**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</th>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>445149</td>
<td>F 278</td>
<td>483.20(g) - (i) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</td>
<td>F 278</td>
<td>The assessment will accurately reflect the resident's status.</td>
<td>9/11/11</td>
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<td>The assessment will accurately reflect the resident's status.</td>
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<td>Resident #7 MDS has been corrected to reflect correct weight as of 08/03/11</td>
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<td>Resident # 8 MDS has been corrected to reflect the O2 usage and Foley catheter per MD order as of 08/03/11</td>
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<td></td>
<td>Resident # 20 MDS has been corrected to reflect no UTI per last assessment period as of 08/03/11</td>
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<td></td>
<td>A audit was completed on all resident's MDS assessments for completeness and accuracy on oxygen therapy, Foley catheter and weights.</td>
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<td></td>
<td></td>
<td>MDS Coordinators will be educated on ensuring accuracy of</td>
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</table>

**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

Kenedie Taylor Administrator August 18, 2011

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 patient. (See instructions.) Except for nursing homes, the findings stated above are disclosable 50 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 required to continued program participation.
Continued from page 1
Foley catheter and oxygen (O2) and a resident with a resolved Urinary Tract Infection for 3 of 25 (Resident #7, 8 and 20) sampled residents.

The findings included:

1. Medical record review for Resident #7 documented an admission date of 7/1/09 with diagnoses of Peripheral Vascular Disease, Ischemic Heart Disease, Congestive Heart Failure and Failure to Thrive. Review of the "Monthly/Weekly Weight Record" documented, "...Year 2011...February 12...67.6 [pounds (lbs)]...March 16...67.2 [lbs]..." Review of the "...Weight History..." documented, "...February 2011...67.6 [lbs]....March 2011...67.2 [lbs]..." Review of the MDS dated 3/10/11 documented, "...Section K Swallowing/Nutritional Status K0200...Weight...75 pounds..." The weight recorded on the 3/10/11 MDS was inaccurate.

During an interview at the 5th floor nurse's station on 8/3/11 at 10:15 AM Nurse #6 confirmed that the weight recorded on the 3/10/11 MDS was inaccurate.

2. Medical record review for Resident #8 documented an admission date of 6/22/11 with diagnoses of Cerebrovascular Accident (CVA), Hypertension (HTN), Dementia, Depression and Status Post Percutaneous Endoscopic Gastrostomy (PEG) Tube Placement. Review of the physician's orders dated 6/23/11 and 7/23/11 documented, "...C2 @ [at] 2L [liters]/[per] min [minute] via ENC [binal nasal cannula]..." Review of the "NURSING ADMISSION INFORMATION" dated 6/22/11 documented, "...CODES...Y = Yes...URINARY...Foley...CODE...Y...Type:

resident's current status by the DON

MDS Coordinators will conduct a weekly random audit for 6 consecutive weeks on MDS assessments accuracy. All results of audits will be reviewed in the PI committee until such time consistent substantial compliance has been achieved as determined by the committee.
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<tr>
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</table>
| F 278 | Continued From page 2  
Bardex...Size: 16 Fr [french]..." Review of the admission MDS dated 6/28/11 documented that Resident #8 had no indwelling catheter and no oxygen therapy.  
Observations in Resident #8's room on 8/1/11 at 9:30 AM revealed Resident #8 had O2 at 2 L/M [minute] BNC In use and a Foley catheter draining urine to a bedside bag (BSB).  
Observations in Resident #8's room on 8/1/11 at 2:15 PM, 8/2/11 at 7:45 AM, 10:00 AM, 1:00 PM, 4:05 PM and 8/3/11 at 7:35 AM revealed Resident #8 had O2 at 3 L/M BNC In use and a Foley catheter draining urine to a BSB.  
During an interview at the 4th floor nurses' station on 8/3/11 at 10:05 AM Nurse #4 confirmed the O2 and Foley catheter should have been on the 6/28/11 MDS.  
During an interview in the 4th floor hall on 8/3/11 at 8.55 AM Nurse # 5 stated, "...I made a mistake. I should have taken that [UTI] off..."  |
| F 280 | SS=D | 483.20(c)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP | F 280 | See next page | |

**Note:** The page contains a form titled "STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION," with specific identifiers and action items related to resident care and medical record review.
F 280
Continued From page 3

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning, 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, 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 policy review, medical record review, observation, and interview it was determined the facility failed to revise and update the comprehensive care plan to address oxygen administration, Foley catheter, and falls for 3 of 22 (Resident #8, #9, and #21) sampled residents.

The findings included:

1. Review of the facility's "Comprehensive Care Plan" policy documented, "...4. Care plans are revised as changes in the resident's condition dictate..."
<table>
<thead>
<tr>
<th>F 280</th>
<th>Continued From page 4</th>
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</thead>
</table>
| 2. Medical record review for Resident #8 documented an admission date of 6/22/11 with diagnoses of Cerebrovascular Accident (CVA), Hypertension (HTN), Dementia, Depression and Status Post Percutaneous Endoscopies Gastrostomy (PEG) Tube Placement. Review of the physician's orders dated 6/23/11 and 7/23/11 documented, "...O2 [oxygen] @ [liters] per min [minute] via BNC [nasal cannula]..." Review of the comprehensive care plan dated 7/14/11 documented no care plan for O2 and Foley catheter. Observations in Resident #8's room on 8/1/11 at 9:30 AM revealed Resident #8 had O2 at 2 LIM (minute) BNC in use and a Foley catheter draining urine to a bedside bag (BSB). Observations in Resident #8's room on 8/1/11 at 2:15 PM, 8/2/11 at 7:45 AM, 10:00 AM, 1:00 PM, 4:05 PM, and 8/3/11 at 7:35 AM revealed Resident #8 had O2 at 2 LIM BNC in use and a Foley catheter draining urine to a BSB. 2. Medical record review for Resident #8 documented an admission date of 4/22/09 with diagnoses of Depression, Dementia, Anxiety, Alzheimer's, Left Clavicle Fracture and HTN. Review of the nurses notes and incident reports documented Resident #8 had falls on 4/8/11, 6/29/11 and 7/16/11. Review of the comprehensive care plan dated 4/12/11 documented, "...Additional approaches: Date...4/16/11...Intervention:...Sensor/pressure Alarm for W/C [wheelchair]..." There was no documentation for a personal alarm as an intervention in the Falls (Interdisciplinary Care Plan) dated 4/12/11 to present. MDS Coordinators and ADON were in-serviced on revising and updating care plans to address oxygen administration, Foley catheter, and falls with appropriate interventions. The MDS Coordinators and ADONs will do random weekly care plan audits for 6 consecutive weeks to ensure care plans are updated and in place for oxygen therapy administration, Foley catheter and falls with appropriate interventions. All results of audits will be reviewed in the PI committee until such time consistent substantial compliance has been achieved as determined by the committee.
<table>
<thead>
<tr>
<th>ID</th>
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<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION</th>
<th>(33) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 5</td>
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<td>F 280</td>
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Observations in Resident #9's room on 8/1/11 at 10:07 AM and 8/3/11 at 7:35 AM revealed Resident #9 sitting in his wheelchair with a personal alarm in place.

Observations at the 4th floor nurses' station on 8/2/11 at 7:55 AM and 12:10 PM revealed Resident #9 sitting in his wheelchair with a personal alarm in place.

Observations in the Restorative Dining Room on 8/2/11 at 1:00 PM revealed Resident #9 sitting in his wheelchair with a personal alarm in place.

Observations in Resident #9's room on 8/3/11 at 7:35 AM revealed Resident #9 lying in bed with a personal alarm in place.

3. Medical record review for Resident #21 documented an admission date of 7/1/09 with diagnoses of CVA, Intracranial Hemorrhage, Convulsions, Aphasia, Speech Disturbance, and Mental Retardation. Review of the nurses notes and incident reports documented Resident #21 had falls on the following days: 5/20/10, 6/17/10, 8/5/10, 8/26/10, 9/6/10, 11/18/10, 12/18/10, 1/11/11, 1/13/11, 2/4/11, 4/21/11, 4/28/11, 5/1/11, 5/21/11, 6/4/11, 6/26/11, 7/26/11 and 7/27/11. The facility was unable to provide documentation of new interventions being put in place after each fall on 8/20/10, 10/10/10, 1/13/11, 2/4/11, 5/1/11, 5/21/11, and 6/4/11.

Observations on the 5th floor hall on 8/3/11 at 8:00 AM revealed Resident #21 seated in his wheelchair close to the 5th floor nursing station.
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<th>DAYS COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 6: During an interview in the conference room on 8/3/11 at 3:44 PM, the Director of Nursing (DON) stated, &quot;...[Resident #21] is very determined...we have really worked with him...biggest thing we can do is prevent injury...&quot; When asked what interventions were put into place after these falls, the DON confirmed there were no interventions and stated, &quot;...I see what you mean...&quot;</td>
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<tr>
<td>F 309</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
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<td>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on medical record review and interview it was determined the facility failed to follow physician orders for medication to be administered for 3 of 25 (Resident #13, 20, and 23) sampled residents.</td>
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<td>The findings included:</td>
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| | 1. Medical record review for Resident #13 documented an admission date of 7/30/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Pneumonia, Coronary Artery Disease, Restless Leg Syndrome and Arthritis. Review of a physician's order dated 7/30/11 documented, "...Regulp 0.25 mg il [symbol for two] tab daily po [by mouth]..." Review of the MAR for August 2011
<table>
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<tr>
<td>F 309</td>
<td></td>
<td>Continued From page 7 documented, &quot;...Requip 0.25 mg III [symbol for 3] po daily...&quot;</td>
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<td>F 309</td>
<td>Nurse #12 was re-educated on the 5 rights of medication, Nurse #12 was re-educated in obtaining BP and pulse for med administration as ordered</td>
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<td>During an interview in the 2nd floor hallway on 8/3/11 at 2:47 PM, when asked about the correct dose of Requip for Resident #13, Nurse #12 stated, &quot;...[Resident #13] been getting three [Requip], supposed to get two .25 [0.25] milligram tablets...&quot;</td>
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<td></td>
<td>All licensed nurses will be in-serviced and educated on facility policy on Medication administration and obtaining BP and pulse as ordered</td>
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**ADONS** will check transcription of medications per facility protocol daily, to check MD orders against the MAR each morning.
F 309 Continued From page 8
pulse assessments prior to administration of the Metoprolol, Nurse #1 stated, ". . . I agree they [B/P and Pulse] are not consistent..." and confirmed B/P and pulse were not documented.


Review of the June 2010 "MEDICATION/TREATMENT ADMINISTRATION RECORD" documented the following:
June 6th -Albuterol 0.083% tx QID- Hour-0900, and 1300 doses circled as not given. June 6th all doses circled as not given.
June 5th-Cefzil 500 mg p.o. BID x 7 days- Hour-0900 and 1700, circled as not given. June 6th all doses circled as not given.

Review of a "DAILY SKILLED NURSE'S NOTE" dated 6/6/10 documented, "1920 [7:20 PM] call place to [named pharmacy] about PO AB [antibiotic], medication started at 7:46 pm..."

During an interview in the Administrator office on 7/10/11 at 3:00 PM, the Director of Nursing verified that the medications should have been available within a few hours and if not the nurses should have notified the pharmacy again."
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| F 315 SS=D    | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  
Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  
This REQUIREMENT is not met as evidenced by:  
Based on policy review, medical record review, observation and interview, it was determined the facility failed to provide documentation of an order and a diagnosis for 1 of 4 (Resident #8) sampled residents with an indwelling catheter.  
The findings included:  
Review of the facility's "CATHETER INSERTION FOLEY [indwelling catheter] FEMALE AND MALE" policy documented, "...Foley catheters will be inserted per order of the physician...The order for a Foley catheter will be specific stating size of Foley, catheter and bulb size and when to be changed..."  
Medical record review for Resident #8 documented an admission date of 8/22/11 with diagnoses of Cerebrovascular Accident, Hypertension, Dementia, Depression and Status Post Percutaneous Endoscopic Gastrostomy (PEG) Tube Placement. Review of the... | F 315                      | The facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.  
A physician's order and a qualifying diagnosis obtained for an indwelling catheter on 08/03/11 for Resident #8.  
ADONS and MDS Coordinators completed a 100% audit of the medical records of residents with indwelling catheters on 08/09/11 to ensure that residents have orders and qualifying diagnosis.  
All charge nurses and ADON's will be in-serviced in obtaining a physician order and a qualifying diagnosis with use of an indwelling catheter by the DON by 08/22/11. | G/1/11                    |
Continued From page 10

Physician's orders dated 6/23/11 and 7/23/11 did not document an order for an indwelling catheter. Review of the "NURSING ADMISSION INFORMATION" dated 6/22/11 documented, "...CODES...Y... Yes...URINARY...Foley...CODE...Y...Type: Bardex...Size: 16 Fr [french]...."

Observations in Resident #8's room on 8/1/11 at 9:30 AM, 2:15 PM, 8/2/11 at 7:45 AM, 10:00 AM, 1:00 PM, 4:05 PM and 8/3/11 at 7:35 AM revealed Resident #8 had an indwelling catheter draining urine to a bedside bag (BSB).

During an interview at the 4th floor nurses' station on 8/3/11 at 9:30 AM, Nurse #3 was unable to provide documentation for an order and a diagnosis for the indwelling catheter.

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, it was determined the facility failed to implement new interventions, revise and update the care plan and implement interventions for 2 of 10 (Resident #9 and 21) sampled residents with falls.

The DON/ADON's will conduct random audits on residents with indwelling catheter for 6 consecutive weeks. All results of audits will be reviewed at the PI committee until such time consistent substantial compliance has been achieved as determined by the committee.
F 323 Continued From page 11

The findings included:

1. Medical record review for Resident #9 documented an admission date of 4/22/09 with diagnoses of Depression, Dementia, Anxiety, Alzheimer’s, Left Clavicle Fracture and Hypertension. Review of the nurses notes and incident reports documented Resident #8 had falls on 4/8/11, 6/29/11 and 7/16/11. Review of the comprehensive care plan dated 4/12/11 to present documented, "...Additional approaches: Date...4/8/11...Intervention:...Sensor/pressure Alarm for WC [wheelchair]..."

Observations at the 4th floor nurses' station on 8/2/11 at 7:55 AM and 12:10 PM revealed Resident #9 sitting in his wheelchair without a sensor/pressure alarm in place.

Observations in the Restorative Dining Room on 8/2/11 at 1:00 PM revealed Resident #9 seated in a wheelchair without a sensor/pressure alarm in place.

During an interview in the 4th floor dining room on 8/3/11 at 10:25 AM Nurse #3 confirmed Resident #8 did not have a sensor/pressure alarm in his chair.

2. Medical record review for Resident #21 documented an admission date of 7/1/09 with diagnoses of Cerebrovascular Accident, Intracranial Hemorrhage, Convulsions, Aphasia, Speech Disturbance, and Mental Retardation. Review of the nurses notes and incident reports documented Resident #21 had falls on the following days: 6/20/10, 6/17/10, 8/5/10, 8/26/10.

Resident #9 care plan has been revised to reflect a sensor or pressure alarm to wheelchair by MDS Coordinator.

Resident 21 have been updated and revised to reflect current interventions after each fall by MDS Coordinator

The nursing management team reviewed care plan for all residents who have been identified as having a potential risk for falls with an appropriate intervention in place.

All licensed nursing staff will be in-serviced on the facility policy for Accident & Supervision. All resident falls/accidents will be reviewed daily by the nursing management team to ensure appropriate implementation of safety interventions including updating care plan.
F 323

Continued From page 12
9/6/10, 11/18/10, 12/18/10, 1/11/11, 1/13/11,
6/28/11, 7/12/11 and 7/27/11. The facility was
unable to provide documentation of new
interventions being put in place after each fall on
8/26/10, 10/10/10, 1/13/11, 2/4/11, 5/1/11,
dated 7/27/11 at 5:40 PM documented, "...found
on floor beside the bed in front of w/c
[wheelchair]...lethargic and slow to respond...sent
[ER [Emergency Room]...Dx [Diagnosis]...Concussion [symbol for without] LOC [loss of
consciousness]."

Observations on the 5th floor hall on 8/3/11 at
8:00 AM, revealed Resident #21 seated in his
wheelchair close to the 9500 hall nursing station.

During an interview in the conference room on
8/3/11 at 3:44 PM, the Director of Nursing (DON)
stated, "...[Resident #21] is very determined...we
have really worked with him...biggest thing we
can do is prevent injury." When asked what
interventions were put into place after these falls,
the DON confirmed there were no new
interventions and stated, "...I see what you
mean." When asked what interventions were
put into place after the fall on 7/27/11, the DON
stated, "...every hour checks for 72 hours...one
on one." Nurse #1 stated, "...putting him in the
dining room in the afternoon...keep near the
nurses' station." When asked where this was
documented, Nurse #1 stated, "...it's not
documented."

During an interview in the conference room on
8/3/11 at 4:30 PM the Rehabilitation Manager
stated there had been new interventions put in
Continued from page 13
place such as bringing the resident to the nurses station, 1on1 in the dining room, and wearing a
heater, but they were not recorded on the care plan.

F 328 
483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS

The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, urostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation, and interview, it was determined the facility failed to ensure oxygen (O2) was administered as prescribed by the physician and that there was an order for O2 for 4 of 9 (Resident # 8, 13, 18, and 19) sampled residents receiving O2 therapy.

The findings included:
1. Review of the facility's "OXYGEN ADMINISTRATION" policy documented, "...Check physician's order for liter flow and method of administration... Set the flow meter to the rate ordered by the physician..."

The facility will ensure that residents receive proper treatment and care for special services (Respiratory Care).

Resident # 8- O2 liter flow was corrected to reflect 2 L/min via BNC per MD order on 08/03/11.
Resident # 13- O2 liter flow was corrected to reflect 3L/min via BNC per MD order on 08/03/11.
Resident # 18- order was received to administer O2 @ 3L/min via BNC on 08/03/11.
Resident # 19- order was received to administer O2@ 3L/min via BNC as needed for shortness of breath instead of continuous
Continued From page 14


Observations in Resident #8's room on 8/1/11 at 2:15 PM, 8/2/11 at 7:45 AM, 10:00 AM, 1:00 PM, 4:05 PM, and 8/3/11 at 7:35 AM revealed Resident #8 had O2 at 3 L/M [liters] BNC in use.

During an interview in Resident #8's room on 8/3/11 at 10:00 AM when asked what the O2 rate was set on, Nurse #2 stated, "It's [O2 rate] on 3 L/M." Nurse #2 confirmed the O2 rate should be set on 2 L/M.

3. Medical record review for Resident #13 documented an admission date of 7/30/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Pneumonia, Coronary Artery Disease, Restless Leg Syndrome and Arthritis. Review of a physician's order dated 7/30/11 documented, "...O2 3L continuously..."

Observations in Resident #13's room on 8/1/11 at 10:25 AM revealed Resident #13 receiving O2 at 6L per binaural cannula.

Observations in Resident #13's room on 8/1/11 at 4:00 PM and on 8/2/11 at 9:30 AM revealed Resident #13 receiving O2 at 4 1/2L per binaural cannula.

The nursing management team audited all residents on oxygen therapy for a physician's order and accurate oxygen liter flow.

DON or designee will in-service all licensed nurses on oxygen administration policy & procedure. All charge nurses will check resident's O2 liter flow as ordered every shift.

DON/designee will complete random weekly audits of residents on oxygen therapy for correct orders and treatment for 6 consecutive weeks.
Continued From page 15

During an interview in the 2nd floor hallway on 8/3/11 at 2:47 PM Nurse #12 confirmed the physician’s order was for O2 at 3L for Resident #13.


Observations in Resident #18’s room on 8/4/11 at 9:45 AM and on 8/3/11 at 7:35 AM, 10:10 AM, and 1:45 PM revealed Resident #18 was receiving O2 at 3 liters per minute via binaural cannula.

During an interview in the hallway outside Resident #18’s room on 8/3/11 at 11:20 AM when asked if Resident #18 is receiving O2, Nurse #7 stated, “Yes.” When asked if there is a physician’s order for O2, Nurse #7 stated, “...It’s not in here [Resident #18’s chart]...”

5. Medical record review for Resident #19 documented an admission date of 5/20/11 with diagnoses of HTN, Hyperlipidemia, Arthritis, Dementia, Huntington’s Disease, Depression, and Bipolar Disorder. Review of a physician’s order dated 5/9/11 documented, “...O2 @ 3L SNC...” Review of the care plan dated 6/3/11 documented, “...Potential for respiratory distress related to shortness of breath...Approach...Administer per Physician Orders...Oxygen...”
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<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tr>
<td>F 328</td>
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<td>Continued From page 16</td>
<td>F 328</td>
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<td>Observations in Resident #19’s room on 8/1/11 at 9:20 AM and on 8/3/11 at 9:40 AM revealed O2 on at 1.5 L with the BNC hanging on the O2 flow meter and Resident #19 was not in the room.</td>
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<td>Observations on the 3rd floor on 8/1/11 at 10:05 AM and on 8/3/11 at 7:32 AM, 9:40 AM, 11:10 AM, and 1:35 PM revealed Resident #18 seated in a wheelchair near the nurses station with no O2 on.</td>
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<td>During an interview at the 3rd floor nurses’ station on 8/3/11 at 11:25 AM when asked if Resident #19 uses O2, Nurse #7 stated, “Yes, it’s PRN [as needed]. She uses it mostly at night...” When asked if the physician’s order is for PRN use of O2, Nurse #7 stated, “...no, it’s continuous...”</td>
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<td>F 332</td>
<td>SS-D</td>
<td>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
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<td>See next page</td>
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<td>The facility must 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 “MED-PASS COMMON INSULINS” provided by the American Society of Consultant Pharmacists, policy review, medical record review, observation and interview, it was determined the facility failed to ensure that 3 of 9 (Nurse #9, 10 and 11) nurses administered medications with a medication error rate of less than 5 percent (%). A total of 3 errors was observed out of 44 opportunities for error, resulting in a medication error rate of 6.8%.
Continued From page 17

The findings included:

1. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Comaptability, and Properties" provided by the American Society of Consultant Pharmacists for typical dosing administration of insulin related to meals documented, "Novolog...ONSET (In hours, unless noted)...15 min [minutes]...TYPICAL DOsing / COMMENTS...5-10 minutes before meals..."

2. Review of the facility's "Medication Administration" policy documented, "...Medication Preperation:...3. Prior to administration, the medication and dosage schedule on the resident's MAR [medication administration record] is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule...Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber..."

3. Medical record review for Random Resident (RR) #1 documented an admission date of 7/20/11 with diagnoses of Motorcycle Crash with Subarachnoid Hemorrhage, Pelvic Fracture, Right Ankle Fracture, Right Pneumothorax Resolved and Subternal Hematoma. Review of a physician's order dated 7/29/11 documented, "...APPLY SILVER SULFADIAZINE 1% TOPICALLY TO BILATERAL ELBOW WOUNDS TWICE DAILY AS DIRECTED..."

Observations in RR #1's room on 8/1/11 at 4:10

F 332 -

The facility will ensure that it is free of medication error rates of five percent or greater

Nurse #9 was in-serviced on facility P & P for medication and treatment administration, and the 5 rights to medication administration. Nurse #9 was monitored on medication pass on 08/05/11 by ADON. Nurse #11 was in-serviced on 5 rights to medication administration as well as monitored on medication pass on 08/05/11 & 08/17/11 by ADON.

Nurse #10 was in-serviced on 5 rights to medication
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>F332</td>
<td>Continued From page 18</td>
<td>PM revealed Nurse #9 applied silver sulfadiazine 1% to RR #1's back. The application of the silver sulfadiazine 1% to RR #1's back resulted in medication error #1.</td>
<td>F332</td>
<td>Nurse #10 was in-serviced on 5 rights to medication administration as well as monitored on administration on 08/05/11 &amp; 08/17/11 by ADON</td>
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<td>During an interview in the 2nd floor hallway on 8/1/11 Nurse #8 stated, &quot;...I got my creams mixed up...&quot;</td>
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<td>Medication administration audits will be conducted by DON/designee to make sure medications are being administered as ordered.</td>
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<td>4. Medical record review for RR #2 documented an admission date of 5/24/11 with diagnoses of Diabetes Mellitus, Cement and Pin Removal Right Knee and Reimplantation Right Total Knee. Review of a physician's order dated 7/7/11 documented, &quot;Acoucheck Q [every] 4 [symbol] for hours w/ [with] Insulin Aspart [Novolog] SS [sliding scale] coverage SQ [subcutaneous]....201-260=5 units...&quot;</td>
<td></td>
<td>All license staff will be in-serviced on facility's medication administration P&amp;P and 5 rights to medication administration by SDC by 08/22/11</td>
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<td>Observations in RR #2's room on 8/2/11 at 10:48 AM, revealed Nurse #11 administered 5 units of Novolog insulin to RR #2. RR #2 did not receive her lunch tray until 11:48 AM. The administration of the insulin 1 hour before lunch was served resulted in medication error #2.</td>
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| F 332 | Continued From page 19 Expectations were for the administration of Insulin, the Director of Nursing stated, "...according to manufacturer's guidelines, especially with Humalog, Novolog..."


Observations in RR #3's room on 8/31/11 at 8:50 AM revealed Nurse #10 administered 2 tablets of Ampicillin 875 mg (total dose of 1750 mg). Nurse #10 administered Amoxicillin 1750 mg instead of Ampicillin 500 mg which resulted in medication error #3.

During an interview in the 3rd floor hallway on 8/31/11 at 9:25 AM Nurse #10 confirmed that she administered the wrong medication and would "...fill out a medication error report."

| F 333 | The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
- Based on review of "MED-PASS COMMON INSULINS" provided by the American Society of Consultant Pharmacists, medical record review, observation and interview, it was determined the

| F 333 | All licensed nurses will be monitored on medication administration by Pharmacist Consultant & ADONs by 08/30/11. Nurse # 9, 11, & 10 will complete a computerized medication administration module to enhance medication skills and knowledge.

All results of audits will be reviewed in the PI committee until such time consistent substantial compliance has been achieved as determined by the committee.

| F333 | The facility must ensure that residents are free of any significant medication errors.

Resident # 20 order was reviewed and clarified by MD for frequency BP and pulse as of 08/12/11 by ADON.
F 333 Continued From page 20

facility failed to ensure that residents were free of medication error by not following physician orders for 2 of 25 (Resident #20 and 23) sampled residents. 1 of 9 (Nurses #1) nurses observed during medication pass failed to administer insulin within the proper time frame related to food to Random Resident (RR) #2.

The findings included:

1. Medical record review for resident #20 documented an admission date of 12/8/10 with diagnoses of Cerebrovascular Accident, Dementia, Hypertension (HTN), and Percutaneous Endoscopic Gastrostomy (PEG) Tube Placement.


Review of the MR documented no pulse was assessed prior to Metoprolol being administered:


PM dose: 6/19/11, 6/21/11, and 7/21/11.

During an interview in the conference room on 8/3/11 at 5:15 PM, when asked about BP and
Continued From page 21

pulse assessments prior to administration of the Metoprolol, Nurse #1 stated, "...I agree they [B/P and Pulse] are not consistent..." and confirmed B/P and pulse were not documented.


Review of the June 2010 "MEDICATION/TREATMENT ADMINISTRATION RECORD" documented the following:
June 5th - Albuterol 0.083% tx QID-Hour-0900, and 1300 doses circled as not given. June 6th all doses circled as not given.
June 5th-Cefzil 500 mg p.o. BID x 7 days- Hour-0900 and 1700, circled as not given. June 6th all doses circled as not given.

Review of a "DAILY SKILLED NURSE'S NOTE" dated 6/6/10 documented, "1920 [7:20 PM] call place to [named pharmacy] about PO AB [antibiotic], medication started at 7:45 p.m..."

During an interview in the Administrator office on 7/19/11 at 3:00 PM the Director of Nursing verified that the medications should have been available within a few hours and if not the nurses should have notified the pharmacy again.

daily, to check MD orders against the MAR each morning.

DON/designee will do random audits weekly for 6 consecutive weeks for accuracy of medication orders on MARS, BP and pulse parameters done as ordered, and ensure medication are being given on time as ordered.
DON/designee will complete random, weekly audits of residents on oxygen therapy for correct orders and treatment for 6 consecutive weeks.
All results of audits will be reviewed in the PI committee until such time consistent substantial compliance has been achieved as determined by the committee.
Continued From page 22

4. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Comparability, and Properties" provided by the American Society of Consultant Pharmacists for typical dosing administration of insulin related to meals documented, "Novolog...ONSET (in hours, unless noted)...15 min [minutes]...TYPICAL DOsing / COMMENTS...5-10 minutes before meals."


Observations in RR #2's room on 8/2/11 at 10:48 AM revealed Nurse #11 administered 5 units of Novolog insulin to RR #2. RR #2 did not receive her lunch tray until 11:48 AM. The administration of the insulin 1 hour before lunch was served resulted in a significant medication error.

During an interview in RR #2's room on 8/2/11 at 11:14 AM when asked if she had eaten anything since receiving her insulin at 10:48 AM, RR #2 stated "No".

During an interview in the 2nd floor hallway on 8/3/11 at 9:38 AM Nurse #11 stated, "the resident should eat within 15 minutes of getting insulin."

During an Interview in the conference room on
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
SIGNATURE HEALTHCARE AT SAINT FRANCIS

**STREET ADDRESS, CITY, STATE, ZIP CODE**
6007 PARK AVE
MEMPHIS, TN 38119

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<tr>
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<tr>
<td>F 333</td>
<td>Continued From page 23 8/3/11 at 5:30 PM when asked what her expectations were for the administration of insulin in the Director of Nursing stated, &quot;...according to manufacturer's guidelines, especially with Humalog, Novolog...&quot;</td>
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<td>F 333</td>
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</table>
| F 425 | 453.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  
A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  
The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.  
This REQUIREMENT is not met as evidenced by:  
Based on policy review, medical record review and interview, it was determined the facility failed to provide medications to meet the needs of the residents for 1 of 25 (Resident #23) sampled residents. | | | | 11/11 |

**MATERIALS AND EQUIPMENT**

**PHARMACEUTICAL SVC - accurate procedures, RPH**

DON has reviewed pharmacy services Provider Agreement and implemented procedures in order that all residents will receive new medication from pharmacy timely. All medications are being received timely from pharmacy according to policy and procedures listed in the Pharmacy Provider Agreement. After hours pharmacy will be utilized when necessary to receive medications. (resident #23 no longer resides in the facility)

All licensed will be in-serviced on medication ordering and receiving of new medication from pharmacy according to the Pharmacy provider agreement. In-servicing will be conducted by DON and ADONS by 08/22/11
ADONs will do a random audit weekly for 6 consecutive weeks on residents receiving new medications timely. All results of the audit will be reviewed in the PI committee meeting until such time consistent substantial compliance has been achieved as determined by the committee.

### Summary of Deficiencies

<table>
<thead>
<tr>
<th>F 426 Continued From page 24</th>
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<tbody>
<tr>
<td><strong>The findings included:</strong></td>
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</table>

1. Review of the facility's "Medication Ordering and Receiving From Pharmacy Provider" policy documented, "...a. New medications except for emergency or "stat" [immediately/at once] medications, are ordered as follows: The first dose of medication is scheduled to be given after the next regularly scheduled pharmacy delivery to the nursing center. If needed before the next regular delivery, fax [facsimile] phone the medication orders to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery..."


Review of the June 2010 "MEDICATION/TREATMENT ADMINISTRATION RECORD" documented the following:

June 5th - Albuterol 0.083% tx QID—Hour-0900, and 1300 doses circled as not given. June 6th all doses circled as not given.

June 5th-Cefzil 500mg p.o. BID x 7 days-Hour...0900 and 1700, circled as not given. June 6th all doses circled as not given.
F 425 Continued From page 25

Review of a "DAILY SKILLED NURSE'S NOTE" dated 6/6/10 documented, "1920 [7:20 PM] call place to [named pharmacy] about PO AB [antibiotic], medication started at 7:45 pm..."

During an interview in the Administrator office on 7/19/11 at 3:00 PM the Director of Nursing verified that the medications should have been available within a few hours and if not the nurses should have notified the pharmacy again."

F 431

SS=D

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the

F 431

Drug records, label/store drugs and biologicals

The expired Famotidine on 4th floor, Dextrose 50ml and Naproxen on 5th floor were immediately disposed.

All medication rooms, medication and treatment carts were checked for expired medications.

All licensed nurses were instructed on proper storage on drugs and biologicals by the DON.
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<tr>
<td>F 431</td>
<td>Continued From page 26</td>
<td>Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</td>
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<td>ADON's will perform random checks on the medication rooms, medication and treatment carts weekly for 6 consecutive weeks for expired medications. All results of audits will be reviewed in the PI committee until such time consistent substantial compliance has been achieved as determined by the committee.</td>
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<td>F 431</td>
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<td>expired 2/1/11, 2 unopened vials of 50% Dextrose 50 ml that had expired 6/1/11, and 1 unopened bottle of All Day Pain Relief (Naproxen Sodium) 220 mg, 100 tablets that had expired 6/11.</td>
<td>F 431</td>
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<td>F 502</td>
<td>SS=D</td>
<td>483.75(1) ADMINISTRATION</td>
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<td>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, and interview, it was determined the facility failed to ensure lab results were obtained in a timely</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

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<td>F 502</td>
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<td>F502</td>
<td>9/1/11</td>
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The facility will provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

Resident #22 on 08/04/11 MD notified of labs not obtained and placed on lab tracking log for every 3 months per MD order.
Resident #25 PT/INR are collected daily according to MD orders. MD notified of PT/INR that was missed on 07/02/11.

DON/designee will conduct an audit to ensure laboratory orders were done as ordered Lab monitoring will be done daily by the ADON and unit secretary. All laboratory orders will be placed on the lab tracking log and followed up daily. ADON, Unit Secretary and licensed nurses will be in-serviced on facility p&p for laboratory management by DON.
**F 502**

**Continued From page 29**

Review of the facility's "COUMADIN ADMINISTRATION "PROTHROMBIN TIME FLOW SHEET" documented, "...7/2/11... PT INR [Prothrombin Time/International Normalized Ratio]... Need INR results..." The facility was unable to provide documentation the INR was obtained 7/2/11 as ordered.

During an interview in the conference room on 8/3/11 at 5:00 PM, Nurse #12 confirmed she could not find any INR results for 7/2/11.

**F 514**

483.75((1)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on review of "2011 Mosby's NURSING DRUG REFERENCE, 24th Edition," medical record review and interview, it was determined the facility failed to ensure the physician's orders and medication administration record (MAR) were accurate for 4 of 25 (Resident #8, 9, 13 and 20)

**F 502**

The DON/designee will conduct random audits of medical records for laboratory orders and timeliness for 6 consecutive weeks.

All results of audits will be reviewed in the PI committee until such time consistent substantial compliance has been achieved as determined by the committee.

**F 514**

The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

ADON made correction to recertification orders on resident #8 on 08/03/11 to reflect current MD orders for bolus feeding as well OT and PT.
F 514 Continued From page 30
sampled residents.

The findings included:

1. Medical record review for Resident #8 documented an admission date of 6/22/11 with diagnoses of Cerebrovascular Accident, Hypertension, Dementia, Depression and Status Post Percutaneous Endoscopic Gastrostomy (PEG) Tube Placement.


During an interview at the 4th floor nurses station on 8/3/11 at 10:40 AM, Nurse #3 confirmed the PEG flush change should be on the recertification orders and the PEG boluses should have been taken off the orders.

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<tr>
<td>F 514</td>
<td>DON/designee will perform random auditing of recertification orders weekly for 6 consecutive weeks to ensure that recertification orders are current according to MD orders. All results of audits will be reviewed in the PI committee until such time consistent substantial compliance has been achieved as determined by the committee.</td>
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During an interview at the 4th floor nurses station on 8/3/11 at 10:40 AM, Nurse #3 confirmed the OT and PT should be on the recertification orders.

2. Medical record review for Resident #9 documented an admission date of 4/22/09 with diagnoses of Depression, Dementia, Anxiety, Alzheimer's, Left Clavicle Fracture and Hypertension. Review of the physician's recertification orders dated 6/14/11 documented, "...SELENIUM 2.5 % [percent] LOTION-SHAMPOO: WASH HAIR THREE TIMES A WEEK ON MON [Monday]-WED [Wednesday]-FRI [Friday]..." Review of a physician's order dated 5/24/11 documented, "...[symbol for change], order for Selenium 2.5 % Solution Shampoo from Three times a week to PRN [as needed]."

Review of the physician's recertification orders dated 6/14/11 documented, HYDROCODON [hydrocodone] -ACETAMINOPHEN 5-325...1 TABLET ORALLY EVERY 8 HOURS SCHEDULED...". Review of a physician's order dated 6/2/11 documented, "...D/C [discontinue] Scheduled Loratab [hydrocodone-acetaminophen] 5/325 mg [milligrams] q [every] 6 hrs. [hours], Give Loratab 5/325 mg 1 TAB [tablet] TID [three times a day]..." The 6/14/11 recertification orders had not been revised to reflect the current orders.

During an interview at the 4th floor nurses' station on 8/3/11 at 10:40 AM, Nurse #3 confirmed the hydrocodone-acetaminophen and the selenium shampoo should be on the 6/14/11 recertification orders.
<table>
<thead>
<tr>
<th>F 514</th>
<th>Continued From page 32 orders.</th>
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<td>3. Review of &quot;2011 Mosby's NURSING DRUG REFERENCE, 24th Edition&quot; documented, &quot;...Digoxin: available forms...tabs 0.125, 0.25, 0.5 mg...&quot;</td>
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<tr>
<td>Medical record review for Resident #13 documented an admission date of 7/30/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Pneumonia, Coronary Artery Disease, Restless Leg Syndrome and Arthritis. Review of the &quot;[Name of hospital] Transfer/Referral Form&quot; documented, &quot;...Digoxin 0.125 mg daily...&quot; Review of the physician's admission orders dated 7/30/11 documented, &quot;...Digoxin 0.125 mcg [micrograms] daily...&quot; Review of the MAR for August 2011 documented, &quot;...Digoxin 0.125 mcg po daily...&quot;</td>
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<tr>
<td>During an interview in the 2nd floor hallway on 9/3/11 at 2:47 PM, when asked about the correct doses of Digoxin for Resident #13, Nurse #12 stated, &quot;...Digoxin should be 125 micrograms [0.125 mcg]...&quot;</td>
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<td>4. Medical record review for Resident #20 documented an admission date of 12/9/10 with a diagnosis of Cerebrovascular Accident, Dementia, Hypertension and PEG tube. Review of the comprehensive care plan dated 12/9/10 documented, &quot;...Pressure Ulcer (Interdisciplinary Care Plan)...Resident has pressure ulcer(s)...L [left] heel...3/26/11 resolved...L foot [lateral heal]...4/22/11 resolved...&quot; Review of the physician's recertification orders dated 7/26/11 documented, &quot;...CLEAN WOUND TO RIGHT HEEL WITH NS [normal saline], PAT DRY, APPLY SANTYL, COVER WITH A 4X [by] 4...&quot;</td>
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[dressing], AND WRAP WITH KERLIX DAILY 
AND PRN...CLEAN LEFT HEEL WITH WOUND 
CLEANSER, PAT DRY APPLY POLYMEN 
[polymer], ABD [abdominal pad], AND COVER 
WITH BULKY GAUZE DAILY AND PRN UNTIL 
HEALED THEN DC [discontinue]...
Review of a physician's order dated 7/15/11 
documented, "...Discontinue previous 
order/treatment to (R) [right] heal, start clean (R) 
heel c [with] N/S [normal saline], pat dry, apply 
Polynum [polymer] daily & PRN till healed..." 
The 7/26/11 recertification orders had not been 
revised to reflect the current orders.

Review of the physician's recertification orders 
dated 7/26/11 documented, "METOPROLOL 
TARTRATE 50 MG...1 TABLET ORALLY EVERY 
MORNING...METOPROLOL TARTRATE 25 
MG...1 TABLET BY MOUTH EVERY 
EVENING..." Review of a physician's order dated 
7/22/11 documented, "...[symbol for increase] 
metoprolol to 50 mg per peg [PEG tube] bid 
[twice a day]." The 7/26/11 recertification orders 
had not been revised to reflect the current orders:

During an interview at the 4th floor nurses station 
on 8/3/11 at 10:40 AM, Nurse #3 confirmed the 
left heel dressing should have been taken off the 
7/26/11 recertification orders and the right heel 
dressing and Metoprolol changes should have 
been put on the 7/26/11 recertification orders.