## Summary Statement of Deficiencies

**F280**

483.20(d)(3), 483.10(k)(2) **RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP**

The resident has the right, unless adjudged in competent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to revise the care plan to include dialysis and/or emergency bleeding for 2 of 10 (Residents #1 and 7) sampled residents.

The findings included:

1. Medical record review for Resident #1 documented a readmission date of 3/24/10 with diagnoses of Status Post Hypotension, End Stage Renal Disease and old Cerebral Vascular Accident with Hemiplegia. Review of Resident

## Corrective Action;

1. The care plan for resident #1 was updated on 4/6/10 to reflect that the resident is receiving dialysis treatments.

The care plan for resident #7 was updated on 4/6/10 to address emergency bleeding from the permacatheter site.

2. The DON and ADON audited dialysis care plans on 4/6/10 to ensure that they accurately address the resident's needs.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F280</td>
<td>Continued From page 1</td>
<td></td>
<td>#1's physician's order dated 3/24/10 documented, &quot;...Dialysis M [Monday], W [Wednesday], F [Friday]...&quot; Review of Resident #1's admission care plan dated 3/24/10 did not address dialysis. During an interview in the conference room on 4/6/10 at 2:54 PM, after reviewing the care plan, the Director of Nursing (DON) stated, &quot;No it's [referring to care plan for dialysis] not there.&quot; 2. Medical record review for Resident #7 documented a readmission date of 3/30/10 with diagnoses of Diabetes Mellitus, Renal Failure and Hypertension. Review of a Resident #7's physician's order dated 3/30/10 documented, &quot;...continue previous dialysis scheduled transport...&quot; Review of Resident #7's admission care plan dated 3/30/10 did not address care for emergency bleeding from the permacatheter site. During an interview in the conference room on 4/6/10 at 2:55 PM, after reviewing the care plan, the DON stated, &quot;No it's not there [referring to emergency bleeding] I'm sure [Named Nurse] thought that dressing dry and intact was okay.&quot;</td>
<td>F320</td>
<td>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
<td>The facility must ensure that it is free of medication error rates of five percent or greater.</td>
<td>4/15/10</td>
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<tr>
<td>F332</td>
<td>SS=D</td>
<td>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
<td>The facility will ensure that it is free of Medication error rates of five percent or greater.</td>
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This REQUIREMENT is not met as evidenced by:
Based on review of the "Medication Guide for Long-Term Care Nurse", medical record review, observation and interview, it was determined the facility failed to ensure 2 of 2 (Nurses #1 and 2)
Continued from page 2:

nurses administered medications without a medication error rate of less than 5 percent (%) for Resident #8 and Random Residents (RR #1 and 2). A total of 3 medication errors were observed out of 47 opportunities for error, resulting in a medication error rate of 6.38%.

The findings included:

1. Review of the "Medication Guide for the Long-Term Care Nurse, Fourth Edition, page 75, for Spacing and Proper Sequence of Inhaled Medications documented "...Wait one minute between "puffs " for multiple inhalations of the same drug..."

Medical record review for RR #2 documented an admission date of 3/24/10 with diagnoses of History of Hypercalcemia, Sycnopal Event, Likely Orthostatic in Nature, possible Transient Ischemic Attack, Stroke Symptoms and Multiple Chronic Medical Conditions. Review of RR #2’s physician’s orders dated 3/28/10 documented "...Flovent 220 mg [micrograms] give 2 puffs inh [inhaler] BID [two times a day]..."

Observations in RR #2’s room on 4/5/10 at 9:29 AM, revealed Nurse #1 gave RR #2 1 puff from the Flovent inhaler. Nurse #1 shook the inhaler for 20 seconds and gave RR #1 the second puff. Nurse #1 did not wait 1 minute before administering the 2nd puff of the Flovent inhaler.

2. Medical record review for Resident #8 documented an admission date of 3/25/10 with diagnoses of Bilateral Knee Effusions, Gout, Type 2 Diabetes, Hypertension and Stage 3 Chronic Kidney Disease. Review of Resident #8’s physician’s order dated 3/26/10 documented, 1. Resident #8’s Nitro-Bid 6.5 mg was received from pharmacy on 4/5/10 and was administered by the licensed nurse as ordered. Random resident #1’s Duoneb was received from pharmacy on 4/5/10 and was administered by the licensed nurse as ordered. Random resident # 2’s Flovent was administered by the licensed nurse as ordered for subsequent doses on 4/5/10.

2. The DON performed an audit on 4/13/10 to ensure that all medications are being administered as ordered by the physician.

3. Licensed nurses were inserviced on 4/5/10 by the DON regarding proper medication administration using the five R’s of verification.

4. The DON and ADON will perform audits weekly for one month, then monthly thereafter and report the findings to the QA Committee.

4/15/10
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"...Nitro-Bid 6.5 mg po [by mouth] BID..."

Observations in Resident #8's room on 4/5/10 at 9:55 AM, revealed Nurse #1 gave Resident #8 Nitroglycerin SlowCap 2.5 mg instead of the ordered 6.5 mg.

During an interview at the nurses station on 4/5/10 at 3:25 PM, the Consultant Pharmacist stated "...Incorrect strength, sent wrong thing, [will] get that order corrected..."

3. Medical record review for RR #1 documented an admission date of 3/17/10 with diagnoses of Hypoxic Respiratory Failure, Chronic Obstructive Pulmonary Disease, Hypertension, Anxiety and Depression. Review of RR #1 physician's orders dated 3/17/10 documented "...2. Duoneb [Ipratropium Bromide 0.5mg and albuterol Sulfate 3 mg inhalation solution] breathing tx [treatment] qid [four times a day]..."

Observations in RR #1's room on 4/5/10 at 3:00 PM, Nurse #2 gave a breathing treatment of Albuterol Sulfate 0.83 milligrams per milliliter (mg/ml) with 2.5 mg/3 milliliter in the treatment. Nurse #2 did not give the Duoneb as ordered.

During an interview on the North hall on 4/5/10 at 3:00 PM, Nurse #2 stated "...she [RR #1] did not get what she should get..." and Nurse #3 stated "...she [RR #1] is supposed to have Duoneb..." and when asked if she got what she should have Nurse #3 stated "No ma'am."