records is in place. Audits will be presented monthly by ADON / Designee to the QAPI committee for review and further recommendations. If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of audit.</p>	
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F 387	<p>Continued From page 171</p> <p>Reflux, Depressive Disorder and Hypertension. The resident was discharged to the hospital on 12/17/14 with Severe Acute Iron Deficiency Anemia and readmitted to the facility 12/24/14.</p> <p>The facility was unable to provide documentation of a physician visit for Resident #1 following the readmission date of 12/24/14.</p> <p>3. Medical record review for Resident #19 documented an admission date of 5/20/11 and readmission date of 12/30/13 with diagnoses of Acute and Chronic Respiratory Failure, Transient Cerebral Ischemia, Hypertension, Dementia with Behavior Disturbance, Osteoarthritis, Bipolar Disorder, Huntington's Chorea, Persistent Vegetative State, Dysphagia and Hypothyroidism.</p> <p>Review of a physician's progress note dated 2/2014 (exact date illegible) was the first physician visit for Resident #19 since the readmission date of 12/30/14.</p> <p>4. Medical record review for Resident #43 documented an admission date of 9/23/14 with diagnoses of Heart Failure, Hypertension, Urinary Tract Infection, Diabetes Mellitus, Other Fracture, Coronary Artery Disease, Congestive Heart Failure, Cardiac Arrhythmia, Atrial Fibrillation, Diabetes Mellitus Type 2, Pulmonary Disease, Anxiety and Depression.</p> <p>Review of a physician's visit note dated 10/1/14 was the first physician's visit for Resident #43 since the admission date of 9/23/14.</p> <p>5. Medical record review for Resident #62 documented an admission date of 8/28/13 and readmission date of 12/9/14 with diagnoses of</p>	F 387		
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F 387	<p>Continued From page 172</p> <p>Acute Kidney Failure, Acute and Chronic Respiratory Failure, Respirator Dependent Status, History of Traumatic Brain Injury, Subarachnoid Hemorrhage, Gastrostomy, Joint Contracture, Muscle Spasms, and History of Alcohol Abuse. The resident was discharged to the hospital 11/24/14 and readmitted to the facility on 12/9/14.</p> <p>The facility was unable to provide documentation of a physician's visit for Resident #62 following the readmission date of 12/9/14.</p> <p>6. Medical record review for Resident #81 documented an admission date 7/1/09 and a readmission date 12/22/14 with diagnoses of Alzheimer's disease, Diabetes Mellitus Type 2, Hypertension, Convulsions and Hyperlipidemia.</p> <p>The facility was unable to provide documentation of a physician visit for Resident #81 following the readmission date of 12/22/14.</p> <p>7. Medical record review for Resident #116 documented an admission date of 11/21/14 with diagnoses of Respiratory Failure, Coronary Artery Disease with Bypass Graft, Defibrillator, Diabetes Mellitus, Congestive Heart Failure and Chronic Kidney Disease.</p> <p>The facility was unable to provide documentation of a physician visit for Resident #116 following the readmission date of 11/21/14.</p> <p>During an interview at the 4th floor nurses' station on 1/22/15 at 10:28 AM, Nurse #1 confirmed the admission medical assessment was completed by the Nurse Practitioner not the physician as per policy.</p>	F 387			

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F 387	<p>Continued From page 173</p> <p>8. Medical record review for Resident #131 documented an admission date of 3/26/10 and a readmission date of 12/2/14 with diagnoses of Hyponatremia, Brain Tumor, Seizures, Dementia, Hearing Loss and Inappropriate Antidiuretic Hormone. The resident was discharged to the hospital on 11/28/14 and readmitted to the facility on 12/2/14.</p> <p>The facility was unable to provide documentation of a physician visit for Resident #131 following the readmission of 12/2/14.</p> <p>9. Medical record review for Resident #151 documented an admission date of 10/7/14 and a readmission date of 12/1/14 with diagnoses of Chronic Obstructive Pulmonary Disease, Personal History of Fall, Chronic Kidney Disease, Hypertension, Diabetes Mellitus Mellitus Type 2, Congestive Heart Failure, Hypothyroidism, Bipolar Disorder, Dementia and Anemia.</p> <p>Review of a physician visit note dated 10/15/14 was the first physician visit following the admission date of 10/7/14.</p> <p>Review of a physician visit note dated 12/10/14 was the first physician visit following the readmission of 12/1/14.</p> <p>10. Medical record review for Resident #192 documented an admission date of 10/31/14 with diagnoses of Cerebrovascular Accident, Atrial Fibrillation, Long Term Anticoagulation Therapy and Weakness.</p> <p>Review of a physician's progress note dated 12/7/14 was the first physician visit for Resident</p>	F 387		
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F 387	<p>Continued From page 174 #192's admission of 10/31/14.</p> <p>11. Medical record review for Resident #222 documented an admission date of 6/26/13 and readmission date of 12/22/14 with diagnoses of Chronic Respiratory Failure on Mechanical Ventilation via Tracheostomy, Traumatic Brain Injury, Seizures, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Hypertension, Percutaneous Endoscopy Gastrostomy (PEG) Tube, Vegetative State and Suprapubic Catheter.</p> <p>Review of a physician's progress note dated 1/21/15 was the first physician visit for Resident #222 following the readmission date of 12/22/14.</p> <p>12. Medical record review for Resident #229 documented an admission date of 10/22/13 and a readmission date of 7/18/14 with diagnoses of Gun Shot Wound, Respiratory Failure with Mechanical Ventilation via Tracheostomy Tube, Vegetative State and Depression.</p> <p>Review of a physician's visit note dated 10/31/14 was the first physician visit for Resident #229 following the readmission date of 7/18/14.</p> <p>13. Medical record review for Resident #239 documented an admission date of 12/9/13 and a readmission date of 6/5/14 with diagnoses of Chronic Respiratory Failure, Hypertension, Pulmonary Embolism, Heart Failure, Coronary Artery Disease with History of Myocardial Infarction, PEG Tube, Tracheostomy and Amyotrophic Lateral Sclerosis (ALS).</p> <p>Review of a physician's visit note dated 8/13/14 was the first physician visit for Resident #239 following the readmission date of 6/5/14.</p>	F 387			

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F 387	Continued From page 175 14. Medical record review for Resident #252 documented an admission date of 8/28/14 with diagnoses of Deep Vein Thrombosis, Chronic Renal Insufficiency, Hypertension, Diabetes Mellitus Type 2, Peripheral Neuropathy, Atrial Fibrillation, Anemia, Hyperlipidemia and Osteoarthritis. Review of a physician visit note dated 9/15/14 was the first physician visit for Resident #252 following the admission date of 8/28/14. 15. Medical record review for Resident #294 documented an admission date 9/9/14 and a readmission date of 11/29/14 with diagnoses of Sepsis, History of Drug and Alcohol Abuse, Diabetes Mellitus, Cerebrovascular Accident - Main Brainstem Infarction, Anoxic Brain Injury, Respiratory Failure, Ventilator Dependent via Tracheostomy, PEG Tube, Acute and Chronic Renal Failure, Pulmonary Embolism, Pneumonia and Anemia. Review of a physician's visit note dated 9/24/14 was the first physician visit for Resident #294 following the admission date on 9/9/14. The facility was unable to provide documentation for a physician visit following the resident's readmission date of 11/29/14. 16. Medical record review for Resident #299 documented an admission date of 8/4/14 and a readmission date of 8/20/14 with diagnosis Cerebrovascular Accident, Chronic Hepatitis C, Diabetes Mellitus Type 2, Hypertension and Chronic Kidney Disease. Review of a physician's visit note dated 8/25/14	F 387			

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F 387	<p>Continued From page 176</p> <p>was the first physician visit for Resident #299 following the admission date of 8/4/14 and readmission date of 8/20/14.</p> <p>17. Medical record review for Resident #358 documented an admission date of 10/3/14 and readmission date of 11/10/14 with diagnoses of Hypertension, Parkinson's Disease, Depressive Disorder, Adult Failure to Thrive, Systemic Lupus Erythematosus, Acute Pancreatitis, Gastrostomy and Malignant Neoplasm of the Parotid Gland and the Salivary Glands.</p> <p>Review of a physician's visit note dated 10/15/14 was the first and only physician visit for Resident #358 following her admission date of 10/3/14 and the readmission date of 11/10/14.</p> <p>18. Medical record review for Resident #361 documented an admission date of 11/6/14 and readmission date of 12/2/14 with diagnoses of Aspiration Pneumonia, Recent Intracranial Hemorrhage with Ventriculoperitoneal Shunt, Hydrocephalus, Anoxic Brain Injury, Acute / Chronic Respiratory Failure, Tracheostomy, Syndrome of Inappropriate Antidiuretic Hormone, PEG Tube and Hypertension.</p> <p>Review of a physician's visit note dated 12/10/14 was the first and only physician visit for Resident #361 following the admission date of 11/6/14 and the readmission date of 12/2/14.</p> <p>19. Medical record review for Resident #394 documented an admission date of 11/28/14 with diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, Deep Vein Thrombosis, Degenerative Joint Disease, Tracheostomy, Morbid Obesity, Respiratory Failure, Motor</p>	F 387			

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F 387	<p>Continued From page 177</p> <p>Vehicle Accident - status post multiple surgeries related to traumatic injuries and Osteoarthritis.</p> <p>Review of a physician's visit note dated 12/3/14 was the first and only physician visit for Resident #394 following the admission date of 11/28/14.</p> <p>20. Medical record review for Resident #399 documented an admission date of 11/20/14 with diagnoses of Status Post Repair of a Tibia-Fibular Fracture, Congestive Heart Failure, Hypertension, Diabetes Mellitus Type 2, Cardiomyopathy and History of Breast Cancer Status Post Lumpectomy and Chemotherapy.</p> <p>Review of a physician's visit note dated 11/26/14 was the first physician visit for Resident #399 following the admission date of 11/20/14.</p> <p>21. Medical record review for Resident #400 documented an admission date of 12/31/14 with diagnoses of Urinary Tract Infection, Fever, Dementia, Mental Status Changes, History of Renal Failure and Urinary Retention, Muscle Weakness and Hypertension.</p> <p>Review of a physician's visit note dated 1/7/15 documented the first and only physician's visit for Resident #400 following the admission date of 12/31/14.</p> <p>22. Medical record review for Resident #403 documented an admission date of 1/9/15 with diagnoses of Multiple Myeloma without mention of having achieved remission, Deconditioning, Peripheral Neuropathy, Chronic Venous Embolism and Thrombosis of Unspecified Deep Vessels of the Lower Extremity, Osteoarthritis Multiple Sites, Hypertension, Muscle Weakness</p>	F 387		

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F 387	<p>Continued From page 178 and Rehabilitation.</p> <p>Review of a physician's visit note dated 1/14/15 was the first physician visit for Resident #403 following the admission date of 1/9/15.</p> <p>23. Medical record review for Resident #405 documented an admission date of 1/6/15 with diagnoses of Hypertension, Pneumonia, Non-Alzheimer's Dementia, Anxiety Disorder, Chronic Obstructive Pulmonary Disease and Personal History of Fall.</p> <p>The facility was unable to provide documentation of a physician's visit for Resident #405 for the admission date of 1/6/15.</p> <p>24. Medical record review for Resident #409 documented an admission date of 12/12/14 with diagnoses of History of Pulmonary Embolus, Hypertension, Orthostatic Hypotension, Left Shoulder Fracture, Personal History of Fall, Dehydration and Hyperlipidemia.</p> <p>The facility was unable to provide documentation of a physician visit for Resident #409 for the resident's stay in the facility.</p> <p>25. Medical record review for Resident #410 documented an admission date of 12/3/14 with diagnosis of Hypertension, Pain in Limb, Right Hip Fracture, Personal History of Fall, Hypothyroidism, Atrial Fibrillation and Osteoporosis.</p> <p>Review of a physician's visit note dated 12/10/14 was the first physician visit for Resident #410 the admission date of 12/3/14.</p>	F 387		

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F 387	Continued From page 179 26. Medical record review for Resident #412 documented an admission date of 7/10/14 with diagnoses of Colon Cancer with Liver Metastasis, Adrenal Gland Mass, Hypertension, Malnutrition, Ascites, Deep Vein Thrombosis, Pulmonary Embolus and Anemia.	F 387		
F 406 SS=G	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility's rehabilitation department failed to provide a restorative nursing program for range of motion (ROM) exercises and failed to provide education to direct care staff for bathing for 2 of 3 (Residents #294 and 409) sampled residents reviewed for rehabilitation of the 53 residents included in the stage 2 review. The facility failed to provide the restorative nursing for ROM which resulted in actual harm when Resident #294, developed limitations in	F 406	1. Resident #294 and 409 is discharged 2. Baseline audit completed by Rehab Service Manager on 2/13/15, to determine status of therapy referrals to restorative. No new issues were identified. A facility wide audit was completed to validate that bath schedules and the documentation of baths are being given according to schedule by the ADON. Residents currently using an external device such as an immobilizer, splint or cast were audited to validate each identified resident has an updated skin assessment, bath schedule is being maintained and physicians order and care plan is present for care of immobilizer, splint or cast 3. Residents will have an established restorative program upon discharge from therapy when indicated. Form used to communicate to nursing will be the Discharge Communication Form. In-service has been provided to full time therapy staff on the protocol.	5/28/2015

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F 406	<p>Continued From page 180 functional ROM of the upper extremities.</p> <p>The findings included:</p> <p>1. Closed medical record review for Resident #294 documented an admission date of 9/9/14 with diagnoses of Acute and Chronic Respiratory Failure, Ventilator Dependence via Tracheostomy, Percutaneous Endoscopy Gastrostomy Tube, History of Drug and Alcohol Abuse, Pulmonary Embolus, Acute and Chronic Renal Failure, Anemia and Cerebrovascular Accident - Main Brainstem Infarction.</p> <p>Review of the comprehensive admission Minimum Data Set (MDS) dated 9/16/14 documented the resident was in a persistent vegetative state with no discernible consciousness requiring extensive assistance with activities of daily living (ADLs), and had no impairment of the upper extremity (UE) in functional limitation of ROM. Review of the quarterly MDS dated 12/7/14 documented the resident was no longer in a persistent vegetative state, continued to require extensive assistance with ADLs, and had impairment on both sides of the UE in functional ROM.</p> <p>Review of a rehab therapy "Discharge Communication Form" dated 10/21/14 documented, "...Discharge Plan D/C [discharge] to facility w [with] / Restorative... Discharge Date 10/30/14... Restorative Nursing Program for ROM... Active Assistive Range of Motion [AAROM] Passive Range of Motion [PROM]... PROGRAM GOALS: Maintain normal ROM, Maintain muscle strength, Prevent deformity..." The "Restorative Nursing Program" for ROM dated 10/21/14 documented PROM the resident's</p>	F 406	<p>Prior to discharge to the Restorative Nursing Program, the responsible therapist will educate the restorative nurse on the specific needs of the resident. The therapist will work with nursing to get an order for discontinuing therapy and transitioning resident to Restorative Program.</p> <p>Certified Nursing Assistants will be in-serviced on how to perform range of motion by Staff Development department by 4/17/2015.</p> <p>Nursing staff received education on 04/17/2015 by the Staff Development Department related to personal care and hygiene with emphasis on resident using an immobilizer, splint or cast. Upon admission, any resident with an external device, such as an immobilizer, splint or cast, will be evaluated by the therapy department. Education will be provided to the nursing staff from the therapy department demonstrating care and use of the device, such as an immobilizer, splint or cast after admission.</p>		

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F 406	<p>Continued From page 181</p> <p>shoulders and AAROM for the resident's elbows and hands.</p> <p>Review of a physician's order dated 11/3/14 documented, "D/C [discontinue] PT [physical therapy] services [after] tx [treatment] this date (eff. [effective] 10/28/14) [secondary] max [maximum] benefit. Restorative program for ROM of UE/LE [lower extremity] & [and] positioning 5d [days] / [per] wk [week] x [for] 6 wks..."</p> <p>Review of the restorative service delivery record for November 2014, December 2014 and January 2015 revealed no exercises were documented as being performed with Resident #294 for the upper extremities.</p> <p>Review of a NP's order dated 12/11/14 documented, "PT to eval [evaluate] / [and] tx [treat] as indicated - pt [patient] more responsive..."</p> <p>Review of an "OT [Occupational Therapy] Evaluation & [and] Plan of Treatment" dated 12/18/14 documented, "...ROM... Right Shoulder = Impaired... Pt's digits [fingers of both hands] remain in a flexed potion [contracted]... Left Shoulder = Impaired... Left Elbow/ Forearm = Impaired... Left Wrist Impaired..."</p> <p>During an interview at the 4th floor nurses' station on 1/29/15 at 11:10 AM, Certified Nursing Assistant (CNA) #10, Resident #294's direct care CNA, was asked if she was performing ROM exercises with Resident #294. CNA #10 stated, "When bathing I would raise her arms to wash. Restorative was going in there and straightening her arms out, [arms] were beginning to draw up toward her chest."</p>	F 406	<p>4: If audits demonstrate substantial compliance and QAPI committee approves, the frequency will be reduced periodically, over time, as indicated.</p> <p>A Personal Hygiene audit will be conducted by ADON Designee for 20% of the resident population five days per week for 4 weeks, then, if QAPI committee approves, once weekly for 4 weeks or until substantial compliance is achieved.</p> <p>Trends will be reported to the QAPI committee for review by the ADON / Designee and further recommendation of continued auditing.</p> <p>If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of audit.</p>	
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F 406	<p>Continued From page 182</p> <p>During an interview in the activity room on 1/30/15 at 9:15 AM, the Therapy Director was asked about ROM exercises for Resident #294's upper body, The Therapy Director stated, "We extended her a week past the original discharge date from occupational therapy and did not do an updated restorative plan. We just flat out missed it."</p> <p>During an interview in the 4th floor employee breakroom on 2/3/15 at 10:10 AM, CNA #9, a Restorative CNA, was asked if she was performing ROM exercises with Resident #294. CNA #9 stated, "She was passive range of motion. It was lower. The program was for lower body exercises." CNA #9 was not performing in ROM exercises for the upper body.</p> <p>The facility's failure to provide ROM exercises for Resident #294's upper body resulted in actual harm when Resident #294 developed contractures, fixed high resistance to passive stretch of a muscle and limiting functional ROM of the upper extremities.</p> <p>2. Medical record review for Resident #409 documented an admission date of 12/12/14 with diagnoses of History of Pulmonary Embolus, Hypertension, Orthostatic Hypotension, Left Shoulder Fracture, Personal History of Fall, Dehydration and Hyperlipidemia.</p> <p>Review of the comprehensive admission MDS assessment dated 12/19/14 documented a cognitive status score of 14 out of a possible 15, indicating the resident was cognitively intact, required the physical help in part of bathing activity of one staff member and had functional</p>	F 406			

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F 406	Continued From page 183 limitation in range of motion of both the UE and LE on one side of his body. Review of a "Formal Complaint Concerning Care Received By [named Resident #409]... between 12/12/2014 and 1/12/2015" documented, "He [Resident #409] had been wearing the same [left] shoulder immobilizer for 10 days and it was beginning to have a foul odor. We asked if a second immobilizer could be obtained so they could be switched out for laundering. We also noted that someone had unfastened the immobilizer in order to put a shirt on under it. I asked when he would be getting a bath and a change of clothes. I was told that bath days were Mon. [Monday], Wed. [Wednesday], and Fri [Friday] and that only therapy could do anything with the immobilizer... 12/16/14 He was still wearing the same clothes he was admitted in. Begged O.T. [Occupational Therapist] to find out who was supposed to be assisting him with personal care. She left his room, stayed gone for some time and returned with bathing supplies, saying she guessed she'd do it herself. She had him lay on his back, unfastened the immobilizer and washed his front... She never washed any part of his back...12/22/14...The shoulder immobilizer had now been in place for 19 days without being laundered. It smelled horrible...12/25/14 [Named Resident #409's] family member assisted him with bathing since [Named Resident #409] stated that he was still not getting the assistance he required... 12/29/14... [Named Nurse #8 and Named Rehab Personnel #1] came to [Named Resident #409's] room to discuss the personal care issue... They asked [Named Resident #409] why the nursing assistants were not assisting him with bathing. He stated he didn't know because none of them had	F 406			

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F 406	<p>Continued From page 184</p> <p>ever mentioned helping him with bathing. They asked if anyone had assisted him with bathing since he had been there. He stated that [Named Rehab Personnel #1] had helped him once and that a family member had helped him once. I told them that [Named CNA #11] and I had also helped him once. [Named Nurse #8 and Named Rehab Personnel #1] assisted him with bathing and putting on clean clothes..."</p> <p>Review of a physician order dated 12/13/14 documented, "...OT to eval [evaluate] and treat as indicated..."</p> <p>Review of an OT Evaluation & [and] Plan of Treatment dated 12/13/14 documented, "...Functional Skills Assessment... Bathing = Max [maximum] (A) [assistance]..."</p> <p>Review of Resident #409's "Bath Report" for the month of December 2014 documented only 3 full baths/showers were given for the month.</p> <p>Review of the OT Treatment Encounter Notes dated 12/29/14 documented, "...Pt [patient] / cg [caregiver] education regarding pt's POC [Plan of Care] / goals completed this date. Education regarding bathing techniques/ protocols for pt with emphasis on managing his immobilizer completed this date with ADON [Assistant Director of Nursing] on 2nd floor with pt's family member in the room. ADON verbalized understanding of techniques and will educate the CNA staff..."</p> <p>During an interview in the activity room on 1/21/15 at 11:15 AM, Rehab Personnel #1 was asked, if the facility staff needed education concerning a resident with an immobilizer</p>	F 406		
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F 406	Continued From page 185 regarding a residents care, what was the appropriate time to complete the education. Rehab Personnel #1 stated, "It should start at the get go. The education should have been initiated at the time his evaluation was done. He [Resident #409] has got this [immobilizer], this is how you work around it." Rehab Personnel #1 was asked the date staff education was documented for Resident #409. Rehab Personnel #1 stated, "The first note I can find is on 12/29/14." The facility's rehabilitation department failed to provide necessary education to direct care staff for bathing a resident with a splint / immobilizer worn due to Resident #409's right humerus fracture.	F 406			
F 505 SS=K	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to promptly notify the physician or nurse practitioner (NP) of laboratory (lab) results so that prompt actions could be taken for 6 of 16 (Residents #43, 211, 252, 192, 410 and 412) sampled residents reviewed for lab monitoring of the 53 residents included in the stage 2 review. The facility's system failure related to reporting lab results for anticoagulant monitoring resulted in Immediate Jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is	F 505	1: Resident #'s 252, 211,192, 410, 411, 412 have been discharged. 2: Resident #' 43 have current signed Physician's order statements, laboratory tests are being done per physician's order and receiving medications per physician order.	5/28/2015	

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F 505	<p>Continued From page 186</p> <p>likely to cause, serious injury, harm, impairment or death to a resident. The facility failed to notify the physician or nurse practitioner of critical or subtherapeutic lab results which placed Residents #43, 211, 252, 192, 410 and 412 at risk for serious injury related to abnormal bleeding and/or hemorrhage, harm, impairment or death.</p> <p>A meeting was conducted in the activity room on 1/27/15 at 3:15 PM with the Administrator and she was informed of the IJ.</p> <p>The survey team received an acceptable Allegation of Compliance (AOC) from the Administrator on 1/30/15 at 12:05 PM.</p> <p>The AOC documented the following: It is the policy of this facility to ensure all resident's abnormal results are reported to the physician/nurse practitioner timely.</p> <p>Validation of the Credible Allegation of Compliance was accomplished on site 2/2/15 through 2/6/15, through record review, review of facility documents, observation and interviews with nursing, administration and corporate staff.</p> <p>The facility provided evidence of in-service training with sign in sheets for all licensed nursing staff dated 1/28/15 through 1/30/15 related to 24 hour chart checks for tracking and promptly reporting abnormal lab results.</p> <p>The facility provided evidence of auditing tools utilized for 24 hour chart checks for tracking and reporting abnormal labs.</p> <p>Medical record review on 2/5/15 documented 9 of 9 new admission charts admitted on or after</p>	F 505 3	<p>Licensed Nurses are responsible for the Laboratory Tracking process for obtaining orders, transcribing orders and validating completion and proper notifications of results. Laboratory tracking is included in morning clinical review five days per week. Frequently there is a follow up review at end of day. The supervising nurse on weekends will validate laboratory tracking process in place.</p> <p>Education and training initiated on 1/28/15 and completed on 1/30/15 with all licensed nursing staff by the Staff Development Coordinator or RN Supervisor regarding facility's policy on performing labs according to physician's orders and physician notification with documentation on the lab when abnormal results are obtained.</p> <p>The licensed nurses that were on leave of absence, vacation or per diem were sent a certified letter on 1/30/15 indicating training regarding the procedure of printing monthly physician order statements and obtaining physician signature, processing of physicians orders related to obtaining, transcribing and obtaining signature and medication reconciliation of physician orders, completion of twenty-four chart checks for current resident and physician orders will be written at the time of admission indicating admission to the facility, physician assigned and that physician orders were verified with a physician must be completed prior to returning for next scheduled shift.</p>	
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F 505	<p>Continued From page 187</p> <p>1/30/15 included the Physician Order Sheets (POS), labs, admission nurses notes documenting verification of orders to ensure the process of chart checks was being done and any follow up was occurring.</p> <p>The licensed staff currently on leave of absence, vacation or per diem was sent a certified letter on 1/30/15 informing staff of the in-service and training and that the training must be completed prior to returning for their next scheduled shift.</p> <p>Observations were conducted on 2/2/15 of licensed staff's shift change reporting methods to validate pertinent resident information including anticoagulant medications, results and/or pending lab testing, and the physician notified as necessary, was reported to the oncoming shift with utilization of the lab tracking tool.</p> <p>The facility provided documentation of a complete laboratory audit completed on 1/28/15 on all active residents to ensure labs were performed according to physician orders and the physician was being notified when abnormal results are obtained and documented on a telephone order if change and treatment is required. The audits were reviewed and current to date and are ongoing.</p> <p>Interviews with facility licensed nursing staff were conducted on 2/4/15 through 2/5/15 with staff from all floors and all shifts validating 24 hour chart checks, physician orders, lab ordering and tracking and clinical pathway for lab reporting and monitoring.</p> <p>Interviews with the Administrator and Corporate Staff (Health Information Management) on 2/4/15</p>	F 505	<p>#4</p> <p>DON, ADON or Weekend Supervisor will audit all physicians orders routinely related to laboratory diagnostics to ensure that labs are obtained according to physician's orders as indicated on care plan and any abnormal results are reported to the physician/nurse practitioner timely. Audit trends are reported to the QAPI committee, by ADON / Designee for review and further recommendations.</p> <p>If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of audit.</p>	
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F 505	<p>Continued From page 188</p> <p>revealed the facility would continue monitoring by a Quality Assurance (QA) meeting to be held weekly for four weeks beginning 2/5/15 and then monthly for findings, recommendations and follow up regarding the plan. The frequency of the audits to be maintained will be decided by the QA committee based on the findings of the audits.</p> <p>The survey team validated the AOC on 2/2/15 through 2/6/14. The IJ was removed as of 1/30/15.</p> <p>Non-compliance of the IJ continues at a scope and severity of an "E" level for F505 for monitoring of corrective actions. The facility is required to submit a plan of correction for all tags.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Anticoagulation - Clinical Protocol" policy documented, "...the nurse shall assess and document/report the following: <ol style="list-style-type: none"> a. Current anticoagulation therapy... b. Recent labs, including therapeutic dose monitoring... The staff should use a warfarin [Coumadin] sheet or comparable monitoring tool to follow trends in anticoagulant dosage response... The staff and physician will monitor for possible complications in individuals who are being anticoagulated..." <p>Review of the facility's "Clinical Pathway for Laboratory Reporting" policy documented, "The facility is expected to follow notification from AMDA [American Medical Director's Association] standards... The following results MUST be called immediately: STAT [immediately] labs, Alert or panic labs... The following abnormal labs: INR [International Normalized Ratio - measures the ability of blood to form a clot] greater than 3.0 or</p>	F 505		
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F 505	<p>Continued From page 189 less than 2.0..."</p> <p>2. Medical record review for Resident #43 documented an admission date of 9/23/14 with diagnoses of Heart Failure, Hypertension, Atrial Fibrillation, Urinary Tract Infection, Diabetes Mellitus, Coronary Artery Disease, Congestive Heart Failure, Diabetes Mellitus, Pulmonary Disease, Anxiety and Depression.</p> <p>Review of a lab report dated 10/7/14 documented, "...PT 15.0... [Ref [reference] range 11.7- [to] 14.9] INR 1.23... [Ref Range 0.00-1.13...]." There was no documentation provided that the physician or NP was notified of PT/INR results on 10/7/14.</p> <p>Review of the lab result dated 10/27/14 documented, "PT 21.3... INR 1.96..." There was no documentation the physician or NP was notified of the PT/INR results on 10/27/14.</p> <p>Review of a lab report dated 11/27/14 documented, "...PT 19.6... INR 1.75..." There was no documentation the NP or physician was notified of the PT/INR results on 11/27/14 as ordered.</p> <p>3. Medical record review for Resident #211 documented an admission date of 1/25/13 with diagnoses of Cerebrovascular Accident (CVA), Anoxic Brain Injury, Chronic Respiratory Failure, Hypertension, Myelopathy and Tracheostomy.</p> <p>Review of lab report dated 4/7/14 documented, "...PT [Prottime-measures the ability of blood to form a clot. Reference range 11.7 to (-) 14.9] 49.1... INR 5.22 [Therapeutic range 2.0-3.0]..."</p> <p>Review of a NP progress note dated 4/7/14 at</p>	F 505		
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F 505	<p>Continued From page 190</p> <p>1:33 PM documented, "...Currently on Warfarin for CVA... Today's INR critical value 5.22. This value was not called to me..." Review of a physician order dated 4/7/14 documented, "...Hold Warfarin x [times] 2 days. Give Vitamin K [increases the ability of blood to clot quickly] 1 mg IM/SQ [intramuscular or subcutaneous] now. Recheck INR in AM..."</p> <p>Review of lab results dated 4/10/14 at 5:00 PM documented, "PT 15.9... INR 1.33..." Review of a NP progress note dated 4/11/14 documented, "...Patient seen today for anticoagulation management. INR was not called to me as ordered. INR subtherapeutic at 1.33. Last INR was 5.22. Patient received Vitamin K..."</p> <p>Review of a lab report dated 6/28/14 documented, "...INR 1.49..." There was no documentation the NP or physician was notified of the subtherapeutic INR level on 6/28/14.</p> <p>During an interview in the Director of Nursing's (DON) office on 2/3/15 at 10:45 AM, the DON confirmed the Clinical Pathway for Laboratory Reporting was not followed and the NP was not notified of INR values less than 2.0 or greater than 3.0. The DON stated, "I see what you are saying, just put it in the tag [deficiency]."</p> <p>4. Medical record review for Resident #252 documented an admission date of 8/28/14 with diagnoses of Deep Vein Thrombosis (DVT), Hypertension, Chronic Renal Insufficiency, Diabetes Mellitus Type 2, Peripheral Neuropathy, Atrial Fibrillation, Anemia, Hyperlipidemia and Osteoarthritis.</p> <p>Review of a lab report dated 8/29/14</p>	F 505		
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F 505	<p>Continued From page 191</p> <p>documented, "...PT 38.3... INR 4.25..." There was no documentation the NP or physician was promptly notified of the elevated INR. They were not notified until 8/30/14.</p> <p>Review of a lab report dated 9/2/14 documented, "...PT 14.2... INR 1.15..." There was no documentation the NP or physician was notified of the subtherapeutic INR level on 9/2/14.</p> <p>Review of a NP's telephone order dated 9/8/14 at 11:30 AM documented, "...PT/INR in [one] wk..."</p> <p>Review of a lab report dated 9/15/14 documented, "...PT 17.8... INR 1.55..." There was no documentation the NP or physician was notified of the subtherapeutic INR level on 9/15/14.</p> <p>Review of a lab report dated 9/22/14 documented, "...PT 17.9... INR 1.56..." There was no documentation the NP or physician was notified of the subtherapeutic INR level on 9/22/14.</p> <p>Review of a NP's telephone order dated 9/19/14 at 1:30 PM documented, "... Transfer to [named hospital] (Per Family Request) Facial Drooping..."</p> <p>Review of a NP's telephone order dated 9/23/14 documented, "...[symbol for increase] Coumadin to 4 mg tab [tablet] po [by mouth] q HS [hour of sleep / bedtime]. PT/INR 9/29/14 A.M..." Review of a lab report dated 9/29/14 printed at 12:09 PM documented, "PT 31.6... INR 3.30..." There was no documentation the NP or physician was notified of the elevated INR level on 9/29/14.</p> <p>Review of a NP's telephone order dated 10/6/14 at 1:20 PM documented, "...Hold Coumadin</p>	F 505		
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F 505	<p>Continued From page 192</p> <p>today. PT/INR in A.M. [symbol for decrease] to 3.5 mg po q HS [hour of sleep]..." Review of a lab report dated 10/7/14 documented, "...PT 31.2... INR 3.24..." There was no documentation the NP or the physician were notified of the elevated PT/INR level on 10/7/14.</p> <p>Review of a lab report dated 10/27/14 printed at 7:21 AM documented, "...PT 14.3... INR 1.16..." There was no documentation the NP or the physician was notified of the subtherapeutic INR level on 10/27/14.</p> <p>Review of a lab report dated 11/3/14 printed at 7:28 AM documented, "...PT 15.2... INR 1.25..." There was no documentation the NP or physician was notified of the subtherapeutic INR level on 11/3/14.</p> <p>During a interview at the 3rd floor nurses' station on 2/9/14 at 4:50 PM, Nurse #6 was asked when the elevated INR should have been reported to the NP or physician. Nurse #6 stated, "The 4.25 INR should have been called as soon as she [the nurse] got the results."</p> <p>5. Medical record review for Resident #192 documented an admission date of 10/31/14 with diagnoses of Cerebrovascular Accident, Atrial Fibrillation, Long Term Anticoagulation Therapy and Weakness.</p> <p>Review of a lab report dated 11/3/14 documented an INR of 1.14. There was no documentation the NP was notified of the subtherapeutic level on 11/3/14.</p> <p>Review of a telephone order dated 11/13/14 documented, "PT INR 11/17/14 AM..." Review of</p>	F 505		
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F 505	<p>Continued From page 193</p> <p>a lab report dated 11/17/14 documented, "...PT 13.0 INR 1.02..." There was no documentation the NP or physician was notified of the subtherapeutic level on 11/17/14.</p> <p>6. Medical record review for Resident #410 documented an admission date of 12/3/14 with diagnoses of Hypertension, Pain in Limb, Right Hip Fracture, Personal History of Fall, Hypothyroidism, History of Chronic Warfarin Anticoagulation, Atrial Fibrillation and Osteoporosis. Resident #410 was transferred to hospital on 12/6/14, underwent a thrombectomy, and returned with a new diagnoses of DVT of the Right Upper Extremity on 12/6/14.</p> <p>Review of a PT/INR dated 12/11/14 printed at 7:06 AM documented, "...PT 16.4... INR 1.39..." There was no documentation the physician or NP was notified of the subtherapeutic INR level on 12/11/14.</p> <p>7. Medical record review for Resident #412 documented an admission date of 7/10/14 with diagnoses of Stage IV Metastatic Colon Cancer, Hypertension, Right Lower Extremity DVT, Failure to Thrive, Pleural Effusion, Malnutrition and Post Hemicolectomy and Ileostomy.</p> <p>Review of lab report dated 7/28/14 documented, "...PT 16.9... INR 1.44..." There was no documentation the NP or physician was notified of the subtherapeutic INR level on 7/28/14.</p> <p>8. The facility failed to ensure abnormal blood levels related to anticoagulant therapy were promptly reported to the physician or NP, this placed Residents #43, 211, 252, 192, 410 and 412 at a high risk for serious injury related to</p>	F 505		

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F 505	Continued From page 194 abnormal bleeding and/or hemorrhage, harm, impairment or death.	F 505	1. Resident #294 has been discharged.		
F 508 SS=D	483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review, it was determined the facility failed to complete a chest x-ray as ordered for 1 of 37 (Resident #294) sampled residents of the 53 residents included in the stage 2 review. The findings included: Closed medical record review for Resident #294 documented an admission date of 9/9/14 with diagnoses of Acute and Chronic Respiratory Failure, Ventilator Dependence via Tracheostomy, Percutaneous Endoscopy Gastrostomy Tube, History of Drug and Alcohol Abuse, Pulmonary Embolus, Acute and Chronic Renal Failure, Anemia and Cerebrovascular Accident - Main Brainstem Infarction. Review of a nurse practitioner (NP) order dated 12/12/15 documented, "...CXR [chest x-ray], portable, today - cough..." Review of a NP progress note dated 12/15/14 documented, "...chest x-ray was requested on 12/12/14... technician says it is not in the	F 508	2. Residents requiring diagnostic tests have the potential to be affected by this practice. Currently residents with physician orders for diagnostic tests are receiving these tests according to physician orders. 3. Inservicing provided by the Staff Development Department on 1/29/15 regarding following physician orders pertaining to diagnostic tests. 4. ADON / Designee will report to QAPI. If audits demonstrate substantial compliance and QAPI committee approves, the frequency will be reduced periodically, over time, as indicated. Audits will be conducted daily times 2 months, then, if approved by QAPI Committee, followed by 5 days per week times 1 month then, if approved by the QAPI Committee, 3 times a week times 1 month then, if approved by the QAPI Committee, weekly until compliance is reached. Any issues identified will be corrected immediately. If substantial compliance is not determined, the facility will re-educate staff and re-establish original frequency of audit.	5/28/2015	

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F 508	Continued From page 195 system..."	F 508		
F 514 SS=K	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>The clinical record must contain sufficient 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, it was determined the facility failed to ensure medical record documentation was complete, accurate, organized and in the appropriate chart for 7 of 37 (Residents #43, 252, 299, 410, 62, 294 and 412) sampled residents of the 53 residents included in the stage 2 review. The failure of the facility to clarify anticoagulant orders, ensure residents with the same name are identified, completely and accurately document the residents' medical conditions and/or wound status and document daily on residents receiving skilled services resulted in an immediate jeopardy (IJ). IJ</p>	F 514	<p>1: Resident #'s 252, 410, 294, 412 have been discharged. Resident #'s 43, 299, 62 medical records are accurate, organized, in the appropriate chart with medical record documentation complete.</p> <p>2: Name alerts were created on 1/29/15 by medical records and unit secretaries for any current residents with same last name residing on the same unit. These name alerts were placed on the medical record as well as the resident room. The process of organizing the medical record by chart order and thinning was initiated on 1/29/15 by medical records and/or unit secretaries for all current residents. A schedule has been created as of 1/29/15 for the medical records department for systematic organizing and thinning of the medical record for future use.</p>	5/28/2015

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F 514	<p>Continued From page 196</p> <p>is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.</p> <p>A meeting was conducted in the activity room on 1/27/15 at 3:15 PM with the Administrator and she was informed of the IJ.</p> <p>The survey team received an acceptable Allegation of Compliance (AOC) from the Administrator on 1/30/15 at 12:05 PM.</p> <p>The AOC documented the following: It is the policy of this facility to maintain clinical records on each resident that are complete, accurately documented, readily accessible and systematically organized. As well as orders for medications and treatments will be consistent with principles of safe and effective order writing.</p> <p>Validation of the Credible Allegation of Compliance was accomplished on site 2/2/15 through 2/6/15, through record review, review of facility documents, observation, and interviews with nursing, administration and corporate staff.</p> <p>The facility provided evidence of in-service training with sign in sheets for all medical records staff and staff responsible for filing documents on the nursing units completed 1/29/15 through 1/30/15 regarding the process for name alerts, filing and general organization of the medical record to include chart order and thinning. The facility provided evidence of in-service training with sign in sheets for all licensed nursing staff dated 1/28/15 through 1/30/15 related to 24 hour chart checks, physician orders, admission orders,</p>	F 514	<p>3:</p> <p>Licensed Nursing staff in-serviced by the Staff Development Department regarding proper documentation of residents receiving skilled services on 3/19, 3/20/15.</p> <p>Education and training was provided and completed on 1/29/15 by Corporate Health Information Management Consultant to the Medical Records Director, Medical Records Assistant and unit secretaries regarding the process for name alerts, filing and general organization of the medical record to include chart order and thinning.</p>		

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F 514	<p>Continued From page 197</p> <p>telephone orders, physician order sheets, and reconciliation of medications with physician orders.</p> <p>The facility provided evidence of auditing tools utilized for medical record review by the Director of Nursing (DON) / Assistant Director of Nursing (ADON) daily to ensure new residents admitted have a name alert if appropriate. Also, an audit of the medical record will be completed weekly by the Administrator or DON to ensure the process of filing, organizing the medical record by chart order and thinning is being completed and the schedule is being followed. The facility provided evidence of auditing tools utilized for 24 hour chart checks, physician orders, admission orders, telephone orders, physician order sheets, and reconciliation of medications with physician orders.</p> <p>Medical record review on 2/5/15 documented 9 of 9 new admission charts admitted on or after 1/30/15 included the Admission to the facility order, Reconciliation of admission medication and treatment orders, Physician Order Sheets (POS), labs, Admission nurses notes documenting verification of orders and admission skin assessments to ensure the process of chart checks was being done and any follow up was occurring.</p> <p>The staff currently on leave of absence, vacation or per diem was sent a certified letter on 1/30/15 informing staff of the in-service and training and that the training must be completed prior to returning for their next scheduled shift.</p> <p>Observations were conducted on all nursing units on 2/2/15 of licensed staff's shift change reporting</p>	F 514	<p>4: If audits demonstrate substantial compliance and QAPI committee approves, the frequency will be reduced periodically, over time, as indicated.</p> <p>An audit of the medical record will be completed by the DON/ADON and/or designee daily to ensure new residents admitted have a name alert if appropriate.</p> <p>An audit of the medical record will be completed weekly by the Health information Director to ensure the process of filing, organizing the medical record by chart order and thinning is being completed and the schedule is being followed.</p> <p>Audit trends will be reported to the QAPI committee by ADON / Designee for review and further recommendations</p> <p>If substantial compliance is not determined, the facility will re- educate staff and re-establish original frequency of audit.</p>	
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F 514	<p>Continued From page 198</p> <p>methods to validate pertinent resident information, including anticoagulant medications was reported to the oncoming shift.</p> <p>Interviews with facility medical records personnel, unit secretaries and licensed staff were conducted on 2/4/15 through 2/5/15 with staff from all floors and all shifts validating facility training.</p> <p>Interviews with the Administrator and Corporate Staff (Health Information Management) on 2/4/15 revealed the facility would continue monitoring by a Quality Assurance (QA) meeting to be held weekly for four weeks beginning 2/5/15 and then monthly for findings, recommendations, and follow up regarding the plan. The frequency of the audits to be maintained will be decided by the QA committee based on the findings of the audits.</p> <p>The survey team validated the AOC on 2/2/15 through 2/6/14. The IJ was removed as of 1/30/15.</p> <p>Non-compliance of the IJ continues at a scope and severity of an "E" level for F514 for monitoring of corrective actions. The facility is required to submit a plan of correction for all tags.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Medical record review for Resident #43 documented an admission date of 9/23/14 with diagnoses of Heart Failure, Hypertension, Urinary Tract Infection, Diabetes Mellitus, Other Fracture, Coronary Artery Disease, Congestive Heart Failure, Cardiac Arrhythmia, Atrial Fibrillation, Diabetes Mellitus, Pulmonary Disease, Anxiety and Depression. 	F 514		

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F 514	<p>Continued From page 199</p> <p>Review of a physician's telephone order dated 1/1/15 documented, "...Transfer resident to [named Hospital] ER [emergency room] d/t [due to] nose bleed out of control..."</p> <p>Review of a physician's telephone order dated 1/1/15 documented, "...ENT [ear nose and throat specialist] consult ASAP [as soon as possible] - preferably 1/2 [1/2/15] or 1/5 [1/5/15] - for removal of nasal packing. Hold Coumadin until seen by ENT..."</p> <p>Review of a physician's telephone order dated 1/5/15 documented, "...Remove nasal packing & [and] Restart Coumadin after observation and no sign of cont. [continued] bleeding..."</p> <p>During an interview in the DON's office on 1/20/15 at 12:00 PM, the DON was asked if Resident #43's 1/5/15 physician's telephone order was complete. The DON stated, "I see where you are going cause it doesn't say the dose of the Coumadin." The DON was asked, how did she expect her nursing staff to write a medication order. The DON stated, "I would want to make it totally clear to state the dose of the Coumadin."</p> <p>2. Medical record review for Resident #252 documented an admission date of 8/28/14 with diagnoses of Deep Vein Thrombosis, Hypertension, Chronic Renal Insufficiency, Diabetes Mellitus Type 2, Peripheral Neuropathy, Atrial Fibrillation, Anemia, Hyperlipidemia and Osteoarthritis. The resident was admitted for skilled services, payer source was Medicare.</p> <p>Review of daily skilled nurses notes revealed no skilled nursing note for 8/29/14; 9/2, 9/3, 9/14,</p>	F 514		
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT SAINT FRANCIS	STREET ADDRESS, CITY, STATE, ZIP CODE 6007 PARK AVE MEMPHIS, TN 38119
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F 514	<p>Continued From page 200</p> <p>9/15, 9/16, 9/22, 9/25, 9/27, 9/28 and 9/29/14; 10/4, 10/5, 10/8, 10/10, 10/12, 10/18, 10/19 and 10/25/14 and 11/3/14.</p> <p>Review of a Nurse Practitioner's [NP] telephone order dated 9/19/14 at 1:30 PM documented, "... Transfer to [named Hospital] (Per Family Request) Facial Drooping..."</p> <p>Review of a daily skilled nurse note dated 9/19/14 documented, "...Facial drooping noted to right side. N.O. [new order] to transfer to [named Hospital] per family request. [named ambulance] notified of need for transfer @ [at] 1:30 PM. [named Nurse at named hospital ED [Emergency Department] notified of resident's status & pending arrival. 1:50 PM [named ambulance] arrived to facility to transfer resident to [named Hospital] ED..." There were no documented vital signs.</p> <p>The daily skilled nurses' notes dated 9/19/14 or 9/20/14 had no further documentation concerning Resident #252's return from the ED or the outcome of the resident's ED visit.</p> <p>The facility was unable to provide a facility to hospital transfer form or hospital to facility transfer form.</p> <p>Review of the Nurse Practitioner's progress note dated 9/23/14 following the ED visit on 9/19/14 documented nothing concerning the encounter or the outcome of tests and procedures performed.</p> <p>During an interview at the 3rd floor nurses' station on 2/9/15 at 4:00 PM, Nurse #6 was asked about the missing documentation from the resident's medical record. Nurse #6 stated, "Should have a</p>	F 514		
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F 514	<p>Continued From page 201</p> <p>nursing home to hospital transfer form documenting information about the resident. The ambulance is not going to accept her without a packet which includes a copy of the face sheet, the telephone order, medications, POST [Physician Order for Scope of Treatment] form, History and Physical and labs. The nurse has to call report and documents vital signs and the resident's condition prior to transfer. The documentation will be on a nurses' note, not necessarily a skilled note and also a transfer form." The facility was unable to provide the documentation except for a copy of the resident's medication list printed 9/19/14.</p> <p>3. Medical record review for Resident #299, date of birth (DOB) 1/19/52, documented an admission date of 8/4/14 and a readmission date of 8/20/14 with diagnosis Cerebrovascular Accident (CVA), Chronic Hepatitis C, Diabetes Mellitus Type 2, Hypertension and Chronic Kidney Disease. The resident was admitted to the 300 hall with medications which included anticoagulant therapy for DVT prevention. The resident was in the facility during the survey.</p> <p>Review of the "Physician's Order Sheet" (POS) generated 7/25/14 and the "POS" generated 8/7/14 documented the resident's first and last name, date of birth 9/8/60. Review of Resident #299's medication administration record for August 2014 documented medication and treatment was provided which did not correspond with the 8/7/14 "POS". Both the 7/25/14 and 8/7/14 "POS" belonged to Resident #412.</p> <p>Review of Nurse Practitioner's progress notes dated 7/24/14 and 7/29/14 and a physician's admission history and physical dated 7/30/14</p>	F 514		
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F 514	<p>Continued From page 202</p> <p>documented the resident's first and last name, date of birth 9/8/60, all belonging to Resident #412.</p> <p>During an interview at the 4th floor nurses' station on 1/23/15 at 4:15 PM, Medical Record Personnel #1 and the DON, were asked about the documents belonging to Resident #412 found in Resident #299's medical record. They both confirmed the documents were in the wrong chart.</p> <p>During an interview at the 4th floor nurses' station on 1/28/15 at 9:00, Medical Record Personnel #1, was asked how documents belonging to Resident #412 were filed in Resident #299's chart. Medical Record Personnel #1 stated, the admission date for Resident #299 confirmed both residents (Resident #299 and 412), sharing the same first and last name were on the same floor and same hallway for 4 days.</p> <p>Review of Resident #299's record revealed information in regard to Resident #412: Resident #412's date of birth (DOB) was 9/8/60, admission date of 7/10/14 and diagnoses of Stage IV Metastatic Colon Cancer, Hypertension, Right Lower Extremity Deep Vein Thrombosis (DVT), Failure to Thrive, Malnutrition, Pleural Effusion and Post Hemicolectomy and Ileostomy. Resident #412 was admitted to the 300 hall with medication orders which included anticoagulant therapy for existing DVT. Review of a physician order dated 8/7/14 at 10:00 AM documented, "D/C [discharge] home today..."</p> <p>4. Medical record review for Resident #410 documented an admission date of 12/3/14 with diagnosis of Hypertension, Pain in Limb, Right</p>	F 514		
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F 514	<p>Continued From page 203</p> <p>Hip Fracture, Personal History of Fall, Hypothyroidism, Atrial Fibrillation and a history of Chronic Coumadin therapy. The diagnosis of DVT of the right arm was added on 12/6/14. The resident was admitted for skilled services, payer source was Medicare.</p> <p>Review of a "Documentation Guidelines" form in the resident's chart documented, "Skilled for Rehab... Daily Nursing Documentation: Vital Signs, Pain, Assistance with bed mobility, transfer, toileting, and eating... Therapy tolerance, Progress related to ADL's [activities of daily living] provided... [Named Resident #410]..."</p> <p>Review of daily skilled nurses' notes revealed no skilled nurses note for 12/5, 12/6, 12/11, 12/12, 12/13, 12/17, 12/19, 12/21, 12/23, 12/24, 12/26 and 12/30/14 and 1/2, 1/7, 1/10, 1/12, 1/14, 1/16, 1/22, 1/26, 1/27 and 1/28/15.</p> <p>5. Medical record review for Resident #62 documented an admission date of 8/28/13 and readmission dates on 3/4/14, 3/31/14 and 12/9/14 with diagnoses of Chronic Respiratory Failure, Anemia, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), HTN, CVA, Seizures and Reflux Disease.</p> <p>Review of Resident #62's weekly pressure ulcer record completed by the treatment nurse to document the stage, measurements, exudates, wound bed, surrounding skin, pain, response to treatment, notification dates, specialty interventions, nutritional interventions and progress notes documented incomplete assessments on the following dates:</p> <p>a. Right elbow - 4/2/14 initial assessment - date</p>	F 514		
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F 514	Continued From page 204 of origin, notification dates, specialty interventions and nutritional interventions not documented. 4/8/14, 4/17/14, 4/21/14 and - notification dates and nutritional interventions are not documented. 4/29/14 - date of origin, notification dates, specialty interventions and nutritional interventions are not documented. 5/6/14 and 5/13/14 - notification dates and nutritional assessments are not documented. 5/20/14 - exudates, notification dates, specialty interventions and nutritional interventions are not documented. 5/6/14 - date of origin, stage, notification dates and nutritional interventions are not documented. 5/13/14 - notification dates, nutritional interventions are not documented. 5/20/14 exudates, pain, notification dates, specialty interventions, nutritional interventions are not documented. 5/26/14 date of origin, stage, notification dates, nutritional interventions are not documented. b. Right hip - 4/29/14 - date of origin, notification dates, specialty interventions, nutritional interventions are not documented. 5/6/14 and 5/12/14 - notification dates and nutritional interventions are not documented. 5/20/14 stage, pain, notification dates, nutritional interventions are not documented. 5/27/14 - date of origin, stage, pain, notification dates, specialty interventions, nutritional interventions are not documented. 6/2/14 - date of origin, stage, notification dates, specialty interventions, nutritional interventions are not documented. 6/7/14 - response to treatment, notification dates, nutritional interventions are not documented. 6/16/14 and 6/25/14 notification dates, nutritional interventions are not documented. c. Left lateral mid foot - 7/2/14 - date of origin,	F 514			

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F 514	<p>Continued From page 205</p> <p>admitted with or facility acquired, notification dates, specialty interventions, nutritional interventions are not documented. 7/8/14 - stage, notification dates, nutritional interventions are not documented. 7/17/14 wound bed, surrounding skin, pain, response to treatment, notification dates, nutritional interventions are not documented. 7/24/14 - surrounding skin, notification dates, nutritional interventions are not documented.</p> <p>d. Left lateral distal foot - 7/2/14 - date of origin, notification dates, nutritional interventions are not documented. 7/8/14 - stage, notification dates, nutritional interventions are not documented. 7/17/14 and 7/24/14 - stage, pain, notification dates, specialty interventions, nutritional interventions, nurse signature are not documented.</p> <p>During an interview in the activity room on 2/6/15 at 12:00 PM, Nurse #11 confirmed the documentation on the pressure ulcer record for Resident #62 was incomplete.</p> <p>6. Closed medical record review for Resident #294 documented an admission date of 9/9/14 with diagnoses of Acute and Chronic Respiratory Failure, Ventilator Dependence via Tracheostomy, Percutaneous Endoscopy Gastrostomy Tube, History of Drug and Alcohol Abuse, Pulmonary Embolus, Acute and Chronic Renal Failure, Anemia and CVA - Main Brainstem Infarction. The resident was admitted for skilled services, payer source was Medicaid.</p> <p>Review of daily skilled nurses notes revealed no skilled nursing note for 9/11, 9/13, 9/14, 9/16 and 9/19 to 9/29/14 (if the resident was out of the</p>	F 514			

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F 514	<p>Continued From page 206</p> <p>facility for 10 days, there was not documentation); 10/4, 10/7, 10/11, 10/15, 10/17, 10/19, 10/29, 10/25 and 10/26/14; 11/1, 11/2, 11/6, 11/7, 11/15, 11/16, 11/22, 11/23 and 11/29/14; 12/6, 12/7, 12/13, 12/14, 12/15, 12/20, 12/21, 12/27, 12/28, 12/29, 12/30 and 12/31 and 1/1, 1/2, 1/3, 1/4, 1/5 and 1/10/15.</p> <p>During an interview in the 4th floor Assistant Director of Nursing/Respiratory's office on 1/23/15 at 10:10 AM, Nurse #2 was asked about required skilled nursing documentation. Nurse #2 stated, "Skilled residents are charted on daily. Odd numbered rooms, daily charting by days [day shift], even numbered rooms daily charting by evenings [evening shift]. [Named Resident #294] was skilled, had a ventilator, wound care and a tube feeding."</p> <p>7. Closed medical record review for Resident #412 documented a DOB of 9/8/60, an admission date of 7/10/14 with diagnoses of Stage IV Metastatic Colon Cancer, Hypertension, Right Lower Extremity Deep Vein Thrombosis (DVT), Failure to Thrive, Malnutrition, Pleural Effusion and Post Hemicolecotomy and Ileostomy. The resident was admitted to the 300 hall with medication orders which included anticoagulant therapy for existing DVT. Review of a physician order dated 8/7/14 at 10:00 AM documented, "D/C [discharge] home today..." This information in regard to Resident #412's was actually in the medical record of Resident #299. Resident #412 was discharged 4 days after Resident #299 was admitted.</p> <p>8. The facility's failure to ensure residents with the same name were identified, clarify anticoagulant orders, completely and accurately</p>	F 514			

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F 514	Continued From page 207 document the residents' medical conditions and/or wound status, and document daily on residents receiving skilled services resulted in an IJ for Residents #43, 252, 299, 410, 62, 294 and 412.	F 514			

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