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	146108	A. BUILDING _____ B. WING _____	06/29/2007

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MANOR COURT OF PEORIA	6900 NORTH STALWORTH PEORIA, IL 61615

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F 520	Continued From page 68 Director, Admissions Coordinator, Social Service Director, Dietary manager, Housekeeping/Laundry, Medical Director, and Assistant Administrator/Human Resource. E1 (Administrator) stated on 6/19/07 at 3:32 p.m. that he has been the administrator of the facility for "6 weeks" and he will have his first Quality Assurance meeting July 20. He said that there was no documentation of previous Quality Assurance meetings left by the previous administrator who left the end of March, 2007. E15 (Housekeeping/Laundry) stated on 6/19/07 at 3:20 p.m. that she has been the supervisor of the Housekeeping/Laundry department since November, 2006, and that during that period she has been to one Quality Assurance meeting, "2 - 3 months ago." The previous administrator, the facility medical director, and the previous director of nurses were at this meeting, among other department heads. E4 (Certified Dietary Manager) stated on 6/19/07 at 3:28 p.m. that she has been with the facility for "2 months" and she has not been to any Quality Assurance meeting during this period. E2 (Director of Nurses / DON) said on 6/19/07 at 4:12 p.m. that he has worked as a DON for 6 weeks or so. E2 stated he has not been to a quarterly Quality Assurance meeting. E2 stated he must have just "missed one in April." E2 was aware that the next Quality Assurance meeting will be in July.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 69 300.610a) 300.610c)2) 300.650f)1) 300.1210b)1)2) 300.1610a)1) 300.1620a)b)c) 300.1630b) 300.1810d) 300.1820c)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. c) These written policies shall include, at a minimum the following provisions: 2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray).	F9999		

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F9999	Continued From page 70 Section 300.650 Personnel Policies f) Orientation and In-Service Training 1) All new employees, including student interns, shall complete an orientation program covering, at a minimum, the following: general facility and resident orientation; job orientation, emphasizing allowable duties of the new employee; resident safety, including fire and disaster, emergency care and basic resident safety; and understanding and communicating with the type of residents being cared for in the facility. In addition, all new direct care staff, including student interns, shall complete an orientation program covering the facility's policies and procedures for resident care services before being assigned to provide direct care to residents. This orientation program shall include information on the prevention and treatment of decubitus ulcers and the importance of nutrition in general health care. Section 300.1210 General Requirements for Nursing and Personal Care b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1610 Medication Policies and Procedures	F9999		

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F9999	Continued From page 71 a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. b) Telephone orders may be taken by a registered nurse, licensed practical nurse or licensed pharmacist. All such orders shall be immediately written on the resident's clinical record or a telephone order form and signed by the nurse or pharmacist taking the order. These orders shall be countersigned by the licensed prescriber within 10 calendar days. c) Review of medication orders: The staff	F9999		

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F9999	Continued From page 72 pharmacist or consultant pharmacist shall review the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical experience and judgment, and Section 300. Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be done at the facility and shall be documented in the clinical record. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon. Section 300.1630 Administration of Medication b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility. Section 300.1810 Resident Record Requirements d) All physician's orders, plans of treatment, Medicare or Medicaid certification, re-certification statements, and similar documents shall have the authentication of the physician. The use of a	F9999		

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F9999	Continued From page 73 physician's rubber stamp signature, with or without initials, is not acceptable. Section 300.1820 Content of Medical Records c) Each resident's medical record shall contain the following: 2) A physician's order sheet that includes orders for all medications, treatments, therapy and rehabilitation services, diet, activities and special procedures or orders required for the safety and well-being of the resident. These REGULATIONS are not met as evidenced by: Based on record review, interview, and observation, the facility, in collaboration with the pharmacist, failed to have a system in place to ensure that medications were administered as ordered, that physician orders for medications were accurate, current, and available to nursing staff, and that diagnostic and laboratory procedures were completed as ordered for 3 of 10 sampled residents (R9, R12, R6). Pharmaceutical monthly reviews of medications were conducted, yet the pharmacy failed to recognize that these systems were not in place. Findings include: Facility policy "Pharmaceutical Procedures" specifies the following: Section III. Physicians' Medication Orders: "All medications, including non-legend drugs (cathartics, headache remedies, vitamins, etc.) shall be given only upon the written order of a	F9999		

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F9999	Continued From page 74 physician. All such orders shall have the signature of the physician and shall be given as prescribed by the physician and at the designated time. When necessary, telephone orders may be taken by a registered nurse or licensed practical nurse. All such orders shall be immediately written and / or entered on the resident's clinical record and / or a 'telephone order form' and signed by the nurse. These orders shall be countersigned by the physician within ten (10) days. All NEW physicians' orders shall be communicated by telephone and / or FAX to the pharmacist by the nurse." Section VI. Drug Administration and Documentation--Administration of Medications: "A. All nursing personnel must have either appropriate training or experience if duties include administering medication to residents. D. The Director of Nursing shall provide on-going supervision of personnel administering medications, including: 1. Regular observation of performance in actual preparation and administration. 2. Coordinating review of medication records for accuracy and any irregularities. E.2. Documentation of administration of PRN meds shall contain the following information: b. Reason for administration of medications c. Results of administration (as best as can be determined, e.g., effective, resident had bowel movement, went to sleep, etc.)	F9999		

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F9999	Continued From page 75 J. The facility shall have all medication records, which shall be used and checked against the physician's order to assure proper administration of medication to each resident. These records shall include or be accompanied by a recent photograph." "Charting of medications shall be done immediately after administration and prior to administration to another resident." Medication Errors and Adverse Reactions: "A. Medication errors are defined as 8. Scheduled medication omitted for no apparent reason." Record Review of Medication Administration facility policy: "7. In the event a medication cannot be given, the reason must be documented in the Nurses Medication Notes on the MAR, and the time frame circled on the MAR." 8. PRN medications must state when and why the medication is to be used. 12. "The physician will review all orders on a monthly basis and sign the order sheet, indicating renewal of the orders." Despite policies which outline how orders are to be taken and processed, interviews with Administration and licensed staff indicate that no effective system was in place to ensure that all physician orders were correctly entered into the facility's computerized system. Licensed staff did not receive medication administration or	F9999		

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F9999	Continued From page 76 medication error report training and were not aware of the policies and procedures they were to be following. According to interview with E2 (Director of Nursing) on 6/19/07 at 2:30 p.m., "the nurses hired should have received the On the Job Training Sheet. I don't know how long training or orientation is. It varies. I'd like to see the nurses receive three days of training. It sort of depends on the nurse. It has been a whirlwind since day one." E2 at this time provided a copy of the "On the Job Checklist for RN and LPN." This four page form indicates that among a multitude of other items, the licensed staff are to be trained on Nursing Policy and Procedure book; Responsibilities of the Nurse including Admission Orders, Resident Return, Telephone orders, Writing and Transcribing Physician Orders, Follow through on all recommendations; and Administration of Medications including Medication Administration System, Narcotic records and narcotic shift counts, and Medication Documentation. E2 (Director of Nursing) was told during this interview that licensed staff interviews indicate that licensed staff had not seen the On the Job Training Sheet and denied having been trained on medication administration and medication errors. E2 responded that " ... based on quality of their work, it seems evident that they have not been trained. I know that there have been omissions on the medication administration sheets and the treatment sheets. I was from the school where if it wasn't documented it wasn't done. We do not have a policy for medication errors. I know training needs to be done and	F9999		

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F9999	Continued From page 77 starting today we will cover medication administration and errors in depth. The only way I would know if there have been medication errors is if the staff were as conscientious as I am." E19 (Registered Nurse / RN) , E18 (RN), and E17 (Licensed Practical Nurse / LPN) provided the following information during interviews on 6/19/07 between 2:30 p.m. and 4:30 p.m.: E19 stated "orientation was a tour of the facility from the DON. I do not have a job description - but I was told I will do weekly skin assessments, admissions, discharges, labs, call labs to doctors based on orders and parameters, input orders in the computer. I also spent half of the (day) being shown computer input for admissions and assessments as far as paperwork. I wouldn't consider that to be orientation at all. My second day I did the admission assessment alone - physical and input it in the computer. It took forever. I have not seen the On the Job Training Sheet, Medication administration, or medication error policy or had training. A nurse saw me give two or three resident's medications. I just look at the MAR and the medication card and check it twice. I receive the hospital physician orders and call our house physician, the Medical Director, and verbally tell her the orders and I input them into the computer. The medication orders go to our pharmacy and print out a MAR. Third shift prints out the physician order report at the end of the month, whatever day is the last day of the month, and the DON sends all of the orders to the physicians. If an order is changed in the middle of the month, it is not printed out until the last day of the month. There is no way to check when orders are returned or if they are returned	F9999		

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F9999	Continued From page 78 from the physician after they are sent on the last day of the month. I think a lot of information gets lost in the computer, too many places for it to go. I had never seen a telephone order until yesterday afternoon after you (surveyor) talked with the DON at the nursing desk. I was never oriented to physician orders or ensuring they are received. I don't feel like I had an orientation. Some nurses will help you, others will let you sink. I've gone home frustrated many times." E17 (LPN) stated that orientation consisted of "this is your cart and start your med pass down there. I went to the DON and said I need help with orientation - so the DON would call during nights and help with computer input...told Director of Nursing, I am not just an agency nurse. I need training. I don't know their system. I did not receive the On the Job Training List. I've seen the blank form in a drawer. I have not received training for medication errors. My first night I left the floor to pass medications at (another section of the complex). I don't do it anymore, because I told them it is just too dangerous on third shift. I made a mistake with the two residents with the same first name, they are in the same room and do not have arm identification bands or any way to recognize them. I don't print out the Medication Administration Records (MARs) on third shift because I asked E31 (Licensed Practical Nurse) what do I compare them to and E31 said I should know. I found on the computer, orders with a check off - I was told 'well I don't really understand the process.' I'm just starting to take over and do what I know is right. I might have seen signed physician orders once on an MAR, I'm not for sure. I think in the front of the MAR there is one sheet for signing initials and the name of the nurse and their discipline."	F9999		

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F9999	Continued From page 79 E18 (RN) related that "a nurse precepted me for three days, I did a med pass and an admission. I did not get to receive information on the computer - because the system was down during that three day period. I have not seen the On the Job Training Sheet previously. There isn't a policy on medication administration or medication errors or documentation of errors. I reported my concerns about medication administration and medication errors to the Director Of Nursing who left in April (2007). I also have reported my concerns to the current DON. I am worried about the facility practice of pulling the medication nurse four times a day to pass medications on (other section of the complex). When the nurse is over there passing medications, which can take up to two hours, the aides go outside to smoke and that is when accidents are happening. There isn't a paging system or intercom over there so the aide must come over and find the nurse. I know there have been medication errors, but we don't document them. I think a lot of the problems started after Medicare certification because we had so many admissions." During interview on 6/20/07 at 11:15 am. Z1 (Medical Director) provided the following information: "I do not know, because of the computer, how the MAR is reconciled. I receive orders once a month in a large stack from the DON to sign. It is the accepted practice standard to have a signed physician order to administer medication. I have recently been made aware there is a problem with not having a telephone order system and have a meeting scheduled for today with the administrator and DON. I think when a new order	F9999		

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F9999	Continued From page 80 is made by a physician-the safest way as far as patient care goes, is to print right away and send to the doctor. I do not have access to the nursing notes since they are on the computer, so when I come and do rounds a nurse goes with me and tells me how resident is doing. I have not been made aware until you have discussed with me today the monthly system for sending the physician order report and not having a system in place to determine if it is received back from the physician, the lack of staff printing orders as they receive them for physician signature, the medication errors on the flow sheets, and the pharmacy consultation recommendations not being sent out to the physicians, nor did I know until today about the training issues for the nurses passing medications. I did not know that the nurses were being pulled from the floor to pass medications on the (other unit in the complex) leaving safety issues and concerns Every medication, treatment, laboratory test, and patient care must have a timely signed physician order, this is the accepted practice standard. I did not realize that the pharmacy review was not being acted upon. I also think that new orders or order changes should be immediately printed out of the computer and faxed to the physicians for signature and order verification not waiting until the end of the month. I think there are policies for medication administration and medication errors, if there aren't there should be." Consulting Pharmacist (Z3) stated on 6/20/07 at 12:27 p.m. "We receive the medication orders from the facility by computer, it is the responsibility of the facility per their policy to obtain physician orders for medications. I cannot speak as to how the facility inputs stat orders, telephone orders. The consultative monthly	F9999		

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F9999	Continued From page 81 pharmacy reports are documented on our yellow sheets on the day of consultation and then the DON receives a written copy of the recommendations which they are to forward to the physician for review and comment, orders, clarification." 1. Admission record for R9 indicates that R9 was admitted to the facility on 4/19/07. At time of the survey, R9's clinical record contained no signed physician orders. The physician order reports were not signed for April, May, or June of 2007, nor was the telephone verification of admission orders from the hospital for R9 signed. E2 (Director of Nursing) reviewed R9's clinical record, and was unable to find any signed physician orders from the 4/19/07 admission date or from the physician visits to the facility on 5/2/07 and 6/13/07. E2 (Director of Nursing) stated on 6/18/07 at 3:00 p.m. that "there should be physician orders, I am faxing them to the doctor now." E2 continued by saying "third shift staff on the last day of the month prints out a Medication Administration Record, (MAR) and compares it to the previous months MAR for the resident. The MAR is not checked against the signed physician order. The Physician Order Report is also printed out by third shift and I (Director of Nursing) mail it to the physician for signature. There is no process in place to check if we have received the signed order back from the physician." R9's record contained four Medication Flowsheets documenting the administration of Lidoderm (pain medication) 5% topical film. The dates on all four flowsheets overlap. Sheets are dated 4/19/07-5/19/07, 5/1/07-5/31/07,	F9999		

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F9999	Continued From page 82 5/23/07-6/22/07, and 6/1/07-6/30/07. Each sheet is documented differently on various days, making it difficult to determine if medications administered as ordered. At the time of the survey R4's most recent physician order was signed May 18, 2007. R8, R13, and R11's files did not have signed physician orders for June 2007. 2. According to Facility Diagnostic Service Policy: Procedure 1-b. All diagnostic services are provided only on the order of a physician. Procedure 1-c. Any abnormal lab results will be promptly reported to the doctor. Any new orders received as a received as a result will be referred to on the lab slip and / or in the nursing notes. example: Doctor notified (date) (time); See order sheet; Signature of staff person reporting. Procedure 1-f. All reports are included in the clinical record. R9's hospital discharge records and signed physician orders dated 4/18/07 document that a PT (protime) is to be done every Monday, Wednesday, and Friday and a Complete Blood Count (CBC) every Friday. Nursing progress note dated 4/19/07 documents that R9 is to receive Warfarin (Coumadin) 1mg. daily at bedtime. An unsigned facility generated physician order report dated 4/11/2007 to 5/11/2007 documents that a Complete blood count (CBC) with	F9999		

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F9999	Continued From page 83 differential and platelet count is to be done Friday of every week at 7:30 a.m. The only CBC completed from 4/2/0/07 to 6/18/07 was done on 4/20/07. Results from this CBC showed Hemoglobin of 9.7 (Expected Value 11.8-14.3), Hematocrit 30.8 (Expected Value of 34-45), White Blood Cells 10.8 (Expected Value of 5.4-9.9), Red Blood Cells 3.56 (Expected Value 3.9-4.8). Facility Medications Flowsheet for 4/19/2007 to 5/19/2007 which would reflect what dosage of Warfarin (Coumadin) would have been administered or if the medication had been administered was not contained in R9's file. E2 stated on 6/27/2007 at 1:50 pm that he could not locate a medication flowsheet that would have contained the Warfarin information. An unsigned physician order report generated dated 4/11/2007 to 5/11/2007 notes that "prothrombin time (PT) every Monday, Wednesday, and Friday every week at 8:00" is to be done. Record review of the entire clinical record showed that PT labs were not done as ordered. A PT lab was done on 4/20/07 which showed Prothrombin Time of 23.9 (Expected Value of 10.0-13.0) and INR (International Normalized Ratio) of 3.1 (Expected Value of 2.0-3.0). Nursing notes document that R9's physician was contacted regarding this lab, with subsequent to "hold Coumadin (blood thinning medication) on 4/20/07, restart on 4/21/07 and re-check labs on 4/23/07." No labs were documented on 4/23/07, 4/27/07,	F9999		

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F9999	Continued From page 84 4/30/07. PT labs were drawn on 5/2/07 with PT of 18.6 (Expected Value 10-13) and INR of 2.0 (Expected Value of 2-3). Records indicate that R9's physician signed an order on 5/2/07 for PT labs to be done weekly with results called to the physician. A nursing progress note dated 5/10/07 indicates that a new order was received for Warfarin (Coumadin) 2 milligrams on Tuesdays and Thursdays, 1 milligram on Sunday, Monday, Wednesday, Friday, and Saturdays. At the time of the survey, there was no signed physician order for this medication order change. E2 verified during interview on 6/18/07 at 2:30 p.m. that there was no signed physician order for this medication. Nursing notes dated 5/11/07 indicate that R9 was diaphoretic (sweaty), breathing labored, decreased responsiveness, some confusion noted...sent to hospital at 12:25 p.m. Nursing notes dated 5/22/07 indicate that R9 returned from the hospital on this date. Discharge instructions include order for Warfarin 1 milligram daily with ProTime to be done every Monday and Thursday. Review of records during survey showed that a new Facility Medication Flowsheet may be pulled up multiple times during the same month. The same Facility Medication Flowsheet is not always used for each calendar month. Instead, the sheets are generated at time of admission and often at re-admission within that same time period. Several Medication Flowsheets were present on multiple records for overlapping time periods. Thus there is no clear picture of medication administration for each resident within that time period.	F9999		

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F9999	Continued From page 85 R9's Facility Medication Flowsheet (equivalent to a Medication Administration Record) generated at time of re-admission to the facility (after hospitalization) is dated 5/23/07-6/23/07. This Medication Flowsheet would not reflect the pattern of changes in R9's medication regime. There were no PT/INR's completed for 5/28/07, 5/31/07. Additionally on the Medication Flow Sheet there is no indication that Coumadin was given as ordered. No notations were documented on the Medication Flowsheet or the Nursing Progress notes as to why medication was not given. Labs drawn on 6/4/07 show PT of 16.0 (Expected Value of 10-13) and INR of 1.6 (Expected Value of 2-3). After interview with E2 (Director of Nursing) on 6/18/07 at 2:30 p.m. (at which time it was pointed out that there were no signed physician orders for the Warfarin order which was given on 5/10/07 and the inconsistencies with Medication Flowsheet dates were discussed), E2 obtained a physician signed Facility Physician Order Report dated 6/1/07-6/30/07. This order report indicated that the Warfarin 2 milligrams was to be given on Tuesday and Thursday, and 1 milligram was to be given on Sunday, Monday, Wednesday, Friday, and Saturday with PT/INR to be done weekly. Despite being shown the discrepancies in the record and the most recent orders for Warfarin of 1 milligram daily, a Medication Flowsheet was provided which was clearly inconsistent with hospital discharge orders, demonstrating the confusing clinical record and lack of checks and balances for medication administration. E19 (Registered Nurse) stated on 6/20/07 at 6:20 p.m. when asked to explain the lab process:	F9999		

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"When a lab order is inputted to the computer, an order is automatically sent to laboratory services, a lab requisition sheet must be manually filled out. If it is a one time order the lab requisition goes into a file folder under the date it is to be collected. The lab service pulls the requisition, obtains the sample, and the sample goes for processing. After being asked about physician orders, I found out we do not have signed or telephone orders from the prescribing physicians because the nurse puts the information into the computer and the order ended there. After the laboratory obtains the sample it is removed from the computer. There are many one time labs that do not have a physician order.

I (E19) just learned from the laboratory service (after many lab results were requested for sampled residents on the survey) that residents with repeating labs did not get completed, because the computer does not automatically generate the order. Most of the nurses thought if you put every Monday, Wednesday, or Friday into the computer or weekly for example the computer would continue to generate the orders. The orders must be put in each week. A separate requisition must also be filled out. I didn't have training on this, I don't think all of the nurses know this.

There isn't a manual or policy for the computer or the laboratory process. I (E19)
would like to have training. I now have to look at each resident and their orders since you started asking about the laboratory process, so we're going to work on it. I go home crying or frustrated sometimes."

According to this interview, staff were not printing

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F9999	Continued From page 87 a copy of the lab order to be signed and verified by the physician that the test was correct as to the actual order. E1 (Administrator) stated on 620/07 at 8:00 p.m., "We do not have manuals for the computer. I have been here for three weeks and requested the manuals for the computer programs the first week I arrived. I was not aware of the laboratory system issues. We will get right on this in the morning. I was not aware of the problems, but I can see the issue regarding physician orders. The computer program is the corporate system. I am also working on implementing staff training programs." 3. On 6/20/07 at approximately 1:30 pm. E2 (DON) was questioned regarding pharmacy consultation. E2 stated "I am not sure what I should have done regarding the pharmacy consultation sheets. Do you mean the ones that are in the chart?" The yellow pharmacy consultative sheet were shown to E2 and an explanation of pharmacy expectations were discussed based on interview with the consultant pharmacist. E2 stated that he was not familiar with the process; these (yellow sheets) were in my box and had my name on them, I wasn't sure why." Record review for R12 shows pharmacy "Medication Regimen Review" consult instruct reader to "see report for noted irregularities" for 4/13/07, 5/4/07, and 6/8/07. These consultation reports were not in the clinical record. E2 located the pharmacy consult report for 4/13/07, but on 6/21/07 at 2:30 pm. E2 stated that he was unable to produce the recommendations from R12's	F9999		

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F9999	Continued From page 88 monthly pharmacy consultations for 5/4/07 and 6/8/07. E2 requested the pharmacy re-fax the consult reports for 5/4/07 and 6/8/07, then faxed all three pharmacy consult reports to the physician. The 4/13/07 Pharmacy Consultation report for R12 notes that R12 "takes benadryl 50 mg. (milligrams) q (every) hs (evening) for sleep. Due to its anticholinergic properties Benadryl is generally not recommended for use as a hypnotic in the elderly, and when used for the treatment of allergies its recommended to limit use to once every three months at the smallest possible dose, for a short duration, it is recommended to use the topical rather than oral preparation. Recommended to re-evaluate continued use and consider discontinuation or alternative therapy, if appropriate for this resident. If this therapy is to continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b). the facility interdisciplinary team ensure ongoing monitoring for potential adverse consequences. (R12's record did not contain the above). Also, "No evidence of a signed consent form in the chart for Benadryl." R 9's pharmacy "Medication Regimen Review" consult sheet prompts staff to "see report for noted irregularities" for 2/15/07, 5/4/07, and 6/8/07. These consultation reports were not in the file. E2 requested the pharmacy re-fax the consult reports for R9. All of the pharmacy consult reports were then faxed on 6/21/07 at 7:40 am. to the physician. The 2/6/07 Pharmacy Consultation Report for R9	F9999		

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notes that R9 "has been identified as taking two or more anti-depressant medications (fluoxetine hcl, nortriptyline hcl) concomitantly. This may increase the potential for adverse events. Please consider re-evaluating continued use of this combination, if therapy is to continue, it is recommended that the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for the resident, the facility ensure ongoing monitoring for potential adverse consequences." (R9's record did not contain the above).

"R9 is currently receiving Nortriptyline 10mg., an anti-depressant and there appears to be no consent form for this medication. However, the patient does have a consent completed for Paxil, which the patient does not have an order for."

The 5/4/07 Pharmacy Consultation Report for R9 states "there appears to be no diagnosis or documentation in the progress notes which supports continued use of the following medications: lidoderm (topical analgesic), nortriptyline (anti-depressant), neurontin (management of postherpetic neuralgia), Prozac (anti-depressant). Please re-evaluate continued use or provide documentation which supports the clinical rationale for routine use of this medication."

Facility was unable to provide any documentation that they had acted on these pharmacy recommendations.

4. R6's current physician orders indicate that R6 is to receive Vicodin every 6 hours for pain. Medication Flowsheets lacked documentation

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F9999	Continued From page 90 that Vicodin was given on 1/19/07 at 6 p.m., 2/2/07 at 6 a.m., 2/27/07 at 6 a.m., 2/28/07 at 12 p.m., 5/23/07 at 6 p.m., 5/28/07 at 6 p.m. During interview with E2 (Director of Nursing) on 6/19/07 at 2:30 p.m, E2 stated "I know that there have been omissions on the medication administration sheets and the treatment sheets. I was from the school where if it wasn't documented it wasn't done. We do not have a policy for medication errors." R6 also has current physician orders for Vasotec (treats high blood pressure). The order states "hold medication if systolic (top number) blood pressure is less than 120." On May 5, 6, and 19, 2007 there was no blood pressure recorded, yet the medication was given. On 5/23/07, blood pressure was recorded as 160 over 89. There is no indication that medication was given although it should have been based on the blood pressure reading. R6 also has a current physician order for Lovenox (anti-coagulant) injection 40 milligrams daily at 8:00 a.m. with a weekly hemoglobin and hematocrit ordered. Record review indicated that from 1/9/07 to 6/21/07, 15 of 24 weekly laboratory tests for hemoglobin and hematocrit were not done. Facility was unable to provide evidence that these tests were done. In this same time period, there are 5 blanks on the Medication Flowsheet indicating that medication was not given. 5. Facility Pharmaceutical policies states that "C-II controlled drugs, will be destroyed on premises by the pharmacist and a representative	F9999		

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F9999	Continued From page 91 of nursing administration." and Controlled Substances "f. A shift count will be done every shift by the off-going and on-coming nurses to verify doses remaining. A shift count form will be used for this purpose and signed by both nurses." Narcotic shift count sheets from 4/27/07 through 6/20/07 indicate 244 shift counts should have been completed, however only 118 shift counts were actually done. Interview on 6/21/07 at 3:00 p.m. with E1 (Administrator) and E2 (DON) showed that E2 has been destroying controlled medication with a facility nurse and flushing the medication down the toilet if a tablet or cutting up patches and disposing of them. E1 stated that "You need to have someone from the pharmacy witness the destruction of controlled narcotics for your protection, I would like you to do it that way in the future. There is also a problem with the environment in flushing controlled narcotics, the pharmacy should have containers for such, talk with them about it." (A) 300.650f)1) 300.670b)1)2) 300.670c)1)2)3) Section 300.650 Personnel Policies f) Orientation and In-Service Training 1) All new employees, including student	F9999		

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F9999	Continued From page 92 interns, shall complete an orientation program covering, at a minimum, the following: general facility and resident orientation; job orientation, emphasizing allowable duties of the new employee; resident safety, including fire and disaster, emergency care and basic resident safety; and understanding and communicating with the type of residents being cared for in the facility. In addition, all new direct care staff, including student interns, shall complete an orientation program covering the facility's policies and procedures for resident care services before being assigned to provide direct care to residents. This orientation program shall include information on the prevention and treatment of decubitus ulcers and the importance of nutrition in general health care. Section 300.670 Disaster Preparedness b) Each facility shall have policies covering disaster preparedness, including a written plan for staff, residents and others to follow. The plan shall include, but not be limited to, the following: 1) All personnel employed on the premises shall be properly instructed in the use of fire extinguishers. 2) A diagram of the evacuation route shall be posted and made familiar to all personnel employed on the premises. c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to:	F9999		

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F9999	Continued From page 93 1) Ensure that all personnel on all shifts are trained to perform assigned tasks; 2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; 3) Evaluate the effectiveness of disaster plans and procedures. These REGULATIONS are not met as evidenced by: Based on interview and record review, the facility failed to train all employees on emergency fire procedures at the time of hire for 7 of 11 direct care staff (E7, E8, E9, E10, E11, E12, and E13) who were interviewed regarding fire procedures. The facility also failed to ensure that fire drills were conducted on all 3 shifts of employees for each quarter, specifically the third shift for the first quarter of 2007. Findings include: On 6/18/07 eleven direct care staff members were interviewed regarding emergency preparedness training, and 7 employees stated a lack of fire training as follows: Interview with E7 (1st shift nurse aide) at 1:30 PM indicated that she did not receive any training on fire procedures when she started. E7 stated that she was only given orientation materials and was not shown locations of fire extinguishers in the building or how to use one. Interview with other 1st shift nurse aides E8 at 1:40 PM, E9 at 2:05 PM, and E10 at 2:00 PM	F9999		

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F9999	Continued From page 94 indicated that none of them received any training on fire procedures or on the use of a fire extinguisher and their locations in the building when they started. Interview with 2nd shift nurse aides E11 at 2:10 PM, E12 at 2:18 PM, and E13 at 2:22 PM indicated that none of them received any training on fire procedures or on the use of a fire extinguisher and their locations in the building when they started. A list prepared by the facility of 46 newly hired employees since 3/1/07 indicated the following hire dates for the aforementioned nurse aides: E7-5/9/07. E8-5/18/07. E9-5/3/07. E10-6/6/07. E11-6/5/07. E12-4/13/07. and E13-5/30/07. Interview with E14 (1st shift nurse aide supervisor) at 1:45 PM on 6/18/07 indicated that received fire and extinguisher training when she started about a year ago when the facility first opened. E14 stated that the facility does fire drills, but that she has not been in one since the winter. When E14 was asked who was training the 1st shift nurse aides in fire procedures and extinguisher usage, she stated that she did not know. E14 said that she was never told by management to do the training. Interview with E1 (Administrator) on 6/18/07 at approximately 2:30 PM indicated that he has only worked at the facility for about 4 weeks. In that time, E1 stated that he has learned that there was no formal orientation of new employees hired within the last 90 days. E1 also stated that the previous Assistant Administrator, who also served as the Human Resource person, neglected her work duties, one of which was new	F9999		