STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 333	Continued From page 7 range for (R3) or any other changes in condition...". No blood pressures are recorded again in the nurses notes until 9:14 p.m. when R3's blood pressure is recorded as 79/48. On 6/24/12 at 10:24 a.m., the nurses' notes indicate R3 was alert and orientated and ambulated to and from the main dining room with a wheeled walker A physician progress noted dated 6/28/12 and written by Z3 (R3's Attending Physician) states, "...Reexamined after complaint of problems with speech and weakness...seen in Emergency Room and under went a CT scan of the head that showed no acute process. Clinically the patient had stroke-like symptoms. (R3) has noted daily improvement...goes to dialysis on Mondays, Wednesdays, and Fridays....Blood pressure is intermittently low and (R3) requires medication to stimulate blood pressure while at dialysis...does have mild expressive aphasia. There is some weakness to the left side of the face...Ischemic CVA (Cardio Vascular Accident) with negative CT scan for bleeding tumor of hemorrhagic stroke...". A Emergency Room Data Record dated 6/26/12 states, "Mild Stroke Non-hemorrhagic". On 9/04/12 at 10:05 a.m., Z8 (Office Nurse for Z3, R3's Attending Physician) stated Z3's office was notified of R3's medication error on 6/23/12 at 8:00 a.m. Z8 reports on 6/23/12 facility nursing staff called again at 9:44 a.m. and reported R3's vital signs were stable but R3's speech was a little slurred and R3 was drowsy. Z8 indicated the medication error for R3 on 6/23/12 was a concern and Z3 wanted R3 monitored.	F 333		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 8 LICENSURE VIOLATIONS: 300.1210 d) 1 300.1610 a) 1 300.1620 a 300.3240 a Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), 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. Section 300.1610 Medication Policies and Procedures 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	F9999		

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F9999	Continued From page 9 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements were not met by the facility as evidenced by: A) Based on observation, record review, and interview the facility failed to follow their policy for administration of transdermal skin patches for three of three residents (R2, R5, and R6) receiving skin patches for pain management in a total sample of six. This failure resulted in an adverse reaction with a change in condition for R2 and subsequent need for hospitalization. B) Based on observation, record review, and interview, the facility failed to follow their policy for administration of oral medications for one of six residents (R3) receiving oral medications in a total sample of six. Findings include: On 8/29/12 at 10:20 a.m., E2 (DON-Director of Nursing) stated there had been medication errors in the past six months and provided Medication Incident Reports related to those errors.	F9999		

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Medication Incident Reports dated 5/23/12, 6/05/12, and 7/16/12 show a total of three medication errors in administration of Fentanyl patches occurred and involved R2, R5, and R6. A policy dated 3/30/12 and titled Applying Transdermal Patches states, "...Remove previous patch prior to applying a new one...Record the date, time, and your initials on patch..."

1) A Medication Incident Report dated 7/16/12 and written by E19 (LPN-Licensed Practical Nurse) states on 7/10/12 at 5:25 a.m. R2 was experiencing a "change in mental status, lethargic, refusing fluid intake. Multiple fentanyl patches noted on resident.... Patches removed and resident sent to hospital...Low blood pressure, lethargic, change in mental status...Seen in ER (Emergency Room) physician...". A History and Physical dictated by Z2 (R2's Attending Physician) states, "...Quite confused...Early this AM the nursing staff called stating that (R2) was combative and quite confused...elevated BUN and signes of clinical dehydration...lethargic and initially not responsive...given Narcan, which did improve (R2's) condition...admitted for adverse reaction to Fentanyl, clinical dehydration, and chronic kidney disease with acute exacerbation...Assessment: Altered mental status, (question) if etiology is a reaction to Fentanyl...".

On 9/04/12 at 9:50 a.m., Z7 (RN-Registered Nurse - Office nurse for Z2, R2's Attending Physician) stated R2 was living at home but had a brief hospital stay just prior to admission to the facility on 7/03/12. Z7 reported R2 became confused and combative at the facility which was not characteristic of R2. Z7 indicated Z2 had

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been working with R2 to address pain management prior to R2 admission to the facility and R2 had orders for the Fentanyl patch while still hospitalized. Regarding the facility staff finding of multiple Fentanyl patches on R2 on 7/10/12, Z7 stated, "...A thorough skin assessment when (R2) came in would have been indicated. It's totally out of (R2's) nature to be confused and combative. The patches not being removed certainly was a reason for R2 ending up in the hospital...".

R2's MAR also indicates from 7/04/12 through 7/09/12 R2 received Tramadol HCL 100 mg (milligram) daily at hour of sleep and Dilaudid 2 mg every six hours as needed for a total of eight doses from 7/04/12 through 7/09/12. R2 also received Alprazolam 0.50 mg every eight hours as needed for a total of six doses from 7/05/12 through 7/09/12. On 8/28/12 at 11:30 a.m., R2 was alert, but mildly confused and resting on (R2's) bed. R2 did not recall a recent hospitalization and denied currently experiencing pain.

R2's nurses' notes dated 7/10/12 and written by E19 (LPN - Licensed Practical Nurse) at 5:25 a.m. state, "...Change in metal status, lethargic, refusing fluid intake...started on admission....has gotten worse since it started...decrease in voiding. (three) pain patches found dated 7/01/12, 7/03/12, and 7/06/12...Vital signs are as follows: (Temperature) 103.5, (pulse) 54, (respirations) 16, (blood pressure) 96/84, mental status or neuro status has changed. Resident (R2) showing signs of confusion...lethargy...". At 5:32 a.m., E19 (LPN) documented, "...new orders received to send in to ER (Emergency Room) for

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evaluation...". R2's MAR (Medication Administration Record) dated 7/03/12 shows R2 was admitted on 7/03/12 with a physician order for Fentanyl Transdermal patch 75 mcg (microgram)/hour. R2's physician order dated 7/03/12 indicates R2's Fentanyl patches are to be changed every three days. The MAR does not indicate Fentanyl Transdermal patch was administered to R2 by the facility on 7/03/12 but does indicate administration on 7/06/12 at 7:30 a.m. by E20 (LPN) and on 7/09/12 at 7:30 a.m. by E21 (LPN). A Controlled Medication Utilization Record for R2's Fentanyl 75 mcg/hour patches shows the facility received five Fentanyl patches for R2 on 7/05/12. Documentation on the Controlled Medication Utilization Record includes administration of the Fentanyl patch to R2 on 7/06/12 by E20 (LPN) and on 7/09/12 by E21 (LPN) and a note stating "removed patch place at hospital". However, R2's nurses' notes on 7/10/12 indicate three Fentanyl patches were found on R2 dated 7/01/12, 7/03/12, and 7/06/12.

On 8/29/12 at 2:00 p.m., E2 stated staff received Inservice training following the medication error on 7/10/12 involving R2's Fentanyl patches. A Training Sign in sheet shows staff were inserviced on transdermal patches on 7/24/12 and 7/26/12. On 9/04/12 at 12:05 p.m., E2 (DON - Director of Nursing) verified there was no further documentation or skin assessment from R2's admission that addresses Fentanyl patch placement.

2) A Medication Incident Report completed by E22 (RN-Registered Nurse) dated 6/05/12 at 5:30 p.m., states R5 "...was observed to have four Fentanyl patches on, two 25 mcg patches to

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(R5's) left upper back with no date and....two 25 mcg patches observed to (R5's) right upper back with the date 6/03/12...". E22 (RN) documents Therapy staff brought the extra patches to E22's attention. R5's MAR dated 5/10/12 shows Fentanyl Transdermal patch 50 mcg/hour was ordered on 5/31/12 and administered by E24 (LPN). R5's MAR dated 6/01/12 shows Fentanyl Transdermal patch 50 mcg/hour was administered by E25 (LPN). R5's record indicates R5 was placed in Hospice care on 6/27/12 and expired on 7/11/12.

3) A Medication Incident Report completed by E23 (LPN) at 10:15 a.m., states "...(R6) had Fentanyl patch on back that was due to be changed - hospital report on 6/24/12 Fentanyl patch was discontinued 6/21/12. Nurse didn't take patch off right upper chest...(R6) was lethargic...was in ER (Emergency Room) and they noted patch on back...Hospital staff in ER removed...". On 8/30/12 at 3:00 p.m., R6 was noted sitting in a wheelchair. R6 was alert and responsive but very confused and unable to answer questions.

A physician order dated 6/21/12 shows R6 had Fentanyl patch 12 mcg/hour every 72 hours ordered on 5/12/12 and discontinued on 6/21/12. R6's MAR shows the Fentanyl patch was discontinued as ordered on the 6/01/12 MAR. R6's current POS (Physician Order Sheet) shows R6 does not have a order for Fentanyl patches.

On 8/29/12 at 2:00 p.m., E2 stated staff received education following the medication error on 6/21/12 involving R6's Fentanyl patches. A Training Sign in sheet shows staff were

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F9999	Continued From page 14 inserviced on transdermal patches on 6/24/12. On 9/04/12 at 12:05 p.m., E2 verified there was no further documentation addressing R6's Fentanyl patch placement. 4) A Medication Incident Report dated 6/23/12 at 7:00 a.m., states E10 (LPN-Licensed Practical Nurse) administered R3, R10's scheduled 7:00 a.m. medications. R3 received R10's 7:00 a.m. medications which included the following: Celexa (Antidepressant) 30 mg (milligram), Lasix (water pill) 20 mg, Vesicare (for overactive bladder) 10 mg, Remeron (antidepressant) 30 mg, and Seroquel (antipsychotic) 200 mg. R3's POS (Physician Order Sheet) dated 8/01/12 shows R3 has diagnoses include Renal Failure, Atrial Fibrillation, and Congestive Heart Failure. R3's MAR (Medication Administration Record) dated 8/01/12 indicates R3's daily medications include: Aspirin 81 mg daily, Coumadin (blood thinner) 6 mg daily, Digoxin (for heart failure and abnormal heart beats) 0.125 mg daily, Gabapentin (for nerve pain) 100 mg daily, Vicodin (for pain) 5-325 mg at bedtime as needed, Midodrine (for low blood pressure when changing positions and renal failure), and Sensipar (to decrease calcium and phosphorous in the body). A physician progress note written by Z3 (R3's Attending Physician) and dated 6/28/12 states, "...(R3's) blood pressure is intermittently low and (R3) requires medication to stimulate blood pressure while at dialysis...". A policy titled Oral Medications dated 12/07/11 states, "...Identify resident...Verify the physician's medication order for the resident's name, drug name, dose, time, and route of administration...".	F9999		

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On 8/30/12 at 1:15 p.m., E10 (LPN) verified a medication error occurred with R3 on 6/23/12 and stated, "..I notified the doctor, the family, and the DON. I saw (R3) part of the day because (R3) went to dialysis. (R3) didn't get dialysis because (R3's) blood pressure was too low but (R3's) blood pressure is low anyway...(R3's) blood pressure was back up when (R3) got back (from dialysis) and they monitored her the rest of the night....". E10 (LPN) stated R3 is normally scheduled for dialysis on Mondays, Wednesdays, and Fridays and 6/23/12 was a Saturday. E10 (LPN) reports R3 gets dialysis on Saturdays too if R3 is retaining fluid. On 8/30/12 at 4:00 p.m., R3 could recall a recent incident when the wrong medications were given to (R3) but denies ill effects due to the error. R3 states, "They told me about it. I knew but I don't remember having any problems from it."

R3's nurses' notes dated 6/23/12 at 8:00 a.m. state, "...On call physician (Z9) noted possible error and gave order to monitor vitals and as long as vitals remain stable for (R3) to continue to dialysis appointment today...Spoke with (dialysis provider) they stated as long as (blood) pressure remained okay they would continue with dialysis...monitored and remained stable throughout morning....11:27 a.m... Vitals signs before leaving for dialysis...(Blood pressure) 92/58, (Pulse) 86, (Respirations) 18, (Blood oxygen level) 96 percent...Dialysis called at 1:45 p.m. to notify (R3) was unable to have dialysis related to pressure dropping..(Blood pressure 58/38)...(Z9 On call Physician) updated...new orders to monitor vitals every hour for 4 hours the every 2 hours for 4 hours, then every 4 hours, notify if blood pressure drops below a normal

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range for (R3) or any other changes in condition...". No blood pressures are recorded again in the nurses notes until 9:14 p.m. when R3's blood pressure is recorded as 79/48. On 6/24/12 at 10:24 a.m., the nurses' notes indicate R3 was alert and orientated and ambulated to and from the main dining room with a wheeled walker

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(B)

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