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	175560	A. BUILDING _____ B. WING _____	12/04/2019

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 12/09/19	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 25 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure that the necessary equipment was available and in proper working condition for the administration of ordered respiratory therapy for Resident (R) 121. Findings included: - The "Electronic Medical Record" (EMR) for R 121 under the "Diagnoses" tab documented diagnoses of respiratory failure with hypoxia (not having enough oxygen in your blood), pneumonia (inflammation of the lungs), and lung cancer (uncontrolled growth of abnormal cells in one or both lungs).	F 695		

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

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The Entry "Minimum Data Set" (MDS) documented that the resident admitted on 11/22/19.

The "Care Area Assessment" (CAA) had not been completed due to resident admission date of 11/22/19.

The "Baseline Care Plan" dated 11/22/19 lacked a care area for respiratory and/or oxygen therapy care upon admission.

The "Physician's orders" tab documented a physician's ordered dated 11/26/19 for Ipratropium-Albuterol Solution (a medication that is inhaled via a nebulizer-a device which changes liquid medication into a mist easily inhaled into the lungs. Used to treat and prevent symptoms of wheezing and shortness of breath) give one application three times a day for dyspnea (shortness of breath), and oxygen (O2) at two liters (L) per nasal cannula (NC- device used to deliver supplemental oxygen) to maintain oxygen saturation (SpO2) above 88% every 12 hours as needed for acute and chronic respiratory failure dated 11/23/19.

The "Medication Administration Record" (MAR) and "Orders Administration Notes" in "Point Click Care" (PCC- electronic medical record system) recorded the following on:

11/26/19 at 10:41 PM Ipratropium-Albuterol Solution was not given due to no machine available;
11/27/19 01:12 PM resident was in therapy all morning, breathing treatment not done;
11/27/19 09:16 PM Ipratropium-Albuterol Solution was not given due to no machine in room;

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11/28/19 2:43 PM and 2:44 PM Ipratropium-Albuterol Solution was not given due to nebulizer machine broke and was ordered;
11/28/19 at 5:27 PM Administration Note Text: Certified Medication Aide (CMA) informed nurse that nebulizer machine was not working correctly. New machine obtained.
11/28/19 9:39 PM Ipratropium-Albuterol Solution was not given due to no tubing available
11/29/19 at 10:35 PM administration note documented no tubing available.

On 12/02/19 R 121 was lying on her bed on top of her covers resting, with no shortness of breath noted. Nebulizer was on the stand next to her bed, no visible date noted on the tubing.

On 12/04/19 at 10:03 AM R 121 was resting on her bed, O2 concentrator (machine used to provide supplemental O2) set at two liters via NC, no date noted on either of the O2 or the nebulizer tubing. R 121 states "I just got the oxygen machine last night".

In an interview with CMA M on 12/04/19 at 08:45 AM, stated that she let the nurse know as soon as she found that the nebulizer in R 121's room was not working, when she worked this weekend. They had to go to a sister facility to get one that worked because the facility did not have any more available at the time.

In an interview with Licensed Nurse (LN) G on 12/04/19 at 10:03 AM, stated that night shift staff is responsible for changing the tubing on the O2 concentrators and nebulizers and that it is done on Sundays. Over the weekend they had to go get a nebulizer for R 121 from a sister facility as they did not have any more on hand here. They

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just got a new nebulizer and concentrator yesterday for resident. The supplier that delivered the equipment to resident's room might not have known that it needed a date on the tubing.

On 12/04/19 at 03:00 PM LN G also stated that typically they have six or seven nebulizers on hand, she was never notified by staff that they were out . The Director of Nursing (DON) ordered more. The CMA's do the breathing treatments and she entrusts that they are doing their job. The CMA's have been in-serviced numerous times recently to tell the nurse if something is not available or not working, and now they are to report it directly to the DON.

On interview with Administrative Nurse D on 12/04/19 at 03:34 PM, she stated that she has directed staff to report directly to her when a medication, supplies and/or equipment are low or not available to avoid a medication or treatment not being given as ordered.

The facility policy for "Administering Medications through a Small Volume (Handheld) Nebulizer" revised on October 2010 documents: The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Assemble the equipment and supplies as needed.

The facility policy for "Departmental (Respiratory Therapy) - Prevention of Infection" revised on November 2011 documented: The following equipment and supplies will be necessary when performing tasks related to this procedure: Appropriate equipment/supplies will be necessary for ordered therapy. It further documented that

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F 695	Continued From page 4 the following should be recorded in the resident's medical record: The date and time the respiratory therapy was performed; type of respiratory therapy performed; the name and title of the individual(s) who performed the respiratory therapy; all assessment data obtained during the treatment; if the resident refused the therapy, the reason(s) why and what was done as a result and the signature and title of the person recording the information. The facility failed to ensure that the appropriate equipment was available and in proper working condition for the administration of ordered respiratory therapy for R 121 which placed R 121 at risk for further respiratory problems and decreased therapeutic benefit from her medication regimen.	F 695		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		

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pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 25 residents. The sample included 14 residents. Based on record review and interview, the facility failed to ensure medications were available to administer as ordered by the physician for five residents, Residents (R) 1, R10, R17, R18 and R71.

Findings included:

- The "Diagnoses" tab of the "Electronic Medical Record" (EMR) for R1 documented diagnoses of Major Depressive Disorder (MDD-characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities).

The resident's 11/22/19 "Admission Minimum Data Set" (MDS) assessment revealed the resident had moderately impaired cognition and minimal depression. She had no behaviors. She required extensive assistance of one to two staff for most activities of daily living (ADLs). She had functional impairment in one of her lower

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extremities and in one of her upper extremities that limited her range of motion during the assessment period. She had no pain at the time of the assessment and received anticoagulant medication for seven days of the assessment. An antibiotic medication for three days and diuretic medication for five days of the assessment period.

The "Cognitive Loss" "Care Area Assessment" dated 11/27/19 documented R1 is alert and oriented with confusion and forgetfulness. She is able to make her needs known to staff and others.

The care plan for "Impaired Thought Process" dated 11/18/19 directed staff to administer medications as ordered.

The "Physician's Order" tab of the EMR documented an order for sertraline 25 milligrams (mg) every evening for MDD.

Review of the "Medication Administration Record" under the orders tab, revealed sertraline was not given due to the medication not being available on 11/23/19, 11/24/19 and 11/25/19.

On 12/04/19 at 03:00 PM Licensed Nurse (LN) G stated, they have stickers that are faxed to the pharmacy. They try to fax the pharmacy to reorder the medications five days in advance of needing them. We do have an emergency kit we can pull some medications from. If a medication is not available, we call the pharmacy and we let the Director of Nursing know.

On 10/29/19 at 09:52 AM Administrative Nursing D stated, she identified medications were being

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documented as not available and she developed a performance improvement plan (PIP). The facility has been working with the pharmacy to improve on medications being available. The facility is now on a cycle-fill with the pharmacy. The pharmacy is not integrated with the EMR and does not automatically get notified when an order is entered into the EMR. We have to call in the orders or fax them.

The facility's "Ordering and Receiving Medications from Provider Pharmacy" policy and procedure dated 03/11 directed staff that the first dose on non-emergency medications is scheduled to be given after the regularly scheduled pharmacy delivery to the facility. Medications should be refilled five days in advance of need to assure an adequate supply is on hand.

The facility failed to ensure medications were available to administer to this resident as ordered by the physician. This deficient practice placed R1 at risk for increased depression.

- The "Electronic Medical Record" (EMR) for R10 under the "Diagnoses" tab documented a diagnosis of vascular dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain).

The resident's 10/03/19 "Admission Minimum Data Set" (MDS) assessment revealed the resident had moderately impaired cognition and minimal depression. She had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) four to six days of the assessment

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period and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) one to three days of the assessment period. She required extensive assistance of one to two staff for most activities of daily living (ADLs), with impairments in her lower extremities that limits her range of motion. She was rarely had pain at the time of the assessment and received antipsychotic, antianxiety and antidepressant, medications for seven days of the assessment.

The "Cognition" Care Area Assessment (CAA) dated 10/11/19 for cognition documented R10 is alert and oriented with confusion and forgetfulness at times. She is able to make her needs and wishes known to staff and others.

The "Dementia" care plan dated 09/22/19 instructed staff to administer medications as ordered.

The "Physician's orders" tab in the EMR documented a physician's order for memantine 28 milligrams (mg) at bedtime for dementia.

Review of the "Medication Administration Record" under the orders tab, revealed memantine was not given due to the medication not being available on 09/21/19, 09/22/19, 09/23/19, 10/27/19 and 10/28/19.

On 12/04/19 at 03:00 PM Licensed Nurse (LN) G stated, they have stickers that are faxed to the pharmacy. They try to fax the pharmacy to

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reorder the medications five days in advance of needing them. We do have an emergency kit we can pull some medications from. If a medication is not available, we call the pharmacy and we let the Director of Nursing know.

On 10/29/19 at 09:52 AM Administrative Nursing D stated, she identified medications were being documented as not available and she developed a performance improvement plan (PIP). The facility has been working with the pharmacy to improve on medications being available. The facility is now on a cycle-fill with the pharmacy. The pharmacy is not integrated with the EMR and does not automatically get notified when an order is entered into the EMR. We have to call in the orders or fax them.

The facility's "Ordering and Receiving Medications from Provider Pharmacy" policy and procedure dated 03/11 directed staff that the first dose on non-emergency medications is scheduled to be given after the regularly scheduled pharmacy delivery to the facility. Medications should be refilled five days in advance of need to assure an adequate supply is on hand.

The facility failed to ensure medications were available to administer to this resident as ordered by the physician. This deficient practice placed R10 at risk for worsening dementia.

- The "Electronic Medical Record" (EMR) for R17 under the "Diagnoses" tab documented a diagnosis of atrial fibrillation (rapid, irregular heart beat).

The resident's 08/13/19 "Significant Change

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Minimum Data Set" (MDS) assessment revealed the resident had severely impaired cognition. He had no depression and no behaviors during the assessment period. He required extensive assistance of one to two staff for most activities of daily living (ADLs), with no limitations in range of motion. He received antianxiety, antidepressant, hypnotic, anticoagulant, and diuretic medications for seven days of the assessment period. He received opioid and antibiotic medications for four days of the assessment period.

The "Cognition" Care Area Assessment (CAA) dated 08/14/19 for cognition documented R17 is alert and oriented with mild confusion and forgetfulness. He is able to make his needs and wishes known to staff and others.

The "Hypertension (elevated blood pressure)" care plan dated 11/13/19 instructed staff to administer medications as ordered.

The "Physician's orders" tab in the EMR documented a physician's order for Brilinta 90 milligrams (mg) two times daily to prevent heart attack/stroke and promethazine with codeine 6.25-10 mg/5 milliliters (ML) give 5 ML four times a day for cough.

Review of the "Medication Administration Record (MAR)" under the orders tab, revealed Brilinta was not given due to the medication not being available on 08/09/19, 08/10/9, 09/10/19, 09/11/19, 09/12/19 and 09/16/19.

Review of the MAR under the orders tab, revealed promethazine with codeine was not given on 10/17/19, 10/18/19, 10/19/19, 10/24/19, 10/27/19 and 10/28/19.

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On 12/04/19 at 03:00 PM Licensed Nurse (LN) G stated, they have stickers that are faxed to the pharmacy. They try to fax the pharmacy to reorder the medications five days in advance of needing them. We do have an emergency kit we can pull some medications from. If a medication is not available, we call the pharmacy and we let the Director of Nursing know.

On 10/29/19 at 09:52 AM Administrative Nursing D stated, she identified medications were being documented as not available and she developed a performance improvement plan (PIP). The facility has been working with the pharmacy to improve on medications being available. The facility is now on a cycle-fill with the pharmacy. The pharmacy is not integrated with the EMR and does not automatically get notified when an order is entered into the EMR. We have to call in the orders or fax them.

The facility's "Ordering and Receiving Medications from Provider Pharmacy" policy and procedure dated 03/11 directed staff that the first dose on non-emergency medications is scheduled to be given after the regularly scheduled pharmacy delivery to the facility. Medications should be refilled five days in advance of need to assure an adequate supply is on hand.

The facility failed to ensure medications were available to administer to this resident as ordered by the physician. This deficient practice placed R17 at risk for heart attack/stroke and increased coughing.

- The "Electronic Medical Record" (EMR) for R18

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under the "Diagnoses" tab documented a diagnosis of rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems).

The resident's 11/07/19 "Admission Minimum Data Set" (MDS) assessment revealed the resident had intact cognition and minimal depression. She had no behaviors. She required extensive assistance of one staff for most activities of daily living (ADLs), with functional limitation of range of motion in one lower extremity. She received an antidepressant medication for five days of the assessment period. She received a hypnotic and opioid medication six days of the assessment period. She received anticoagulant and diuretic medication two days of the assessment period.

The "Activity of Daily Living (ADL)" care area assessment (CAA) dated 11/13/19 documented R18 requires extensive assistance of one staff member for all ADLs.

The "Mobility" care plan dated 11/13/19 instructed staff R18 requires assistance of one staff member and uses a front wheeled walker.

The "Physician's orders" tab in the EMR documented a physician's order for hydroxychloroquine sulfate 200 milligrams (mg) two times a day for rheumatoid arthritis.

Review of the "Medication Administration Record (MAR)" under the orders tab, revealed hydroxychloroquine sulfate was not administered due to the medication not being available on 11/02/19 and 11/03/19.

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On 12/04/19 at 03:00 PM Licensed Nurse (LN) G stated, they have stickers that are faxed to the pharmacy. They try to fax the pharmacy to reorder the medications five days in advance of needing them. We do have an emergency kit we can pull some medications from. If a medication is not available, we call the pharmacy and we let the Director of Nursing know.

On 10/29/19 at 09:52 AM Administrative Nursing D stated, she identified medications were being documented as not available and she developed a performance improvement plan (PIP). The facility has been working with the pharmacy to improve on medications being available. The facility is now on a cycle-fill with the pharmacy. The pharmacy is not integrated with the EMR and does not automatically get notified when an order is entered into the EMR. We have to call in the orders or fax them.

The facility's "Ordering and Receiving Medications from Provider Pharmacy" policy and procedure dated 03/11 directed staff that the first dose on non-emergency medications is scheduled to be given after the regularly scheduled pharmacy delivery to the facility. Medications should be refilled five days in advance of need to assure an adequate supply is on hand.

The facility failed to ensure medications were available to administer to this resident as ordered by the physician. This deficient practice placed R18 at risk for an increase in her rheumatoid arthritis symptoms.

- The "Electronic Medical Record" (EMR) for R71 under the "Diagnoses" tab documented a

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	175560	A. BUILDING _____ B. WING _____	12/04/2019

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diagnosis of narcolepsy (chronic sleep disorder characterized by overwhelming daytime drowsiness and sudden attacks of sleep).

The resident's 08/19/19 "Quarterly Minimum Data Set" (MDS) assessment revealed the resident had intact cognition, minimal depression and no behaviors. She required extensive assistance of one to two staff for her activities of daily living (ADLs), with impairments in range of motion in her upper and lower extremities. She had occasional pain at the time of the assessment and received antidepressant, anticoagulant, and diuretic medications for seven days of the assessment.

Admission MDS was in progress as of 12/04/19.

The "ADL" care plan dated 11/13/19 instructed staff R71 requires extensive assistance of one staff member.

The "Physician's orders" tab in the EMR documented a physician's order for modafinil 100 milligrams (mg) in the morning for narcolepsy.

Review of the "Medication Administration Record (MAR)" under the orders tab, revealed modafinil was not administered due to the medication not being available on 11/27/19, 11/28/19 and 11/29/19.

On 12/04/19 at 03:00 PM Licensed Nurse (LN) G stated, they have stickers that are faxed to the pharmacy. They try to fax the pharmacy to reorder the medications five days in advance of needing them. We do have an emergency kit we can pull some medications from. If a medication is not available, we call the pharmacy and we let

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F 755	Continued From page 15 the Director of Nursing know. On 10/29/19 at 09:52 AM Administrative Nursing D stated, she identified medications were being documented as not available and she developed a performance improvement plan (PIP). The facility has been working with the pharmacy to improve on medications being available. The facility is now on a cycle-fill with the pharmacy. The pharmacy is not integrated with the EMR and does not automatically get notified when an order is entered into the EMR. We have to call in the orders or fax them. The facility's "Ordering and Receiving Medications from Provider Pharmacy" policy and procedure dated 03/11 directed staff that the first dose on non-emergency medications is scheduled to be given after the regularly scheduled pharmacy delivery to the facility. Medications should be refilled five days in advance of need to assure an adequate supply is on hand. The facility failed to ensure medications were available to administer to this resident as ordered by the physician. This deficient practice placed R71 at risk for an increase in her narcolepsy symptoms.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		

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duplicate drug therapy); or

§483.45(d)(2) For excessive duration; or

§483.45(d)(3) Without adequate monitoring; or

§483.45(d)(4) Without adequate indications for its use; or

§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified as census of 25 residents. The sample included 14 residents, five of the residents in the sample were reviewed for medication review. Based on observation, record review, and interview the facility failed to ensure that prescribed medications were signed off as given and no documentation reflecting why medication was not given as scheduled for resident (R) 3.

Findings Included:

--The "Electronic Medical Record" (EMR) for R3 under the "Diagnoses" tab documented diagnoses of multiple sclerosis (MS- a progressive disease of the nerve fibers of the brain and spinal cord), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), major depressive disorder (major mood disorder-characterized by a combination of symptoms that

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interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities),and gastro-esophageal reflux disorder (GERD- backflow of stomach contents to the esophagus).

The "Admission Minimum Data Set (MDS)" dated 04/05/19 documented a "Brief Interview for Mental Status" (BIMS) of 15 indicating intact cognition. She is total care assist of one to two with all "Activities of Daily Living" (ADLs). On seven of seven days during the lookback period she took an anti-psychotic (class of medications used to treat psychosis and other mental emotional conditions), an anticoagulant (medication used to prevent blood clots) and an anti-depressant (class of medications used to treat mood disorders and relieve symptoms of depression).

The quarterly MDS dated 09/15/19 documented BIMS of 13 indicating intact cognition with no other changes from previous MDS.

The "ADLs Care Area Assessment" (CAA) dated 04/07/19 documented that R3 required total assistance for all cares of one to two staff.

The "GERD" care plan revised 09/17/19 documented to give R3 her medications as ordered, monitor/document side effects and effectiveness.

The "Pain" care plan documented R3 takes medications for MS and neuropathic pain. Administer medications as ordered.

The "Skin" care plan documented R3 give treatments and medications as ordered.

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Monitor/document for side effects and effectiveness.

The physician's order under the "Orders" tab in PCC dated 04/12/19 documented an order for probiotic capsule orally two times a day for gastro-intestinal prophylaxis.

The physician's order under the "Orders" tab in PCC dated 03/25/19 documented an order for baclofen (a medication used to treat muscle spasms caused by MS) 20 milligrams (mg) by mouth four times a day for pain related to MS.

The physician's order under the "Orders" tab in PCC dated 04/12/19 documented an order for Flagyl 500mg tablet (an antibiotic medication used to treat infections) for wound infection.

The physician's order under the "Orders" tab in PCC dated 04/15/19 documented an order for Vancomycin solution one gram intravenously (IV-administering fluids/medications into a vein) two times a day for wound infection.

The physician's order under the "Orders" tab in PCC dated 06/12/19 documented an order for oxycodone 10mg by mouth two times a day for pain management.

The "Medication Administration Record" (MAR) lacked signoff and/or documentation that R3's probiotic was administered on 04/17/19 and 08/16/19.

The MAR lacked signoff and/or documentation that R3's oxycodone was administered on 08/16/19.

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The MAR lacked signoff and/or documentation that R3's Flagyl was administered on 04/17/19.

The MAR lacked signoff and/or documentation that R3's baclofen was administered on 04/17/19 and 08/16/19.

The MAR lacked signoff and/or documentation that R3's vancomycin was administered on 04/19/19 and 04/20/19.

Interview with Licensed Nurse (LN) G on 12/04/19 at 10:03 AM stated that R3 had a card for her scheduled oxycodone as well as one for an as needed (PRN) dose. Sometimes the CMA uses the PRN card if they are out of the scheduled temporarily, but it should be signed off as given for the scheduled one.

On 12/04/19 at 03:00 PM LN G also stated that the CMA administers all medications except for IV medications. If a medication is not available, she would expect the CMA to notify her right away and call the pharmacy right away. She would also expect the CMA to notify the nurse if a medication was not given so she could chart an entry into PCC in the progress notes as to why medication dose was missed or not given. She is not aware of anyone that audits or checks the MAR or documentation for errors.

Interview with Administrative Nurse D on 12/04/19 at 03:34 PM AM stated she has done a lot of education with staff members and they are now to call her when something is out or missing. She would expect something to be charted in PCC if a medication is not available or not given.

The facility's policy for "Administering

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F 757	Continued From page 20 Medications" revised December 2012 documented: Medications shall be administered in a safe and timely manner, and as prescribed. The facility failed to document prescribed medications were administered R3, which could have caused adverse effects for R3.	F 757		