STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105884	A. BUILDING ______ B. WING ______	C 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2811 CAMPUS HILL DR TAMPA, FL 33612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS SKILLED NURSING FACILITY A Complaint Investigation CCR# 2015002905, CCR# 20150037087, and CCR# 2015003927 was conducted off hours at 6:30a.m. Monday to Excel Rehabilitation and Health Center is not in compliance with 42 C.F.R. Part 483 Requirements for Long Term Care Facilities. Immediate Jeopardy was identified on A partial extended survey was completed on Substandard Quality of Care was identified at F 333. Findings of Immediate Jeopardy were identified at F 281 S/S: K; F 282 S/S: K; F 333 S/S: K; F 490 S/S: K and F 501 S/S: K The Administrator was informed of the Immediate Jeopardy on at 9:50 A.M. It was determined that the Immediate Jeopardy was removed on at 5:30 PM and the severity and scope was reduced to an E.	F 000	Preparation and submission of This plan of correction does not Constitute and admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law. **This plan of correction will serve as the Facility's allegation of substantial compliance.** RECEIVED MAY 29 2015 AHCA HQA5/6	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	F 166	accepted 6/2/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 5/21/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to act on, resolve, and log resident grievances for two (Resident #6 and Resident #23) of twenty-three sampled residents. Findings include: (1) During an interview with Resident #6 on at 10:30 a.m. stated that she has multiple concerns with the facility including waiting for assistance with activities of daily living (ADL) care, staff slow to answer call lights, and concerns related to nursing staff providing her medications as ordered. She stated that she has voiced these concerns to multiple facility staff. Review of the following nursing notes revealed that the staff was made aware by Resident #6 that she had concerns related to care and services on and Review of the Grievance log from revealed no grievances logged for Resident #6. (2) During an interview with Resident #23 on at 3:10 p.m. he stated that when he pressed his call light for assistance that the staff will come into his , turn off the call light and stay that they are going to get his Certified Nursing Assistant (CNA). He stated that this happens consistently and that he has to do this a few times before his CNA actually comes into the help him. He stated that there has been times when he has asked the assigned CNA had anyone told them that he needed assistance and	F 166	1.Resident #6concern recorded In nurses note regarding timing of her medication, order was written by MD on to change to times requested by res. #6. Concern resolved at that time. Res. #6 concern recorded in nurse's note regarding res. choice of lift resident was provided choice of 2 lift pads,resident chose which one she wanted to use, this was resolved on Social Service met with resident #23 on advised resident that call light audit was being implemented to address any negative trends with call light response time. resident expressed no further concerns at that time. Social Service met with Resident #6 on to review Facility grievance process. Resident stated she had no concerns or grievances at this time. Social Service met with Resident #23 on to review facility grievance process. Resident stated he had no grievances/concerns at this time. Resident #23 discharged home on	

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F 166	Continued From page 2 they tell him no. He stated that the CNA staff has told him that they are working short or are working on another hall so they cannot see when his call light goes off. He stated that many times, staff not assigned to his just walk past his he has his call light on for assistance. He stated that he has talked with the unit manager and the nurses related to staff coming into his , turning off the call light and leaving without providing him assistance but it has done no good because they continue to do it. During an interview with the Nursing Home Administrator (NHA) on at 4:34 p.m. she stated that Resident #23 was angry about a number of things when he first arrived at the facility on including some things related to his . She stated that they had changed his the concerns he had were never placed on the grievance form or grievance log. She was asked if all residents ' grievances are not logged, then how the concerns are reviewed by the Quality Assurance Committee to identify patterns or trends per the facility policy. She stated that " if grievances are not logged then it is impossible to track and trend them ". She confirmed that there was no grievance logged related to Resident #23 having concerns. A review of the nursing notes for Resident #23 revealed that on several staff made administration aware that the resident had concerns related to staff not answering the call light in a timely manner, taking too long to serve the food. It was noted that the Nursing Home Administrator, DON, Social Worker, and Unit Manager met with the resident at bedside. Review of the Grievance log from	F 166	2. Grievance p&p reviewed by Social Services at resident council meeting, and then quarterly with resident council. Call light audit to be completed by Social Service/designees on all 3 shifts starting through with results reported at QAPI meeting. Call light audit will continue on all three shifts for three months by Social Service/designees with results reported by Social Service at monthly QAPI meeting. Negative trends identified in call light response time will be addressed by inservice to staff involved and documented as a resident grievance if indicated. Tracking and trending of all resident grievance reports will continue monthly, with results presented at monthly QAPI meeting. Negative trends identified with grievance type will be investigated by Risk Manager/Administrator for quality improvement plan and resolution via root cause analysis. 3.Resident Grievance p&p is posted at each nurses station and in the Main lobby. Grievance p&p reviewed at resident council meeting, and then Quarterly with resident council. Resident's receive a copy of the Grievance p&p at the time of admission . All staff to be inserviced by Social Service/staff development on grievance p&p by Grievance forms placed on clipboards at each nurses station for ease of access .	

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F 166	Continued From page 3 revealed no grievances logged for Resident #23. Review of the Grievance Policy (no date) revealed the following: Any resident or responsible party has the right to voice grievances ... grievances include those with respect to treatment and services furnished, as well as those not furnished, and may be expressed at any time, both verbally and in writing. Grievances will be monitored by the Quality Assurance Committee. In order to be remedied, residents and responsible parties report the concern to staff.	F 166	4.Resident grievance tracking and trending will continue monthly with Social Service reporting results at monthly qapi. Call light audits will be completed by Social Service/designee for all 3 shifts x 3months. Social Service will present results of call light audits x3 months at monthly qapi committee to identify any negative trends and ensure they are analysed and addressed through root cause analysis .	
F 254 SS=E	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION [illegible] linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and resident interviews, the facility failed to ensure that there was sufficient linen (towels, wash cloths and gowns) for the resident population on two (Skilled Rehab Unit and the Life Enrichment Unit) of two units in the facility. Findings include: On at 6:15 a.m. the linen the Skilled Rehab Unit (SRU) was observed to have no wash cloths, towels, or gowns. During an interview with Staff J, a Registered Nurse, on at 6:34 a.m. she stated that	F 254	Additional linen was put ordered over 11,200 disposable washcloths since . Housekeeping Supervisor rounds daily to ensure sufficient linen supply. Laundry staff deliver linen every 2 hours or as needed. Linen order received Linen inventory completed by disposable wet wipes implemented on to use for resident incontinence care.	15

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F 254	Continued From page 4 Certified Nursing Assistant (CNA) staff had complained to her that they have to work with very little linen and wipes. There were no disposable wash cloths/wipes observed in the supply ... that time. On ... at 6:36 a.m. the linen ... the Life Enrichment Unit (LEU) was observed to have two towels and no wash cloths or gowns. During an interview with Staff K, CNA on ... at 6:36 a.m. she stated that she has worked at the facility for many years. She stated that there are not a lot of towels or wash cloths and that they often work with a short linen supply. During an interview with Staff L, CNA on ... at 6:40 a.m. she was asked if she had enough supplies. She stated, "It is bad. Sometimes you only have two towels for 10 patients." She stated, "This place was not always like this. It has really gone down." On ... at 3:30 p.m. the linen ... the Skilled Rehab Unit (SRU) was observed to have no wash cloths, towels, or gowns. On ... at 3:40 p.m. the linen ... the Life Enrichment Unit (LEU) was observed to have no towels, wash cloths, or gowns. During an interview with Staff N, CNA on ... at 3:45 she stated that the facility is always short on having linen (wash cloths, towels and gowns). She stated that the disposable wash cloths are scarce. She stated, "When I see some, I have to grab three or four packs because we usually don't have any. When my resident has a (bowel movement) I will sometimes have to go	F 254	Laundry aide added for midnight shift, facility will process laundry 24 hours per day. Wet wipes implemented ... for incontinence care. Housekeeping Supervisor will maintain monthly linen audit and order as needed to ensure par levels for linen are maintained. Linen delivery form implemented by ... Licensed nurse on each wing will sign off to verify count on all linen deliveries at time of delivery. Nursing staff inserviced by staff development by ... on linen service,linen delivery and linen delivery form. Housekeeping supervisor/designee will report to monthly qapi meeting x3months any negative trends in linen inventory or delivery. Negative trends will be addressed through root cause analysis for resolution.	

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

FORM APPROVED
OMB NO. 0938-0391

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F 254	Continued From page 5 into other residents to find wipes or something to clean them up with." During an interview with Staff O, CNA on at 3:55 p.m. she stated that she has been at the facility for only a couple weeks. She stated, "I have to ask other aides for (linen). Towels and wash cloths are hard to find here." Interview with Staff P, CNA on at 4:05 p.m. she stated that sometimes they do not have enough linen available for all of the residents. She stated that they do have wipes but sometimes they run out of those too. She was asked what she does when they run out. The staff was observed to shrug her shoulders and stated, "We have to just use whatever we got." During an interview with Staff Q, CNA on at 4:15 p.m. she stated that the supply of linen has been a problem on all shifts. She stated that sometimes the CNA staff has to use paper towels with soap and water to clean the residents when they have a bowel movement because they don't have linen. She stated, "You just gotta do the best you can for them." During an interview with Housekeeping Supervisor on 4/28/2015 at 4:15 p.m. she stated that the staff had just placed a cart of linen on each unit at 3: 00 p.m. She stated that the laundry staff takes carts of clean linen out to the floors three times a day. She stated that she does not know what the CNA staff does with the linen after that. She stated, "We have plenty of boxes of new linen." She was asked if she brings out the new linen for the CNA staff to use. She stated that she does bring out new linen "sometimes."	F 254		

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F 254	Continued From page 6 On at 4:15 p.m. a tour was conducted on the Long Term Care Unit with the Housekeeping Supervisor. A tour of the linen closet was conducted and there was no linen in the linen . The CNA staff on the unit stated that they placed the linen that they were provided in the residents already. The 300 hall were toured to observe the linen supply for the resident population. The Housekeeping Supervisor was able to find eleven towels and four wash clothes available for fourteen residents. The 100 hall were toured to observe the linen supply for the resident population. The Housekeeping Supervisor was able to find ten towels and two wash clothes available for fourteen residents. was observed and the resident in the A bed had a wash cloth placed on her bed. The resident in B bed had a gown placed on her bed. An interview was conducted with the two residents at that time. They both confirmed that there is a lack of linen in the facility. The resident in bed B stated, "Yes, that is a problem. I guess since I get a gown, I don't get a wash cloth."	F 254		
F 281 SS=K	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on a review of the Nurse Practice Act, record review, interviews with the facility staff, the Attending Physician, the Medical Director, facility Administration and review of the facility ' s policy	F 281		

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F 281

Continued From page 8

administered five doses of on 3/7, 10, 13, 15, 19/2015. Resident #18 was not administered four doses of on 4/2, 11, 13 and . Resident #19 missed four doses of Pradaxa from . Resident #20 was not administered seven doses of from . The facility ' s Licensed Nursing staff failed follow physician ' s orders and administer medications.

Based on record review and interview, the nurses also failed to administer medications for two (#2, #8) out of forty-eight (48) residents reviewed for medication accuracy. Resident #2 ' s physician ordered and were omitted for 10 days. There was a three day delay in starting a physician ordered for Resident #8 and two doses were omitted.

The nursing staffs failure to administer medications resulted in the findings of Immediate Jeopardy existing in the facility as of
The facility Administration was informed on at 9:50 a.m. The Immediate Jeopardy was removed on at 5:30 p.m. and the scope and severity was reduced to a " E. "

Findings include:

The Florida Nurse Practice Act, Section 464.003, Definitions Part (3) (a) "Practice of professional nursing" means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of biological, physical, and social sciences which shall include, but not be limited to:
1. The observation, assessment, nursing diagnosis, planning, intervention, and evaluation

F 281 (Provider's Plan of Correction)

1. Resident #6 is receiving their as ordered by the physician since . Resident #2 has been discharged from the facility . A medication error report was completed for this resident and the physician was notified. Resident #10 is currently receiving 40 mg once a day. Residents #14 was discharged on and was a closed record. A medication error report was completed with physician notification. Resident #15 was discharged a medication error report was completed and the physician was notified. Resident #16 is not currently receiving
Resident #17 is receiving 3 mg once a day. Resident #18 is receiving Coumadin 8.5 mg once a day. Resident #19 is receiving Pradaxa 150 mg twice a day. Resident # 20 is receiving Enoxaparin 40 mg every twelve hours. All medications are being administered under "Practice of Professional Nursing".

2. A complete facility review was completed on to assure that all resident medication orders are current and transcribed on the medication administration records. All residents are receiving their medications as ordered by their physicians under "Practice of Professional Nursing".

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F 281	Continued From page 9 of care; health teaching and counseling of the ill, injured, or infirm; and the promotion of wellness, maintenance of health, and prevention of illness of others. (b) Practice of practical nursing " means the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured , or infirm and the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician ,a licensed osteopathic physician, a licensed podiatric physician , or a licensed dentist. 1. The facility identified thirty residents receiving . All thirty residents were sampled. The following residents were identified with medications errors by the Licensed Nursing staff at the facility related to Review of Resident #6 ' s Medication Administration Record dated 2015 revealed a typed order dated 15 MG tablet one tablet by mouth once a day. Directly underneath the typed order a hand written entry; resume . The Medication Administration Record (MAR) revealed the Licensed Nurses documented for and " HOLD. " On the MAR indicated to resume The remainder of the MAR from through was reviewed with no indication that the medication had been given and no indication as to why the medication was not given. The MAR indicated that six Licensed Nurses were assigned on the 3-11 p.m. shift and failed to administer the as ordered by the attending physician. During an interview on at 4:10 p.m.	F 281	3. Nursing staff has been re-educated on holding a resident's medication. orders on hold will be discontinued and the physician will be called to obtain new orders when the is to be restated and the new dose that the physician wants implemented. Any other that requires a hold will be documented as hold and the ordered will be yellowed out. The order will be rewritten and arrowed over to the restart date and the date of the restart will be written on the order. All holds for will be tracked on the twenty-four hour report until it is restarted. A new tracking log has been implemented and the nursing staff has been educated on how to utilize this tool. This was provided on 4-27-15. Nursing staff has been re-educated by the Pharmacy Nursing Consultant on all aspects of medication management including obtaining orders, transcribing orders and implementing orders. All residents on will be reviewed at a weekly Standards of Care meeting, this will include review of current orders, labs and Medication Administration Records and that the medication is on hand and available. All new admissions will be reviewed at the Daily Clinical	

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F 281	Continued From page 10 Employee (Registered Nurse) E, a nurse that cared for the resident on 12 of the 26 evening shifts, stated that she had been a nurse for a long time and worked in long term care. She stated that she was familiar with Resident #6. She stated that she was aware the resident needed . The medication was not administered. She stated that she did not think the order was on going. She stated that it was on hold. She stated that she did not have the time to research the order and was aware that Resident #6 was at high risk for . She stated that she questioned the medication to other staff; however, she did not recall who the staff member was. She stated that the doctor came in and then realized the medication should have been resumed. The nurse stated that when a medication was held, the nurse should write hold on the days that the medication is to be held and then indicate when the medication should be resumed. The nurse confirmed the MAR and confirmed that there was no indication the medication had been given. She stated that she did not recall the resume date. The nurse stated that " my philosophy is if I don ' t see the medication and don ' t see a stop order, then I question with another nurse as to whether the medication is on hold or should be discontinued. " She stated that she would call the pharmacy. She stated that the medication card was not in the cart. The nurse also confirmed that she did not document any omissions in the chart. She stated that she did not look at the chart to find the original order. An interview was conducted on at 4:30 p.m. with Employee Licensed Practical Nurse (LPN) D she stated that she worked at the facility . When asked about her training she stated she had trained for two to three days	F 281	Meeting to assure implementation of all orders and assure transcription of orders to the appropriate MAR/TAR. Medication errors will be will be documented on the Medication Error Report and all necessary notifications will be made. These will be investigated by the Risk Manager according to risk management standards and root cause analysis. A shift to shift MAR/TAR review has been implemented to assure that residents have received all of their medications. There will also be a daily Nursing Administration review of the MAR/TAR to assure compliance with this process. Binders with current nursing education has been implemented for the agency nursing staff and they are required to review this material and sign off each time they work at the facility. This will all be overseen by the Director of Nursing/Designee and the Interdisciplinary Team. 4. These areas of care will be monitored by the Director of Nursing/Designee utilizing data collection tools weekly times four weeks and then monthly on an ongoing basis to assure continued compliance. This will also be overseen by the Administrator and the QAPI Committee.	

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F 281	Continued From page 11 and was on her own by the fourth day. She said she had felt that it was " 50/50 " on her orientation process as far as knowing the processes and was able to always go back and ask questions. Employee (LPN) D stated that she recalled caring for Resident #6. She confirmed that she was on and stated that she cared for her several times. The staff member reviewed the MAR and confirmed that she worked on 3/6/15, , 3/13/15, 3/19/15, and . The LPN D. next confirmed the order for and then confirmed the order said to resume . The nurse stated that she would not have given a medication without signing the MAR. The DON and NHA on 4/27/2015 at 3:30 p.m. confirmed that they were aware of Resident #6 medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of the medication errors for Resident #6 only after the Doppler confirmed the positive . It is unclear due to the lack of the investigation of how and why the medication error was found. During an interview on at 3:30 p.m. the DON stated " she checks the MARs two times a week by flipping through all of the MARs", she confirmed there was no documentation related to this process. The DON said that the ADON and Unit Manger check every MAR daily for accuracy and completeness. During an interview on at 8:50 a.m., Assistant Director of Nurses stated that she randomly checked the MARs on a daily basis for accuracy and completeness. She stated that she checked new admissions and " maybe two others. " She stated that the Unit Manager was responsible for checking at least five residents on each cart on a daily basis. The ADON stated that	F 281		

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F 281	Continued From page 12 there was not a definite system of checking the MARs. During an interview on 4/30/15 at 9:30 a.m., Employee (LPN) A Interim Unit Manager, stated that she checked all new admissions for accuracy of orders and double checks with the MAR for accuracy. She stated that she did not do anything with the MARs on a daily basis. No one informed her she was supposed to be checking the MARs. She stated that she gets the new orders and the 24 hour report in the morning and then gives them to the ADON or DON to take them to the morning meeting. She does not usually go to the morning meetings and was not aware of any plan to begin to go. She stated that no education or training was provided to be a Unit Manager. The ADON told her the things that needed to be done and she was "just helping them out not doing the whole position." The regular Unit Manager (LPN) B on the Long Term Care unit is currently on medical leave and was unable to be contacted. During an interview on at 10:13 a.m. and at 10:43 a.m., the DON stated that the process of checking the MARs was an informal process that was implemented inconsistently and the ADON and Unit Manager assist with the process. There is not a written policy or procedure. The DON stated that she had been in the role of DON for one year and the process of checking the MARs had been an expectation since her arrival and she had continued that process since then. The DON also stated on at 10:43 a.m. that she was unaware the ADON and Unit Managers were not checking the MARs daily. On at 9:50 a.m. the Nursing Home Administrator, DON and the facility's corporate nurse confirmed that an in service was not	F 281		

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F 281	Continued From page 13 conducted related to Resident #6 ' s omissions of her scheduled medications. Review of the Pharmacy Dispensing Record for Resident #6 ' s from 1-A 2015. The pharmacy sent 14 pills at a time. Review of the Dispensing Log revealed the facility last received 14 pills on All of the medication would have been administered by Therefore, there was no available for administration. The medication was not a routinely stocked medication in the Emergency Drug Kit. The Licensed nursing staff failed to reorder after Review of the Drug Manufacturer ' s Pharmaceutical Medication Guide for revealed; " XARELTO® is a prescription medicine used to treat and , and to help reduce the risk of these conditions occurring again. lowers your chance of having a by helping to prevent clots from forming. If you stop taking XARELTO®, you may have increased risk of forming a clot in your . Do not stop taking XARELTO® without talking to the doctor who prescribes it for you. Stopping increases your risk of having a If you have to stop taking XARELTO®, your doctor may prescribe another medicine to prevent a clot from forming. Do not stop taking without talking to your doctor first. Your doctor may stop for a short time before any surgery, medical or dental procedure. Your doctor will tell you when to start taking again after your surgery or procedure. " Further review of the physician orders dated on " Stop x 3 days prior to and resume one day post p.m. " A telephone order dated	F 281		

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F 281	Continued From page 14 revealed a Doppler STAT and a third order dated for the same day 80 MG SQ (two times) was ordered for 5 days. Review of the Physician ' s Progress Notes revealed on , the Attending Physician assessed Resident #6 and diagnosed her with an acute The physician documented: " Redness and left leg, 4+ L > left leg. " The physician also documented that the resident had been " Off 15 MG for 3 weeks by nurse ' s error " . Further review of the Attending Physician ' s progress note revealed he documented " Doppler was ordered. " There was no corresponding physician ' s order for the Doppler Studies until three days after the physician assessed the resident. Review of the Nurses ' Notes on revealed no documentation of a red, leg. There was no documentation of the omission of the medication, the physician visit or the new orders. On , employee (LPN) A documented: the resident complained of pain and redness to her leg, upon assessment the leg was warm to touch and was Painful, 2+ pitting. The doctor was paged and made aware and stated he saw her on Saturday. New orders for Bactroban were obtained. On 3/31/2015 at 3:25 a.m. the nurse documented at " 12:45 a.m. patient states she thinks she has a to her LLE. Area of slight redness noted to inner calf to LLE, to LE. Skin temp within normal limits, refill is brisk . Unable to assess pulse related to Patient rates pain level #1 at this time on a scale of 1-10 with 10 being the worst. Patient states she has had multiple in the past and knows what it feels like. Notified resident	F 281		

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F 281	Continued From page 15 physicians of above and new orders were received for a STAT Doppler of the LLE to rule out . At 0200 (2:00 100mg was administered for c/o pain to LLE with a pain level of #9. was effective. At 0330 (the mobile service) arrived to perform Doppler. Patient remained on bed rest. Patient remained alert and responding appropriately to verbal and stimuli. No s/s of distress noted. Vitals 97.8-74-1 . Patient received new order on to restart was not discontinued). " Review of Ultra Sound Report dated: Examination: Doppler extremity/limb, left. Clinical Indications: of Limb, Findings: Real time color imaging shows no collateral and augmentation of post , popliteal deep and common of left leg. There are no excessive collateral veins. Left lower Extremity duplex Impression: Extensive seen. During a telephone interview on at 11:42 a.m., Resident #6 ' s Attending Physician stated; " The nurses did not give her medication . The medication was only on hold for a few days for her dental surgery. " The physician was asked why the medication Xarieto was not restarted after her dental surgery. The physician stated he did not understand why the nurses did not restart the medication. " I gave the nurses the order they should have restarted the after the dental procedure was completed. The is to prevent her from getting a if she would have received the medication she would not have gotten a ." During an interview on at 12:20 p.m., the Attending Physician confirmed he assessed the resident on and documented the resident	F 281		

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F 281	Continued From page 16 ' s leg was red and . He also ordered a Doppler study. The physician stated that he was informed by Employee (LPN) A of the leg and the lack of the on . He verbally gave the order to Employee A. The Attending Physician confirmed the Doppler order was not completed until and also confirmed that no medication was started until . He was unsure of why there would have been a delay in obtaining treatment, necessary tests or initiating the medication. During an interview on 4/28/ at 10:30 a.m. Resident #6 stated she was diagnosis with a . She said it was not just a it was an extensive . The resident stated that " the doctor said it was from my knee to my foot and I think there was more than one . " The resident was asked if the nurse had spoken to her about her she said " No, the doctor told me the nurses were not giving me my medication, he was really pissed. " They (the nurses) had to give me two times a day for five days and I hate needles. " Resident #6 said that when she first had come to the facility she had a in her left arm " that is why I take the every day. " The resident stated that she used to check her medications every day and now has to start checking them again. " It ' s not my job to have to ask if all my medications are there or not is it? " Further review of Resident #6 ' s medical record revealed that she had resided in the facility for approximately fifteen months and was fifty three years old. Resident #6 ' s medical history included and a history of . On a (BIMS) revealed a Score of 15 indicating no	F 281		

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F 281	Continued From page 17 An interview was conducted with the facility ' s Director of Nursing (DON) on at 3:00 p.m. A list of medication errors for the month of 2015 was provided by the DON. The DON stated that she was aware of the medication error for Resident #6. She stated that a nurse found the error after performing a " medication review. " The DON stated that she was unsure of why the error occurred. She stated that the facility ' s intervention was the and the physician and the resident were notified of the error. The DON confirmed that no audits or education were provided to the Licensed Nursing staff following the medication error. The DON also confirmed that there was no evidence of an investigation. The DON stated that her conclusion of the omitted medication for Resident #6 was " we performed an , and started giving her injections and elevated her left leg. " During an interview on 4/29/15 at 2:45 p.m., the Medical Director stated that he had been the Medical Director of the facility since 2012. He stated that he participated in the QA monthly meetings and the facility followed a set agenda. He stated that he was made aware of incidents for his patients and that the attending physician for the other residents would be notified of incidents. He stated that he would expect to be notified of incidents, including medication errors. Specifically for system failures that could affect all residents. He stated that he was here at the facility every Wednesday and Friday. However, someone from his physician group was present daily and should be notified. He expected that the nurses notify the physician of any incident. He confirmed again that he was not made aware of any medication errors for Resident #6. He was not aware of any issues in QA related to	F 281		

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F 281	Continued From page 18 medication administration. He stated that he was aware that the facility used a lot of agency staff and had a lot of turnover. The Medical Director stated that there was no action plan identified or implemented related to staffing or staff procedures. He also stated that he was aware of a concern with nurses not implementing physician orders timely. He stated that the nurse would pass off the order to the oncoming shifts and the medication would not be started. He stated that he provided education to the staff " within the year " related to medication implementation. The education was to have a second nurse initial the order to assure implementation. He confirmed that there was nothing in Quality Assurance (QA) related to the medication administration and order implementation process. The Medical Director stated that if the facility had a good system in place, then any staff member should be able to come in and care for the resident with no breaks in the system. He stated that the " system was not perfect and should not have failed. " The Medical Director was asked if it was expected that the facility notify him of negative outcomes; he stated, " I would love to. " When referring to the incident for Resident #6, the Medical Director stated that it was a " negative outcome and that he was afraid for his patients. " He stated that " there was not a plan in place. " During an interview on , at 10:15 a.m., the Administrator stated that she was informed of this medication error on 1st. She was informed the Unit Manager had educated the staff involved. The DON informed her that she was assembling her investigation and would bring the information to the next QA meeting on . The QA meeting was initially scheduled on and it was delayed due to a trial. The Nursing Home Administrator (NHA) said usually the QA is	F 281		

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F 281	Continued From page 19 scheduled every third Tuesday of the month. The facility has done Ad Hoc meetings in the past but the DON wanted to sure everything was done before hand and an Ad Hoc meeting was not scheduled. The DON informed her that the physician had been notified. The DON also informed her that the facility was still working the concern. The Administrator stated that she was aware the process was in place. The four point process was not completed and had not been presented. A review of Resident #6 ' s Care Plan indicated Focus on Anticoagulat has a potential for abnormal Date Initiated updated: Goal will be free from signs and symptoms of abnormal Interventions: Administer as MD ordered. The Care Plan was not followed. Review of the facility ' s policy entitled " Medication Administration General Guidelines for the Administration of Medications " policy 6.2 (page one of three) (no dated) was reviewed and it is expected that the Licensed Nurses administer medications per the physician ' s orders. 2. During an interview on 04/27/2015 at 3:45 p.m. the facility ' s Director of Nursing (DON) she stated: " we have had another problem with an gulant, it happened to Resident #2. " The DON said that when Resident #2 was admitted on and the nurse had written up the physician orders on one of our order sheets. The was written on a regular sheet that did not have a copy that was used for the medication administration record. We the (DON and ADON) did not find out about the medication not being given until " The DON was asked what the process was on checking	F 281		

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F 281	Continued From page 20 admission orders for their accuracy she said that usually the unit manager will check the orders the next morning and then added the unit manager was out on maternity leave. The DON was asked who would be responsible to verify the physician ordered medications were accurately transcribed into the Medication Administration Record (MAR) she said the ADON or herself. The DON said " We checked the physician order sheet and they were written correctly but because the Coumadin order was not put on the physician order sheet that contained a copy it did not show up on the MAR. " When the DON confirmed she did not review the MAR to make sure all the physician orders were transcribed. The DON was asked how that had happened she stated; " I ' m still trying to figure out how it happened and when I do find it out it has unfortunately already occurred. " When asked if the facility uses a check off system for newly admitted residents she said " we used to but now it is computerized. The computer tells us what to do. " She stated she was there the day of the verbal teaching but she did not sign the in-service verifying that she had attended. A medical record review was conducted for Resident #2 and revealed he had resided in the facility for approximately three weeks. His diagnoses included; and The Medication Administration Record for Resident #2 ' s physician orders were to give Coumadin 4 mg by mouth on Sunday, Tuesday, Wednesday, Thursday and Saturday and to administer Coumadin 2 mg on Monday and Friday. The MAR indicated that on; 4/8, 4/9, 4/12, 4/13, and on 4/16/2015 both orders were initialed/signed as being administered resulting in a total of 6 mg of . On the	F 281		

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F 281	Continued From page 21 order was discontinued and rewritten to give 4 mg by mouth on Sunday, Tuesday, Wednesday, Thursday and Saturday and to administer 2 mg on Monday and Friday. (The same identical order, this time the initial boxes were outlined indicating which day of the week the medication needed to be given). On at 11:45 a.m. a telephone interview was conducted with Resident #2 ' s attending physician. He confirmed he was notified that the resident had been receiving double doses of his and confirmed that his International Ratio was 3.2 and not critical erapeutic) . The physician confirmed the facility did not follow his orders and should have administered the proper dosages of on the proper days as ordered. The physician stated " they need to fix it, I don ' t know if it ' s the DON or the corporation they have to fix these things so it doesn ' t happen again. " The DON provided a copy of an in-service that was conducted on (three days after the medication omission was found) Teaching Method: Verbal Topic: and Protocol, Make sure INR is done, Call MD with results before giving medication, check orders daily and make sure log is accurate. The DON was asked about any in-servicing that was provided to the licensed staff on physician orders not being transcribed accurately in the residents MAR or not being transcribed at all, she did not respond. The DON and NHA on confirmed that they were aware of Resident #2 ' s medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of Resident #2 ' s medication error on however, no negative outcomes occurred. (It was unclear due to the	F 281		

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F 281	Continued From page 22 lack of the investigation of how and why the medication error was found.) 3. The facility admitted Resident #10 on with diagnoses including , Accident and per the physician order summary list of diagnoses. Review of the Medication Administration Record revealed Resident #10 the nurses failed to document the administration of the on 4/9 or . There was no documentation on the back side of the MAR as to why the medication was omitted. Review of the Admission Physician Orders dated revealed the resident was prescribed 40 unit daily at 9 a.m. Review of the Care Plan dated revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11:00 a.m. No additional information was provided related to why the medication would not have been given to Resident #10. 4. The facility admitted Resident #14 on with diagnoses including Acute and , per the demographic face sheet. Review of Resident #14 ' s Medication Administration Record for 2015 revealed the nursing staff failed to document the administration of for 4 out of the 6 available doses. She did not receive any	F 281		

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F 281	Continued From page 23 on . The resident did not receive on at 9 a.m., at 9 a.m. or at 9 a.m. There was no documentation in the nurses ' notes or the back of the Medication Administration Record as to why the medication was not given. Further review of the medical record revealed a physician ' s telephone order dated for 30 units twice daily. The resident was placed on due to sub-therapeutic INR (International Normalizing Ratio) levels and she was at risk for developing additional clots. Review of the Laboratory results revealed on , Resident #14 ' s INR was 1.1. On the was discontinued. The resident remained sub-therapeutic and the physician was attempting to adjust her On the resident was noted to have redness and to her right leg. An was ordered and the resident was diagnosed with a Review of the Care Plan dated revealed a problem area was identified for " , potential for abnormal ." The approaches included " administer as MD ordered. " During an interview on at 2:30 p.m., the Nurse Consultant confirmed the missed doses of . He stated that the medication should have been available from pharmacy and was unable to determine why the nurses would not have given the medication. He stated that the at least one dose of the should have been given on 5. The facility admitted Resident #15 on with diagnoses including and	F 281		

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per the demographic face sheet.
Review of Resident #15 ' s Medication Administration Record for 2015 revealed the nurses failed to document the administration of the on and
Review of the Physician Orders revealed Resident #15 was prescribed 40 unit daily for two weeks.
Review of the Care Plan dated revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. "
The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11:00 a.m. No additional information was provided related to why the medication would not have been given to Resident #15.

6. The facility admitted Resident #16 on with diagnoses including and per the physician diagnoses listed on the Medication Administration Record.
Review of Resident #16 ' s Medication Administration Record for 2015 revealed the nurses failed to document to review the resident ' s pertinent laboratory data (INR) and administered four extra doses of on , and He received four doses of after the medication should have been discontinued per the INR value of 2.5.
Review of the Physician ' s Orders revealed on Resident #16 was prescribed " 60 units every 12 hours, D/C (discontinue) when INR (international normalizing ratio) above 2. "
Review of the Laboratory Data revealed an INR

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F 281	Continued From page 25 was collected on that was 2.5. Further review of the Laboratory Data revealed an INR was collected on and the resident was erapeutic at 3.9. Record review revealed no indication of abnormal was noted. Review of the Care Plan dated revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the resident received the when the medication should have been discontinued. 7. The facility admitted Resident #17 on with diagnoses including Accident and per the demographic face sheet. Review of Resident #17 ' s 2015 Medication Administration Record revealed the nurses did not document the administration of the prescribed for 5 doses; 4/7, and . There was no documentation in the nurses ' notes or on the back of the MAR as to why the medication was omitted. Review of the Physician ' s Orders for 2015 revealed the resident was prescribed 3 mg PO daily at 5 p.m. Review of the Care Plan dated revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses	F 281		

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F 281	Continued From page 26 on at 11:00 a.m. No additional information was provided related to why the medication would not have been given to Resident #17. 8. The facility admitted Resident #18 on and readmitted him on with diagnoses including Chest Pain and Review of Resident #18 ' s 2015 Medication Administration Record revealed the nurses did not document the administration of his on 4/2, or . There was no documentation on the back side of the MAR as to why the medication was not given. A review of the Physician ' s Orders, dated revealed Resident #18 was prescribed 8.5 mg daily at 9 p.m.. Review of the Care Plan dated revealed a problem area was identified for " potential for abnormal " The approaches included " administer as MD ordered. " During an interview with Resident #18 on at 3:20 p.m. he stated that there have been occasions where he did not receive all of his ordered mediations from the nurse. He stated that he now has to check all his medications for accuracy. He stated that when he brought it to the nurse ' s attention when he did not receive his medications, they told him that they were either out of the medication or they would go back and bring him his ordered medication. He stated that he used to have a medication book on his bedside table that he would utilize to check his medications but that the medications are changed from the manufactures or the pharmacy so often now that it is obsolete. The findings were confirmed by the Nurse	F 281		

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F 281	Continued From page 27 Consultant, Administrator and Director of Nurses on at 11:00 a.m. No additional information as provided related to why the medication would not have been given to Resident #18. 9. Resident #19 was admitted to the facility in 2015. Her admitting diagnosis was and Resident #19 was identified and listed on " Current active orders for " that was provided by the facility. Resident #19 ' s Medication Administration Record for 2015 revealed the nurses failed to administer four doses of Pradaxa on at 5:00 p.m., at 5:00 p.m., at 9:00 a.m. and again at 5:00 p.m. The physician orders were reviewed with an order dated to administer Pradaxa 150 mg capsule one capsule by mouth two times daily for a diagnosis of The nursing notes revealed for the days the medication had been omitted there was neither documentation nor notification to the physician on why a prescribed medication was not administered as ordered. Review of resident #19 Care plan Focus on Anticoagulation has a potential for abnormal Date Initiated; Goal will be free from signs and symptoms of abnormal Interventions: Administer as MD ordered. The Care Plan was not followed. 10. Resident #20 was admitted to the facility on with a history of recent for of right with Resident #20 ' s 2015 Medication Administration Record revealed the nurses failed	F 281		

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to administer 7 doses of On at 9:00 p.m. the box on the MAR was without an initial, 9:00 a.m. the box was initialed with a circle, at 9:00 a.m. the box was initialed with a circle, at 9:00 p.m. the box MAR was without an initial, at 9:00 p.m. no initialed as given, and on at 9:00 am. the box was initialed with a circle.
Review of resident physician orders dated she is to receive 40 mg every 12 hours for preventative measures.
The back of the MAR nursing notes for at 9:00 p.m. indicated that the was not available to give. A second nursing note for at 9:00 a.m. indicated the pharmacy was notified.

11. An additional medical record review was conducted on Resident #2 ' s admission orders dated on . The admission orders indicated he was to receive 40 mg by mouth one time daily and 15 units in the morning and 5 units at night time. Resident #2 did not receive his from . Resident #2 did not receive his scheduled morning dosage from and the night time dosage from . The MAR revealed orders dated to start 40 mg one time daily and 15 units in the morning and 5 units at night time, hold if BS is less than 110.
Resident #2 nursing notes were reviewed for at 3:16 p.m. " there was a med error for patient in patient , patient and was never given patient was supposed to be on daily weight not done. Physician has been paged. Waiting for call back.

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F 281	Continued From page 29 " The nursing notes for at 1:54 a.m. " New order for INR ordered for the AM for the dosage error. " On at 11:45 a.m. a telephone interview was conducted with Resident #2 ' s attending physician. The attending physician also confirmed that he was notified that resident did not receive his ordered for ten days after being admitted and he did not receive his for ten days after being admitted to the facility. The attending physician was asked if a resident had a diagnosis of being does that mean he needs monitoring. The attending physician stated " yes, he needs his sugars monitored he could have went into or and worse yet into " The physician stated " they need to fix it, I don ' t know if it ' s the DON or the corporation they have to fix these things so it doesn ' t happen again. " 12. The facility admitted Resident #8 on with diagnoses including Hip and Review of the Physician Telephone Orders dated revealed the physician ordered a Urinalysis with Culture and Sensitivity and also ordered 500 mg every 8 hours for 7 days for a Review of the Laboratory Data revealed Resident #8 did not have a Urinalysis collected. Review of the and 2015 Medication Administration Records revealed Resident #8 ' s was not started until (a three day delay in initiating the physician ' s order). Further review of the MAR revealed the 6 a.m. dose was given on however, the 2 p.m. and 10 p.m. doses were omitted. During an interview on at 2 p.m., the	F 281		

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F 281	Continued From page 30 Nurse Consultant stated that the Urinalysis had not been collected. He stated that he was unsure why the nurses would not have gotten the sample. He also stated that the 6 a.m. dose of on was taken from the Emergency Drug Kit. He confirmed the 2 p.m .and 10 p.m. doses were not given. The Nurse Consultant also confirmed there was no documentation related to why the urinalysis was not collected, why the medication not initiated for 3 days or why the resident missed two doses of her During an interview on at 11:10 a.m., a Credible Allegation of Compliance was received related to . The plan included the following: An audit was completed of all residents. Physician orders, labs, notification of the physician if there was a change and the Log was accurate. No significant issues were found. NRs were updated. A 100% house audit was completed of all resident medications and orders on Nursing education was completed between for nursing staff related to managing residents on flow sheets and medication documentation. Three nurses that work as needed (PRN) have not been provided education and will not be allowed to work until educated. Agency nurses will be provided a packet that includes Managing Residents on Anticoagulation . The packet will include the Anticoagulation Policy and the facility ' s new protocol on documenting medications that are on " Hold. " All new admissions will be reviewed in the morning meeting to assure all orders will be	F 281		

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F 281	Continued From page 31 transcribed onto the POS and MAR/TAR. The weekend supervisor is responsible for new admissions on the weekends (not a new process). All residents that are receiving will be reviewed in a weekly care meeting with all orders, labs, and MARs reviewed. New anti-co orders were added under the daily clinical meeting and medications were added to the weekly care meeting. Looking to assure that the medication is transcribed, the flow sheet if needed, medication on hand, transcribed onto MAR and that the medication is being administered. The Flow Sheet will be implemented for any resident receiving For residents that have Hold Orders: The order will be blocked off and yellowed out. A new order will be re-written with a restart date. The new process will be visible to the nurses. The hold medication will be added on the 24 hour report. Medication Errors will be investigated and documented following Risk Management standards and Root Cause Analysis. Evidence of investigation will be kept. Based on the analysis, the policies, practices and systems, changes will occur as needed. A new shift to shift MAR review with each nurse was also implemented. The nurses, together, will review the entire MAR/TAR for holes and for accuracy. If the nurse is sure that she administered the medications, then she can initial, if she was unsure then it would be classified as a medication error. Nursing Administration would be responsible for daily checks of the nurse to nurse MAR review. Nursing Administration will also initial for accuracy. The audits will be reviewed daily by the DON.	F 281		

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F 281	Continued From page 32 All lab results will be reviewed in the daily Clinical Meeting. All INRs will be reviewed in the morning clinical meeting and checked against the orders and MAR. The Medical Director had been informed and had approved the action plan as of	F 281		
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 resident record review, interviews with the facility staff, the Attending Physician, the Medical Director, and facility Administration, the facility failed to ensure care planning interventions/approaches were implemented to assure residents were free of significant medication errors. Based on a review of all current residents receiving , ten of thirty residents care plans were not followed and residents did not receive their per the physician ' s orders. Residents #2, #6, #10, #14, #15, #16, #17, #18, #19 and #20 were identified as not receiving that were necessary to prevent clots or Resident #6 was not administered for twenty six days. The medication was placed on hold for three days for a dental procedure. The facility staff failed to implement the order and resume the medication on , 2015. Resident #6 reported pain to the nursing staff and reported that the pain was consistent with a Deep	F 282	1. Resident's #2 was discharged on , a medication error report was completed and the physician was notified. Resident #14 was discharged o , a medication error report was completed and the physician was notified. Resident#15 was discharged , a medication error report was completed and the physician was notified. Resident #16 is not currently receiving Resident's #6, #10, #16, #17, #18, #19 and #20 all have current up to date comprehensive care plans related to their and are actively being implemented. They are also receiving their medications as ordered by their attending physicians. The physician for resident #8 was notified of the omitted doses of and the urinalysis and culture not being completed. There were no further orders obtained related to this situation. 2. All residents receiving have been reviewed by the Interdisciplinary Team and all have a current up to date comprehensive care plan that is actively being implemented. A full complete review was completed on to assure that all medication orders are current and transcribed on the medication administration records. All residents are receiving their medications as ordered by their physicians.	

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. The physician was notified on and ordered the necessary tests. The facility failed to implement those orders for three days, further delaying treatment to the resident until . Resident #6 required injections of to dissolve the clot. Resident #2 was administered a double dose of on 4/8, 9, 12, 13, 14 and . His INR was erapeutic on at 3.2. Resident #10 was not administered her prescribed on 4/9 and . Resident #14 was not administered four of six available doses of . Resident #15 was not administered her on and on . Resident #16 ' s was to be discontinued when the International Normalizing Ratio (INR) was greater than 2. On the laboratory results indicated that her INR was 2.5 and the was continued for four additional doses. Resident #17 was not administered five doses of on 3/7, 10, 13, 15, . Resident #18 was not administered four doses of on 4/2, 11, 13 and . Resident #19 missed four doses of Pradaxa from . Resident #20 was not administered seven doses of from

The facility ' s Licensed Nurse ' s failed to administer medications in accordance with physician ' s orders and plan of care. The failure to follow the resident ' s plan of care and administer their resulted in significant medication errors that subsequently caused Resident #6 to develop an avoidable clot

Based on record review and interview, the facility failed to administer medication timely and accurately in two (#2, #8) out of forty-eight (48) residents reviewed for medication accuracy. Resident #2 ' s physician ordered and

F 282

3. Nursing staff has been re-educated 5-19, 20,21 and 22, 2015 on assuring that the resident's comprehensive care plans are being followed. New interim care plans have been implemented . New admissions will be reviewed at the daily clinical meeting and care plans will be reviewed to assure that and are being addressed. Residents receiving will be monitored on the twenty-four hour report throughout the course of . Residents receiving will be reviewed at the weekly Standards of Care meeting, this will include review of current orders, labs, MARs, and comprehensive care plans. This will be overseen by the Director of Nursing and the Interdisciplinary Team.
4. These areas of care will be monitored by the Director of Nursing/Designee utilizing a data collection tool, weekly time four weeks and then monthly on an ongoing basis to assure continued compliance. This will also be overseen by the Administrator and the QAPI Committee.

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were omitted for 10 days. There was a three day delay in starting a physician ordered for Resident #8 and two days were omitted.
The facility failed to follow the individualized care plans and monitor the administration of medications on a routine basis. The facility failed to systematically identify, investigate and report medication errors. The failure of the facility resulted in the findings of Immediate Jeopardy existing in the facility as of . The facility Administration was informed on at 9:50 a.m. The Immediate Jeopardy was removed on at 5:30 pm and the scope and severity was reduced to a " E. "

Findings include:

1. Review of Resident #6 ' s medical record revealed that she had resided in the facility for approximately fifteen months and was fifty three years old. Resident #6 ' s medical history included and a history of per the recorded admission information. On a revealed a Score of 15 indicating no
Resident #6 ' s Plan of Care included administer the as ordered by the attending physician. Review of Resident #6 ' s Care plan Focus on Anticoagulation reflected the resident had a " potential for abnormal " The date Initiated was and it was updated . Goal " will be free from signs and symptoms of abnormal . Interventions: Administer as MD ordered. " The Care Plan was not followed. Resident #6 was not administered for 26 days.
The MAR indicated that six nurses, assigned on

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F 282	Continued From page 35 the 3-11 p.m. shift, failed to follow Resident #6 ' s plan of care and administer the Xarleto as ordered by the attending physician. Review of the Medication Administration Record (MAR), dated 2015, revealed a typed order dated 15 MG tablet one tablet by mouth once a day. Directly underneath the typed order was a hand written entry; resume . The Medication Administration Record (MAR) revealed the nurses documented for , and the word " HOLD. " On , the MAR indicated to resume Xarleto. The boxes, where an initial should have been written, were empty (indicating the dose was not administered). The remainder of the MAR from through was reviewed with no indication that the medication had been given and no indication as to why the medication was not given. Further review of the physician orders, dated on , found directions to " Stop x 3 days prior to and resume one day post p.m. " A telephone order was dated on ordering a Doppler STAT and a third order was dated for the same day 80 MG SQ ((two times), was ordered for 5 days. During an interview on at 10:30 a.m., Resident #6 stated she was diagnosed with a (DTV). She said it was not just a it was an extensive . The resident stated that " the doctor said it was from my knee to my foot and I think there was more than one . " The resident was asked if the nurse had spoken to her about her . She said, " No, the doctor told me the nurses were not giving me my medication, he was really pissed. They (the nurses) had to give me	F 282		

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F 282	Continued From page 36 two times a day for five days and I hate needles. " Resident #6 said that when she first came to the facility, she had a in her left arm and " that is why I take the every day. " The resident stated that she used to check her medications every day and now has to start checking them again. " It ' s not my job to have to ask if all my medications are there or not is it? " During an interview on at 4:10 p.m. Employee (RN) E, a nurse that cared for the resident on 12 of the 26 evening shifts, stated that she had been a nurse for a long time and worked in long term care. She stated that she was familiar with Resident #6. She stated that she was aware the resident needed . The medication was not administered. She stated that she did not think the order was on going. She stated that it was on hold. She stated that she did not have the time to research the order and was aware that Resident #6 was at high risk for . She stated that she questioned the medication to other staff; however, she did not recall who the staff member was. She stated that the doctor came in and then realized the medication should have been resumed. The nurse stated that when a medication was held, the nurse should write hold on the days that the medication is to be held and then indicate when the medication should be resumed. The nurse confirmed the MAR and confirmed that there was no indication the medication had been given. She stated that she did not recall the resume date. The nurse stated that " my philosophy is if I don ' t see the medication and don ' t see a stop order, then I question with another nurse as to whether the medication is on hold or should be discontinued. " She stated that she would call the pharmacy. She stated that the medication card was not in the cart. The nurse also	F 282		

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F 282	Continued From page 37 confirmed that she did not document any omissions in the chart. She stated that she did not look at the chart to find the original order. An interview was conducted on at 4:30 p.m. with Employee (LPN) D. She stated that she worked at the facility When asked about her training, she stated she had trained for two to three days and was on her own by the fourth day. She said she had felt that it was " " on her orientation process as far as knowing the processes and was able to always go back and ask questions. Employee (LPN) D. stated that she recalled caring for Resident #6. She confirmed that she was on and stated that she cared for her several times. The staff member reviewed the MAR and confirmed that she worked on and The nurse next confirmed the order for and then confirmed the order said to resume . The nurse stated that she would not have given a medication without signing the MAR. These dates were blank, with no initials. During a telephone interview on at 11:42 a.m., Resident #6 ' s Attending Physician stated; " the nurses did not give her medication , the medication was only on hold for a few days for her dental surgery. The physician was asked why the medication Xarleto was not restarted after her dental surgery. The physician stated he did not understand why the nurses did not restart the medication. " I gave the nurses the order, they should have restarted the after the dental procedure was completed. The is to prevent her from getting a . If she would have received the medication, she would not have gotten a ." During an interview on at 12:20 p.m., the Attending Physician confirmed he assessed the	F 282		

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F 282	Continued From page 38 resident on and documented the resident ' s leg was red and . He also ordered a Doppler study. The physician stated that he was informed by Employee (LPN) A of the leg and the lack of the on He verbally gave the order to Employee A. The Attending Physician confirmed the Doppler order was not completed until and also confirmed that no medication was started until . He was unsure of why there would have been a delay in obtaining treatment, necessary tests or initiating the medication. A review of the Physician ' s Progress Notes revealed on , the Attending Physician assessed Resident #6 and diagnosed her with an acute The physician documented: " Redness and left leg, 4+ L > left leg. " The physician also documented that the resident had been " Off 15 for 3 weeks by nurse ' s error. " Further review of the Attending Physician ' s progress note revealed he documented " Doppler was ordered. " There was no corresponding physician ' s order for the Doppler Studies until three days after the physician assessed the resident. Review of the Nurses ' Notes on revealed no documentation of a red, leg. There was no documentation of the omission of the medication, the physician visit or the new orders. On , employee (LPN) A documented: " the resident complained of pain and redness to her leg, upon assessment the leg was warm to touch and was . Painful, 2+ pitting. The doctor was paged and made aware and stated he saw her on Saturday. New orders for were obtained. " On at 3:25 a.m., the nurse documented at	F 282		

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F 282	Continued From page 39 " 12:45 a.m. patient states she thinks she has a to her LLE. Area of slight redness noted to inner calf to LLE, to LE. Skin temp within normal limits. refill is brisk . Unable to assess pulse related to Patient rates pain level #1 at this time on a scale of 1-10 with 10 being the worst. Patient states she has had multiple T's in the past and knows what it feels like. Notified resident physicians of above and new orders were received for a STAT Doppler of the LLE to rule out At 0200 (2:00 a.m.) 100mg was administered for c/o pain to LLE with a pain level of 9 out of 10. was effective. At 0330 (3:30 a.m.), the mobile service arrived to perform Doppler. Patient remained on bed rest. Patient remained alert and responding appropriately to verbal and stimuli. No s/s of distress noted. Vitals Patient received new order on to restart was not discontinued). " A review of the Ultra Sound Report, date of service: revealed: Examination: Doppler extremity/limb, left. Clinical Indications: of Limb, Findings: Real time color imaging shows no collateral and augmentation of post , popliteal , deep and common of left leg. There are no excessive collateral veins. Left lower Extremity duplex Impression: Extensive seen. An interview was conducted with the facility ' s Director of Nursing (DON), on , at 3:00 p.m. A list of medication errors for the month of 2015 was provided by the DON. The DON stated that she was aware of the medication error for Resident #6. She stated that a nurse found the error after performing a " medication review. "	F 282		

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F 282	Continued From page 40 The DON stated that she was unsure of why the error occurred. She stated that the facility ' s intervention was the and the physician and the resident were notified of the error. The DON confirmed that no audits or education were provided to the staff following the medication error. The DON also confirmed that there was no evidence of an investigation. The DON stated that her conclusion of the omitted medication for Resident #6 was " we performed an , and started giving her injections and elevated her left leg. " On at 3:30 p.m., the Nursing Home Administrator and D.O.N. confirmed that they were aware of Resident #6 ' s medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of the medication errors for Resident #6 only after the Doppler confirmed the positive . It was unclear, due to the lack of the investigation of how and why, the medication error was found. During an interview on at 3:30 p.m., the DON stated, " she checks the MARs two times a week by flipping through all of the MARs. " She confirmed there is no documentation related to this process. The DON said that the ADON and Unit manger check every MAR daily for accuracy and completeness. During an interview on at 8:50 a.m., The Assistant Director of Nurses stated that she randomly checked the MARs on a daily basis for accuracy and completeness. She stated that she checked new admissions and " maybe two others. " She stated that the Unit Manager was responsible for checking at least five residents on each cart on a daily basis. The ADON stated that there was not a definite system of checking the MARs.	F 282		

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F 282	Continued From page 41 An interview was conducted on at 9:30 a.m. with Employee (LPN) A, Interim Unit Manager (started on Monday . She stated that she checked all new admissions for accuracy of orders and double checked the MAR for accuracy. She stated that she did not do anything with the MARs on a daily basis. No one informed her she was supposed to be checking the MARs. She stated that she gets the new orders and the 24 hour report in the morning and then gives them to the ADON or DON to take them to the morning meeting. She did not usually go to the morning meetings and was not aware of any plan to begin to go. She stated that no education or training was provided to be a Unit Manager. The ADON told her the things that needed to be done and she was " just helping them out not doing the whole position. " The regular Unit Manager (LPN) B on the Long Term Care unit was currently on medical leave and was unable to be contacted. During an interview on at 10:13 a.m. and at 10:43 a.m., The DON stated that the process of checking the MARs was an informal process that was implemented inconsistently and the ADON and Unit Manager assist with the process. There was not a written policy or procedure. The DON stated that she had been in the role of DON for one year and the process of checking the MARs had been an expectation since her arrival and she had continued that process since then. The DON also stated, on at 10:43 a.m., that she was unaware the ADON and Unit Managers were not checking MARs daily. During an interview on at 2:45 pm, the Medical Director stated that he had been the Medical Director of the facility since 2012. He stated that he participated in the QA monthly	F 282		

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F 282	Continued From page 42 meetings and the facility followed a set agenda. He stated that he was made aware of incidents for his patients and that the attending physician for the other residents would be notified of incidents. He stated that he would expect to be notified of incidents, including medication errors and, specifically, for system failures that could affect all residents. He stated that he was here at the facility every Wednesday and Friday. However, someone from his physician group was present daily and should be notified. He expected that the nurses notify the physician of any incident. He confirmed, again, that he was not made aware of any medication errors for Resident #6. He was not aware of any issues in QA related to medication administration. He stated that he was aware that the facility used a lot of agency staff and had a lot of turnover. The Medical Director stated that there was no action plan identified or implemented related to staffing or staff procedures. He also stated that he was aware of a concern with nurses not implementing physician orders timely. He stated that the nurse would pass off the order to the oncoming shifts and the medication would not be started. He stated that he provided education to the staff " within the year " related to medication implementation. The education was to have a second nurse initial the order to assure implementation. He confirmed that there was nothing in Quality Assurance (QA) related to the medication administration and order implementation process. The Medical Director stated that if the facility had a good system in place, then any staff member should be able to come in and care for the resident with no breaks in the system. He stated that the " system was not perfect and should not have failed. " The Medical Director was asked if it was expected	F 282		

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F 282	Continued From page 43 that the facility notify him of negative outcomes; he stated, " I would love to. " When referring to the incident for Resident #6, the Medical Director stated that it was a " negative outcome and that he was afraid for his patients. " He stated that " there was not a plan in place. " During an interview on , at 10:15 a.m., the Administrator stated that she was informed of Resident #6 ' s med error on 1st. The DON stated that the Unit Manager had educated the staff involved. The DON information her that she was assembling her investigation and would bring the information to the next QA meeting on . The meeting was initially scheduled on and it was delayed due to a trial. The Nursing Home Administrator (NHA) said, usually, the QA is scheduled every third Tuesday of the month. The facility had done Ad Hoc meetings in the past but the DON wanted to make sure everything was done before hand and the AD Hoc meeting was not scheduled. The DON informed her that the physician had been notified. The DON also informed her that the facility was still working the concern. The Administrator stated that she was aware the process was in place. The four point process was not completed and had not been presented. A review was conducted of the Pharmacy Dispensing Record for Resident #6 ' s from 1-A 2015. The pharmacy sent 14 pills at a time. Review of the Dispensing Log revealed the facility last received 14 pills on . All of the medication would have been administered by . Therefore, there was no available for administration. The medication was not a routinely stocked medication in the Emergency Drug Kit. Review of the Drug Manufacturer ' s	F 282		

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F 282	Continued From page 44 Pharmaceutical Medication Guide for revealed; " is a prescription medicine used to treat and , and to help reduce the risk of these conditions occurring again. lowers your chance of having a by helping to prevent clots from forming. If you stop taking , you may have increased risk of forming a clot in your . Do not stop taking without talking to the doctor who prescribes it for you. Stopping increases your risk of having a . If you have to stop taking , your doctor may prescribe another medicine to prevent a clot from forming. Do not stop taking without talking to your doctor first. Your doctor may stop for a short time before any surgery, medical or dental procedure. Your doctor will tell you when to start taking again after your surgery or procedure. " 2. Review of Resident #2 ' s Care plan Focus on Anticoagulation reflected the resident had a " potential for abnormal ." The goal reflected " will be free from signs and symptoms of abnormal . Interventions: Administer as MD ordered. " The Care Plan was not followed. Review of the Medication Administration Record for Resident #2 included orders to give 4 mg by mouth on Sunday, Tuesday, Wednesday, Thursday and Saturday and to administer 2 mg on Monday and Friday. The MAR indicated that on; 4/8, 4/9, , and on both orders were initialed/signed as being administered resulting in a total of 6 mg of . On , the order was discontinued and rewritten to give 4 mg by mouth on Sunday, Tuesday,	F 282		

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F 282	Continued From page 45 Wednesday, Thursday and Saturday and to administer 2 mg on Monday and Friday. This was the same identical order, however, this time the initial boxes were outlined indicating which day of the week the medication needed to be given. A medical record review was conducted for Resident #2 and revealed he had resided in the facility for approximately three weeks. His diagnoses included: , and During an interview on at 3:45 p.m., the facility ' s Director of Nursing (DON) stated: " we have had another problem with an it happened to Resident #2. " The DON said that when Resident #2 was admitted on the nurse had written up the physician orders on one of our order sheets. The was written on a regular sheet that did not have a copy that is used for the medication administration record. We (DON and ADON) did not find out about the medication not being given until " The DON was asked what the process was on checking admission orders for their accuracy. She said that, usually, the Unit Manager will check the orders the next morning and then, added, the Unit Manager was out on maternity leave. The DON was asked who would be responsible to verify the physician ordered medications were accurately transcribed into the Medication Administration Record (MAR) and she said the ADON or me. The DON said, " We checked the physician order sheet and they were written correctly, but, because the order was not put on the physician order sheet that contained a copy it did not show up on the MAR. " The DON confirmed she did not review the MAR to make sure all the physician orders were transcribed.	F 282		

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F 282	Continued From page 46 The DON was asked how that had happened. She stated; " I ' m still trying to figure out how it happened and then I do find it out it has unfortunately already occurred. " When asked if the facility used a check off system for newly admitted residents she said, " we used to but now it is computerized. The computer tells us what to do. " She stated she was there the day of the verbal teaching but she did not sign the in-service verifying that she had attended. On at 11:45 a.m., a telephone interview was conducted with Resident #2 ' s attending physician. He confirmed he was notified that the resident had been receiving double doses of his and confirmed that his International Ratio was 3.2 and not critical erapeutic) . The physician confirmed the facility did not follow his orders and should have administered the proper dosages of on the proper days as ordered. The DON provided a copy of an in-service that was conducted on (three days after the medication omission was found) Teaching Method: Verbal Topic: and Protocol. Make sure INR is done, call MD with results before giving medication, check orders daily and make sure log is accurate. The DON was asked about any in-servicing that was provided to the licensed staff on physician orders not being transcribed accurately in the resident ' s MAR or not being transcribed at all, she did not respond. The DON and NHA ON confirmed that they were aware of Resident #2 ' s medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of Resident #2 ' s medication error on however, no negative outcomes occurred. It was unclear, due to the	F 282		

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F 282	Continued From page 47 lack of the investigation, of how and why the medication error was found. On the DON stated " I check the MARs two times a week by flipping through all of the MARs. " She confirmed there was no documentation related to this process. The DON said that the ADON and Unit Manager check every MAR daily for accuracy and completeness. 3. The facility admitted Resident #10 on with diagnoses including Accident and per the physician order summary list of diagnoses. Review of the Care Plan, dated , revealed a problem area was identified for " , potential for abnormal . " The approaches included " administer as MD ordered. " The resident was not administered as ordered. Review of the Admission Physician Orders, dated , revealed the resident was prescribed 40 unit daily at 9 a.m. Review of the 2015, Medication Administration Record revealed Resident #10 did not receive on 4/9 or . There was no documentation on the back side of the MAR as to why the medication was omitted. The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information was provided related to why the medication would not have been given to Resident #10. 4. The facility admitted Resident #14 on with diagnoses including Acute and per the demographic face sheet. Review of the Care Plan, dated revealed a problem area was identified for "	F 282		

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F 282	Continued From page 48 potential for abnormal " The approaches included " administer as MD ordered. " The resident was not administered as ordered. Review of the Medication Administration Record for 2015 revealed Resident #14 did not receive for 4 out of the 6 available doses. She did not receive any on . The resident did not receive on at 9 a.m., at 9 a.m., or at 9 a.m. There was no documentation in the nurses ' notes or the back of the Medication Administration Record as to why the medication was not given. Further review of the medical record revealed a physician ' s telephone order, dated for 30 units twice daily. The resident was placed on due to sub-therapeutic INR (International Normalizing Ratio) levels and she was at risk for developing additional clots. Review of the Laboratory results revealed on , Resident #14 ' s INR was 1.1. On , the was discontinued. The resident remained sub-therapeutic and the physician was attempting to adjust her On the resident was noted to have redness and to her right leg. An was ordered and the resident was diagnosed with a During an interview on at 2:30 pm, the Nurse Consultant confirmed the missed doses of . He stated that the medication should have been available from pharmacy and was unable to determine why the nurses would not have given the medication. He stated that the at least one dose of the should have been given on Review of the medical record revealed Resident	F 282		

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F 282	Continued From page 49 #14 was transferred to a Hospice House for end of life care. 5. The facility admitted Resident #15 on with diagnoses including and per the demographic face sheet. Review of the Care Plan, dated , revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " The resident was not administered as ordered. Review of the 2015 Physician Orders revealed Resident #15 was prescribed 40 units daily for two weeks. Review of the Medication Administration Record for 2015 revealed Resident #15 did not receive her on and . The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11:00 a.m. No additional information as provided related to why the medication would not have been given to Resident #15. 6. The facility admitted Resident #16 on with diagnoses including and per the physician diagnoses listed on the Medication Administration Record. Review of the Care Plan, dated , revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " The resident was not administered as ordered. Review of the Medication Administration Record for 2015 revealed Resident #16 was given on and . He	F 282		

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F 282	Continued From page 50 received four doses of after the medication should have been discontinued per the INR value of 2.5. Review of the Physician ' s Orders revealed on Resident #16 was prescribed " 60 units every 12 hours, D/C (discontinue) when INR (international normalizing ratio) above 2. " Review of the Laboratory Data revealed an INR was collected on that was 2.5. Further review of the Laboratory Data revealed an INR was collected on and the resident was erapeutic at 3.9. Record review revealed no indication of abnormal was noted. The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the resident received the when the medication should have been discontinued. 7. The facility admitted Resident #17 on with diagnoses including Accident and per the demographic face sheet. Review of the Care Plan, dated , revealed a problem area was identified for " potential for abnormal " The approaches included " administer as MD ordered. " The resident was not administered as ordered. Review of the 2015 Medication Administration Record revealed Resident #17 did not receive the prescribed for 5 doses; 4/7, and There was no documentation in the nurses ' notes or on the back of the MAR as to why the medication was omitted. Review of the Physician ' s Orders for 2015 revealed the resident was prescribed 3	F 282		

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F 282	Continued From page 51 mg PO daily at 5 pm. The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the medication would not have been given to Resident #17. 8. The facility admitted Resident #18 on and was readmitted on with diagnoses including Chest Pain and Review of the Care Plan, dated , revealed a problem area was identified for " , potential for abnormal " The approaches included " administer as MD ordered. " The resident was not administered his as ordered. Review of the 2015 Medication Administration Record revealed Resident #18 did not receive his on 4/2, or . There was no documentation on the back side of the MAR as to why the medication was not given. Review of the Physician ' s Orders, dated revealed Resident #18 was prescribed 8.5 mg daily at 9 pm. During an interview with Resident #18 on at 3:20 p.m., he stated that there have been occasions where he did not receive all of his ordered medications from the nurse. He stated that he now has to check all his medications for accuracy. He stated that when he brought it to the nurse ' s attention when he did not receive his medications, they told him that they were either out of the medication or they would go back and bring him his ordered medication. He stated that he used to have a medication book on his bedside table that he would utilize to check his medications but that the medications were changed from the manufacturers or the pharmacy	F 282		

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F 282	Continued From page 52 so often now that it is obsolete. The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the medication would not have been given to Resident #18. 9. Resident #19 was admitted to the facility in 2015 her admitting diagnosis and Resident #19 was identified and listed on " Current active orders for " that was provided by the facility. Review of Resident #19 ' s Care plan Focus on Anticoagulation determined the resident had a potential for abnormal . The date Initiated; stated the goal will be free from signs and symptoms of abnormal Interventions included Administer as MD ordered. The Care Plan was not followed, the residents Pradaxa was not administered as ordered. The MAR was reviewed for 2015 and it was identified Resident # 19 had missed four doses of Pradaxa on at 5:00 p.m., at 5:00 p.m., at 9:00 a.m., and again at 5:00 p.m. The physician orders were reviewed with an order, dated , to administer Pradaxa 150 mg capsule one capsule by mouth two times daily for a diagnosis of The nursing notes revealed for the days the medication had been omitted there was neither documentation nor notification to the physician on why a prescribed medication was not administered as ordered. 10. Resident #20 was admitted to the facility on with a history of recent for of right with , per the admission demographic information.	F 282		

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F 282	Continued From page 53 Review of Resident #20 ' s Care plan with Focus on Anticoagulation identified a potential for abnormal with date initiated of . The goal stated, " will be free from signs and symptoms of abnormal " Interventions included " Administer as MD ordered. " The Care Plan was not followed. The MAR was reviewed for 2015 and it revealed seven separate missing initials or circles around initials indicating the medication was not administered as ordered. On at 9:00 p.m., the box on the MAR was without an initial, 4/1 15 9:00 a.m., the box was initialed with a circle, at 9:00 a.m., the box was initialed with a circle, at 9:00 p.m., the box on the MAR was without an initial, at 9:00 p.m., not initialed as given, and on at 9:00 am., the box was initialed with a circle. The back of the MAR nursing notes for at 9:00 p.m. indicated that the was not available to give. A second nursing note for at 9:00 a.m. indicated that the pharmacy was notified. Review of resident physician orders, dated reflected the resident was to receive 40 mg every 12 hours for preventative measures. 11. The facility admitted Resident #8 on with diagnoses including Hip and according to admission demographic information. Review of the Laboratory Data revealed Resident #8 did not have a Urinalysis collected, in accordance with physician ' s orders. Review of the and 2015 Medication Administration Records revealed Resident #8 ' s was not started until (a three	F 282		

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F 282	Continued From page 54 day delay in initiating the physician ' s order). Further review of the MAR revealed the 6 am dose was given on ; however, the 2 pm and 10 pm doses were omitted. Review of the Physician Telephone Orders, dated , revealed the physician ordered a Urinalysis with Culture and Sensitivity and also ordered 500 mg every 8 hours for 7 days for a During an interview on at 2 pm, the Nurse Consultant stated that the Urinalysis had not been collected. He stated that he was unsure why the nurses would not have gotten the sample. He also stated that the 6 am dose of on was taken from the Emergency Drug Kit. He confirmed the 2 pm and 10 pm doses were not given. The Nurse Consultant also confirmed there was no documentation related to why the urinalysis was not collected, why the medication not initiated for 3 days, or why the resident missed two doses of her 12. A Medical record review was conducted on Resident #2 ' s admission orders dated on . The admission orders indicated he was to receive 40 mg by mouth, one time daily, and 15 units in the morning and 5 units at night time. Resident #2 did not receive his from Resident #2 did not receive his scheduled morning dosage from and the night time dosage from . The MAR revealed orders, dated , to start 40 mg one time daily and 15 units in the morning and 5 units at night time, " hold if BS is less than 110. " Resident #2 ' s nursing notes were reviewed for at 3:16 p.m. which reflected that " there was a med error for patient in	F 282		

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F 282	Continued From page 55	F 282		

, patient and was never given patient was supposed to be on daily weight not done. Physician has been paged. Waiting for call back. " The nursing notes for at 1:54 a.m. " New order for INR ordered for the AM for the dosage error. "
On at 11:45 a.m., a telephone interview was conducted with Resident #2 ' s attending physician. The attending physician also confirmed that he was notified that the resident did not receive his ordered for ten days after being admitted and he did not receive his for ten days after being admitted to the facility. The attending physician was asked, if a resident had a diagnosis of being did that mean he needs monitoring. The attending physician stated, " yes, he needs his sugars monitored. He could have gone into or and worse, yet, into " The physician stated, " they need to fix it, I don ' t know if it ' s the DON or the corporation. They have to fix these things so it doesn ' t happen again. "
The DON was asked if the nurse that had not transcribed the and in resident #2 MAR had attended the in-service that she had on The DON stated, " The nurse was there but she did not sign on the sign in sheet. "
When asked if there was any other information that she had on training her nursing staff she stated, " We were going to bring it into our QA meeting on Tuesday "
13. During an interview on at 11:10 a.m., the facility provided a plan of action received related to
The plan included the following:
A Performance Improvement Plan that was initiated on related to

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F 282	Continued From page 56 An audit was completed of all residents. Physician orders, labs, notification of the physician if there was a change and the Log was accurate. No significant issues were found. NRs were updated. A 100% house audit was completed of all resident medications and orders on Nursing education was completed between for nursing staff related to managing residents on flow sheets and medication documentation. Three nurses that worked as needed (PRN) had not been provided education and will not be allowed to work until educated. Agency nurses will be provided a packet that includes Managing Residents on Anticoagulation . The packet will include the Anticoagulation Policy and the facility ' s new protocol on documenting medications that are on " Hold. " All new admissions will be reviewed in the morning meeting to assure all orders will be transcribed onto the POS and MAR/TAR. The weekend supervisor is responsible for new admissions on the weekends (not a new process). All residents that are receiving will be reviewed in a weekly care meeting with all orders, labs, and MARs reviewed. New anti-co orders were added under the daily clinical meeting and medications were added to the weekly care meeting. Looking to assure that the medication is transcribed, the flow sheet if needed, medication on hand, transcribed onto MAR and that the medication is being administered. The Flow Sheet will be implemented for any resident receiving (not a new process).	F 282		

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F 282	Continued From page 57 For residents that have Hold Orders: The order will be blocked off and yellowed out. A new order will be re-written with a restart date. The new process will be visible to the nurses. The hold medication will be added on the 24 hour report. Medication Errors will be investigated and documented following Risk Management standards and Root Cause Analysis. Evidence of investigation will be kept. New Process (not completed before). Based on the analysis, the policies, practices and systems, changes will occur as needed. New Process ..... a new shift to shift MAR review with each nurse. The nurses together will review the entire MAR/TAR for holes and completeness for accuracy. If the nurse is sure that she administered the medications, then she can initial, if unsure then it would be classified as a medication error. Nursing Administration is responsible for daily checks of the nurse to nurse MAR review. Nursing Administration will initial for accuracy. The audits will be reviewed daily by the DON. The 7-3 nurses are being educated today. All lab results will be reviewed in the daily Clinical Meeting. NEW PROCESS- all INRs will be reviewed in the morning clinical meeting and checked against the orders and MAR. Monitoring: the MAR checks will be monitored by the DON daily for 30 days The Medical Director has been informed and is aware of the plan and has approved it. A QA meeting will be held on ... On all nurses on the first and second shift and a sample of nurses from the night shift were interviewed regarding the facility ' s new system related to . The nurses were able to ..... the facility ' s policy on	F 282		

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F 282	Continued From page 58 documentation of administration. The nurses also were able to explain the process of the shift to shift Medication Administration Report review. Shift change was observed on between 3:30 to 4:15 p.m. with all nurses appropriately performing the MAR reviews. The nurses were initialing the newly implemented form. A medication pass was observed with all administered appropriately per the physician ' s orders.	F 282		
F 333 SS=K	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident record review, interviews with the facility staff, the Attending Physician, the Medical Director, facility Administration and review of the facility ' s policy and procedures related to medication administration the facility failed to assure residents were free of significant medication errors. Based on a review of all current residents receiving , ten of thirty residents did not receive their per the physician ' s orders. Residents #2, #6, #10, #14, #15, #16, #17, #18, #19 and #20 were identified as not receiving that were necessary to prevent clots or . Resident #6 was not administered for twenty six days. The medication was placed on hold for three days for a dental procedure. The facility staff failed to implement the order and resume the medication	F 333	1. Medication Error reports were completed for resident's #2, #6, #8, #10, #14, #15, #16, #17, #18, #19 and #20. Their perspective attending physicians were notified of the medication errors and any new orders regarding the errors have been implemented. All required notifications regarding the errors were made to the pharmacy and medical director. These residents are receiving their medications as ordered by the physician at this time. 2. A complete facility review was completed on 4-30-15 to assure that all resident medication orders are current and transcribed on the medication administration records. All residents are receiving their medications as ordered by their physicians. No other errors were identified in this review.	

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F 333	Continued From page 59 on , 2015. Resident #6 reported pain to the nursing staff and reported that the pain was consistent with a . The physician was notified on and ordered the necessary tests. The facility failed to implement those orders for three days, delaying treatment to the resident until . Resident #6 required injections of to dissolve the clot. Resident #2 was administered a double dose of on 4/8, 9, 12, 13, 14 and . His INR was erapeutic on at 3.2. Resident #10 was not administered her prescribed on 4/9 and . Resident #14 was not administered four of six available doses of . Resident #15 was not administered her on and on . Resident #16 ' s was to be discontinued when the International Normalizing Ratio (INR) was greater than 2. On the laboratory results indicated that her INR was 2.5 and the was continued for four additional doses. Resident #17 was not administered five doses of on 3/7, 10, 13, 15, . Resident #18 was not administered four doses of on 4/2, 11, 13 and 15/2015. Resident #19 missed four doses of Pradaxa from . Resident #20 was not administered seven doses of from . The facility ' s Licensed Nursing staff failed to administer medications in accordance with physician ' s orders. The failure of the nurses to administer resulted in significant medication errors that subsequently caused Resident #6 to develop an avoidable clot Based on record review and interview, the nurses failed to administer medications timely and accurately for two (#2, #8) out of forty-eight (48) residents reviewed for medication accuracy.	F 333	3. Nursing staff has been re-educated on the process of completing a medication error report 5-11,15,18,19,20,21 and 22-2015 New medication error reports have been implemented with all of the required components on the report. The attending physician, pharmacy, Family/Responsible Party will be notified at the time of the error identification. Medication error reports will be forwarded to the Director of Nursing for further investigation following risk management standards and root cause analysis. Identified trends will be brought to the QAPI Committee for further review and resolution. A shift to shift MAR/TAR review has been implemented to assure that residents are receiving all of their medications. There will also be a daily Nursing Administration review of the MAR/TAR to assure compliance with this process. Nursing staff has been re-educated by the Nurse Pharmacy Consultant on all aspects of medication management including, obtaining orders, transcribing orders and implementing orders. These areas of care will be overseen by the Director of Nursing/Designee, Unit Managers and Supervisors. 4. These areas of care will be monitored by the Director of Nursing/Designee weekly times four weeks and then monthly on an ongoing basis to assure continued compliance. Medication Error Reports will be reviewed as identified errors ocurr. This will also be overseen by the Administrator and the QAPI Committee.	

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F 333	Continued From page 60 Resident #2 ' s physician ordered and that were omitted for 10 days. There was a three day delay in starting a physician ordered for Resident #8 and two doses were omitted. The facility failed to monitor the administration of medications on a routine basis. The facility failed to systematically identify, investigate and report medication errors. The failure of the facility resulted in the findings of Immediate Jeopardy existing in the facility as of . The facility Administration was informed on at 9:50 a.m. The Immediate Jeopardy was removed on at 5:30 p.m. and the scope and severity was reduced to an " E. " Findings Include: 1. During an interview on at 10:30 a.m. Resident #6 stated she was diagnosed with a she said it was not just a it was an extensive . The resident stated that " the doctor said it was from my knee to my foot and I think there was more than one ." The resident was asked if the nurse had spoken to her about her she said " No, the doctor told me the nurses were not giving me my medication, he was really pissed. " They (the nurses) had to give me two times a day for five days and I hate needles. " Resident #6 stated that when she first had come to the facility she had a in her left arm " that is why I take the every day. " The resident stated that she used to check her medications every day and now has to start checking them again. " It ' s not my job to have to ask if all my medications are there or not is it? "	F 333		

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F 333	Continued From page 61 During a telephone interview on at 11:42 a.m., Resident #6 ' s Attending Physician stated; " the nurses did not give her medication the medication was only on hold for a few days for her dental surgery. The physician was asked why the was not restarted after her dental surgery. The physician stated he did not understand why the nurses did not restart the medication, " I gave the nurses the order; they should have restarted the after the dental procedure was completed. The is to prevent her from getting a if she would have received the medication she would not have gotten a " During an interview on at 12:20 p.m., the Attending Physician confirmed he assessed the resident on and documented the resident ' s leg was red and He also ordered a Doppler study. The physician stated that he was informed by Employee (LPN) A of the leg and the lack of the on He verbally gave the order to Employee A. The Attending Physician confirmed the Doppler order was not completed until and also confirmed that no medication was started until He was unsure of why there would have been a delay in obtaining treatment, necessary tests or initiating the medication. Further review of the physician orders dated on " Stop x 3 days prior to and resume one day post p.m. " A telephone order dated revealed a Doppler was ordered STAT. Also on 80 MG SQ was ordered (two times) for 5 days. There were no orders for when the physician was first made aware of the	F 333		

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F 333	Continued From page 62 Review of the Medication Administration Record (MAR) dated 2015 revealed a typed order dated for 15 tablet one tablet by mouth once a day. Directly underneath the typed order a hand written entry; resume . The Medication Administration Record (MAR) revealed the nurses documented for , and " HOLD. " The MAR for when the was to be restarted, indicated the boxes, where an initial should have been written, were empty (indicating the dose was not administered). The remainder of the MAR from through was reviewed with no indication that the medication had been given and no indication as to why the medication was not given. A review of the Physician ' s Progress Notes revealed on , the Attending Physician assessed Resident #6 and diagnosed her with an acute . The physician documented: " Redness and left leg, 4+ L > left leg. " The physician also documented that the resident had been " Off 15 for 3 weeks by nurse ' s error. " Further review of the Attending Physician ' s progress note revealed he documented " Doppler was ordered. " There was no corresponding physician ' s order for the Doppler Studies until , three days after the physician assessed the resident. Further review of Resident #6 ' s medical record revealed that she had resided in the facility for approximately fifteen months and was fifty three years old. Resident #6 ' s medical history included and a history of . On a revealed a Score of 15 indicating no Review of the Nurses ' Notes on	F 333		

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F 333	Continued From page 63 revealed no documentation of a red, leg. There was no documentation of the omission of the medication, the physician visit or the new orders. On , Employee (LPN) A documented: the resident complained of pain and redness to her leg, upon assessment the leg was warm to touch and was . Painful, 2+ pitting. The doctor was paged and made aware and stated he saw her on Saturday. New orders for were obtained. On at 3:25 a.m. the nurse documented at " 12:45 a.m. patient states she thinks she has a to her LLE. Area of slight redness noted to inner calf to LLE, to LE. Skin temp within normal limits. refill is brisk . Unable to assess pulse related to . Patient rates pain level #1 at this time on a scale of 1-10 with 10 being the worst. Patient states she has had multiple in the past and knows what it feels like. Notified resident physicians of above and new orders were received for a STAT Doppler of the LLE to rule out . At 0200 (2:00 p.m.) 100mg was administered for c/o pain to LLE with a pain level of 9 out of 10. was effective. At 0330 (3:30 a.m.), the mobile service arrived to perform Doppler. Patient remained on bed rest. Patient remained alert and responding appropriately to verbal and stimuli. No s/s of distress noted. Vitals Patient received new order on to restart was not discontinued). " A review of the Report, dated revealed: " Examination: Doppler extremity/limb, left. Clinical Indications: of Limb, Findings: Real time color imaging shows no collateral and augmentation of post , popliteal , deep and common of left leg. There are no	F 333		

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F 333	Continued From page 64 excessive collateral veins. Left lower Extremity duplex : Impression: Extensive seen. " An interview was conducted with the facility ' s Director of Nursing (DON), on at 3:00 p.m. A list of medication errors for the month of 2015 was provided by the DON. The DON stated that she was aware of the medication error for Resident #6. She stated that a nurse found the error after performing a " medication review. " The DON stated that she was unsure of why the error occurred. She stated that the facility ' s intervention was the and the physician and the resident were notified of the error. The DON confirmed that no audits or education were provided to the staff following the medication error. The DON also confirmed that there was no evidence of an investigation. The DON stated that her conclusion of the omitted medication for Resident #6 was " we performed an , and started giving her injections and elevated her left leg. " On at 9:50 a.m. the Nursing Home Administrator, DON and the facility ' s corporate nurse confirmed that an in service was not conducted related to Resident #6 ' s omissions of her scheduled medications. The DON and NHA on at 3:30 p.m. confirmed that they were aware of Resident #6 ' s medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of the medication errors for Resident #6 only after the Doppler confirmed the positive . It was unclear due to the lack of the investigation of how and why the medication error was found. The DON was unable to present any information regarding her investigation, education or audits. No formal action plan had been put in place as of	F 333		

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F 333	Continued From page 65 the time of the start of the survey on During an interview on , at 3:30 p.m., the DON stated " she checks the MARs two times a week by flipping through all of the MARs. " She confirmed there was no documentation related to this process. The DON said that the ADON and Unit manger check every MAR daily for accuracy and completeness. During an interview on , at 8:50 a.m., the Assistant Director of Nurses stated that she randomly checked the MARs on a daily basis for accuracy and completeness. She stated that she checked new admissions and " maybe two others. " She stated that the Unit Manager was responsible for checking at least five residents on each cart on a daily basis. The ADON stated that there was not a definite system of checking the MARs. During an interview on at 9:30 a.m., Employee (LPN) A, Interim Unit Manager (started on Monday stated that she checked all new admissions for accuracy of orders and double checks with the MAR for accuracy. She stated that she did not do anything with the MARs on a daily basis. No one informed her she was supposed to be checking the MARs. She stated that she gets the new orders and the 24 hour report in the morning and then gives them to the ADON or DON to take them to the morning meeting. She does not usually go to the morning meetings and was not aware of any plan to begin to go. She stated that no education or training was provided to be a Unit Manager. The ADON told her the things that needed to be done and she was " just helping them out not doing the whole position. " The regular Unit Manager (LPN) B on the Long Term Care unit was currently on medical leave and was unable to be contacted.	F 333		

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F 333	Continued From page 66 During an interview on at 10:13 a.m. and at 10:43 a.m., the DON stated that the process of checking the MARs was an informal process that was implemented inconsistently and the ADON and Unit Manager assisted with the process. There was not a written policy or procedure. The DON stated that she had been in the role of DON for one year and the process of checking the MARs had been an expectation since her arrival and she had continued that process since then. The DON also stated on at 10:43 am that she was unaware the ADON and Unit Managers were not checking the MARs daily. During an interview on at 2:45 p.m., the Medical Director stated that he had been the Medical Director of the facility since 2012. He stated that he participated in the QA monthly meetings and the facility followed a set agenda. He stated that he was made aware of incidents for his patients and that the attending physician for the other residents would be notified of incidents. He stated that he would expect to be notified of incidents, including medication errors. Specifically, for system failures that could affect all residents. He stated that he was here at the facility every Wednesday and Friday. However, someone from his physician group was present daily and should be notified. He expected that the nurses notify the physician of any incident. He confirmed again that he was not made aware of any medication errors for Resident #6. He was not aware of any issues in QA related to medication administration. He stated that he was aware that the facility used a lot of agency staff and had a lot of turnover. The Medical Director stated that there no action plan identified or implemented related to staffing or staff procedures. He also stated that he was aware of	F 333		

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F 333	Continued From page 67 a concern with nurses not implementing physician orders timely. He stated that the nurse would pass off the order to the oncoming shifts and the medication would not be started. He stated that he provided education to the staff " within the year " related to medication implementation. The education was to have a second nurse initial the order to assure implementation. He confirmed that there was nothing in Quality Assurance (QA) related to the medication administration and order implementation process. The Medical Director stated that if the facility had a good system in place, then any staff member should be able to come in and care for the resident with no breaks in the system. He stated that the " system was not perfect and should not have failed. " The Medical Director was asked if it was expected that the facility notify him of negative outcomes; he stated, " I would love to. " When referring to the incident for Resident #6, the Medical Director stated that it was a " negative outcome and that he was afraid for his patients. " He stated that " there was not a plan in place. " During an interview on at 10:15 a.m., the Administrator stated that she was informed of Resident #6 ' s medication error on , 2015. She was informed that the Unit Manager had educated the staff involved. The DON informed her that she was assembling her investigation and would bring the information to the next QA meeting on . The QA meeting was initially scheduled on and it was delayed due to a trial. The Nursing Home Administrator (NHA) said usually the QA is scheduled every third Tuesday of the month. The facility has done Ad Hoc meetings in the past but the DON wanted to make sure everything was done before hand and an Ad Hoc meeting was not scheduled. The DON informed her that the physician had been	F 333		

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F 333	Continued From page 68 notified. The DON also, informed her that the facility was still working the concern. The Administrator stated that she was aware the process was in place. The four point process was not completed and had not been presented. The MAR indicated that six nurses assigned on the 3-11 p.m. shift failed to administer the as ordered by the attending physician. During an interview on at 4:10 p.m. Employee (RN) E, a nurse that cared for the resident on 12 of the 26 evening shifts, stated that she had been a nurse for a long time and worked in long term care. She stated that she was familiar with Resident #6. She stated that she was aware the resident needed . The medication was not administered. She stated that she did not think the order was on going. She stated that it was on hold. She stated that she did not have the time to research the order and was aware that Resident #6 was at high risk for . She stated that she questioned the medication to other staff; however, she did not recall who the staff member was. She stated that the doctor came in and then realized the medication should have been resumed. The nurse stated that when a medication was held, the nurse should write hold on the days that the medication is to be held and then indicate when the medication should be resumed. The nurse confirmed the MAR and confirmed that there was no indication the medication had been given. She stated that she did not recall the resume date. The nurse stated that " my philosophy is if I don ' t see the medication and don ' t see a stop order, then I question with another nurse as to whether the medication is on hold or should be discontinued. " She stated that she would call the pharmacy. She stated that the medication card was not in the cart. The nurse also	F 333		

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F 333	Continued From page 69 confirmed that she did not document any omissions in the chart. She stated that she did not look at the chart to find the original order. An interview was conducted on at 4:30 p.m. with Employee (LPN) D. She stated that she worked at the facility When asked about her training she stated she had trained for two to three days and was on her own by the fourth day. She said she had felt that it was " " on her orientation process as far as knowing the processes and was able to always go back and ask questions. Employee (LPN) D stated that she recalled caring for Resident #6. She confirmed that she was on and stated that she cared for her several times. The staff member reviewed the MAR and confirmed that she worked on and The nurse next confirmed the order for and then confirmed the order said to resume The nurse stated that she would not have given a medication without signing the MAR. These dates were blank, with no initials. Review of the Pharmacy Dispensing Record for Resident #6 ' s from 1-A 2015. The pharmacy sent 14 pills at a time. Review of the Dispensing Log revealed the facility last received 14 pills on All of the medication would have been administered by Therefore, there was no available for administration. The medication was not a routinely stocked medication in the Emergency Drug Kit. Review of the Drug Manufacturer ' s Pharmaceutical Medication Guide for revealed; " is a prescription medicine used to treat and , and to help reduce the risk of these conditions occurring again.	F 333		

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F 333	Continued From page 70 lowers your chance of having a by helping to prevent clots from forming. If you stop taking you may have increased risk of forming a clot in your . Do not stop taking without talking to the doctor who prescribes it for you. Stopping increases your risk of having a . If you have to stop taking , your doctor may prescribe another medicine to prevent a clot from forming. Do not stop taking without talking to your doctor first. Your doctor may stop for a short time before any surgery, medical or dental procedure. Your doctor will tell you when to start taking again after your surgery or procedure. " Review of Resident #6 ' s Care plan Focus on Anticoagulation reflected the resident had a " potential for abnormal " Date Initiated; updated: Goal will be free from signs and symptoms of abnormal . Interventions: Administer as MD ordered. " The Care Plan was not followed. Review of the facility policy entitled " Medication Administration General Guidelines for the Administration of Medications " policy 6.2 (page one of three) (no dated) was reviewed and it was expected that the nurses administer medications per the physician ' s orders. The facility identified thirty residents receiving . All thirty residents were sampled. The following residents were identified with medications errors related to 2. During an interview on at 3:45 p.m. the facilities Director of Nursing (DON) she stated: " we have had another problem with an , it happened to Resident #2. " The	F 333		

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F 333	Continued From page 71 DON said that when Resident #2 was admitted on [redacted] and the nurse had written up the physician orders on one of our order sheets. The [redacted] was written on a regular sheet that did not have a [redacted] copy that was used for the medication administration record. We the (DON and ADON) did not find out about the medication not being given until [redacted]. " The DON was asked what the process was on checking admission orders for their accuracy she said that usually the unit manager will check the orders the next morning and then added the Unit Manager was out on maternity leave. The DON was asked who would be responsible to verify the physician ordered medications were accurately transcribed into the Medication Administration Record (MAR) she said the ADON or me. The DON said " We checked the physician order sheet and they were written correctly but because the [redacted] order was not put on the physician order sheet that contained a [redacted] copy it did not show up on the MAR. " The DON confirmed she did not review the MAR to make sure all the physician orders were transcribed. The DON was asked how that had happened she stated; " I ' m still trying to figure out how it happened and when I do find it out it has unfortunately already occurred. " When asked if the facility uses a check off system for newly admitted residents she said " we used to but now it is computerized. The computer tells us what to do. " She stated she was there the day of the verbal teaching but she did not sign the in-service verifying that she had attended. A medical record review was conducted for Resident #2 and revealed he had resided in the facility for approximately three weeks. His diagnoses included: [redacted] Dependent [redacted]	F 333		

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F 333	Continued From page 72 and Review of Resident #2 ' s admission orders revealed he was prescribed 4 mg on Sunday, Tuesday, Wednesday, Thursday and Saturday and 2 mg on Monday and Friday. Review of the 2015 Medication Administration Record for Resident #2 revealed the 4 mg and 2 mg doses were initialed on: 4/8, 4/9, , , , and on , resulting in a total of 6 mg of On the order was discontinued and rewritten to give 4 mg by mouth on Sunday, Tuesday, Wednesday, Thursday and Saturday and to administer 2 mg on Monday and Friday. (The same identical order, this time the initial boxes were outlined indicating which day of the week the medication needed to be given). On at 11:45 a.m. a telephone interview was conducted with Resident #2 ' s Attending Physician. He confirmed he was notified that the resident had been receiving double doses of his and confirmed that his International Normalizing Ratio was 3.2 and not critical erapeutic). The physician confirmed the facility did not follow his orders and should have administered the proper dosages of on the proper days as ordered. The physician stated " they need to fix it, I don ' t know if it ' s the DON or the corporation they have to fix these things so it doesn ' t happen again. " The DON provided a copy of an in-service that was conducted on (three days after the medication omission was found) Teaching Method: Verbal Topic: and Protocol. Make sure INR is done, Call MD with results before giving medication, check orders daily and make sure log is accurate. The DON was asked about any	F 333		

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F 333	Continued From page 73 in-servicing that was provided to the licensed staff on physician orders not being transcribed accurately in the residents MAR or not being transcribed at all, she did not respond. The DON and NHA on at 3:30 p.m. confirmed that they were aware of Resident #2 ' s medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of Resident #2 ' s medication error on ; however, no negative outcomes occurred. It is unclear due to the lack of the investigation of how and why the medication error was found. On the DON stated " she checks the MARs two times a week by flipping through all of the MARs, she confirmed there was no documentation related to this process. The DON said that the ADON and Unit manger check every MAR daily for accuracy and completeness. 3. The facility admitted Resident #10 on with diagnoses including Accident and per the physician order summary list of diagnoses. Review of the Admission Physician Orders dated revealed the resident was prescribed 40 unit daily at 9 a.m. Review of the Medication Administration Record revealed Resident #10 did not receive on 4/9 or . There was no documentation on the back side of the MAR as to why the medication was omitted. Review of the Care Plan dated revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses	F 333		

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F 333	Continued From page 74 on at 11 am. No additional information was provided related to why the medication would not have been given to Resident #10. 4. The facility admitted Resident #14 on with diagnoses including Acute and per the demographic face sheet. Review of the medical record revealed Resident #14 was transferred to a Hospice House for end of life care. Further review of the medical record revealed a physician ' s telephone order dated for 30 units twice daily. The resident was placed on due to sub-therapeutic INR (International Normalizing Ratio) levels and she was at risk for developing additional clots. Review of the Laboratory results revealed on , Resident #14 ' s INR was 1.1. On the was discontinued. The resident remained sub-therapeutic and the physician was attempting to adjust her Review of the Medication Administration Record for 2015 revealed Resident #14 did not receive for 4 out of the 6 available doses. She did not receive any on The resident did not receive on at 9 a.m., at 9 a.m. or at 9 a.m. There was no documentation in the nurses ' notes or the back of the Medication Administration Record as to why the medication was not given. On the resident was noted to have redness and to her right leg. An was ordered and the resident was diagnosed with a Review of the Care Plan dated revealed a problem area was identified for "	F 333		

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F 333	Continued From page 75 potential for abnormal ." The approaches included " administer as MD ordered. " During an interview on at 2:30 p.m., the Nurse Consultant confirmed the missed doses of . He stated that the medication should have been available from pharmacy and was unable to determine why the nurses would not have given the medication. He stated that the at least one dose of the should have been given on 5. The facility admitted Resident #15 on with diagnoses including and per the demographic face sheet. Review of the Physician Orders for 2015 revealed Resident #15 was prescribed 40 unit daily for two weeks. Review of the Medication Administration Record for 2015 revealed Resident #15 did not receive her on and Review of the Care Plan dated revealed a problem area was identified for " , potential for abnormal ." The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11:00 a.m. No additional information as provided related to why the medication would not have been given to Resident #15. 6. The facility admitted Resident #16 on with diagnoses including and per the physician diagnoses listed on the Medication Administration Record. Review of the Physician ' s Orders revealed on	F 333		

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F 333	Continued From page 76 Resident #16 was prescribed " 60 units every 12 hours, D/C (discontinue) when INR (international normalizing ratio) above 2. " Review of the Laboratory Data revealed an INR was collected on that was 2.5. Review of the Medication Administration Record for 2015 revealed Resident #16 was given on , and . He received four doses of after the medication should have been discontinued per the INR value of 2.5. Further review of the Laboratory Data revealed an INR was collected on and the resident was erapeutic at 3.9. Record review revealed no indication of abnormal was noted. Review of the Care Plan dated revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the resident received the when the medication should have been discontinued. 7. The facility admitted Resident #17 on with diagnoses including Accident and per the demographic face sheet. Review of the Physician ' s Orders for 2015 revealed the resident was prescribed 3 mg PO daily at 5 p.m.. Review of the 2015 Medication Administration Record revealed Resident #17 did not receive the prescribed for 5 doses; 4/7, , and . There was no documentation in the nurses ' notes or on the	F 333		

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F 333	Continued From page 77 back of the MAR as to why the medication was omitted. Review of the Care Plan dated revealed a problem area was identified for " , potential for abnormal ." The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the medication would not have been given to Resident #17. 8. The facility admitted Resident #18 on and was readmitted on with diagnoses including Chest Pain and Review of the Physician ' s Orders dated revealed Resident #18 was prescribed 8.5 mg daily at 9 p.m.. Review of the 2015 Medication Administration Record revealed Resident #18 did not receive his on or There was no documentation on the back side of the MAR as to why the medication was not given. Review of the Care Plan dated revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " During an interview with Resident #18 on at 3:20 p.m. he stated that there have been occasions where he did not receive all of his ordered mediations from the nurse. He stated that he now has to check all his medications for accuracy. He stated that when he brought it to the nurse ' s attention when he did not receive his medications, they told him that they were either out of the medication or they would go back and	F 333		

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F 333	Continued From page 78 bring him his ordered medication. He stated that he used to have a medication book on his bedside table that he would utilize to check his medications but that the medications are changed from the manufactures or the pharmacy so often now that it is obsolete. The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the medication would not have been given to Resident #18. 9. Resident #19 was admitted to the facility in 2015 her admitting diagnosis and . Resident #19 was identified and listed on " Current active orders for " that was provided by the facility. The physician orders were reviewed with an order dated to administer Pradaxa 150 mg capsule one capsule by mouth two times daily for a diagnosis of The MAR was reviewed for 2015 and it was identified resident # 19 had missed four doses of Pradaxa on at 5:00 p.m., at 5:00 p.m., at 9:00 a.m. and again at 5:00 p.m. The nursing notes revealed for the days the medication had been omitted there was neither documentation nor notification to the physician on why a prescribed medication was not administered as ordered. Review of resident #19 Care plan Focus on Anticoagulation has a potential for abnormal Date Initiated; Goal will be free from signs and symptoms of abnormal Interventions: Administer as MD ordered. The Care Plan was not followed. 10. Resident #20 was admitted to the facility on	F 333		

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F 333	Continued From page 79 with a history of recent for of right with Review of resident physician orders dated she is to receive 40 mg every 12 hours for preventative measures. The MAR was reviewed for 2015 and it revealed seven separate missing initials or circles around initials indicating the medication was not administered as ordered. On at 9:00 p.m. the box on the MAR was without an initial, 9:00 a.m. the box was initialed with a circle, at 9:00 a.m. the box was initialed with a circle, at 9:00 p.m. the box MAR was without an initial, at 9:00 p.m. no initialed as given, and on at 9:00 am. the box was initialed with a circle. The back of the MAR nursing notes for at 9:00 p.m. indicated that the was not available to give. A second nursing note for at 9:00 a.m. indicated tea the pharmacy was notified. 11. The facility admitted Resident #8 on with diagnoses including Hip and Review of the Physician Telephone Orders dated revealed the physician ordered a Urinalysis with Culture and Sensitivity and also ordered 500 mg every 8 hours for 7 days for a Review of the Laboratory Data revealed Resident #8 did not have a Urinalysis collected. Review of the and 2015 Medication Administration Records revealed Resident #8 ' s was not started until (a three day delay in initiating the physician ' s order). Further review of the MAR revealed the 6 am dose was given on ; however, the 2 p.m. and 10 p.m. doses were omitted.	F 333		

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F 333	Continued From page 80 During an interview on at 2 p.m., the Nurse Consultant stated that the Urinalysis had not been collected. He stated that he was unsure why the nurses would not have gotten the sample. He also stated that the 6 am dose of on was taken from the Emergency Drug Kit. He confirmed the 2 p.m. and 10 p.m. doses were not given. The Nurse Consultant also confirmed there was no documentation related to why the urinalysis was not collected, why the medication not initiated for 3 days or why the resident missed two doses of her 12. Further record review of Resident # ' 2's Medical Record revealed his admissions orders dated were for 40 mg by mouth one time daily and 15 units in the morning and 5 units at night time. Resident #2 did not receive his from Resident #2 did not receive his scheduled morning dosage from and the night time dosage from . The MAR revealed orders dated to start 40 mg one time daily and 15 units in the morning and 5 units at night time, hold if BS is less than 110. Resident #2 nursing notes were reviewed for at 3:16 p.m. " there was a med error for patient there was error in patient patient and was never given patient was supposed to be on daily weight not done. Physician has been paged. Waiting for call back " . The nursing notes for at 1:54 a.m. " New order for INR ordered for the AM for the dosage error " . There was no corresponding nurses ' notes related to the omissions of Resident #2 ' s or	F 333		

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F 333	Continued From page 81 On at 11:45 a.m. a telephone interview was conducted with Resident #2 ' s Attending Physician. The Attending Physician confirmed that he was notified that Resident #2 did not receive his ordered for ten days after being admitted and he did not receive his for ten days after being admitted to the facility. The Attending Physician was asked if a resident had a diagnosis of being does that mean he needs monitoring. The Attending Physician stated " yes, he needs his sugars monitored he could have went into or and worse yet into " The physician stated " they need to fix it, I don ' t know if it ' s the DON or the corporation they have to fix these things so it doesn ' t happen again. " The DON was asked if the nurse that had not transcribed the and in Resident #2 ' s MAR had attended the in-service that she had on The DON stated " The nurse was there but she did not sign on the sign-in sheet. " When asked if there was any other information that she had on training her nursing staff she stated " We were going to bring it into our QA meeting on Tuesday 13. During an interview on at 11:10 am, a Plan of Action was received related to The plan included the following: An audit was completed of all residents. Physician orders, labs, notification of the physician if there was a change and the Log was accurate. No significant issues were found. NRs were updated. A 100% house audit was completed of all resident medications and orders on Nursing education was completed between for nursing staff related to managing	F 333		

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F 333	Continued From page 82 residents on flow sheets and medication documentation. Three nurses that work as needed (PRN) have not been provided education and will not be allowed to work until educated. Agency nurses will be provided a packet that includes Managing Residents on Anticoagulation. The packet will include the Anticoagulation Policy and the facility ' s new protocol on documenting medications that are on " Hold " . All new admissions will be reviewed in the morning meeting to assure all orders will be transcribed onto the POS and MAR/TAR. The weekend supervisor is responsible for new admissions on the weekends (not a new process). All residents that are receiving will be reviewed in a weekly care meeting with all orders, labs, and MARs reviewed. New anti-co orders were added under the daily clinical meeting and medications were added to the weekly care meeting. Looking to assure that the medication is transcribed, the flow sheet if needed, medication on hand, transcribed onto MAR and that the medication is being administered. The Flow Sheet will be implemented for any resident receiving For residents that have Hold Orders: The order will be blocked off and yellowed out. A new order will be re-written with a restart date. The new process will be visible to the nurses. The hold medication will be added on the 24 hour report. Medication Errors will be investigated and documented following Risk Management standards and Root Cause Analysis. Evidence of investigation will be kept. Based on the analysis, the policies, practices and systems, changes will	F 333		

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F 333	Continued From page 83 occur as needed. A new shift to shift MAR review with each nurse was also implemented. The nurses, together, will review the entire MAR/TAR for holes and for accuracy. If the nurse is sure that she administered the medications, then she can initial, if she was unsure then it would be classified as a medication error. Nursing Administration would be responsible for daily checks of the nurse to nurse MAR review. Nursing Administration will also initial for accuracy. The audits will be reviewed daily by the DON. All lab results will be reviewed in the daily Clinical Meeting. All INRs will be reviewed in the morning clinical meeting and checked against the orders and MAR. The Medical Director had been informed and had approved the action plan as of	F 333		
F 441 SS=D	483.65 CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of and (a) Control Program The facility must establish an Control Program under which it - (1) Investigates, controls, and prevents in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to	F 441	1. Resident #21 is receiving care according to acceptable standards of care and following control standards and guidelines. Residents are being provided meal service with acceptable hand washing standards with hand sanitation being completed between each meal delivery.	

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F 441	Continued From page 84 (b) Preventing Spread of (1) When the Control Program determines that a resident needs isolation to prevent the spread of , the facility must the resident. (2) The facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of This REQUIREMENT is not met as evidenced by: Based on observations, record review, interview and review of the facility's policies on Care and Hand Hygiene the facility failed to (1) assure one of three residents (Resident #21) reviewed for care received the necessary treatments to prevent Employee F contaminated the Resident #21's exposed and failed to wash her hands before touching clean items and prior to exiting the resident's the treatment. The facility identified 84 residents. Further, the facility failed to ensure that staff performed hand hygiene during one of two meal observations by not washing or sanitizing hands prior to and after resident interactions.	F 441	2. Random observations have been made related to care and residents are receiving care according to acceptable standards of care and control guidelines. Identified areas of concern have been addressed. Observations have been made related to meal service delivery and any identified areas of concern have been addressed. 3. Staff have been re-educated on the provision of care and hand washing standards 5-7,11,13 and 14,2015. This included assuring that dressings are covering wounds prior to care being provided, preventing contamination of wounds during care, washing hands at the appropriate time when care is being delivered, assuring that hands are washed prior to leaving resident or soiled utility . This is being monitored by the Nursing Administration team on a weekly basis with random observations being made with the Certified Nursing Assistant staff. The Care policy was updated to include the utilization of pre-moisten perineal wipes in the provision of care. Hand sanitizer units have been place on the meal delivery carts to make sanitizer readily accessible during the meal delivery process. 4. These areas of care will be monitored by the Director of Nursing/Designee utilizing data collection tools, weekly times four weeks and then monthly. This will also be overseen by the Administrator and the QAPI Committee until resolved by the Committee.	

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F 441	Continued From page 85 The findings included: (1) The facility admitted Resident #21 on with diagnoses including , Paraplegia, and per the demographic face sheet. During an observation of care on beginning at 10 am, Employee F (Certified Nursing Assistant) washed her hands in the soiled utility . She then obtained 2 towels and 4 washcloths from the clean linen . She knocked on the door and entered the . The CNA placed the clean linen onto the barrier that was set up for care that had gauze, bullets, applicators and a clean dressing. The CNA exited the obtain a basin. She re-entered the her hands and donned gloves. She uncovered the resident and cleansed the resident's and . She then assisted the resident to a side lying position. The resident was noted to not have a dressing on her . The CNA used a soapy wash cloth and wiped from the resident's area and over the . Fecal material was observed on the wash cloth. The CNA used another wash cloth and again wiped up and over the with a brownish colored residue noted on the cloth. The CNA rinsed the resident with clean water, again wiping over the and then dried the resident, wiping over the . The CNA was then observed to then open the closet door with her soiled gloved hand, obtain a clean brief and chuck and place them on the resident's bed. The CNA washed her hands and donned clean gloves. She placed the brief under the resident and positioned her for comfort. The findings were shared with the Director of	F 441		

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F 441	Continued From page 86 Nurses and the Nurse Consultant on at 2:50 p.m. The DON and the Nurse Consultant agreed that the CNA contaminated the when she cleaned over the exposed with fecal material present on the wash cloth. They also confirmed that the CNA should have removed or covered the care supplies before using the bedside table for supplies needed during care. The DON and Nurse Consultant also confirmed that the CNA should not have opened the closet and obtained clean supplies with soiled gloves. Review of the facility's policy entitled Care dated 2010 revealed the purpose was "to provide cleanliness and comfort to the resident, to prevent and skin irritation and to observe the resident's skin condition." Under the Procedure section items 1-8 were related to setting up and preparing the resident for the care. Items 9 a and 9 b pertained to cleaning a female resident's and Item 9 c. "Instruct or assist resident to turn to her side with her top leg slightly bent, if able. D. Rinse cloth and apply soap or cleansing agent. E. Wash area thoroughly, wiping from towards and extending over the . Do not use the same washcloth or water to clean F. Rinse thoroughly using the same technique. G. Dry area thoroughly." Item 11. "Discard disposable items into designated containers. 12. Remove gloves and discard into disposable container. Wash and dry your hands thoroughly. 13. Reposition bed covers. Make resident comfortable. 14. Place call light within easy reach of the resident. 15. Clean wash basin and return to designated storage area. 16. Clean the bedside stand. 17. Wash and dry your hands thoroughly."	F 441		

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F 441	Continued From page 87 Review of the facility's policy entitled Hand Washing/Hand Hygiene dated 2007 revealed: "5. Employees must wash their hands for 10 to 15 seconds using soap and water under the following conditions: a. before and after direct contact with residents ...c. after contact with , body fluids, on non-intact skin. D. after removing gloves ..." "6. In most situations, the preferred method of hand hygiene is with and based hand rub. If hands are not visibly soiled, use an based hand rub containing 60-95% or isopropanol for all of the following situations: a. before and after direct contact with residents ...f. before moving from a contaminated body site to a clean body site during resident care ..." (2) On at 11:54 a.m. a lunch observation was conducted on the Skilled Rehabilitation Unit (SRU). Staff , was observed to serve her meal tray. She was observed to place the resident meal tray on the bedside table, assist the resident with sitting up in bed, pushed the bedside table up to resident and assisted with setting up meal tray. She was observed to then go back to the tray cart and remove a tray. She was observed to go into , place the tray on the bedside table and push the table up to the resident and set the resident meal tray up. She was observed to exit the go to the tray cart and remove another tray. She was observed to then enter . She was observed to place the meal tray on the bedside table, assist the resident in with his wheelchair leg rest, then move bedside table up to the resident, set up the residents meal, place the resident call light onto his wheelchair and then exit the . She was	F 441		

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F 441	Continued From page 88 observed to go to the tray cart, remove another tray and enter . She was observed to place the meal on the bedside table, move the table in front of the resident. She was then observed to exit the . She then went back into the the lift the resident's head of the bed up. She then went back to the tray cart and removed a tray and entered . She was observed to place the meal tray on the bedside table, push the table in front of the resident, assisted the resident with meal set up, and placed a napkin on the resident chest. She was then observed to exit the go back to the tray cart and open the cart. At that point, at 12:02 p.m. the staff was asked if she had used any hand sanitizer or washed her hands during the tray pass. She stated that she only uses hand sanitizer one time when she starts passing trays but not in-between passing trays. She stated that she used the hand sanitizer on the wall in the residents she first started passing trays.	F 441		
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on review of the facility ' s Administrator ' s Job Description, review of the facility ' s policy and procedure for medication administration, resident record review, interviews with the facility	F 490		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2811 CAMPUS HILL DR TAMPA, FL 33612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 89 staff, the Attending Physician, the Medical Director and Administration, the facility administration failed to administer effectively and failed to utilize resources to assure residents were free from significant errors. Based on a review of all current residents receiving ten of thirty residents did not receive their per the physician ' s orders. Resident ' s #2, #6, #10, #14, #15, #16, #17, #18, #19 and #20 were identified as not receiving that were necessary to prevent clots or . Resident #6 was not administered for twenty six days. The medication was placed on hold for three days for a dental procedure. The facility staff failed to implement the order and resume the medication on , 2015. Resident #6 reported pain to the nursing staff and reported that the pain was consistent with a . The physician was notified on and ordered the necessary tests. The facility failed to implement those orders for three days, delaying treatment to the resident until . Resident #6 required injections of to dissolve the clot. Resident #2 was administered a double dose of on 4/8, 9, 12, 13, 14 and . His INR was erapeutic on at 3.2. Resident #10 was not administered her prescribed on 4/9 and . Resident #14 was not administered four of six available doses of . Resident #15 was not administered her on and on . Resident #16 ' s was to be discontinued when the International Normalizing Ratio (INR) was greater than 2. On the laboratory results indicated that her INR was 2.5 and the was continued for four additional doses. Resident #17 was not administered five doses of on 3/7, 10, 13, 15,	F 490	1. Resident #6 is receiving their as ordered by the physician since 3-31-15. Resident #2 has been discharged from the facility . A medication error report was completed for this resident and the physician was notified. Resident #10 is currently receiving 40 mg once a day. Resident's #14 was discharged on and was a closed record. A medication error report was completed with physician notification. Resident #15 was discharged 5-14-15, a medication error report was completed and the physician was notified. Resident #16 is not currently receiving Resident #17 is receiving 3 mg once a day. Resident #18 is receiving 8.5 mg once a day. Resident #19 is receiving Pradaxa 150 mg twice a day. Resident # 20 is receiving 40 mg every twelve hours. All medications are being administered under "Practice of Professional Nursing". 2. A complete facility review was completed on to assure that all resident medication orders are current and transcribed on the medication administration records. All residents are receiving their medications as ordered by their physicians under "Practice of Professional Nursing".	

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F 490	Continued From page 90	F 4~~		

Resident #18 was not administered four doses of on 4/2, 11, 13 and . Resident #19 missed four doses of Pradaxa from . Resident #20 was not administered seven doses of from

The facility ' s Licensed Nursing staff failed to follow physician ' s orders and administer medications resulting in significant medication errors that subsequently caused Resident #6 to develop an avoidable clot (Deep)

Based on record review and interview, the facility administration failed to assure residents were free of medication errors for two (#2, #8) out of forty-eight (48) residents for medication accuracy. Resident #2 ' s physician ordered and that were omitted for 10 days. There was a three day delay in starting a physician ordered for resident #8 and two doses were omitted.

The failure of the facility administration to effectively utilize resources related to medication administration resulted in the findings of Immediate Jeopardy existing in the facility as of . The facility Administration was informed on at 9:50 a.m. Based on a Credible Allegation of Compliance the Immediate Jeopardy was removed on at 5:30 pm and the scope and severity was reduced to an " E. "

Findings Include:

1) Review of the Administrator ' s Job Description revealed the Purpose of Your Job Position described as " the primary position is to direct the day to day functions of the facility in accordance with the current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our

3. The following policies and procedures were reviewed, Anticoagulation –Clinical Protocol, Care, Hand Washing/Hygiene, Medication Holds and Documentation of Medication Administration by the QAPI Committee overseen by the Administrator on 5- and have been revised and updated as needed. Education has been provided to the QAPI Committee including the Administrator on the QAPI process by the Nurse Consultant on 5- utilizing CMS QAPI at a Glance educational materials. The QAPI Committee will utilize this for continued identification, analysis and planning for identified opportunities for improvement in the facility. The Medical Director also participated in this educational program and is current with the QAPI . Identified opportunities for improvement will be brought to the QAPI Committee for review and implementation of the QAPI process. QAPI Meetings are currently being held on a weekly basis times eight weeks and then bi-monthly times eight weeks and the monthly. Facility operations will be overseen by the Administrator/Medical Director on an ongoing basis.

4. Facility operations will be monitored by the Administrator and the Medical Director on a monthly basis and identified areas of concern will be addressed by them through the QAPI Process.

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F 490	Continued From page 91 residents at all times. " The Job Duties and Responsibilities include to " Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the facility. Assist department directors in the development, use, and implementation of departmental policies and procedures and professional standards of practice. To ensure that all employees follow the established policies and procedures. Committee Functions; Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identify quality deficiencies. " Report problems to the Medical director. " During an interview on at 10:15 am, the Administrator stated that on she received a report of a concern with Resident #6. She was informed of a medication error. The Unit Manager had educated the staff involved. The DON informed her that she was assembling her investigation and would bring the information to the next QA meeting on The meeting was initially scheduled on and it was delayed due to a trial. The Nursing Home Administrator (NHA) said, usually, the QA is scheduled every third Tuesday of the month. The facility had done Ad Hoc meetings in the past, but, the DON wanted to make sure everything was done before hand. The DON informed her that the physician had been notified. The DON informed her that the facility was still working that process. The Administrator stated that she was aware the process was in place. The four point process was not completed and had not been presented. During an interview on at 2:45 pm, the Medical Director stated that he had been the Medical Director of the facility since 2012. He	F 490		

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F 490	Continued From page 92 stated that he participated in the QA monthly meetings and the facility followed a set agenda. He stated that he was made aware of incidents for his patients and that the attending physician for the other residents would be notified of incidents. He stated that he would expect to be notified of incidents, including medication errors, specifically, for system failures that could affect all residents. He stated that he was here at the facility every Wednesday and Friday. However, someone from his physician group was present daily and should be notified. He expected that the nurses notify the physician of any incident. He confirmed again that he was not made aware of any medication errors for Resident #6. He was not aware of any issues in QA related to medication administration. He stated that he was aware that the facility used a lot of agency staff and had a lot of turnover. The Medical Director stated that there was no action plan identified or implemented related to staffing or staff procedures. He also stated that he was aware of a concern with nurses not implementing physician orders timely. He stated that the nurse would pass off the order to the oncoming shifts and the medication would not be started. He stated that he provided education to the staff " within the year " related to medication implementation. The education was to have a second nurse initial the order to assure implementation. He confirmed that there was nothing in Quality Assurance (QA) related to the medication administration and order implementation process. The Medical Director stated that if the facility had a good system in place, then any staff member should be able to come in and care for the resident with no breaks in the system. He stated that the " system was not perfect and should not have failed. " The Medical Director was asked if it was expected	F 490		

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F 490	Continued From page 93 that the facility notify him of negative outcomes; he stated, " I would love to. " When referring to the incident for Resident #6, the Medical Director stated that it was a " negative outcome and that he was afraid for his patients. " He stated that " there was not a plan in place. " Review of the facility policy entitled, " Medication Administration General Guidelines for the Administration of Medications " policy 6.2 (page one of three) (no date) was reviewed and it was expected that the nurses administer medications per the physician ' s orders. An interview was conducted with the facility ' s Director of Nursing (DON), on at 3:00 p.m. A list of medication errors for the month of 2015 was provided by the DON. The DON stated that she was aware of the medication error for Resident #6. She stated that a nurse found the error after performing a " medication review. " The DON stated that she was unsure of why the error occurred. She stated that the facility ' s intervention was the and the physician and the resident were notified of the error. The DON confirmed that no audits or education was provided to the staff following the medication error. The DON also confirmed that there was no evidence of an investigation. The DON stated that her conclusion of the omitted medication for Resident #6 was " we performed an , and started giving her injections and elevated her left leg. " On at 9:50 a.m., the Nursing Home Administrator, DON and the facility ' s corporate nurse confirmed that an in service was not conducted related to Resident #6 ' s omissions of her scheduled medications. The DON and NHA ON at 3:30 p.m. confirmed that they were aware of Resident #6 ' s medication errors and provided a facility	F 490		

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F 490	Continued From page 94 document that indicated a medication error had occurred. The facility was aware of the medication errors for Resident #6 only after the Doppler confirmed the positive . It was unclear due to the lack of the investigation of how and why the medication error was found. During an interview on at 3:30 p.m., the DON stated " she checks the MARs two times a week by flipping through all of the MARs. " She confirmed there was no documentation related to this process. The DON said that the ADON and Unit manger check every MAR daily for accuracy and completeness. During an interview on at 8:50 a.m., The Assistant Director of Nurses stated that she randomly checked the MARs on a daily basis for accuracy and completeness. She stated that she checked new admissions and " maybe two others. " She stated that the Unit Manager was responsible for checking at least five residents on each cart on a daily basis. The ADON stated that there was not a definite system of checking the MARs. An interview was conducted on at 9:30 a.m. with Employee (LPN) A Interim Unit Manager (started on Monday She stated that she checked all new admissions for accuracy of orders and double checks with the MAR for accuracy. She stated that she did not do anything with the MARs on a daily basis. No one informed her she was supposed to be checking the MARs. She stated that she gets the new orders and the 24 hour report in the morning and then gives them to the ADON or DON to take them to the morning meeting. She did not usually go to the morning meetings and was not aware of any plan to begin to go. She stated that no education or training was provided to be a Unit Manager. The ADON told her the things that	F 490		

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F 490	Continued From page 95 needed to be done and she was " just helping them out not doing the whole position. " The regular Unit Manager (LPN) B on the Long Term Care unit was currently on medical leave and was unable to be contacted. During an interview on at 10:13 a.m. and at 10:43 a.m., The DON stated that the process of checking the MARs was an informal process that was implemented inconsistently and the ADON and Unit Manager assisted with the process. There was not a written policy or procedure. The DON stated that she had been in the role of DON for one year and the process of checking the MARs had been an expectation since her arrival and she had continued that process since then. The DON also stated, on at 10:43 a.m., that she was unaware the ADON and Unit Managers were not checking MARs daily. During an interview with the DON, she was unable to present any information regarding her investigation, education or audits. No formal action plan had been put in place as of the time of the start of the survey on 2) During an interview on at 10:30 a.m. Resident #6 stated she was diagnosed with a She said it was not just a it was an extensive The resident stated that " the doctor said it was from my knee to my foot and I think there was more than one " The resident was asked if the nurse had spoken to her about her She said, " No, the doctor told me the nurses were not giving me my medication. He was really pissed. " They (the nurses) had to give me two times a day for five days and I hate needles. " Resident #6 said that when she first had come to the facility she had a in her left arm and " that is why I take the every	F 490		

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F 490	Continued From page 96 day. " The resident stated that she used to check her medications every day and now has to start checking them again. " It ' s not my job to have to ask if all my medications are there or not is it? " During a telephone interview on at 11:42 a.m., Resident #6 ' s attending physician stated; " the nurses did not give her medication , the medication was only on hold for a few days for her dental surgery. " The physician was asked why the medication Xarleto was not restarted after her dental surgery. The physician stated he did not understand why the nurses did not restart the medication. " I gave the nurses the order and they should have restarted the after the dental procedure was completed. The is to prevent her from getting a . If she would have received the medication she would not have gotten a " During an interview on at 12:20 p.m., the attending Physician confirmed he assessed the resident on and documented the resident ' s leg was red and . He also ordered a Doppler study. The physician stated that he was informed by Employee (LPN) A of the leg and the lack of the on . He verbally gave the order to Employee A. The attending physician confirmed the Doppler order was not completed until and also confirmed that no medication was started until . He was unsure of why there would have been a delay in obtaining treatment, necessary tests or initiating the medication. Further review of the physician orders, dated on , reflected " Stop x 3 days prior to and resume one day post p.m. " A written telephone	F 490		

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F 490	Continued From page 97 order, dated on , referenced Doppler STAT and a third order dated for the same day , directed 80 MG SQ ((two times) for 5 days. Review of the Medication Administration Record, dated 2015, revealed a typed order dated for 15 MG tablet one tablet by mouth once a day. Directly underneath the typed order a hand written entry stated resume . The Medication Administration Record (MAR) revealed the nurses documented for and : " HOLD. " The was to be restarted on . The boxes, where an initial should have been written, were empty (indicating the dose was not administered). The remainder of the MAR from through was reviewed with no indication that the medication had been given and no indication as to why the medication was not given. A review of the Physician ' s Progress Notes revealed on the Attending Physician assessed Resident #6 and diagnosed her with an acute The physician documented: " Redness and left leg, 4+ L > left leg. " The physician also documented that the resident had been " Off 15 MG for 3 weeks by nurse ' s error. " Further review of the Attending Physician ' s progress note revealed he documented " Doppler was ordered. " There was no corresponding physician ' s order for the Doppler Studies until , three days after the physician assessed the resident. Further review of Resident #6 ' s medical record revealed that she had resided in the facility for approximately fifteen months and was fifty three years old. Resident #6 ' s medical history	F 490		

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F 490	Continued From page 98 included and a history of . On , a revealed a Score of 15 indicating no Review of the Nurses ' Notes on revealed no documentation of a red, leg. There was no documentation of the omission of the medication, the physician visit or the new orders. On , employee (LPN) A documented: the resident complained of pain and redness to her leg and upon assessment the leg was warm to touch and was . Painful, 2+ pitting. The doctor was paged and made aware and stated he saw her on Saturday. New orders for were obtained. On at 3:25 a.m., the nurse documented at " 12:45 a.m. patient states she thinks she has a to her LLE. Area of slight redness noted to inner calf to LLE, to LE. Skin temp within normal limits. refill is brisk . Unable to assess pulse related to . Patient rates pain level #1 at this time on a scale of 1-10 with 10 being the worst. Patient states she has had multiple in the past and knows what it feels like. Notified resident physician of above and new orders were received for a STAT Doppler of the LLE to rule out . At 0200 (2:00 a.m.) 100mg was administered for c/o pain to LLE with a pain level of 9 out of 10. was effective. At 0330 (3:30 a.m.), the mobile service arrived to perform Doppler. Patient remained on bed rest. Patient remained alert and responding appropriately to verbal and stimuli. No s/s of distress noted. Vitals Patient received new order on to restart was not discontinued). " A review of the Ultra Sound Report, date of service: revealed: " Examination:	F 490		

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F 490	Continued From page 99 Doppler extremity/limb, left. Clinical Indications: of Limb, Findings: Real time color imaging shows no collateral and augmentation of post popliteal deep and common of left leg. There are no excessive collateral veins. Left lower Extremity duplex Impression: Extensive seen. " The MAR indicated that six nurses assigned on the 3-11 p.m. shift failed to follow Resident #6 ' s Plan of Care and administer the as ordered by the attending physician. During an interview on at 4:10 p.m. Employee (RN) E, a nurse that cared for the resident on 12 of the 26 evening shifts, stated that she had been a nurse for a long time and worked in long term care. She stated that she was familiar with Resident #6. She stated that she was aware the resident needed . The medication was not administered. She stated that she did not think the order was on going. She stated that it was on hold. She stated that she did not have the time to research the order and was aware that Resident #6 was at high risk for . She stated that she questioned the medication to other staff; however, she did not recall who the staff member was. She stated that the doctor came in and then realized the medication should have been resumed. The nurse stated that when a medication was held, the nurse should write hold on the days that the medication is to be held and then indicate when the medication should be resumed. The nurse confirmed the MAR and confirmed that there was no indication the medication had been given. She stated that she did not recall the resume date. The nurse stated that " my philosophy is if I don ' t see the medication and don ' t see a stop	F 490		

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F 490	Continued From page 100 order, then I question with another nurse as to whether the medication is on hold or should be discontinued. " She stated that she would call the pharmacy. She stated that the medication card was not in the cart. The nurse also confirmed that she did not document any omissions in the chart. She stated that she did not look at the chart to find the original order. An interview was conducted on at 4:30 p.m. with past Employee (LPN) D She stated that she worked at the facility She said that she was a new LPN, graduated 2014, and it was her first job in a Skilled Nursing Facility. When asked about her training she stated she had trained for two to three days and was on her own by the fourth day. She said she had felt that it was " " on her orientation process as far as knowing the processes and was able to always go back and ask questions. Employee (LPN) D stated that she recalled caring for Resident #6. She confirmed that she was on and stated that she cared for her several times. The staff member was asked and visually confirmed the MAR and confirmed that she worked on and The nurse next confirmed the order for and then confirmed the order said to resume The nurse stated that she would not have given a medication without signing the MAR. These dates were blank, with no initials. The Pharmacy Dispensing Record for Resident #6 ' s from 1-A 2015 was reviewed. The pharmacy sent 14 pills at a time. Review of the Dispensing Log revealed the facility last received 14 pills on All of the medication would have been administered by Therefore, there was no available for administration. The medication was not a	F 490		

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F 490	Continued From page 101 routinely stocked medication in the Emergency Drug Kit. Review of the Drug Manufacturer ' s Pharmaceutical Medication Guide for revealed; " is a prescription medicine used to treat and , and to help reduce the risk of these conditions occurring again. lowers your chance of having a by helping to prevent clots from forming. If you stop taking , you may have increased risk of forming a clot in your Do not stop taking without talking to the doctor who prescribes it for you. Stopping increases your risk of having a If you have to stop taking your doctor may prescribe another medicine to prevent a clot from forming. Do not stop taking without talking to your doctor first. Your doctor may stop for a short time before any surgery, medical or dental procedure. Your doctor will tell you when to start taking again after your surgery or procedure. " Review of Resident #6 ' s Care plan Focus on Anticoagulation reflected the resident had a " potential for abnormal . The date Initiated was and updated The goal included will be free from signs and symptoms of abnormal Interventions: " Administer as MD ordered. " The Care Plan was not followed. 3) During an interview on at 3:45 p.m. the facility ' s Director of Nursing (DON) stated: " we have had another problem with an . It happened to Resident #2. " The DON said that Resident #2 was admitted on and the nurse had written up the physician orders on one of our order sheets. The	F 490		

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F 490	Continued From page 102 was written on a regular sheet that did not have a copy that is used for the medication administration record. We (DON and ADON) did not find out about the medication not being given until ." The DON was asked what the process was on checking admission orders for their accuracy. She said that, usually, the unit manager would check the orders the next morning and then added the unit manager was out on maternity leave. The DON was asked who would be responsible to verify the physician ordered medications were accurately transcribed into the Medication Administration Record (MAR). She said the ADON or me. The DON said " We checked the physician order sheet and they were written correctly, but, because the order was not put on the physician order sheet that contained a copy it did not show up on the MAR. " The DON confirmed she did not review the MAR to make sure all the physician orders were transcribed. The DON was asked how that had happened she stated; " I ' m still trying to figure out how it happened and then I do find it out it had unfortunately already occurred. " When asked if the facility uses a check off system for newly admitted residents she said " we used to but now it is computerized. The computer tells us what to do. " She stated she was there the day of the verbal teaching but she did not sign the in-service verifying that she had attended. A medical record review was conducted for Resident #2 and revealed he had resided in the facility for approximately three weeks. His diagnoses included: and according to admitting documents. The Medication Administration Record for Resident #2 ' s orders were to give 4	F 490		

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F 490	Continued From page 103 mg by mouth on Sunday, Tuesday, Wednesday, Thursday and Saturday and to administer 2 mg on Monday and Friday. The MAR indicated that on; 4/8, 4/9, and on both orders were initialed/signed as being administered resulting in a total of 6 mg of . On , the order was discontinued and rewritten to give 4 mg by mouth on Sunday, Tuesday, Wednesday, Thursday and Saturday and to administer 2 mg on Monday and Friday. On at 11:45 a.m. a telephone interview was conducted with Resident #2 ' s attending physician. He confirmed he was notified that the resident had been receiving double doses of his and confirmed that his International Ratio was 3.2 and not critical erapeutic) . The physician confirmed the facility did not follow his orders and should have administered the proper dosages of on the proper days as ordered. " The DON provided a copy of an in-service that was conducted on (three days after the medication omission was found). The documentation included " Teaching Method: Verbal Topic: and Protocol. Make sure INR is done, Call MD with results before giving medication, check orders daily and make sure log is accurate. " The DON was asked about any in-servicing that was provided to the licensed staff on physician orders not being transcribed accurately in the residents MAR or not being transcribed at all. She did not respond. When asked if there was any other information that she had on training her nursing staff she stated " We were going to bring it into our QA meeting on Tuesday "	F 490		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2811 CAMPUS HILL DR TAMPA, FL 33612

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F 490	Continued From page 104 The DON and NHA on at 3:30 p.m. confirmed that they were aware of Resident #2 ' s medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of Resident #2 ' s medication error on however, no negative outcomes occurred. It was unclear, due to the lack of the investigation, of how and why the medication error was found. On the DON stated, She " checks the MARs two times a week by flipping through all of the MARs. " She confirmed there was no documentation related to this process. The DON said that the ADON and Unit Manger check every MAR daily for accuracy and completeness. 4) The facility admitted Resident #10 on with diagnoses including Accident and per the physician order summary list of diagnoses. Review of the Admission Physician Orders dated , revealed the resident was prescribed 40 unit daily at 9 a.m. Review of the Medication Administration Record revealed Resident #10 did not receive on 4/9 or There was no documentation on the back side of the MAR as to why the medication was omitted. Review of the Care Plan, dated revealed a problem area was identified for " potential for abnormal " The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information was provided related to why the medication would not have been given to Resident #10. 5) The facility admitted Resident #14 on	F 490		

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F 490	Continued From page 105 with diagnoses including Acute and , per the demographic face sheet. Review of the medical record revealed Resident #14 was transferred to a Hospice House for end of life care. Further review of the medical record revealed a physician ' s telephone order dated , for 30 units twice daily. The resident was placed on due to sub-therapeutic INR (International Normalizing Ratio) levels and she was at risk for developing additional clots. Review of the Laboratory results revealed on , Resident #14s INR was 1.1. On , the was discontinued. The resident remained sub-therapeutic and the physician was attempting to adjust her . Review of the Medication Administration Record for 2015 revealed Resident #14 did not receive for 4 out of the 6 available doses. She did not receive any on . The resident did not receive on at 9 a.m., at 9 a.m., or at 9 a.m. There was no documentation in the nurses ' notes or the back of the Medication Administration Record as to why the medication was not given. On the resident was noted to have redness and to her right leg. An was ordered and the resident was diagnosed with a Deep . Review of the Care Plan, dated , revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " During an interview on at 2:30 pm, the	F 490		

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F 490	Continued From page 106 Nurse Consultant confirmed the missed doses of . He stated that the medication should have been available from pharmacy and was unable to determine why the nurses would not have given the medication. He stated that at least one dose of the should have been given on 6) The facility admitted Resident #15 on with diagnoses including and per the demographic face sheet. Review of the 2015 Physician Orders revealed Resident #15 was prescribed 40 unit daily for two weeks. Review of the Medication Administration Record for 2015 revealed Resident #15 did not receive her on and Review of the Care Plan, dated revealed a problem area was identified for " , potential for abnormal ." The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11:00 a.m. No additional information as provided related to why the medication would not have been given to Resident #15. 7) The facility admitted Resident #16 on with diagnoses including and per the physician diagnoses listed on the Medication Administration Record. Review of the Physician ' s Orders revealed, on , Resident #16 was prescribed " 60 units every 12 hours, D/C (discontinue) when INR (international normalizing ratio) above 2. " Review of the Laboratory Data revealed an INR	F 490		

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F 490	Continued From page 107 was collected on that was 2.5. Review of the Medication Administration Record for 2015 revealed Resident #16 was given on , and . He received four doses of after the medication should have been discontinued per the INR value of 2.5. Further review of the Laboratory Data revealed an INR was collected on and the resident was erapeutic at 3.9. Record review revealed no indication of abnormal was noted. Review of the Care Plan, dated , revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the resident received the when the medication should have been discontinued. 8) The facility admitted Resident #17 on with diagnoses including Accident and per the demographic face sheet. Review of the Physician ' s Orders for 2015 revealed the resident was prescribed 3 mg PO daily at 5 pm. Review of the 2015 Medication Administration Record revealed Resident #17 did not receive the prescribed for 5 doses; 4/7, 4/10, and . There was no documentation in the nurses ' notes or on the back of the MAR as to why the medication was omitted. Review of the Care Plan, dated revealed a problem area was identified for "	F 490		

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F 490	Continued From page 108 , potential for abnormal " The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the medication would not have been given to Resident #17. 9) The facility admitted Resident #18 on and was readmitted on with diagnoses including Chest Pain and Review of the Physician ' s Orders, dated , revealed Resident #18 was prescribed 8.5 mg daily at 9 pm. Review of the 2015 Medication Administration Record revealed Resident #18 did not receive his on 4/2, , or There was no documentation on the back side of the MAR as to why the medication was not given. Review of the Care Plan, dated , revealed a problem area was identified for " : potential for abnormal " The approaches included " administer as MD ordered. " During an interview with Resident #18 on at 3:20 p.m., he stated that there have been occasions where he did not receive all of his ordered mediations from the nurse. He stated that he now has to check all his medications for accuracy. He stated that when he brought it to the nurse ' s attention when he did not receive his medications, they told him that they were either out of the medication or they would go back and bring him his ordered medication. He stated that he used to have a medication book on his bedside table that he would utilize to check his	F 490		

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F 490	Continued From page 109 medications but that the medications are changed from the manufacturers or the pharmacy so often now that it is obsolete. The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the medication would not have been given to Resident #18. 10) Resident #19 was admitted to the facility in 2015. Her admitting diagnoses included , and . Resident #19 was identified and listed on " Current active orders for : " that was provided by the facility. The physician orders were reviewed with an order, dated to administer Pradaxa 150 mg capsule one capsule by mouth two times daily for a diagnosis of . The MAR was reviewed for 2015 and it was identified Resident # 19 had missed four doses of Pradaxa on at 5:00 p.m., at 5:00 p.m., at 9:00 a.m. and again at 5:00 p.m. The nursing notes revealed, for the days the medication had been omitted, indicated there was neither documentation nor notification to the physician on why a prescribed medication was not administered as ordered. Review of Resident #19 ' s Care plan identified Focus on Anticoagulation has a potential for abnormal . The date Initiated was . The goal was, will be free from signs and symptoms of abnormal . Interventions included: Administer as MD ordered. The Care Plan was not followed. 11) Resident #20 was admitted to the facility on with a history of recent	F 490		

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F 490	Continued From page 110 for of right with according to demographic information. Review of resident physician orders, dated , revealed she was to receive 40 mg every 12 hours for preventative measures. The MAR was reviewed for 2015 and it revealed seven separate missing initials or circles around initials indicating the medication was not administered as ordered. On at 9:00 p.m., the box on the MAR was without an initial, 9:00 a.m., the box was initialed with a circle, at 9:00 a.m., the box was initialed with a circle, at 9:00 p.m., the box MAR was without an initial, at 9:00 p.m. no initialed as given, and, on at 9:00 am., the box was initialed with a circle. The back of the MAR nursing notes for at 9:00 p.m. indicated that the was not available to give. A second nursing note for at 9:00 a.m. indicated that the pharmacy was notified. 12) A Medical record review was conducted on Resident #2's admission orders dated on . The admission orders indicated he was to receive 40 mg by mouth one time daily and 15 units in the morning and 5 units at night time. Resident #2 did not receive his from Resident #2 did not receive his scheduled morning dosage from and the night time dosage from . The MAR revealed orders dated to start 40 mg one time daily and 15 units in the morning and 5 units at night time, hold if BS is less than 110. Resident #2's nursing notes were reviewed for	F 490		

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F 490	Continued From page 111 at 3:16 p.m. which reflected, "There was a med error for patient in patient , patient and was never given patient was supposed to be on daily weight not done. Physician has been paged. Waiting for call back " . The nursing notes for at 1:54 a.m. " New order for INR ordered for the AM for the dosage error." On at 11:45 a.m. a telephone interview was conducted with Resident #2 ' s attending physician. The attending physician also confirmed that he was notified that resident did not receive his ordered for ten days after being admitted and he did not receive his for ten days after being admitted to the facility. The attending physician was asked if a resident had a diagnosis of being does that mean he needs monitoring. The attending physician stated " yes, he needs his sugars monitored he could have went into or and worse yet into " The physician stated " they need to fix it, I don ' t know if it ' s the DON or the corporation they have to fix these things so it doesn ' t happen again. " 13) The facility admitted Resident #8 on with diagnoses including s Hip and Review of the Physician Telephone Orders dated revealed the physician ordered a Urinalysis with Culture and Sensitivity and also ordered 500 mg every 8 hours for 7 days for a Review of the Laboratory Data revealed Resident #8 did not have a Urinalysis collected. Review of the and 2015 Medication Administration Records revealed Resident #8 ' s was not started until (a three	F 490		

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F 490	Continued From page 112 day delay in initiating the physician ' s order). Further review of the MAR revealed the 6 am dose was given on ; however, the 2 pm and 10 pm doses were omitted. During an interview on at 2 p.m., the Nurse Consultant stated that the Urinalysis had not been collected. He stated that he was unsure why the nurses would not have gotten the sample. He also stated that the 6 am dose of on was taken from the Emergency Drug Kit. He confirmed the 2 pm and 10 pm doses were not given. The Nurse Consultant also confirmed there was no documentation related to why the urinalysis was not collected, why the medication not initiated for 3 days or why the resident missed two doses of her 14) During an interview on at 11:10 a.m., a Credible Allegation of Compliance was received related to The plan included the following: An audit was completed of all residents. Physician orders, labs, notification of the physician if there was a change and the Log was accurate. No significant issues were found. NRs were updated. A 100% house audit was completed of all resident medications and orders on Nursing education was completed between for nursing staff related to managing residents on flow sheets and medication documentation. Three nurses that work as needed (PRN) have not been provided education and will not be allowed to work until educated. Agency nurses will be provided a packet that includes Managing Residents on Anticoagulation The packet will include the Anticoagulation Policy and the facility ' s new	F 490		

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F 490	Continued From page 113 protocol on documenting medications that are on " Hold. " All new admissions will be reviewed in the morning meeting to assure all orders will be transcribed onto the POS and MAR/TAR. The weekend supervisor is responsible for new admissions on the weekends (not a new process). All residents that are receiving will be reviewed in a weekly care meeting with all orders, labs, and MARs reviewed. New anti-co orders were added under the daily clinical meeting and medications were added to the weekly care meeting. Looking to assure that the medication is transcribed, the flow sheet if needed, medication on hand, transcribed onto MAR and that the medication is being administered. The Flow Sheet will be implemented for any resident receiving For residents that have Hold Orders: The order will be blocked off and yellowed out. A new order will be re-written with a restart date. The new process will be visible to the nurses. The hold medication will be added on the 24 hour report. Medication Errors will be investigated and documented following Risk Management standards and Root Cause Analysis. Evidence of investigation will be kept. Based on the analysis, the policies, practices and systems, changes will occur as needed. A new shift to shift MAR review with each nurse was also implemented. The nurses, together, will review the entire MAR/TAR for holes and for accuracy. If the nurse is sure that she administered the medications, then she can initial, if she was unsure then it would be classified as a medication error. Nursing Administration would be responsible for	F 490		

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F 490	Continued From page 114 daily checks of the nurse to nurse MAR review. Nursing Administration will also initial for accuracy. The audits will be reviewed daily by the DON. All lab results will be reviewed in the daily Clinical Meeting. All INRs will be reviewed in the morning clinical meeting and checked against the orders and MAR. The Medical Director had been informed and had approved the action plan as of	F 490		
F 501 SS=K	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on a review of the facility ' s Medical Director Service Agreement , interviews with the facility staff, the Attending Physician, facility Administration, and the facility ' s policy and procedures on medication administration, the Medical Director failed to assure resident care policies were implemented related to medication administration. Based on a review of all current residents receiving , ten of thirty residents did not receive their per the physician ' s orders. Residents ' #2, #6, #10, #14, #15, #16, #17, #18, #19 and #20 were identified as not receiving that were necessary to prevent clots or Resident #6 was not administered for	F 501	1. The Medical Director was informed of all of the medication errors that occurred He was informed that Medication Error reports were being completed on Resident' #2, #6. #8, #10, #14, #15, #16, #17, #18, #19 and #20 and that their perspective physicians were being notified of the errors. 2. A full facility review was completed on to assure that all medication orders were current and transcribed on the medication administration records. No medication errors were identified during this review. 3. The Medical Director participated in educational training regarding the QAPI process on The Medical Director will review all medication error reports and sign that they have been reviewed. He/she will attend the QAPI meetings as scheduled. He/she will provide feedback to the committee of any identified areas concerns for progression through the QAPI process. The Medical Director reviewed all related policy and procedures and assisted in the update and revision of those policies. The Medical Director will continue to be an active participant in the over site of the care and services provided to this resident population. 4. The Medical Director will monitor the delivery of care and services provided at the facility by ongoing participation in the QAPI Program and feedback form the QAPI Committee on a monthly basis.	

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F 501	Continued From page 115 twenty six days. The medication was placed on hold for three days for a dental procedure. The facility staff failed to implement the order and resume the medication on , 2015. Resident #6 reported pain to the nursing staff and reported that the pain was consistent with a . The physician was notified on and ordered the necessary tests. The facility failed to implement those orders for three days, delaying treatment to the resident until . Resident #6 required injections of to dissolve the clot. Resident #2 was administered a double dose of on 4/8, 9, 12, 13, 14 and . His INR was erapeutic on at 3.2. Resident #10 was not administered her prescribed on 4/9 and . Resident #14 was not administered four of six available doses of . Resident #15 was not administered her on and on . Resident #16 ' s was to be discontinued when the International Normalizing Ratio (INR) was greater than 2. On , the laboratory results indicated that her INR was 2.5 and the was continued for four additional doses. Resident #17 was not administered five doses of on 3/7, 10, 13, 15, . Resident #18 was not administered four doses of on 4/2, 11, 13 and . Resident #19 missed four doses of Pradaxa from . Resident #20 was not administered seven doses of from . The facility ' s Licensed Nursing staff failed to administer medications in accordance with physician ' s orders. The failure of the nurses to administer resulted in significant medication errors that subsequently caused Resident #6 to develop an avoidable clot	F 501		

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F 501	Continued From page 116 Based on record review and interview, the facility ' s Medical Director failed to assure policies and procedures related to medication administration were followed in two (#2, #8) out of forty-eight (48) residents reviewed for medication accuracy. Resident #2 ' s physician ordered .... and .... that were omitted for 10 days. There was a three day delay in starting a physician ordered .... for Resident #8 and two doses were admitted. The facility ' s Medical Director failed to assure medication administration policies and procedures were implemented. The facility ' s medical director also failed to assure policies and procedures were implemented to systematically identify, investigate and report medication errors. The failure of the Medical Director facility resulted in the findings of Immediate Jeopardy existing in the facility as of .... The facility Administration was informed on .... at 9:50 a.m. The Immediate Jeopardy was removed on ..... at 5:30 p.m. and the scope and severity was reduced to a " E. " Findings include: 1. Review of the Medical Director Services Exhibit A; (1) " Assume the administrative authority, responsibility, and accountability of implementing Facility ' s medical services, policies and procedures. (2) Coordinate medical care, maintain effective liaison with attending physicians and implement methods to keep the quality of care under constant monitoring. (3) Participate in the development of written policies, rules, and regulations to govern the nursing care and related medical and other health services provided. Medical Director is responsible for seeing that these policies reflect an awareness of	F 501		

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F 501	Continued From page 117 and have provisions for meeting the total needs of the residents. (4) Ensure that Facility ' s resident ' s receive adequate services appropriate to their needs. " Review of the facility policy entitled " Medication Administration General Guidelines for the Administration of Medications " policy 6.2 (page one of three) (not dated) was reviewed and it was expected that the nurses administer medications per the physician ' s orders. During an interview on at 2:45 p.m., the Medical Director stated that he had been the Medical Director of the facility since 2012. He stated that he participated in the QA monthly meetings and the facility followed a set agenda. He stated that he was made aware of incidents for his patients and that the attending physician for the other residents would be notified of incidents. He stated that he would expect to be notified of incidents, including medication errors, specifically, for system failures that could affect all residents. He stated that he was here at the facility every Wednesday and Friday. However, someone from his physician group was present daily and should be notified. He expected that the nurses notify the physician of any incident. He confirmed again that he was not made aware of any medication errors for Resident #6. He was not aware of any issues in QA related to medication administration. He stated that he was aware that the facility used a lot of agency staff and had a lot of turnover. The Medical Director stated that there was no action plan identified or implemented related to staffing or staff procedures. He also stated that he was aware of a concern with nurses not implementing physician orders timely. He stated that the nurse would pass off the order to the oncoming shifts and the medication would not be started. He stated that	F 501		

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F 501	Continued From page 118 he provided education to the staff " within the year " related to medication implementation. The education was to have a second nurse initial the order to assure implementation. He confirmed that there was nothing in Quality Assurance (QA) related to the medication administration and order implementation process. The Medical Director stated that if the facility had a good system in place, then any staff member should be able to come in and care for the resident with no breaks in the system. He stated that the " system was not perfect and should not have failed. " The Medical Director was asked if it was expected that the facility notify him of negative outcomes; he stated, " I would love to. " When referring to the incident for Resident #6, the Medical Director stated that it was a " negative outcome and that he was afraid for his patients. " He stated that " there was not a plan in place. " 2. During an interview on at 10:15 a.m., the Administrator stated that she was informed of Resident #6 ' s medication error on 2015. She was informed that the Unit Manager had educated the staff involved. The DON informed her that she was assembling her investigation and would bring the information to the next QA meeting on . The QA meeting was initially scheduled on and it was delayed due to a trial. The Nursing Home Administrator (NHA) said usually the QA is scheduled every third Tuesday of the month. The facility had done Ad Hoc meetings in the past but the DON wanted to make sure everything was done before hand and an Ad Hoc meeting was not scheduled. The DON informed her that the physician had been notified. The DON also, informed her that the facility was still working the concern. The Administrator stated that she was aware the process was in	F 501		

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F 501	Continued From page 119 place. The four point process was not completed and had not been presented. 3. An interview was conducted with the facility ' s Director of Nursing (DON), on , at 3:00 p.m. A list of medication errors for the month of 2015 was provided by the DON. The DON stated that she was aware of the medication error for Resident #6. She stated that a nurse found the error after performing a " medication review. " The DON stated that she was unsure of why the error occurred. She stated that the facility ' s intervention was the and the physician and the resident were notified of the error. The DON confirmed that no audits or education was provided to the staff following the medication error. The DON also confirmed that there was no evidence of an investigation. The DON stated that her conclusion of the omitted medication for Resident #6 was " we performed an , and started giving her injections and elevated her left leg. " During an interview with the DON at approximately 2:30 p.m., she was unable to present any information regarding her investigation, education or audits. No formal action plan had been put in place as of the time of the start of the survey on On at 9:50 a.m. the Nursing Home Administrator, DON and the facility ' s corporate nurse confirmed that an in service was not conducted related to Resident #6 ' s omissions of her scheduled medications. The DON and NHA ON at 3:30 p.m. confirmed that they were aware of Resident #6 ' s medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of the medication errors for Resident #6 only after the	F 501		

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F 501	Continued From page 120 Doppler confirmed the positive . It was unclear, due to the lack of the investigation, of how and why the medication error was found. During an interview on , at 3:30 p.m., the DON stated " she checks the MARs two times a week by flipping through all of the MARs. " She confirmed there was no documentation related to this process. The DON said that the ADON and Unit manger check every MAR daily for accuracy and completeness. During an interview on at 8:50 a.m., The Assistant Director of Nurses stated that she randomly checked the MARs on a daily basis for accuracy and completeness. She stated that she checked new admissions and " maybe two others. " She stated that the Unit Manager was responsible for checking at least five residents on each cart on a daily basis. The ADON stated that there was not a definite system of checking the MARs. 4. An interview was conducted on at 9:30 a.m., Employee (LPN) A Interim Unit Manager (started on Monday She stated that she checked all new admissions for accuracy of orders and double checks with the MAR for accuracy. She stated that she did not do anything with the MARs on a daily basis. No one informed her she was supposed to be checking the MARs. She stated that she gets the new orders and the 24 hour report in the morning and then gives them to the ADON or DON to take them to the morning meeting. She did not usually go to the morning meetings and was not aware of any plan to begin to go. She stated that no education or training was provided to be a Unit Manager. The ADON told her the things that needed to be done and she was " just helping them out not doing the whole position. "	F 501		

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F 501	Continued From page 121 5. The regular Unit Manager (LPN) B, on the Long Term Care unit was currently on medical leave and was unable to be contacted. 6. During an interview on at 10:13 a.m. and at 10:43 a.m., The DON stated that the process of checking the MARs was an informal process that is implemented inconsistently and the ADON and Unit Manager assist with the process. There was not a written policy or procedure. The DON stated that she had been in the role of DON for one year and the process of checking the MARs had been an expectation since her arrival and she had continued that process since then. The DON also stated on at 10:43 am that she was unaware the ADON and Unit Managers were not checking MARs daily. 7. During an interview on at 10:30 a.m. Resident #6 stated she was diagnosed with a She said it was not just a it was an extensive . The resident stated that " the doctor said it was from my knee to my foot and I think there was more than one " The resident was asked if the nurse had spoken to her about her . She said, " No, the doctor told me the nurses were not giving me my medication, he was really pissed. " They (the nurses) had to give me two times a day for five days and I hate needles. " Resident #6 said that when she first had come to the facility she had a in her left arm and, " that is why I take the every day. " The resident stated that she used to check her medications every day and now has to start checking them again. " It ' s not my job to have to ask if all my medications are there or not is it? " During a telephone interview on at 11:42 a.m., Resident #6 ' s attending physician	F 501		

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F 501	Continued From page 122 stated; " the nurses did not give her medication . The medication was only on hold for a few days for her dental surgery. " The physician was asked why the medication Xarleto was not restarted after her dental surgery. The physician stated he did not understand why the nurses did not restart the medication. " I gave the nurses the order they should have restarted the after the dental procedure was completed. The is to prevent her from getting a , if she would have received the medication she would not have gotten a " During an interview on at 12:20 p.m., the attending Physician confirmed he assessed the resident on and documented the resident ' s leg was red and He also ordered a Doppler study. The physician stated that he was informed by Employee (LPN) A of the leg and the lack of the on He verbally gave the order to Employee A. The attending physician confirmed the Doppler order was not completed until and also confirmed that no medication was started until He was unsure of why there would have been a delay in obtaining treatment, necessary tests or initiating the medication. Further review of the physician orders dated on " Stop x 3 days prior to and resume one day post p.m. " The order did not contain a nursing signature. The next order that was written; Clarification 15 mg orally every HS- (this order was not dated). A hand written telephone order, dated reflected Doppler STAT and a third order dated for the same day 80 MG SQ ((two times) for 5 days.	F 501		

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F 501	Continued From page 123 Review of the Medication Administration Record, dated 2015, revealed a typed order dated 15 MG tablet one tablet by mouth once a day. Directly underneath the typed order, a hand written entry stated resume . The Medication Administration Record (MAR) revealed the nurses documented for , and " HOLD. " The MAR for , when the was to be restarted was reviewed. The boxes, where an initial should have been written, were empty (indicating the dose was not administered). The remainder of the MAR from through was reviewed with no indication that the medication had been given and no indication as to why the medication was not given. The medical record in Resident #6 ' s chart contained a Progress note/Monthly Evaluation " dated: Listed under current complaints was " Redness and left leg. " Documented (under extremities) was 4+ L > left leg (new finding). The Resident had been " Off 15 MG for 3 weeks by nurse ' s error. " Further review of the attending physician ' s progress note indicated that Resident #6 had a Recurrent to her left leg that was new and had worsened. Hand written next to the word worsened " Doppler was ordered. " A review of the Physician ' s Progress Notes revealed on , the Attending Physician assessed Resident #6 and diagnosed her with an acute . The physician documented: " Redness and left leg, 4+ L > left leg. " The physician also documented that the resident had been " Off 15 MG for 3 weeks by nurse ' s error. " Further review of the Attending Physician ' s progress note revealed he documented " Doppler was ordered. "	F 501		

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F 501	Continued From page 124 There was no corresponding physician ' s order for the Doppler Studies until , three days after the physician assessed the resident. Further review of Resident #6 ' s medical record revealed that she had resided in the facility for approximately fifteen months and was fifty three years old. Resident #6 ' s medical history included and a history of On , a revealed a Score of 15 indicating no Review of the Nurses ' Notes on revealed no documentation of a red, leg. There was no documentation of the omission of the medication, the physician visit or the new orders. On , employee (LPN) A documented: the resident complained of pain and redness to her leg, upon assessment the leg was warm to touch and was Painful, 2+ pitting. The doctor was paged and made aware and stated he saw her on Saturday. New orders for were obtained. On at 3:25 a.m. the nurse documented at " 12:45 a.m. patient states she thinks she has a to her LLE. Area of slight redness noted to inner calf to LLE, to LE. Skin temp within normal limits. refill is brisk . Unable to assess pulse related to Patient rates pain level #1 at this time on a scale of 1-10 with 10 being the worst. Patient states she has had multiple in the past and knows what it feels like. Notified resident physicians of above and new orders were received for a STAT Doppler of the LLE to rule out . At 0200 (2:00 a.m.) 100mg was administered for c/o pain to LLE with a pain level of 9 out of 10. was effective. At 0330 (3:30 a.m.), the mobile service arrived to perform Doppler. Patient remained on bed rest.	F 501		

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F 501	Continued From page 125 Patient remained alert and responding appropriately to verbal and stimuli. No s/s of distress noted. Vitals Patient received new order on to restart " was not discontinued. " A review of the Ultra Sound Report, date of service: revealed: Examination: Doppler extremity/limb, left. Clinical Indications: of Limb, Findings: Real time color imaging shows no collateral and augmentation of post popliteal deep and common of left leg. There are no excessive collateral veins. Left lower Extremity duplex Impression: Extensive seen. The MAR indicated that six nurses, assigned on the 3-11 p.m. shift, failed to administer the as ordered by the attending physician. During an interview on at 4:10 p.m. Employee (RN) E, a nurse that cared for the resident on 12 of the 26 evening shifts, stated that she had been a nurse for a long time and worked in long term care. She stated that she was familiar with Resident #6. She stated that she was aware the resident needed . The medication was not administered. She stated that she did not think the order was on going. She stated that it was on hold. She stated that she did not have the time to research the order and was aware that Resident #6 was at high risk for . She stated that she questioned the medication to other staff; however, she did not recall who the staff member was. She stated that the doctor came in and then realized the medication should have been resumed. The nurse stated that when a medication was held, the nurse should write hold on the days that the medication is to be held and then indicate when	F 501		

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F 501	Continued From page 126 the medication should be resumed. The nurse confirmed the MAR and confirmed that there was no indication the medication had been given. She stated that she did not recall the resume date. The nurse stated that " my philosophy is if I don ' t see the medication and don ' t see a stop order, then I question with another nurse as to whether the medication is on hold or should be discontinued. " She stated that she would call the pharmacy. She stated that the medication card was not in the cart. The nurse also confirmed that she did not document any omissions in the chart. She stated that she did not look at the chart to find the original order. An interview was conducted on at 4:30 p.m. with past Employee (LPN) D. She stated that she worked at the facility When asked about her training she stated she had trained for two to 3 days and was on her own by the fourth day. She said she had felt that it was " " on her orientation process as far as knowing the processes and was able to always go back and ask questions. Employee (LPN) D, stated that she recalled caring for Resident #6. She confirmed that she was on and stated that she cared for her several times. The staff member was asked and visually confirmed the MAR and confirmed that she worked on and . The nurse next confirmed the order for and then confirmed the order said to resume . The nurse stated that she would not have given a medication without signing the MAR. These dates were blank, with no initials. A review was conducted of the Pharmacy Dispensing Record for Resident #6 ' s from 1-A 2015. The pharmacy sent 14 pills at a time. Review of the Dispensing Log	F 501		

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F 501	Continued From page 127 revealed the facility last received 14 pills on . All of the medication would have been administered by . Therefore, there was no available for administration. The medication was not a routinely stocked medication in the Emergency Drug Kit. Review of the Drug Manufacturer ' s Pharmaceutical Medication Guide for revealed; " is a prescription medicine used to treat and , and to help reduce the risk of these conditions occurring again. lowers your chance of having a by helping to prevent clots from forming. If you stop taking you may have increased risk of forming a clot in your . Do not stop taking without talking to the doctor who prescribes it for you. Stopping increases your risk of having a . If you have to stop taking , your doctor may prescribe another medicine to prevent a clot from forming. Do not stop taking without talking to your doctor first. Your doctor may stop for a short time before any surgery, medical or dental procedure. Your doctor will tell you when to start taking again after your surgery or procedure. " Review of Resident #6 ' s Care plan Focus on Anticoagulation reflected the resident had a " potential for abnormal . " Date Initiated; updated: . Goal will be free from signs and symptoms of abnormal . Interventions: Administer as MD ordered. " The Care Plan was not followed. 8. During an interview on at 3:45 p.m. the facility ' s Director of Nursing (DON) stated: " we have had another problem with an	F 501		

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F 501	Continued From page 128 It happened to Resident #2. " The DON said that when Resident #2 was admitted on and the nurse had written up the physician orders on one of our order sheets, the was written on a regular sheet that did not have a copy that is used for the medication administration record. We (DON and ADON) did not find out about the medication not being given until The DON was asked what the process was on checking admission orders for their accuracy she said that usually the unit manager will check the orders the next morning and then added the unit manager was out on maternity leave. The DON was asked who would be responsible to verify the physician ordered medications were accurately transcribed into the Medication Administration Record (MAR), she said the ADON or me. The DON said, " We checked the physician order sheet and they were written correctly but because the order was not put on the physician order sheet that contained a copy it did not show up on the MAR. " The DON confirmed she did not review the MAR to make sure all the physician orders were transcribed. The DON was asked how that had happened and stated; " I ' m still trying to figure out how it happened and then I do find it out it has unfortunately already occurred. " When asked if the facility used a check off system for newly admitted residents she said, " we used to but now it is computerized. The computer tells us what to do. " She stated she was there the day of the verbal teaching but she did not sign the in-service verifying that she had attended. A medical record review was conducted for Resident #2 and revealed he had resided in the facility for approximately three weeks. His diagnoses included: Dependent	F 501		

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F 501	Continued From page 129 and Review of resident #2's admission orders were to give 4 mg by mouth on Sunday, Tuesday, Wednesday, Thursday and Saturday and to administer 2 mg on Monday and Friday. The MAR indicated that on; 4/8, 4/9, , , , and on both orders were initialed/signed as being administered resulting in a total of 6 mg of . On the order was discontinued and rewritten to give 4 mg by mouth on Sunday, Tuesday, Wednesday, Thursday and Saturday and to administer 2 mg on Monday and Friday. (The same identical order, this time the initial boxes were outlined indicating which day of the week the medication needed to be given). A Medical record review of admission orders indicated that Resident #2 ' s admission orders for indicated he was to receive 40 mg by mouth one time daily. The MAR did not reflect this order until (ten days after he was admitted). The facility failed to administer 15 units in the morning and 5 units at night time until , ten days after being admitted to the facility. This order was also missed on admission. The facility also failed to ensure Resident #2, with a diagnosis of , had glucose levels monitored as ordered and he was not administered sliding scale of until , again, ten days after he had been admitted to the facility. On at 11:45 a.m. a telephone interview was conducted with Resident #2 ' s attending physician. He confirmed he was notified that the resident had been receiving double doses of his and confirmed that his International	F 501		

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F 501	Continued From page 130 Ratio was 3.2 and not critical erapeutic). The physician confirmed the facility did not follow his orders and should have administered the proper dosages of on the proper days as ordered. The attending physician also confirmed that he was notified that resident did not receive his ordered for eleven days after being admitted and he did not receive his for eleven days after being admitted to the facility. The attending physician was asked if a resident had a diagnosis of being does that mean he needs monitoring? The attending physician stated " yes, he needs his sugars monitored, he could have went into or and worse yet into ." The physician stated " they need to fix it, I don ' t know if it ' s the DON or the corporation they have to fix these things so it doesn ' t happen again. " The DON provided a copy of an in-service that was conducted on (three days after the medication omission was found) Teaching Method: Verbal Topic: and Protocol. Make sure INR is done, Call MD with results before giving medication, check orders daily and make sure log is accurate. The DON was asked about any in-servicing that was provided to the licensed staff on physician orders not being transcribed accurately in the residents MAR or not being transcribed at all, she did not respond. The DON was asked if the nurse that had not transcribed the and in Resident #2 ' s MAR had attended the in-service that she had on . The DON stated, " The nurse was there but she did not sign on the sign in sheet. " When asked if there was any other information that she had on training her nursing staff she	F 501		

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F 501	Continued From page 131 stated, " We were going to bring it into our QA meeting on Tuesday " On the DON and NHA confirmed that they were aware of Resident #2's medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of Resident #2 ' s medication error on however, no negative outcomes occurred. It was unclear due to the lack of the investigation of how and why the medication error was found. On , the DON stated she " checks the MARs two times a week by flipping through all of the MARs. " She confirmed there was no documentation related to this process. The DON said that the ADON and Unit manger check every MAR daily for accuracy and completeness. 9. The facility admitted Resident #10 on with diagnoses including Accident and per the physician order summary list of diagnoses. Review of the Admission Physician Orders, dated , revealed the resident was prescribed 40 unit daily at 9 a.m. Review of the Medication Administration Record revealed Resident #10 did not receive on 4/9 or . There was no documentation on the back side of the MAR as to why the medication was omitted. Review of the Care Plan, dated , revealed a problem area was identified for " potential for abnormal . " The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information was provided related to why the medication would	F 501		

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F 501	Continued From page 132 not have been given to Resident #10. 10. The facility admitted Resident #14 on with diagnoses including Acute and per the demographic face sheet. Review of the medical record revealed Resident #14 was transferred to a Hospice House for end of life care. Further review of the medical record revealed a physician ' s telephone order, dated for 30 units twice daily. The resident was placed on due to sub-therapeutic INR (International Normalizing Ratio) levels and she was at risk for developing additional clots. Review of the Laboratory results revealed, on Resident #8 ' s INR was 1.1. On , the was discontinued. The resident remained sub-therapeutic and the physician was attempting to adjust her 11. Review of the Medication Administration Record for 2015 revealed Resident #14 did not receive for 4 out of the 6 available doses. She did not receive any on . The resident did not receive on at 9 a.m., at 9 a.m. or at 9 a.m. There was no documentation in the nurses ' notes or the back of the Medication Administration Record as to why the medication was not given. On the resident was noted to have redness and to her right leg. An was ordered and the resident was diagnosed with a Review of the Care Plan, dated revealed a problem area was identified for " , potential for abnormal " The approaches included " administer	F 501		

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F 501	Continued From page 133 as MD ordered. " During an interview on at 2:30 pm, the Nurse Consultant confirmed the missed doses of He stated that the medication should have been available from pharmacy and was unable to determine why the nurses would not have given the medication. He stated that at least one dose of the should have been given on 12. The facility admitted Resident #15 on with diagnoses including and per the demographic face sheet. Review of the 2015 Physician Orders revealed Resident #15 was prescribed 40 unit daily for two weeks. Review of the Medication Administration Record for 2015 revealed Resident #15 did not receive her on and Review of the Care Plan, dated revealed a problem area was identified for " , potential for abnormal . " The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11:00 a.m. No additional information as provided related to why the medication would not have been given to Resident #15. 13. The facility admitted Resident #16 on with diagnoses including and per the physician diagnoses listed on the Medication Administration Record. Review of the Physician ' s Orders revealed on Resident #16 was prescribed " 60 units every 12 hours, D/C (discontinue) when	F 501		

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F 501	Continued From page 134 INR (international normalizing ratio) above 2. " Review of the Laboratory Data revealed an INR was collected on that was 2.5. Review of the Medication Administration Record for 2015 revealed Resident #16 was given on , and . He received four doses of after the medication should have been discontinued per the INR value of 2.5. Further review of the Laboratory Data revealed an INR was collected on and the resident was erapeutic at 3.9. Record review revealed no indication of abnormal was noted. Review of the Care Plan, dated , revealed a problem area was identified for " : , potential for abnormal ." The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information was provided related to why the resident received the when the medication should have been discontinued. 14. The facility admitted Resident #17 on with diagnoses including Accident and per the demographic face sheet. Review of the Physician ' s Orders for 2015 revealed the resident was prescribed 3 mg PO daily at 5 pm. Review of the 2015 Medication Administration Record revealed Resident #17 did not receive the prescribed for 5 doses; 4/7, , and . There was no documentation in the nurses ' notes or on the back of the MAR as to why the medication was omitted.	F 501		

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F 501	Continued From page 135 Review of the Care Plan, dated revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the medication would not have been given to Resident #17. 15. The facility admitted Resident #18 on and the resident was readmitted on with diagnoses including Chest Pain and Review of the Physician ' s Orders, dated revealed Resident #18 was prescribed 8.5 mg daily at 9 p.m. Review of the 2015 Medication Administration Record revealed Resident #18 did not receive his on 4/2, or . There was no documentation on the back side of the MAR as to why the medication was not given. Review of the Care Plan, dated revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " During an interview with Resident #18 on at 3:20 p.m. he stated that there had been occasions where he did not receive all of his ordered mediations from the nurse. He stated that he now had to check all his medications for accuracy. He stated that when he brought it to the nurse ' s attention when he did not receive his medications, they told him that they were either out of the medication or they would go back and bring him his ordered medication. He stated that	F 501		

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F 501	Continued From page 136 he used to have a medication book on his bedside table that he would utilize to check his medications but that the medications are changed from the manufacturers or the pharmacy so often now that it is obsolete. The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 a.m. No additional information as provided related to why the medication would not have been given to Resident #18. 16. Resident #19 was admitted to the facility in 2015 with admitting diagnoses of and Resident #19 was identified and listed on " Current active orders for " that was provided by the facility. The physician orders were reviewed with an order, dated , to administer Pradaxa 150 mg capsule one capsule by mouth two times daily for a diagnosis of The MAR was reviewed for 2015 and it identified that Resident # 19 had missed four doses of Pradaxa on at 5:00 p.m., at 5:00 p.m., at 9:00 a.m. and, again, at 5:00 p.m. The nursing notes revealed that for the days the medication had been omitted, there was neither documentation nor notification to the physician on why a prescribed medication was not administered as ordered. Review of Resident #19 ' s Care plan Focus on Anticoagulation . has a potential for abnormal . Date Initiated; Goal " will be free from signs and symptoms of abnormal . " Interventions: Administer as MD ordered. The Care Plan was not followed. 17. Resident #20 was admitted to the facility on	F 501		

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F 501	Continued From page 137 with a history of recent for of right with Review of resident physician orders, dated . determined the resident was to receive 40 mg every 12 hours for preventative measures. The MAR was reviewed for 2015 and it revealed seven separate missing initials or circles around initials indicating the medication was not administered as ordered. On at 9:00 p.m., the box on the MAR was without an initial, 9:00 a.m. the box was initialed with a circle, at 9:00 a.m., the box was initialed with a circle, at 9:00 p.m., the box MAR was without an initial, at 9:00 p.m., not initialed as given, and, on at 9:00 a.m., the box was initialed with a circle. The back of the MAR nursing notes for at 9:00 p.m. indicated that the was not available to give. A second nursing note for at 9:00 a.m. indicated that the pharmacy was notified. 18. The facility admitted Resident #8 on with diagnoses including Hip and , per the demographic information in the record. Review of the Physician Telephone Orders, dated , revealed the physician ordered a Urinalysis with Culture and Sensitivity and also ordered 500 mg every 8 hours for 7 days for a Review of the Laboratory Data revealed Resident #8 did not have a Urinalysis collected. Review of the and 2015 Medication Administration Records revealed Resident #8 ' s was not started until (a three day delay in initiating the physician ' s order). Further review of the MAR revealed the 6 a.m. dose was given on ; however, the 2 p.m.	F 501		

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F 501	Continued From page 138 and 10 p.m. doses were omitted. During an interview on at 2 p.m., the Nurse Consultant stated that the Urinalysis had not been collected. He stated that he was unsure why the nurses would not have gotten the sample. He also stated that the 6 am dose of on was taken from the Emergency Drug Kit. He confirmed the 2 p.m. and 10 p.m. doses were not given. The Nurse Consultant also confirmed there was no documentation related to why the urinalysis was not collected, why the medication not initiated for 3 days or why the resident missed two doses of her 19. During an interview on at 11:10 a.m., the facility provided a plan of action received related to The plan included the following: A Performance Improvement Plan that was initiated on related to An audit was completed of all residents. Physician orders, labs, notification of the physician if there was a change and the Log was accurate. No significant issues were found. NRs were updated. A 100% house audit was completed of all resident medications and orders on Nursing education was completed between for nursing staff related to managing residents on flow sheets and medication documentation. Three nurses that work as needed (PRN) have not been provided education and will not be allowed to work until educated. Agency nurses will be provided a packet that includes Managing Residents on Anticoagulation . The packet will include the Anticoagulation Policy and the facility ' s new	F 501		

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F 501	Continued From page 139 protocol on documenting medications that are on " Hold. " All new admissions will be reviewed in the morning meeting to assure all orders will be transcribed onto the POS and MAR/TAR. The weekend supervisor is responsible for new admissions on the weekends (not a new process). All residents that are receiving will be reviewed in a weekly care meeting with all orders, labs, and MARs reviewed. New anti-co orders were added under the daily clinical meeting and medications were added to the weekly care meeting. Looking to assure that the medication is transcribed, the flow sheet if needed, medication on hand, transcribed onto MAR and that the medication is being administered. The Flow Sheet will be implemented for any resident receiving (not a new process). For residents that have Hold Orders: The order will be blocked off and yellowed out. A new order will be re-written with a restart date. The new process will be visible to the nurses. The hold medication will be added on the 24 hour report. Medication Errors will be investigated and documented following Risk Management standards and Root Cause Analysis. Evidence of investigation will be kept. This is a new process not completed before. Based on the analysis, the policies, practices and systems, changes will occur as needed. New Process a new shift to shift MAR review with each nurse. The nurses together will review the entire MAR/TAR for holes and completeness for accuracy. If the nurse is sure that she administered the medications, then she can initial, if unsure then it would be classified as	F 501		

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F 501	Continued From page 140 a medication error. Nursing Administration is responsible for daily checks of the nurse to nurse MAR review. Nursing Administration will initial for accuracy. The audits will be reviewed daily by the DON. The 7-3 nurses are being educated today. All lab results will be reviewed in the daily Clinical Meeting. All INRs will be reviewed in the morning clinical meeting and checked against the orders and MAR. Monitoring: the MAR checks will be monitored by the DON daily for 30 days The Medical Director has been informed and is aware of the plan and has approved it. A QA meeting will be held on On all nurses on the first and second shift and a sample of nurses from the night shift were interviewed regarding the facility ' s new system related to . The nurses were able to the facility ' s policy on documentation of administration. The nurses also were able to explain the process of the shift to shift Medication Administration Report review. Shift change was observed on between 3:30 to 4:15 p.m. with all nurses appropriately performing the MAR reviews. The nurses were initialing the newly implemented form. A medication pass was observed with all administered appropriately per the physician ' s orders.	F 501		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		

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F 520 — Continued From page 141

assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on the review of the facilities Quality Assessment and Assurance Committee, resident record review, interviews with the facility staff, the Attending Physician, the Medical Director, facility Administration and review of the facility ' s policy and procedures related to medication administration the facility failed identify, implement and monitor a known deficient systemic practice of : administration. Based on a review of all current residents receiving , ten of thirty residents did not receive their per the physician ' s orders. Residents ' #2, #6, #10, #14, #15, #16, #17, #18, #19 and #20 were

F 520

1. Medication Error reports were completed for resident's #2, #6, #8, #9, #14, #15, #16, #17, #18, #19 and #20. Their perspective attending physicians were notified of the medication errors and nay new orders regarding the errors have been implemented. All required notifications regarding the errors were made to the pharmacy and medical director. These residents are receiving their medications as ordered by their physicians at this time.
2. A complete facility review was completed on 4-30-15 to assure that all resident medication orders were transcribed on the medication administration records. All residents are receiving their medications as ordered by their physicians. No other errors were identified in this review.

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F 520	Continued From page 142 identified as not receiving that were necessary to prevent clots or Additionaly the nurses failed to administer , and medications timely and accurately for two (#2, #8) out of forty-eight (48) residents reviewed for medication accuracy. Resident #6 was not administered for twenty six days. The medication was placed on hold for three days for a dental procedure. The facility staff failed to implement the order and resume the medication on , 2015. Resident #6 reported pain to the nursing staff and reported that the pain was consistent with a Deep . The physician was notified on and ordered the necessary tests. The facility failed to implement those orders for three days, delaying treatment to the resident until . Resident #6 required injections of to dissolve the clot. Resident #2 was administered a double dose of on 4/8, 9, 12, 13, 14 and . His INR was erapeutic on at 3.2. Resident #2's physician ordered and that were omitted for 10 days. Resident #10 was not administered her prescribed on 4/9 and . Resident #14 was not administered four of six available doses of . Resident #15 was not administered her on and on . Resident #16 ' s was to be discontinued when the International Normalizing Ratio (INR) was greater than 2. On the laboratory results indicated that her INR was 2.5 and the was continued for four additional doses. Resident #17 was not administered five doses of on 3/7, 10, 13, 15, . Resident #18 was not administered four doses of on 4/2, 11, 13 and . Resident #19 missed four doses of Pradaxa from	F 520	3. The following policies and procedures were reviewed, Anticoagulation –Clinical Protocol, Care, Hand Washing/Hygiene, Medication Holds and Documentation of Medication Administration by the QAPI Committee on and have been revised and updated as needed. Education has been provided to the QAPI Committee on the QAPI process by the Nurse Consultant on utilizing CMS QAPI at a Glance educational materials. The QAPI Committee will utilize this for continued identification, analysis and planning for identified opportunities for improvement in the facility. The Medical Director also participated in this educational program and is current with the QAPI . Identified opportunities for improvement will be brought to the QAPI Committee for review and implementation of the QAPI process. QAPI Meetings are currently be held on a weekly basis times eight weeks and then bi-monthly times eight weeks and the monthly. 4. QAPI will be monitored by the Nurse Consultant bi-monthly for three months and then quarterly. This program will also be over seen by the Administrator and the Medical Director on an ongoing basis.	

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F 520	Continued From page 143 Resident #20 was not administered seven doses of from Resident #8 there was a three day delay in starting a physician ordered and then two doses were omitted. Findings include: 1) A review of the facilities policy 2004) " Quality Assurance and Performance Improvement Committee (QAPI). Goals of the committee: (2) promote the consistent use of facility systems and process during provision of care and services. (3) Help identify actual and potential negative outcomes relative to resident care and resolve the appropriately. (5) Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care. " " Committee Meetings: (2) Special meeting may be called by the coordinator as needed to address issues that cannot be held until the next regular scheduled meeting." 2) Review of the facility policy entitled " Medication Administration General Guidelines for the Administration of Medications " policy 6.2 (page one of three) (no dated) was reviewed and it was expected that the nurses administer medications per the physician ' s orders. 3) The DON and NHA ON at 3:30 p.m. confirmed that they were aware of Resident #6 ' s medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of the medication errors for Resident #6 only after the Doppler confirmed the positive It was	F 520		

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F 520	Continued From page 144 unclear, due to the lack of the investigation, of how and why the medication error was found. During an interview on at 10:15 a.m., the Administrator stated that on she received a report of the concern with Resident #6. She was informed of the medication error. The Unit Manager had educated the staff involved. The DON informed her that she was assembling her investigation and would bring the information to the next QA meeting on . The meeting was initially scheduled on and it was delayed due to a trial. The Nursing Home Administrator (NHA) said usually the QA is scheduled every third Tuesday of the month. The facility has done Ad Hoc meetings in the past but the DON wanted to make sure everything was done before hand. The DON informed her that the physician had been notified. The DON informed her that the facility was still working that process. The Administrator stated that she was aware the process was in place. The four point process was not completed and had not been presented. The NHA confirmed she was aware of the medication errors in the facility and failed to implement or monitor other residents that could be at risk. Resident #6 medication error was identified on the next scheduled " Quality Assurance and Performance Improvement Committee (QAPI)" is (28 days after a significant medication error that caused an extensive clot). 4) During an interview with the DON at approximately 2:30 p.m., she was unable to present any information regarding her investigation, education or audits. No formal	F 520		

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F 520	Continued From page 145 action plan had been put in place as of the time of the start of the survey on An interview was conducted with the facility ' s Director of Nursing (DON), on at 3:00 p.m. A list of medication errors for the month of 2015 was provided by the DON. The DON stated that she was aware of the medication error for Resident #6. She stated that a nurse found the error after performing a " medication review. " The DON stated that she was unsure of why the error occurred. She stated that the facility ' s intervention was the and the physician and the resident were notified of the error. The DON confirmed that no audits or education was provided to the staff following the medication error. The DON also confirmed that there was no evidence of an investigation. The DON stated that her conclusion of the omitted medication for Resident #6 was " we performed an and started giving her injections and elevated her left leg. " On at 9:50 a.m. the Nursing Home Administrator, DON and the facility ' s corporate nurse confirmed that an in service was not conducted related to Resident #6 ' s omissions of her scheduled medications. 5) During an interview on at 2:45 p.m., the Medical Director stated that he had been the Medical Director of the facility since 2012. He stated that he participated in the QA monthly meetings and the facility followed a set agenda. He stated that he was made aware of incidents for his patients and that the attending physician for the other residents would be notified of incidents. He stated that he would expect to be notified of incidents, including medication errors,	F 520		

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F 520	Continued From page 146 specifically, for system failures that could affect all residents. He stated that he was here at the facility every Wednesday and Friday. However, someone from his physician group was present daily and should be notified. He expected that the nurses notify the physician of any incident. He confirmed again that he was not made aware of any medication errors for Resident #6. He was not aware of any issues in QA related to medication administration. He stated that he was aware that the facility used a lot of agency staff and had a lot of turnover. The Medical Director stated that there was no action plan identified or implemented related to staffing or staff procedures. He also stated that he was aware of a concern with nurses not implementing physician orders timely. He stated that the nurse would pass off the order to the oncoming shifts and the medication would not be started. He stated that he provided education to the staff " within the year " related to medication implementation. The education was to have a second nurse initial the order to assure implementation. He confirmed that there was nothing in Quality Assurance (QA) related to the medication administration and order implementation process. The Medical Director stated that if the facility had a good system in place, then any staff member should be able to come in and care for the resident with no breaks in the system. He stated that the " system was not perfect and should not have failed. " The Medical Director was asked if it was expected that the facility notify him of negative outcomes; he stated, " I would love to. " 6) During an interview on at 10:30 a.m. Resident #6 stated she was diagnosed with a (DTV). She said it was not just a it was an extensive The	F 520		

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F 520	Continued From page 147 resident stated that " the doctor said it was from my knee to my foot and I think there was more than one . " The resident was asked if the nurse had spoken to her about her . She said, " No, the doctor told me the nurses were not giving me my medication, he was really pissed. " They (the nurses) had to give me two times a day for five days and I hate needles. " Resident #6 said that when she first had come to the facility she had a in her left arm and, " that is why I take the every day. " The resident stated that she used to check her medications every day and now has to start checking them again. " It ' s not my job to have to ask if all my medications are there or not is it? " During a telephone interview on at 11:42 a.m., Resident #6 ' s attending physician stated; " the nurses did not give her medication . The medication was only on hold for a few days for her dental surgery. The physician was asked why the medication Xarleto was not restarted after her dental surgery. The physician stated he did not understand why the nurses did not restart the medication. " I gave the nurses the order they should have restarted the after the dental procedure was completed. The is to prevent her from getting a if she would have received the medication she would not have gotten a . " During an interview on at 12:20 p.m., the attending Physician confirmed he assessed the resident on and documented the resident ' s leg was red and . He also ordered a Doppler study. The physician stated that he was informed by Employee (LPN) A. of the leg and the lack of the on	F 520		

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F 520	Continued From page 148	F 520		

He verbally gave the order to Employee A. The attending physician confirmed the Doppler order was not completed until and also confirmed that no medication was started until . He was unsure of why there would have been a delay in obtaining treatment, necessary tests or initiating the medication.

Further review of the physician orders dated on " Stop x 3 days prior to and resume one day post p.m. " The order did not contain a nursing signature. The next order that was written; Clarification 15 mg orally every HS- (this order was not dated). A hand written telephone order, dated on Doppler STAT and a third order dated for the same day 80 MG SQ ((two times) for 5 days.

Review of the Medication Administration Record, dated 2015, revealed a typed order dated 15 MG tablet one tablet by mouth once a day. Directly underneath the typed order a hand written entry; resume . The Medication Administration Record (MAR) revealed the nurses documented for and " HOLD. " The MAR for , when the was to be restarted was reviewed. The boxes, where an initial should have been written, were empty (indicating the dose was not administered). The remainder of the MAR from through was reviewed with no indication that the medication had been given and no indication as to why the medication was not given.

The medical record in Resident #6 ' s chart

FORM APPROVED
OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	Continued From page 149 contained a Progress note/Monthly Evaluation " dated: Listed under current complaints: " Redness and left leg. " Documented (under extremities): 4+ L > left leg (new finding). Resident had been " Off 15 MG for 3 weeks by nurse ' s error. " Further review of the attending physician ' s progress note indicated that Resident #6 had a Recurrent to her left leg that is new and has worsened. Hand written next to the word worsened " Doppler was ordered. " A review of the Physician ' s Progress Notes revealed on 3/28/15, the Attending Physician assessed Resident #6 and diagnosed her with an acute The physician documented: " Redness and left leg, 4+ L > left leg. " The physician also documented that the resident had been " Off 15 MG for 3 weeks by nurse ' s error. " Further review of the Attending Physician ' s progress note revealed he documented " Doppler was ordered. " There was no corresponding physician ' s order for the Doppler Studies until , three days after the physician assessed the resident. Further review of Resident #6 ' s medical record revealed that she had resided in the facility for approximately fifteen months and was fifty three years old. Resident #6 ' s medical history included and a history of On 12/22/2014 a revealed a Score of 15 indicating no Review of the Nurses ' Notes on revealed no documentation of a red, leg. There was no documentation of the omission of the medication, the physician visit or the new	F 520		

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F 520	Continued From page 150 orders. On , employee (LPN) A documented: the resident complained of pain and redness to her leg, upon assessment the leg was warm to touch and was Painful, 2+ pitting. The doctor was paged and made aware and stated he saw her on Saturday. New orders for were obtained. On at 3:25 a.m. the nurse documented at " 12:45 a.m. patient states she thinks she has a to her LLE. Area of slight redness noted to inner calf to LLE, to LE. Skin temp within normal limits. refill is brisk . Unable to assess pulse related to ... Patient rates pain level #1 at this time on a scale of 1-10 with 10 being the worst. Patient states she has had multiple in the past and knows what it feels like. Notified resident physicians of above and new orders were received for a STAT Doppler of the LLE to rule out . At 0200 (2:00 p.m.) 100mg was administered for c/o pain to LLE with a pain level of 9 out of 10. was effective. At 0330 (3:30 a.m.), the mobile service arrived to perform Doppler. Patient remained on bed rest. Patient remained alert and responding appropriately to verbal and stimuli. No s/s of distress noted. Vitals Patient received new order on to restart was not discontinued). " A review of the Ultra Sound Report, date of service: revealed: Examination: Doppler extremity/limb, left. Clinical Indications: of Limb, Findings: Real time color imaging shows no collateral and augmentation of post , popliteal , deep and common of left leg. There are no excessive collateral veins. Left lower Extremity duplex	F 520		

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F 520	Continued From page 151 Impression: Extensive seen. During an interview on , at 3:30 p.m., the DON stated " she checks the MARs two times a week by flipping through all of the MARs. " She confirmed there is no documentation related to this process. The DON said that the ADON and Unit manger check every MAR daily for accuracy and completeness. During an interview on , at 8:50 a.m., The Assistant Director of Nurses stated that she randomly checked the MARs on a daily basis for accuracy and completeness. She stated that she checked new admissions and " maybe two others. " She stated that the Unit Manager was responsible for checking at least five residents on each cart on a daily basis. The ADON stated that there was not a definite system of checking the MARs. An interview was conducted on at 9:30 a.m., Employee (LPN) A. Interim Unit Manager (started on Monday . She stated that she checked all new admissions for accuracy of orders and double checks with the MAR for accuracy. She stated that she did not do anything with the MARs on a daily basis. No one informed her she was supposed to be checking the MARs. She stated that she gets the new orders and the 24 hour report in the morning and then gives them to the ADON or DON to take them to the morning meeting. She does not usually go to the morning meetings and was not aware of any plan to begin to go. She stated that no education or training was provided to be a Unit Manager. The ADON told her the things that needed to be done and she was " just helping them out not doing the	F 520		

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F 520	Continued From page 152 whole position. " The regular unit manager (LPN) B, on the Long Term Care unit was currently on medical leave and was unable to be contacted. The MAR indicated that six nurses, assigned on the 3-11 p.m. shift, failed to administer the as ordered by the attending physician. During an interview on at 4:10 p.m. Employee (RN) E, a nurse that cared for the resident on 12 of the 26 evening shifts, stated that she had been a nurse for a long time and worked in long term care. She stated that she was familiar with Resident #6. She stated that she was aware the resident needed The medication was not administered. She stated that she did not think the order was on going. She stated that it was on hold. She stated that she did not have the time to research the order and was aware that Resident #6 was at high risk for . She stated that she questioned the medication to other staff; however, she did not recall who the staff member was. She stated that the doctor came in and then realized the medication should have been resumed. The nurse stated that when a medication was held, the nurse should write hold on the days that the medication is to be held and then indicate when the medication should be resumed. The nurse confirmed the MAR and confirmed that there was no indication the medication had been given. She stated that she did not recall the resume date. The nurse stated that " my philosophy is if I don ' t see the medication and don ' t see a stop order, then I question with another nurse as to whether the medication is on hold or should be	F 520		

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F 520	Continued From page 153 discontinued. " She stated that she would call the pharmacy. She stated that the medication card was not in the cart. The nurse also confirmed that she did not document any omissions in the chart. She stated that she did not look at the chart to find the original order. An interview was conducted on at 4:30 p.m. with past Employee (LPN) D. she stated that she worked at the facility She said she was a new LPN, graduated 2014, and it was her first job in a Skilled Nursing Facility. When asked about her training she stated she had trained for two to 3 days and was on her own by the fourth day. She said she had felt that it was " " on her orientation process as far as knowing the processes and was able to always go back and ask questions. Employee (LPN) D, stated that she recalled caring for Resident #6. She confirmed that she was on and stated that she cared for her several times. The staff member was asked and visually confirmed the MAR and confirmed that she worked on and . The nurse next confirmed the order for and then confirmed the order said to resume . The nurse stated that she would not have given a medication without signing the MAR. These dates were blank, with no initials. A review was conducted of the Pharmacy Dispensing Record for Resident #6 ' s from 1-A 2015. The pharmacy sent 14 pills at a time. Review of the Dispensing Log revealed the facility last received 14 pills on . All of the medication would have been administered by . Therefore, there was no available for administration. The	F 520		

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F 520	Continued From page 154 medication was not a routinely stocked medication in the Emergency Drug Kit. Review of the Drug Manufacturer ' s Pharmaceutical Medication Guide for revealed; " is a prescription medicine used to treat and , and to help reduce the risk of these conditions occurring again. lowers your chance of having a by helping to prevent clots from forming. If you stop taking , you may have increased risk of forming a clot in your . Do not stop taking without talking to the doctor who prescribes it for you. Stopping increases your risk of having a . If you have to stop taking , your doctor may prescribe another medicine to prevent a clot from forming. Do not stop taking without talking to your doctor first. Your doctor may stop for a short time before any surgery, medical or dental procedure. Your doctor will tell you when to start taking again after your surgery or procedure. " Review of Resident #6 ' s Care plan Focus on Anticoagulation reflected the resident had a " potential for abnormal . " Date Initiated; updated: . Goal will be free from signs and symptoms of abnormal . Interventions: Administer as MD ordered. " The Care Plan was not followed. The facility identified thirty residents receiving . All thirty residents were sampled. The following residents were identified with medications errors related to	F 520		

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F 520	Continued From page 155 7) During an interview on at 3:45 p.m. the facility ' s Director of Nursing (DON) stated: " we have had another problem with an it happened to Resident #2. " The DON said that when Resident #2 was admitted on and the nurse had written up the physician orders on one of our order sheets, the was written on a regular sheet that did not have a copy that is used for the medication administration record. We (DON and ADON) did not find out about the medication not being given until " The DON was asked what the process was on checking admission orders for their accuracy she said that usually the unit manager will check the orders the next morning and then added the unit manager was out on maternity leave. The DON was asked who would be responsible to verify the physician ordered medications were accurately transcribed into the Medication Administration Record (MAR), she said the ADON or me. The DON said, " We checked the physician order sheet and they were written correctly but because the order was not put on the physician order sheet that contained a copy it did not show up on the MAR. " The DON confirmed she did not review the MAR to make sure all the physician orders were transcribed. The DON was asked how that had happened and stated; " I ' m still trying to figure out how it happened and then I do find it out it has unfortunately already occurred. " When asked if the facility used a check off system for newly admitted residents she said, " we used to but now it is computerized. The computer tells us what to do. " She stated she was there the day of the verbal teaching but she did not sign the in-service verifying that she had	F 520		

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F 520	Continued From page 156 attended. The Medication Administration Record for Resident #2 orders were to give 4 mg by mouth on Sunday, Tuesday, Wednesday, Thursday and Saturday and to administer 2 mg on Monday and Friday. The MAR indicated that on; 4/8, 4/9, and on both orders were initialed/signed as being administered resulting in a total of 6 mg of . On the order was discontinued and rewritten to give 4 mg by mouth on Sunday, Tuesday, Wednesday, Thursday and Saturday and to administer 2 mg on Monday and Friday. (The same identical order, this time the initial boxes were outlined indicating which day of the week the medication needed to be given). The DON provided a copy of an in-service that was conducted on (three days after the medication omission was found) Teaching Method: Verbal Topic: and Protocol. Make sure INR is done, Call MD with results before giving medication, check orders daily and make sure log is accurate. The DON was asked about any in-servicing that was provided to the licensed staff on physician orders not being transcribed accurately in the residents MAR or not being transcribed at all, she did not respond. " We were going to bring it into our QA meeting on Tuesday A further medical record review was conducted for Resident #2 and revealed he had resided in the facility for approximately three weeks. His diagnoses included: and	F 520		

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F 520	Continued From page 157 Resident # ' 2s Medical Record also revealed admissions orders dated for 40 mg by mouth one time daily and 15 units in the morning and 5 units at night time. Resident #2 did not receive his from . Resident #2 did not receive his scheduled morning dosage from and the night time dosage from The MAR revealed orders dated to start 40 mg one time daily and 15 units in the morning and 5 units at night time, hold if BS is less than 110. Resident #2 nursing notes were reviewed for at 3:16 p.m. " there was a med error for patient in patient . patient and was never given patient was supposed to be on daily weight not done. Physician has been paged. Waiting for call back " . The nursing notes for at 1:54 a.m. " New order for INR ordered for the AM for the dosage error " . There was no corresponding nurses ' notes related to the omissions of Resident #2 ' s or On at 11:45 a.m. a telephone interview was conducted with Resident #2 ' s Attending Physician. He confirmed he was notified that the resident had been receiving double doses of his and confirmed that his International Ratio was 3.2 and not critical erapeutic). The physician confirmed the facility did not follow his orders and should have administered the proper dosages of on the proper days as ordered. The Attending Physician also confirmed that he was notified that Resident #2 did not receive his ordered for ten days after being admitted and he did not receive his for ten days after being admitted to the	F 520		

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F 520	Continued From page 158 facility. The Attending Physician was asked if a resident had a diagnosis of being does that mean he needs monitoring. The Attending Physician stated " yes, he needs his sugars monitored he could have went into or and worse yet into " The physician stated " they need to fix it, I don ' t know if it ' s the DON or the corporation they have to fix these things so it doesn ' t happen again. " On , the DON and NHA confirmed that they were aware of Resident #2 ' s medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of Resident #2 ' s medication error on , however, no negative outcomes occurred. It is unclear due to the lack of the investigation of how and why the medication error was found. On the DON stated she " checks the MARs two times a week by flipping through all of the MARs. " She confirmed there was no documentation related to this process. The DON said that the ADON and Unit manger check every MAR daily for accuracy and completeness. 8) The facility admitted Resident #10 on with diagnoses including Accident and per the physician order summary list of diagnoses. Review of the Admission Physician Orders, dated revealed the resident was prescribed 40 unit daily at 9 a.m. Review of the Medication Administration Record revealed Resident #10 did not receive	F 520		

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F 520	Continued From page 159 on 4/9 or . There was no documentation on the back side of the MAR as to why the medication was omitted. Review of the Care Plan, dated , revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information was provided related to why the medication would not have been given to Resident #10. 9) The facility admitted Resident #14 on with diagnoses including Acute and , per the demographic face sheet. Review of the medical record revealed Resident #14 was transferred to a Hospice House for end of life care. Further review of the medical record revealed a physician ' s telephone order, dated for 30 units twice daily. The resident was placed on due to sub-therapeutic INR (International Normalizing Ratio) levels and she was at risk for developing additional clots. Review of the Laboratory results revealed, on Resident #14 ' s INR was 1.1. On , the was discontinued. The resident remained sub-therapeutic and the physician was attempting to adjust her 10) Review of the Medication Administration Record for 2015 revealed Resident #14 did not receive for 4 out of the 6 available doses. She did not receive any	F 520		

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F 520	Continued From page 160 on . The resident did not receive on at 9 a.m., at 9 a.m. or at 9 a.m. There was no documentation in the nurses ' notes or the back of the Medication Administration Record as to why the medication was not given. On the resident was noted to have redness and to her right leg. An was ordered and the resident was diagnosed with a Review of the Care Plan, dated , revealed a problem area was identified for " potential for abnormal ." The approaches included " administer as MD ordered. " During an interview on at 2:30 p.m., the Nurse Consultant confirmed the missed doses of . He stated that the medication should have been available from pharmacy and was unable to determine why the nurses would not have given the medication. He stated that at least one dose of the should have been given on 11) The facility admitted Resident #15 on with diagnoses including and per the demographic face sheet. Review of the 2015 Physician Orders revealed Resident #15 was prescribed 40 unit daily for two weeks. Review of the Medication Administration Record for 2015 revealed Resident #15 did not receive her on and Review of the Care Plan, dated , revealed a problem area was identified for " potential for abnormal ." The approaches included " administer	F 520		

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F 520	Continued From page 161 as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11:00 a.m. No additional information as provided related to why the medication would not have been given to Resident #15. 12) The facility admitted Resident #16 on with diagnoses including and per the physician diagnoses listed on the Medication Administration Record. Review of the Physician ' s Orders revealed on Resident #16 was prescribed " 60 units every 12 hours, D/C (discontinue) when INR (international normalizing ratio) above 2. " Review of the Laboratory Data revealed an INR was collected on that was 2.5. Review of the Medication Administration Record for 2015 revealed Resident #16 was given on and He received four doses of after the medication should have been discontinued per the INR value of 2.5. Further review of the Laboratory Data revealed an INR was collected on and the resident was erapeutic at 3.9. Record review revealed no indication of abnormal was noted. Review of the Care Plan, dated revealed a problem area was identified for " potential for abnormal . " The approaches included " administer as MD ordered. " The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information was provided related to why the resident received	F 520		

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	105884	A. BUILDING ______ B. WING ______	C 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL REHABILITATION AND HEALTH CENTER	2811 CAMPUS HILL DR TAMPA, FL 33612

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F 520	Continued From page 162	F 520		

the when the medication should have been discontinued.

13) The facility admitted Resident #17 on with diagnoses including Accident and per the demographic face sheet.
Review of the Physician ' s Orders for April 2015 revealed the resident was prescribed 3 mg PO daily at 5 p.m.
Review of the 2015 Medication Administration Record revealed Resident #17 did not receive the prescribed for 5 doses; 4/7, and . There was no documentation in the nurses ' notes or on the back of the MAR as to why the medication was omitted.
Review of the Care Plan, dated revealed a problem area was identified for " potential for abnormal ". The approaches included " administer as MD ordered. "
The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the medication would not have been given to Resident #17.

14) The facility admitted Resident #18 on and the resident was readmitted on with diagnoses including Chest Pain and

Review of the Physician ' s Orders, dated revealed Resident #18 was prescribed an 8.5 mg daily at 9 pm.
Review of the 2015 Medication Administration Record revealed Resident #18 did not receive his on 4/2,

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F 520	Continued From page 163 or . There was no documentation on the back side of the MAR as to why the medication was not given. Review of the Care Plan, dated , revealed a problem area was identified for " . potential for abnormal ." The approaches included " administer as MD ordered. " During an interview with Resident #18 on at 3:20 p.m. he stated that there had been occasions where he did not receive all of his ordered mediations from the nurse. He stated that he now had to check all his medications for accuracy. He stated that when he brought it to the nurse ' s attention when he did not receive his medications, they told him that they were either out of the medication or they would go back and bring him his ordered medication. He stated that he used to have a medication book on his bedside table that he would utilize to check his medications but that the medications are changed from the manufacturers or the pharmacy so often now that it is obsolete. The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 a.m. No additional information as provided related to why the medication would not have been given to Resident #18. 15) Resident #19 was admitted to the facility in 2015 with admitting diagnoses of and . Resident #19 was identified and listed on " Current active orders for " that was provided by the facility. The physician orders were reviewed with an order, dated to administer and Pradaxa 150 mg capsule one capsule by mouth two times daily for a diagnosis	F 520		

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F 520	Continued From page 164 of The MAR was reviewed for 2015 and it identified that resident # 19 had missed four doses of Pradaxa on at 5:00 p.m., at 5:00 p.m., at 9:00 a.m. and, again, at 5:00 p.m. The nursing notes revealed that for the days the medication had been omitted, there was neither documentation nor notification to the physician on why a prescribed medication was not administered as ordered. Review of Resident #19 ' s Care plan Focus on Anticoagulation , has a potential for abnormal , Date Initiated; Goal " will be free from signs and symptoms of abnormal ." Interventions: Administer as MD ordered. The Care Plan was not followed. 16) Resident #20 was admitted to the facility on with a history of recent for of right with Review of resident physician orders, dated determined the resident was to receive an 40 mg every 12 hours for preventative measures. The MAR was reviewed for 2015 and it revealed seven separate missing initials or circles around initials indicating the medication was not administered as ordered. On at 9:00 p.m., the box on the MAR was without an initial, 9:00 a.m. the box was initialed with a circle, at 9:00 a.m. the box was initialed with a circle, at 9:00 p.m. the box MAR was without an initial, at 9:00 p.m. not initialed as given, and, on at 9:00 a.m., the box was initialed with a circle. The back of the MAR nursing notes for	F 520		

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105884	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 05/01/2015

NAME OF PROVIDER OR SUPPLIER

EXCEL REHABILITATION AND HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

2811 CAMPUS HILL DR
TAMPA, FL 33612

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F 520	Continued From page 165 at 9:00 p.m. indicated that the was not available to give. A second nursing note for at 9:00 a.m. indicated that the pharmacy was notified. 17.) The facility admitted Resident #8 on 3/16/15 with diagnoses including Hip and Review of the Physician Telephone Orders dated revealed the physician ordered a Urinalysis with Culture and Sensitivity and also ordered 500 mg every 8 hours for 7 days for a Review of the Laboratory Data revealed Resident #8 did not have a Urinalysis collected. Review of the and 2015 Medication Administration Records revealed Resident #8 ' s was not started until (a three day delay in initiating the physician ' s order). Further review of the MAR revealed the 6 am dose was given on however, the 2 pm and 10 pm doses were omitted. During an interview on at 2 pm, the Nurse Consultant stated that the Urinalysis had not been collected. He stated that he was unsure why the nurses would not have gotten the sample. He also stated that the 6 am dose on was taken from the Emergency Drug Kit. He confirmed the 2 pm and 10 pm doses were not given. The Nurse Consultant also confirmed there was no documentation related to why the urinalysis was not collected, why the medication not initiated for 3 days or why the resident missed two doses of her During an interview on at 10:13 a.m. and at 10:43 a.m., The DON stated that the process of checking the MARs was an informal process that is implemented inconsistently and	F 520		

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F 520	Continued From page 166 the ADON and Unit Manager assist with the process. There was not a written policy or procedure. The DON stated that she had been in the role of DON for one year and the process of checking the MARs had been an expectation since her arrival and she had continued that process since then. The DON also stated on at 10:43 am that she was unaware the ADON and Unit Managers were not checking MARs daily. The next QA meeting is to be held on	F 520		

AND PLAN OF CORRECTION | IDENTIFICATION NUMBER: 62932 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______ | (X3) DATE SURVEY COMPLETED C 05/01/2015

NAME OF PROVIDER OR SUPPLIER: **EXCEL REHABILITATION AND HEALTH CENTE**

STREET ADDRESS, CITY, STATE, ZIP CODE: **2811 CAMPUS HILL DR TAMPA, FL 33612**

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N 000	INITIAL COMMENTS SKILLED NURSING FACILITY COMPLAINT INVESTIGATION CCR#2015002905, CCR# 2015003708, and CCR# 2015003927. A Complaint investigation and Extended Survey was conducted off hours at 6:30a.m. Monday to A Partial Extended survey was conducted EXCEL REHABILITATION and HEALTH CENTER had deficiencies identified at the time of the visit. A Class I deficiency was identified at N 201	N 000	Preparation and submission of This plan of correction does not Constitute and admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law. **This plan of correction will serve as the Facility's allegation of substantial compliance.**	
N 042 SS=D	400.1183 FS Resident Grievances and Complaints (1) Every nursing home must have a grievance procedure available to its residents and their families. The grievance procedure must include: (a) An explanation of how to pursue redress of a grievance. (b) The names, job titles, and telephone numbers of the employees responsible for implementing the facility ' s grievance procedure. The list must include the address and the toll-free telephone numbers of the ombudsman and the agency. (c) A simple description of the process through which a resident may, at any time, contact the toll-free telephone hotline of the ombudsman or the agency to report the unresolved grievance. (d) A procedure for providing assistance to residents who cannot prepare a written grievance without help. (2) Each nursing home facility shall maintain	N 042	accepted 6/8/15	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 5/21/15

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N 042	Continued From page 1 records of all grievances and a report, subject to agency inspection, of the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances. (3) Each facility must respond to the grievance within a reasonable time after its submission. (4) The agency may investigate any grievance at any time. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to act on, resolve, and log resident grievances for two (Resident #6 and Resident #23) of twenty-three sampled residents. Findings include: (1) During an interview with Resident #6 on at 10:30 a.m. stated that she has multiple concerns with the facility including waiting for assistance with activities of daily living (ADL) care, staff slow to answer call lights, and concerns related to nursing staff providing her medications as ordered. She stated that she has voiced these concerns to multiple facility staff. Review of the following nursing notes revealed that the staff was made aware by Resident #6 that she had concerns related to care and services on and Review of the Grievance log from revealed no grievances logged for Resident #6. (2) During an interview with Resident #23 on at 3:10 p.m. he stated that when he pressed his call light for assistance that the staff will come into his , turn off the call light and	N 042	1.Resident #6concern recorded In nurses note regarding timing of her medication, order was written by MD on to change to times requested by res. #6. Concern resolved at that time. Res. #6 concern recorded in nurse's note regarding res. choice of lift , resident was provided choice of 2 lift pads,resident chose which one she wanted to use, this was resolved on . Social Service met with resident #23 on advised resident that call light audit was being implemented to address any negative trends with call light response time. resident expressed no further concerns at that time. Social Service met with Resident #6 on to review Facility grievance process. Resident stated she had no concerns or grievances at this time. Social Service met with Resident #23 on to review facility grievance process. Resident stated he had no grievances/concerns at this time. Resident #23 discharged home on	

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N 042	Continued From page 2 stay that they are going to get his Certified Nursing Assistant (CNA). He stated that this happens consistently and that he has to do this a few times before his CNA actually comes into the help him. He stated that there has been times when he has asked the assigned CNA had anyone told them that he needed assistance and they tell him no. He stated that the CNA staff has told him that they are working short or are working on another hall so they cannot see when his call light goes off. He stated that many times, staff not assigned to his just walk past his he has his call light on for assistance. He stated that he has talked with the unit manager and the nurses related to staff coming into his , turning off the call light and leaving without providing him assistance but it has done no good because they continue to do it. During an interview with the Nursing Home Administrator (NHA) on at 4:34 p.m. she stated that Resident #23 was angry about a number of things when he first arrived at the facility on including some things related to his . She stated that they had changed his the concerns he had were never placed on the grievance form or grievance log. She was asked if all residents ' grievances are not logged, then how the concerns are reviewed by the Quality Assurance Committee to identify patterns or trends per the facility policy. She stated that " if grievances are not logged then it is impossible to track and trend them " . She confirmed that there was no grievance logged related to Resident #23 having concerns. A review of the nursing notes for Resident #23 revealed that on several staff made administration aware that the resident had concerns related to staff not answering the call	N 042	2. Grievance p&p reviewed by Social Services at resident council meeting, and then quarterly with resident council. Call light audit to be completed by Social Service/designees on all 3 shifts starting through with results reported at QAPI meeting. Call light audit will continue on all three shifts for three months by Social Service/designees with results reported by Social Service at monthly QAPI meeting. Negative trends identified in call light response time will be addressed by inservice to staff involved and documented as a resident grievance if indicated. Tracking and trending of all resident grievance reports will continue monthly, with results presented at monthly QAPI meeting. Negative trends identified with grievance type will be investigated by Risk Manager/Administrator for quality improvement plan and resolution via root cause analysis. 3.Resident Grievance p&p is posted at each nurses station and in the Main lobby. Grievance p&p reviewed at resident council meeting, and then Quarterly with resident council. Resident's receive a copy of the Grievance p&p at the time of admission . All staff to be inserviced by Social Service/staff development on grievance p&p by Grievance forms placed on clipboards at each nurses station for ease of access .	

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N 042	Continued From page 3 light in a timely manner, taking too long to serve the food. It was noted that the Nursing Home Administrator, DON, Social Worker, and Unit Manager met with the resident at bedside. Review of the Grievance log from 1/1/2015- revealed no grievances logged for Resident #23. Review of the Grievance Policy (no date) revealed the following: Any resident or responsible party has the right to voice grievances ... grievances include those with respect to treatment and services furnished, as well as those not furnished, and may be expressed at any time, both verbally and in writing. Grievances will be monitored by the Quality Assurance Committee. In order to be remedied, residents and responsible parties report the concern to staff. Class III	N 042	4.Resident grievance tracking and trending will continue monthly with Social Service reporting results at monthly qapi. Call light audits will be completed by Social Service/designee for all 3 shifts x 3months. Social Service will present results of call light audits x3 months at monthly qapi committee to identify any negative trends and ensure they are analysed and addressed through root cause analysis .	
N 063 SS=E	400.23(3)(a)1 FS; 59A-4.108(4) FAC Minimum Nursing Staff 59A-4.108(4) The nursing home facility shall have sufficient nursing staff, on a 24-hour basis to provide nursing and related services to residents in order to maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility will staff, at a minimum, an average of 1.7 hours of certified nursing assistant and .6 hours of licensed nursing staff time for each resident during a 24 hour period.	N 063	Facility reviewed C.N.A staffing schedule to ensure minimum staffing requirements for C.N.A'S was met and would continue to be met each day. Staffing coordinator will meet daily with HR,DON or Administrator To review daily staffing levels and staffing for week at hand to ensure minimum staffing requirements for C.N.A's are met.	

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N 063	Continued From page 4 400.23(3)(a)1. The agency shall adopt rules providing minimum staffing requirements for nursing home facilities. These requirements must include, for each facility: a. A minimum weekly average of certified nursing assistant and licensed nursing staffing combined of 3.6 hours of direct care per resident per day. As used in this sub-subparagraph, a week is defined as Sunday through Saturday. b. A minimum certified nursing assistant staffing of 2.5 hours of direct care per resident per day. A facility may not staff below one certified nursing assistant per 20 residents. c. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day. A facility may not staff below one licensed nurse per 40 residents. 2. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing ratio for certified nursing assistants if their job responsibilities include only nursing-assistant-related duties. 3. Each nursing home facility must document compliance with staffing standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public. 4. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants if the nursing home facility otherwise meets the minimum staffing requirements for licensed nurses and the licensed nurses are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted toward the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified	N 063	Daily staffing sheet was revised for ease of use and will continue to be posted by shift at each nurses station. all licensed nurses will be inserviced by by staff development regarding daily staffing sheet and mandatory requirement for Licensed nurses to call staffing coordinator as well as Director of Nursing to advise of any call offs or issues with staffing to ensure adequate coverage. DON/Administrator will monitor Staffing levels on a daily basis and ensure any potential negative variances are addressed. DON will report x3 months to monthly QAPI committee status of Staffing hours.	

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N 063	Continued From page 5	N 063		

nursing assistant for the entire shift and not also be counted toward the minimum staffing requirements for licensed nurses. If the agency approved a facility ' s request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. The hours of a licensed nurse with dual job responsibilities may not be counted twice.

This Statute or Rule is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to ensure that they met the minimum staffing requirements for Certified Nursing Assistant's (CNA's) during an observation of the 11:00 p.m-7:00 a.m. shift one (Skilled Rehabilitation Unit) of two units in the facility and during three : and of twelve days reviewed from the two weeks prior to the survey.

Findings include:

On at 6:15 a.m. Staff I stated that the Skilled Rehabilitation Unit (SRU) had a census of fifty-four residents. She stated that there were two Certified Nursing Assistant (CNA) employees working on the unit (Staff R and Staff H). The staff assignment sheet dated was observed to be posted on the assignment board and noted that there were two CNA's scheduled to care for the SRU residents on the 11:00 p.m.-7:00 a.m. shift (Staff R and Staff H).

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N 063	Continued From page 6 During an interview with Staff J, RN, on at 6:34 a.m. she confirmed that the CNA staff often have to work short on the 11:00 p.m.-7:00 a.m. shift, with an assignment of more than twenty residents. During an interview with Staff K, CNA on at 6:36 a.m. she stated that they sometimes have to work with only 2 CNA's and that when they work short, they have an assignment of more than 20 residents. During an interview with Staff L, CNA on at 6:40 a.m. she stated that one day last week she had twenty-eight residents to care for on the 11:00 p.m-7:00 a.m. shift. She stated, "This place was not always like this. It has really gone down." She was asked if she felt that she could meet the resident's needs when she has had to work with twenty-eight residents. She stated "I try. There really is not enough time to give them proper care." On at 6:55 p.m. Staff M, CNA confirmed that she was currently assigned to care for twenty-nine residents on this shift. She confirmed that this was not the first time that she has been assigned to care for more than twenty residents. She stated, "It's hard. We consistently work short." On at 6:58 p.m. Staff H, an agency CNA confirmed that he was currently assigned to care for twenty-five residents on this shift. He confirmed that this is not the first time at that he has had to work with more than twenty residents in the two weeks that he has been coming to the facility. During an interview with Staff P, CNA on	N 063		

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N 063	Continued From page 7 at 4:05 p.m. she stated that she has worked the 11:00 p.m-7:00 a.m. shift and that the she has had to work short on that shift, receiving an assignment with more than twenty residents. She confirmed that she does not always have enough time to provide the residents with quality care when they have to work short staffed. During an interview with Staff Q, CNA on at 4:15 p.m. she stated that she has worked all shifts at the facility. She stated that she has been assigned to care for twenty-five residents on the 11:00 p.m-7:00 a.m. shift. She stated that it was "extremely hard" to provide quality care for so many residents. During an interview with the Director of Nursing (DON) on at 2:05 p.m. she was asked about the CNA resident ratio. She stated that the CNA's never work under the 1:20 ratio. She stated that they utilize agency staff and that the CNA's rarely work short. She was asked if any of the CNA staff ever have more than twenty residents. She stated that she is not aware of the CNA staff ever having more than 20 residents. She was asked to provide the time sheets for the 11:00 p.m-7:00 a.m. shift staff CNA's for the past two weeks prior to the survey for review. She was told that upon entrance that there were two CNA staff for fifty-four residents on SRU. She stated that she was not aware of the staff only working with two CNA's for the unit. During an interview with the Nursing Home Administrator (NHA) on at 10:20 a.m. she confirmed that upon entrance of the survey team on the 11-7 shift CNA's were working short; 2 CNA's for 54 residents on the SRU unit. She stated that although the 11-7 shift worked short, the facility did meet the daily	N 063		

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N 063	Continued From page 8 staffing hour requirements. She stated, "I cannot control when staff calls in. We use agency staff but sometimes they don't show up." She stated that the 11-7 agency and facility staff were not reliable and confirmed that this has affected the 11-7 shift. She was asked if the continuity of care was affected by the CNA staff having 25-30 residents. She did not answer this question, but stated, "I understand." During a review of lists provide by the facility on revealed that following: There are 30 residents on SRU requiring assistance. There are 17 residents on SRU requiring assistance of two persons with bed mobility and transferring. During a review of the Excel Spread Sheet for the two weeks' pay period immediately prior to survey and a reconciliation of the assignments sheets, the individual employee time cards, and the agency staff daily invoices revealed that the facility did not meet all the staff hour requirements: · On Monday the facility staffed five CNA's; the minimum per shift CNA's was noted to be six. · On Tuesday the facility staffed five CNA's; the minimum per shift CNA's was noted to be six. · On Thursday the facility staffed four CNA's; the minimum per shift CNA's was noted to be six. Class III	N 063		
N 111 SS=E	59A-4.122(2), FAC Physical Environment - Specifics	N 111		

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N 111	Continued From page 9 The facility shall provide: (a) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; (b) Clean bed and bath linens that are in good condition; (c) Private closet space for each resident; (d) Furniture, such as a bed-side cabinet, drawer space; (e) Adequate and comfortable lighting levels in all areas; (f) Comfortable and safe temperature levels; and (g) The maintenance of comfortable sound levels. Individual radios, TVs and other such transmitters belonging to the residentwill be tuned to stations of the resident ' s choice. This Statute or Rule is not met as evidenced by: Based on observations, staff interviews, and resident interviews, the facility failed to ensure that there was sufficient linen (towels, wash cloths and gowns) for the resident population on two (Skilled Rehab Unit and the Life Enrichment Unit) of two units in the facility. Findings include: On at 6:15 a.m. the linen the Skilled Rehab Unit (SRU) was observed to have no wash cloths, towels, or gowns. During an interview with Staff J, a Registered Nurse, on at 6:34 a.m. she stated that Certified Nursing Assistant (CNA) staff had complained to her that they have to work with very little linen and wipes. There were no disposable wash cloths/wipes observed in the supply that time.	N 111	Additional linen was put out on as well as disposable washcloths. Facility ordered over 11,200 disposable washcloths since . Housekeeping Supervisor rounds daily to ensure sufficient linen supply. Laundry staff deliver linen every 2 hours or as needed. Linen order received Linen inventory completed by disposable wet wipes implemented on to use for resident incontinence care. Laundry aide added for midnight shift, facility will process laundry 24 hours per day. Wet wipes implemented for incontinence care. Housekeeping Supervisor will maintain monthly linen audit and order as needed to ensure par levels for linen are maintained. Linen delivery form implemented by . Licensed nurse on each wing will sign off to verify count on all linen deliveries at time of delivery. Nursing staff inserviced by staff development by on linen service,linen delivery and linen delivery form. Housekeeping supervisor/designee will report to monthly qapi meeting x3months any negative trends in linen inventory or delivery. Negative trends will be addressed through root cause analysis for resolution.	

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N 111	Continued From page 10	N 111		

On at 6:36 a.m. the linen the Life Enrichment Unit (LEU) was observed to have two towels and no wash cloths or gowns.

During an interview with Staff K, CNA on at 6:36 a.m. she stated that she has worked at the facility for many years. She stated that there are not a lot of towels or wash cloths and that they often work with a short linen supply.

During an interview with Staff L, CNA on at 6:40 a.m. she was asked if she had enough supplies. She stated, "It is bad. Sometimes you only have two towels for 10 patients." She stated, "This place was not always like this. It has really gone down."

On at 3:30 p.m. the linen the Skilled Rehab Unit (SRU) was observed to have no wash cloths, towels, or gowns.

On at 3:40 p.m. the linen the Life Enrichment Unit (LEU) was observed to have no towels, wash cloths, or gowns.

During an interview with Staff N, CNA on at 3:45 she stated that the facility is always short on having linen (wash cloths, towels and gowns). She stated that the disposable wash cloths are scarce. She stated, "When I see some, I have to grab three or four packs because we usually don't have any. When my resident has a (bowel movement) I will sometimes have to go into other residents to find wipes or something to clean them up with."

During an interview with Staff O, CNA on at 3:55 p.m. she stated that she has been at the facility for only a couple weeks. She stated, "I have to ask other aides for (linen).

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N 111	Continued From page 11 Towels and wash cloths are hard to find here." Interview with Staff P, CNA on at 4:05 p.m. she stated that sometimes they do not have enough linen available for all of the residents. She stated that they do have wipes but sometimes they run out of those too. She was asked what she does when they run out. The staff was observed to shrug her shoulders and stated, "We just have to just use whatever we got." During an interview with Staff Q, CNA on at 4:15 p.m. she stated that the supply of linen has been a problem on all shifts. She stated that sometimes the CNA staff has to use paper towels with soap and water to clean the residents when they have a bowel movement because they don't have linen. She stated, "You just gotta do the best you can for them." During an interview with Housekeeping Supervisor on at 4:15 p.m. she stated that the staff had just placed a cart of linen on each unit at 3: 00 p.m. She stated that the laundry staff takes carts of clean linen out to the floors three times a day. She stated that she does not know what the CNA staff does with the linen after that. She stated, "We have plenty of boxes of new linen." She was asked if she brings out the new linen for the CNA staff to use. She stated that she does bring out new linen "sometimes." On at 4:15 p.m. a tour was conducted on the Long Term Care Unit with the Housekeeping Supervisor. A tour of the linen closet was conducted and there was no linen in the linen . The CNA staff on the unit stated that they placed the linen that they were provided in the residents already. The 300 hall were toured to observe the linen supply for	N 111		

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N 111	Continued From page 12 the resident population. The Housekeeping Supervisor was able to find eleven towels and four wash clothes available for fourteen residents. The 100 hall .... were toured to observe the linen supply for the resident population. The Housekeeping Supervisor was able to find ten towels and two wash clothes available for fourteen residents. .... was observed and resident in the A bed had a wash cloth placed on her bed. The resident in B bed had a gown placed on her bed. An interview was conducted with the two residents at that time. They both confirmed that there is a lack of linen in the facility. The resident in bed B stated, "Yes, that is a problem. I guess since I get a gown, I don't get a wash cloth." Class III	N 111		
N 201 SS=K	400.022(1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on resident record review, interviews with the facility staff, the Attending Physician, the Medical Director, facility Administration and review of the facility's policy and procedures related to medication administration the facility	N 201	1. Medication Error reports were completed for resident's #2, #6, #8, #9, #14, #15, #16, #17, #18, #19 and #20. Their perspective attending physicians were notified of the medication errors and nay new orders regarding the errors have been implemented. All required notifications regarding the errors were made to the pharmacy and medical director. These residents are receiving their medications as ordered by their physicians at this time. 2. A complete facility review was completed on 4-30-15 to assure that all resident medication orders were transcribed on the medication administration records. All residents are receiving their medications as ordered by their physicians. No other errors were identified in this review.	

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N 201	Continued From page 13 failed to ensure residents received adequate and appropriate health care including therapeutic services consistent with the resident's Care Plan. Based on a review of all current residents receiving , ten of thirty residents did not receive their per the physician's orders. Residents #2, #6, #10, #14, #15, #16, #17, #18, #19 and #20 were identified as not receiving that were necessary to prevent clots or Resident #6 was not administered for twenty six days. The medication was placed on hold for three days for a dental procedure. The facility staff failed to implement the order and resume the medication on , 2015. Resident #6 reported pain to the nursing staff and reported that the pain was consistent with a Deep . The physician was notified on and ordered the necessary tests. The facility failed to implement those orders for three days, delaying treatment to the resident until . Resident #6 required injections of to dissolve the clot. Resident #2 was administered a double dose of on 4/8, 9, 12, 13, 14 and . His INR was erapeutic on at 3.2. Resident #10 was not administered her prescribed on 4/9 and . Resident #14 was not administered four of six available doses of . Resident #15 was not administered her on and on . Resident #16 ' s was to be discontinued when the International Normalizing Ratio (INR) was greater than 2. On the laboratory results indicated that her INR was 2.5 and the was continued for four additional doses. Resident #17 was not administered five doses of on 3/7, 10, 13, 15, . Resident #18 was not administered four doses of on 4/2, 11, 13 and . Resident	N 201	3. The following policies and procedures were reviewed, Anticoagulation –Clinical Protocol, Care, Hand Washing/ Medication Holds and Documentation of Medication Administration by the QAPI Committee on and have been revised and updated as needed. Education has been provided to the QAPI Committee on the QAPI process by the Nurse Consultant on utilizing CMS QAPI at a Glance educational materials. The QAPI Committee will utilize this for continued identification, analysis and planning for identified opportunities for improvement in the facility. The Medical Director also participated in this educational program and is current with the QAPI . Identified opportunities for improvement will be brought to the QAPI Committee for review and implementation of the QAPI process. QAPI Meetings are currently be held on a weekly basis times eight weeks and then bi-monthly times eight weeks and the monthly. 4. QAPI will be monitored by the Nurse Consultant bi-monthly for three months and then quarterly. This program will also be over seen by the Administrator and the Medical Director on an ongoing basis.	

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N 201	Continued From page 14 #19 missed four doses of Pradaxa from . Resident #20 was not administered seven doses of . from The facility ' s Licensed Nursing staff failed to administer medications in accordance with physician ' s orders. The failure of the nurses to administer resulted in significant medication errors that subsequently caused Resident #6 to develop an avoidable clot Based on record review and interview, the nurses failed to administer medications timely and accurately for two (#2, #8) out of forty-eight (48) residents reviewed for medication accuracy. Resident #2 ' s physician ordered and were omitted for 10 days. There was a three day delay in starting a physician ordered for Resident #8 and two of the doses were omitted. This resulted in the findings of Immediate Jeopardy existing in the facility as of The facility Administration was informed of the this Class I on at 9:50 a.m. Findings Include: 1. During an interview on at 10:30 a.m. Resident #6 stated she was diagnosed with a she said it was not just a it was an extensive . The resident stated that "the doctor said it was from my knee to my foot and I think there was more than one The resident was asked if the nurse had spoken to her about her she said "No, the doctor told me the nurses were not giving me my medication, he was really pissed." They (the nurses) had to give me two times a day for five days and I hate needles. "Resident #6 stated that when she first had come to the facility she had a in her left arm" that is why I take	N 201		

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N 201	Continued From page 15	N 201		

the every day." The resident stated that she used to check her medications every day and now has to start checking them again. "It's not my job to have to ask if all my medications are there or not is it?"

During a telephone interview on at 11:42 a.m., Resident #6's Attending Physician stated; "the nurses did not give her medication , the medication was only on hold for a few days for her dental surgery. The physician was asked why the was not restarted after her dental surgery. The physician stated he did not understand why the nurses did not restart the medication, "I gave the nurses the order; they should have restarted the after the dental procedure was completed. The is to prevent her from getting a if she would have received the medication she would not have gotten a

During an interview on at 12:20 p.m., the Attending Physician confirmed he assessed the resident on and documented the resident's leg was red and He also ordered a Doppler study. The physician stated that he was informed by Employee (LPN) A of the leg and the lack of the on . He verbally gave the order to Employee A. The Attending Physician confirmed the Doppler order was not completed until and also confirmed that no medication was started until He was unsure of why there would have been a delay in obtaining treatment, necessary tests or initiating the medication.

Further review of the physician orders dated on "Stop x 3 days prior to and resume one day post

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N 201	Continued From page 16 p.m." A telephone order dated revealed a Doppler was ordered STAT. Also on 80 MG SQ was ordered (two times) for 5 days. There were no orders for when the physician was first made aware of the Review of the Medication Administration Record (MAR) dated 2015 revealed a typed order dated for 15 MG tablet one tablet by mouth once a day. Directly underneath the typed order a hand written entry; resume . The Medication Administration Record (MAR) revealed the nurses documented for and "HOLD." The MAR for when the was to be restarted, indicated the boxes, where an initial should have been written, were empty (indicating the dose was not administered). The remainder of the MAR from through was reviewed with no indication that the medication had been given and no indication as to why the medication was not given. A review of the Physician's Progress Notes revealed on , the Attending Physician assessed Resident #6 and diagnosed her with an acute . The physician documented: "Redness and left leg, 4+ L > left leg." The physician also documented that the resident had been "Off 15 MG for 3 weeks by nurse's error." Further review of the Attending Physician's progress note revealed he documented Doppler was ordered." There was no corresponding physician's order for the Doppler Studies until three days after the physician assessed the resident.	N 201		

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Further review of Resident #6's medical record revealed that she had resided in the facility for approximately fifteen months and was fifty three years old. Resident #6's medical history included and a history of . On a ( ) revealed a Score of 15 indicating no

Review of the Nurses' Notes on revealed no documentation of a red, leg. There was no documentation of the omission of the medication, the physician visit or the new orders. On , Employee (LPN) A documented: the resident complained of pain and redness to her leg, upon assessment the leg was warm to touch and was . Painful, 2+ pitting. The doctor was paged and made aware and stated he saw her on Saturday. New orders for were obtained. On at 3:25 a.m. the nurse documented at "12:45 a.m. patient states she thinks she has a to her LLE. Area of slight redness noted to inner calf to LLE, to LE. Skin temp within normal limits. refill is brisk . Unable to assess pulse related to . Patient rates pain level #1 at this time on a scale of 1-10 with 10 being the worst. Patient states she has had multiple in the past and knows what it feels like. Notified resident physicians of above and new orders were received for a STAT Doppler of the LLE to rule out . At 0200 (2:00 p.m.) 100mg was administered for c/o pain to LLE with a pain level of 9 out of 10. was effective. At 0330 (3:30 a.m.), the mobile service arrived to perform Doppler. Patient remained on bed rest. Patient remained alert and responding appropriately to verbal and stimuli. No s/s of distress noted. Vitals 97. - . Patient received new order on

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N 201	Continued From page 18 to restart (was not discontinued)." A review of the Report, dated revealed: "Examination: Doppler extremity/limb, left. Clinical Indications: of Limb, Findings: Real time color imaging shows no collateral and augmentation of post , popliteal , deep and common of left leg. There are no excessive collateral veins. Left lower Extremity duplex : Impression: Extensive seen." An interview was conducted with the facility's Director of Nursing (DON), on , at 3:00 p.m. A list of medication errors for the month of 2015 was provided by the DON. The DON stated that she was aware of the medication error for Resident #6. She stated that a nurse found the error after performing a "medication review." The DON stated that she was unsure of why the error occurred. She stated that the facility ' s intervention was the and the physician and the resident were notified of the error. The DON confirmed that no audits or education were provided to the staff following the medication error. The DON also confirmed that there was no evidence of an investigation. The DON stated that her conclusion of the omitted medication for Resident #6 was "we performed an , and started giving her injections and elevated her left leg." On at 9:50 a.m. the Nursing Home Administrator, DON and the facility's corporate nurse confirmed that an in service was not conducted related to Resident #6's omissions of her scheduled medications.	N 201		

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N 201	Continued From page 19 The DON and NHA on at 3:30 p.m. confirmed that they were aware of Resident #6's medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of the medication errors for Resident #6 only after the Doppler confirmed the positive . It was unclear due to the lack of the investigation of how and why the medication error was found. The DON was unable to present any information regarding her investigation, education or audits. No formal action plan had been put in place as of the time of the start of the survey on During an interview on at 3:30 p.m., the DON stated "she checks the MARs two times a week by flipping through all of the MARs." She confirmed there was no documentation related to this process. The DON said that the ADON and Unit manger check every MAR daily for accuracy and completeness. During an interview on at 8:50 a.m., the Assistant Director of Nurses stated that she randomly checked the MARs on a daily basis for accuracy and completeness. She stated that she checked new admissions and "maybe two others." She stated that the Unit Manager was responsible for checking at least five residents on each cart on a daily basis. The ADON stated that there was not a definite system of checking the MARs. During an interview on at 9:30 a.m., Employee (LPN) A, Interim Unit Manager (started on Monday stated that she checked all new admissions for accuracy of orders and double checks with the MAR for accuracy. She stated that she did not do anything with the MARs on a daily basis. No one informed her she was	N 201		

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supposed to be checking the MARs. She stated that she gets the new orders and the 24 hour report in the morning and then gives them to the ADON or DON to take them to the morning meeting. She does not usually go to the morning meetings and was not aware of any plan to begin to go. She stated that no education or training was provided to be a Unit Manager. The ADON told her the things that needed to be done and she was "just helping them out not doing the whole position."

The regular Unit Manager (LPN) B on the Long Term Care unit was currently on medical leave and was unable to be contacted.

During an interview on [redacted] at 10:13 a.m. and [redacted] at 10:43 a.m., the DON stated that the process of checking the MARs was an informal process that was implemented inconsistently and the ADON and Unit Manager assisted with the process. There was not a written policy or procedure. The DON stated that she had been in the role of DON for one year and the process of checking the MARs had been an expectation since her arrival and she had continued that process since then. The DON also stated on [redacted] at 10:43 am that she was unaware the ADON and Unit Managers were not checking the MARs daily.

During an interview on [redacted] at 2:45 p.m., the Medical Director stated that he had been the Medical Director of the facility since 2012. He stated that he participated in the QA monthly meetings and the facility followed a set agenda. He stated that he was made aware of incidents for his patients and that the attending physician for the other residents would be notified of incidents. He stated that he would expect to be

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N 201	Continued From page 21 notified of incidents, including medication errors. Specifically, for system failures that could affect all residents. He stated that he was here at the facility every Wednesday and Friday. However, someone from his physician group was present daily and should be notified. He expected that the nurses notify the physician of any incident. He confirmed again that he was not made aware of any medication errors for Resident #6. He was not aware of any issues in QA related to medication administration. He stated that he was aware that the facility used a lot of agency staff and had a lot of turnover. The Medical Director stated that there no action plan identified or implemented related to staffing or staff procedures. He also stated that he was aware of a concern with nurses not implementing physician orders timely. He stated that the nurse would pass off the order to the oncoming shifts and the medication would not be started. He stated that he provided education to the staff "within the year" related to medication implementation. The education was to have a second nurse initial the order to assure implementation. He confirmed that there was nothing in Quality Assurance (QA) related to the medication administration and order implementation process. The Medical Director stated that if the facility had a good system in place, then any staff member should be able to come in and care for the resident with no breaks in the system. He stated that the "system was not perfect and should not have failed." The Medical Director was asked if it was expected that the facility notify him of negative outcomes; he stated, "I would love to." When referring to the incident for Resident #6, the Medical Director stated that it was a "negative outcome and that he was afraid for his patients." He stated that "there was not a plan in place."	N 201		

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N 201	Continued From page 22 During an interview on at 10:15 a.m., the Administrator stated that she was informed of Resident #6's medication error on , 2015. She was informed that the Unit Manager had educated the staff involved. The DON informed her that she was assembling her investigation and would bring the information to the next QA meeting on . The QA meeting was initially scheduled on and it was delayed due to a trial. The Nursing Home Administrator (NHA) said usually the QA is scheduled every third Tuesday of the month. The facility has done Ad Hoc meetings in the past but the DON wanted to make sure everything was done before hand and an Ad Hoc meeting was not scheduled. The DON informed her that the physician had been notified. The DON also, informed her that the facility was still working the concern. The Administrator stated that she was aware the process was in place. The four point process was not completed and had not been presented. The MAR indicated that six nurses assigned on the 3-11 p.m. shift failed to administer the as ordered by the attending physician. During an interview on at 4:10 p.m. Employee (RN) E, a nurse that cared for the resident on 12 of the 26 evening shifts, stated that she had been a nurse for a long time and worked in long term care. She stated that she was familiar with Resident #6. She stated that she was aware the resident needed . The medication was not administered. She stated that she did not think the order was on going. She stated that it was on hold. She stated that she did not have the time to research the order and was aware that Resident #6 was at high risk for . She stated that she questioned the medication to other staff; however, she did not	N 201		

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recall who the staff member was. She stated that the doctor came in and then realized the medication should have been resumed. The nurse stated that when a medication was held, the nurse should write hold on the days that the medication is to be held and then indicate when the medication should be resumed. The nurse confirmed the MAR and confirmed that there was no indication the medication had been given. She stated that she did not recall the resume date. The nurse stated that "my philosophy is if I don't see the medication and don't see a stop order, then I question with another nurse as to whether the medication is on hold or should be discontinued." She stated that she would call the pharmacy. She stated that the medication card was not in the cart. The nurse also confirmed that she did not document any omissions in the chart. She stated that she did not look at the chart to find the original order.

An interview was conducted on at 4:30 p.m. with Employee (LPN) D. She stated that she worked at the facility When asked about her training she stated she had trained for two to three days and was on her own by the fourth day. She said she had felt that it was ' on her orientation process as far as knowing the processes and was able to always go back and ask questions. Employee (LPN) D stated that she recalled caring for Resident #6. She confirmed that she was on and stated that she cared for her several times. The staff member reviewed the MAR and confirmed that she worked on and The nurse next confirmed the order for and then confirmed the order said to resume The nurse stated that she would not have given a medication without signing the MAR.

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N 201	Continued From page 24 These dates were blank, with no initials. Review of the Pharmacy Dispensing Record for Resident #6's from 1-A 2015. The pharmacy sent 14 pills at a time. Review of the Dispensing Log revealed the facility last received 14 pills on All of the medication would have been administered by Therefore, there was no available for administration. The medication was not a routinely stocked medication in the Emergency Drug Kit. Review of the Drug Manufacturer's Pharmaceutical Medication Guide for revealed; is a prescription medicine used to treat and , and to help reduce the risk of these conditions occurring again. lowers your chance of having a by helping to prevent clots from forming. If you stop taking XARELTO®, you may have increased risk of forming a clot in your Do not stop taking without talking to the doctor who prescribes it for you. Stopping increases your risk of having a If you have to stop taking your doctor may prescribe another medicine to prevent a clot from forming. Do not stop taking XARELTO® without talking to your doctor first. Your doctor may stop XARELTO® for a short time before any surgery, medical or dental procedure. Your doctor will tell you when to start taking again after your surgery or procedure." Review of Resident #6's Care plan Focus on Anticoagulation reflected the resident had a "potential for abnormal Date Initiated; updated: Goal	N 201		

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will be free from signs and symptoms of abnormal . Interventions: Administer as MD ordered." The Care Plan was not followed.

Review of the facility policy entitled "Medication Administration General Guidelines for the Administration of Medications" policy 6.2 (page one of three) (no dated) was reviewed and it was expected that the nurses administer medications per the physician's orders.

The facility identified thirty residents receiving . All thirty residents were sampled. The following residents were identified with medications errors related to

2. During an interview on at 3:45 p.m. the facilities Director of Nursing (DON) she stated: "we have had another problem with an , it happened to Resident #2." The DON said that when Resident #2 was admitted on and the nurse had written up the physician orders on one of our order sheets. The was written on a regular sheet that did not have a copy that was used for the medication administration record. We the (DON and ADON) did not find out about the medication not being given until . The DON was asked what the process was on checking admission orders for their accuracy she said that usually the unit manager will check the orders the next morning and then added the Unit Manager was out on maternity leave. The DON was asked who would be responsible to verify the physician ordered medications were accurately transcribed into the Medication Administration Record (MAR) she said the ADON or me. The DON said "We checked the physician order sheet and they were

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N 201	Continued From page 26 written correctly but because the order was not put on the physician order sheet that contained a copy it did not show up on the MAR." The DON confirmed she did not review the MAR to make sure all the physician orders were transcribed. The DON was asked how that had happened she stated; "I'm still trying to figure out how it happened and when I do find it out it has unfortunately already occurred." When asked if the facility uses a check off system for newly admitted residents she said "we used to but now it is computerized. The computer tells us what to do." She stated she was there the day of the verbal teaching but she did not sign the in-service verifying that she had attended. A medical record review was conducted for Resident #2 and revealed he had resided in the facility for approximately three weeks. His diagnoses included: , and Review of Resident #2's admission orders revealed he was prescribed 4 mg on Sunday, Tuesday, Wednesday, Thursday and Saturday and 2 mg on Monday and Friday. Review of the 2015 Medication Administration Record for Resident #2 revealed the 4 mg and 2 mg doses were initialed on: 4/8, 4/9, 4/12, , , and on , resulting in a total of 6 mg of . On the order was discontinued and rewritten to give 4 mg by mouth on Sunday, Tuesday, Wednesday, Thursday and Saturday and to administer 2 mg on Monday and Friday. (The same identical order, this time the initial boxes were outlined indicating which day of the week the medication needed to be given).	N 201		

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N 201	Continued From page 27 On at 11:45 a.m. a telephone interview was conducted with Resident # 2's Attending Physician. He confirmed he was notified that the resident had been receiving double doses of his and confirmed that his International Normalizing Ratio was 3.2 and not critical erapeutic). The physician confirmed the facility did not follow his orders and should have administered the proper dosages of on the proper days as ordered. The physician stated "they need to fix it, I don't know if it's the DON or the corporation they have to fix these things so it doesn't happen again." The DON provided a copy of an in-service that was conducted on (three days after the medication omission was found) Teaching Method: Verbal Topic: and Protocol. Make sure INR is done, Call MD with results before giving medication, check orders daily and make sure log is accurate. The DON was asked about any in-servicing that was provided to the licensed staff on physician orders not being transcribed accurately in the residents MAR or not being transcribed at all, she did not respond. The DON and NHA on at 3:30 p.m. confirmed that they were aware of Resident #2's medication errors and provided a facility document that indicated a medication error had occurred. The facility was aware of Resident #2's medication error on however, no negative outcomes occurred. It is unclear due to the lack of the investigation of how and why the medication error was found. On the DON stated "she checks the MARs two times a week by flipping through all of the MARs, she confirmed there was no documentation related to	N 201		

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N 201	Continued From page 28 this process. The DON said that the ADON and Unit manger check every MAR daily for accuracy and completeness. 3. The facility admitted Resident #10 on with diagnoses including Accident and per the physician order summary list of diagnoses. Review of the Admission Physician Orders dated revealed the resident was prescribed 40 unit daily at 9 a.m. Review of the Medication Administration Record revealed Resident #10 did not receive on 4/9 or There was no documentation on the back side of the MAR as to why the medication was omitted. Review of the Care Plan dated revealed a problem area was identified for potential for abnormal The approaches included "administer as MD ordered." The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information was provided related to why the medication would not have been given to Resident #10. 4. The facility admitted Resident #14 on with diagnoses including Acute and , per the demographic face sheet. Review of the medical record revealed Resident #14 was transferred to a Hospice House for end of life care. Further review of the medical record revealed a physician's telephone order dated for 30 units twice daily. The resident was placed on due to	N 201		

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N 201	Continued From page 29 sub-therapeutic INR (International Normalizing Ratio) levels and she was at risk for developing additional clots. Review of the Laboratory results revealed on , Resident #14's INR was 1.1. On the was discontinued. The resident remained sub-therapeutic and the physician was attempting to adjust her Review of the Medication Administration Record for 2015 revealed Resident #14 did not receive for 4 out of the 6 available doses. She did not receive any on . The resident did not receive on at 9 a.m., at 9 a.m. or at 9 a.m. There was no documentation in the nurses' notes or the back of the Medication Administration Record as to why the medication was not given. On the resident was noted to have redness and to her right leg. An was ordered and the resident was diagnosed with a Review of the Care Plan dated revealed a problem area was identified for potential for abnormal The approaches included "administer as MD ordered." During an interview on at 2:30 p.m., the Nurse Consultant confirmed the missed doses of He stated that the medication should have been available from pharmacy and was unable to determine why the nurses would not have given the medication. He stated that the at least one dose of the should have been given on 5. The facility admitted Resident #15 on with diagnoses including and per the demographic face	N 201		

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N 201	Continued From page 30 sheet. Review of the Physician Orders for 2015 revealed Resident #15 was prescribed 40 unit daily for two weeks. Review of the Medication Administration Record for 2015 revealed Resident #15 did not receive her on and Review of the Care Plan dated revealed a problem area was identified for potential for abnormal The approaches included "administer as MD ordered." The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11:00 a.m. No additional information as provided related to why the medication would not have been given to Resident #15. 6. The facility admitted Resident #16 on with diagnoses including and per the physician diagnoses listed on the Medication Administration Record. Review of the Physician's Orders revealed on Resident #16 was prescribed 60 units every 12 hours, D/C (discontinue) when INR (international normalizing ratio) above 2." Review of the Laboratory Data revealed an INR was collected on that was 2.5. Review of the Medication Administration Record for 2015 revealed Resident #16 was given on , and He received four doses of after the medication should have been discontinued per the INR value of 2.5. Further review of the Laboratory Data revealed an INR was collected on and the resident was erapeutic at 3.9. Record review revealed no indication of abnormal	N 201		

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was noted.
Review of the Care Plan dated revealed a problem area was identified for , potential for abnormal The approaches included "administer as MD ordered."
The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the resident received the when the medication should have been discontinued.

7. The facility admitted Resident #17 on with diagnoses including , Accident and per the demographic face sheet.
Review of the Physician's Orders for 2015 revealed the resident was prescribed 3 mg PO daily at 5 p.m.
Review of the 2015 Medication Administration Record revealed Resident #17 did not receive the prescribed for 5 doses; 4/7, , and There was no documentation in the nurses' notes or on the back of the MAR as to why the medication was omitted.
Review of the Care Plan dated revealed a problem area was identified for , potential for abnormal The approaches included "administer julant as MD ordered."
The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 a.m. No additional information as provided related to why the medication would not have been given to Resident #17.

8. The facility admitted Resident #18 on and was readmitted on with

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N 201	Continued From page 32 diagnoses including Chest Pain and Review of the Physician's Orders dated revealed Resident #18 was prescribed 8.5 mg daily at 9 p.m. Review of the 2015 Medication Administration Record revealed Resident #18 did not receive his on 4/2, or . There was no documentation on the back side of the MAR as to why the medication was not given. Review of the Care Plan dated revealed a problem area was identified for potential for abnormal The approaches included "administer as MD ordered." During an interview with Resident #18 on at 3:20 p.m. he stated that there have been occasions where he did not receive all of his ordered mediations from the nurse. He stated that he now has to check all his medications for accuracy. He stated that when he brought it to the nurse's attention when he did not receive his medications, they told him that they were either out of the medication or they would go back and bring him his ordered medication. He stated that he used to have a medication book on his bedside table that he would utilize to check his medications but that the medications are changed from the manufactures or the pharmacy so often now that it is obsolete. The findings were confirmed by the Nurse Consultant, Administrator and Director of Nurses on at 11 am. No additional information as provided related to why the medication would not have been given to Resident #18. 9. Resident #19 was admitted to the facility in 2015 her admitting diagnosis and	N 201		

FORM APPROVED

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 33 Resident #19 was identified and listed on "Current active orders for ' that was provided by the facility. The physician orders were reviewed with an order dated to administer Pradaxa 150 mg capsule one capsule by mouth two times daily for a diagnosis of The MAR was reviewed for 2015 and it was identified resident # 19 had missed four doses of Pradaxa on at 5:00 p.m., at 5:00 p.m., at 9:00 a.m. and again at 5:00 p.m. The nursing notes revealed for the days the medication had been omitted there was neither documentation nor notification to the physician on why a prescribed medication was not administered as ordered. Review of resident #19 Care plan Focus on Anticoagulation has a potential for abnormal Date Initiated; Goal will be free from signs and symptoms of abnormal Interventions: Administer as MD ordered. The Care Plan was not followed. 10. Resident #20 was admitted to the facility on with a history of recent for of right with Review of resident physician orders dated she is to receive 40 mg every 12 hours for preventative measures. The MAR was reviewed for 2015 and it revealed seven separate missing initials or circles around initials indicating the medication was not administered as ordered. On at 9:00 p.m. the box on the MAR was without an initial, 9:00 a.m. the box was initialed with a circle, at 9:00 a.m. the box was initialed with a circle, at 9:00 p.m. the	N 201		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62932	A. BUILDING: ______ B. WING ______	C 05/01/2015

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EXCEL REHABILITATION AND HEALTH CENTE	2811 CAMPUS HILL DR TAMPA, FL 33612

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N 201	Continued From page 34 box MAR was without an initial, at 9:00 p.m. no initialed as given, and on at 9:00 am. the box was initialed with a circle. The back of the MAR nursing notes for at 9:00 p.m. indicated that the was not available to give. A second nursing note for at 9:00 a.m. indicated tea the pharmacy was notified. 11. The facility admitted Resident #8 on with diagnoses including , Hip and Review of the Physician Telephone Orders dated revealed the physician ordered a Urinalysis with Culture and Sensitivity and also ordered 500 mg every 8 hours for 7 days for a Review of the Laboratory Data revealed Resident #8 did not have a Urinalysis collected. Review of the and 2015 Medication Administration Records revealed Resident #8's was not started until (a three day delay in initiating the physician's order). Further review of the MAR revealed the 6 am dose was given on ; however, the 2 p.m. and 10 p.m. doses were omitted. During an interview on at 2 p.m., the Nurse Consultant stated that the Urinalysis had not been collected. He stated that he was unsure why the nurses would not have gotten the sample. He also stated that the 6 am dose of on was taken from the Emergency Drug Kit. He confirmed the 2 p.m. and 10 p.m. doses were not given. The Nurse Consultant also confirmed there was no documentation related to why the urinalysis was not collected, why the medication not initiated for 3 days or why the resident missed two doses of her	N 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62932	A. BUILDING: ______ B. WING ______	C 05/01/2015

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N 201	Continued From page 35	N 201		

12. Further record review of Resident #2's Medical Record revealed his admissions orders dated were for 40 mg by mouth one time daily and 15 units in the morning and 5 units at night time. Resident #2 did not receive his from . Resident #2 did not receive his scheduled morning dosage from and the night time dosage from . The MAR revealed orders dated to start 40 mg one time daily and 15 units in the morning and 5 units at night time, hold if BS is less than 110.

Resident #2 nursing notes were reviewed for at 3:16 p.m. "there was a med error for patient there was error in patient , patient and was never given patient was supposed to be on daily weight not done. Physician has been paged. Waiting for call back." The nursing notes for at 1:54 a.m. "New order for INR ordered for the AM for the dosage error." There was no corresponding nurses' notes related to the omissions of Resident #2's or

On at 11:45 a.m. a telephone interview was conducted with Resident #2's Attending Physician. The Attending Physician confirmed that he was notified that Resident #2 did not receive his ordered for ten days after being admitted and he did not receive his for ten days after being admitted to the facility. The Attending Physician was asked if a resident had a diagnosis of being does that mean he needs monitoring. The Attending Physician stated "yes, he needs his sugars monitored he could have went into or and worse yet into ' The physician stated "they

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62932	A. BUILDING: ______ B. WING ______	C

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N 201	Continued From page 36 need to fix it, I don't know if it's the DON or the corporation they have to fix these things so it doesn't happen again." The DON was asked if the nurse that had not transcribed the ...... and ...... in Resident #2's MAR had attended the in-service that she had on . The DON stated "The nurse was there but she did not sign on the sign-in sheet." When asked if there was any other information that she had on training her nursing staff she stated "We were going to bring it into our QA meeting on Tuesday" Class I	N 201		

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Excel Rehabilitation And Health Center
2811 Campus Hill Drive
Tampa, FL 33612

RE: CCR# 2015002905 & CCR# 2015003927 & CCR# 2015003708

Dear Administrator:

On , 2015 . 2015, a survey was conducted in your facility by representative(s) of this office. Your facility was found not in substantial compliance with the participation requirements. A partial extended survey was conducted , 2015.

The findings of the survey revealed Immediate Jeopardy at
N0201 -- S/S: K -- 400.022(1)(l), FS -- Right To Adequate And Appropriate Health Care
F0281 -- S/S: K -- 483.20(k)(3)(i) -- Services Provided Meet Professional Standards
F0282 -- S/S: K -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0333 -- S/S: K -- 483.25(m)(2) -- Residents Free Of Significant Med Errors
F0490 -- S/S: K -- 483.75 -- Effective Administration/resident Well-Being
F0501 -- S/S: K -- 483.75(i) -- Responsibilities Of Medical Director,
identified on , 2015, which was removed on , 2015.

Your facility's noncompliance with F0333 -- S/S: K -- 483.25(m)(2) -- Residents Free Of Significant Med Errors has been determined to constitute substandard quality of care as defined at §488.301. **Sections 1819(g)(5)(c) and 1919(g)(5)(c) of the Social Security Act and 42 CFR 488.325(b) require that the attending physician of the affected resident, who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with §488.325(g), you are required to provide this office with the name and address of the attending physician of the affected residents in your facility within 10 working days of your receipt of this letter. Please note that, in accordance with §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of alternative remedies.**

List of affected resident(s): #2, #6, #8, #10, #14, #15, #16, #17, #18, #19 and #20

As a result of the survey, this Agency is forwarding a copy of the CMS-2567 to the Centers for Medicare and Medicaid Services (CMS) and a copy of these results to you.

You will not receive a copy of this letter and attachments in the mail; you will only

receive this faxed report.

CMS will communicate with you after they have received this documentation.

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Recommended Remedies:
Remedies will be recommended for imposition by CMS or the State Medicaid Agency.

- **Civil Money Penalty, in an amount and duration to be determined by CMS.**
- **Discretionary denial of payment for new admissions Medicare/Medicaid as soon as notice requirements are met.**
- **Termination of the Medicare Agreement effective , 2015.**

Informal Dispute Resolution
In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Attention: IDR Coordinator
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 9-A
Tallahassee, Florida 32308
FAX (850) 414-6946
or
Phone number: (850) 412-4301
IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey

process.

If you have questions, please contact . .. Freed, RNC at (727) 552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/rk
Enclosure