F 155
483.10(b)(4) NOTICE OF RIGHTS AND SERVICES

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of a Power of Attorney (POA), review of an Emergency Medical Services (EMS) report and interview, it was determined the facility failed to ensure that a resident's rights was honored for: Do Not Resuscitate (DNR) for 1 of 25 (Resident #15) sampled residents.

The findings included:
Medical record review for Resident #15 documented an admission date of 6/24/05 with diagnoses of Acute Myocardial Infarction, Congestive Heart Failure, Peripheral Vascular Disease and Chronic Ulcers. Review of the Minimum Data Set (MDS) dated 2/7/09 for Section B2 for memory coded Resident #15 as "1-0", indicating the resident had problems with short term memory and no problems with long term memory. Section B4 for cognitive skills for daily decision making coded Resident #15 as "2" indicating the resident was moderately impaired in decision making skills. Review of Physician's orders for scope of treatment (POST) signed and dated 8/13/06 documented, "Section A-CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is no breathing...Do Not Attempt Resuscitate (DNR/no..."

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.
**NAME OF PROVIDER OR SUPPLIER:**

GOLDEN LIVINGCENTER - BRANDYWOOD

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

555 E BLEDSOE

GALLATIN, TN 37065

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<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>(X5) COMPLETION DATE</th>
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| F 155              | Continued From page 1  
CPR)... Do not transfer to hospital for life-sustaining treatment... Section E Discussed with X-other-POA [Power of Attorney] drs [daughters]. The Basis for These Orders Is: X-Patients best interest (patient lacks capacity or preference unknown..."  
Review of a POA for Resident #15 documented the following: "1: Principal and Health Care Agent- Health Care Agent: [Named Daughter]. 2. Authority of Health Care Agent- I authorize my Agent to exercise any powers relating to my health care. This authority includes the power to admit me to a psychiatric or mental health institution and authorize any mental health treatments or procedures, without my consent, should my Agent deem it in my best interest. The authority of my Agent to act for me under this Advance Directive shall be effective immediately and shall continue in effect if I become incapacitated or disabled...I authorize my Agent to examine my medical records and consent to their disclosure..."  
Resident 15 has returned to facility and has POST form in place.  
Residents with Do Not Resuscitate order have the potential to be affected by this alleged deficient practice.  
Audit of POST forms will be completed to check for completion by 2/28/10 by LPN.  
In servicing to nursing staff, admission staff will be conducted to ensure understanding of POST form and residents rights to refuse treatment by DNS or designee.  
POST forms will be reviewed on admissions, readmissions and with annual MDS care planning process to validate the POST form is reflecting resident wishes by Medical Records or designee. Will monitor in QAA for 3 months with any issues being address. QAA members include Executive Director, Director of Nursing, Medical Director, Activities Director, Social Services, Dietary Manager, Therapy; MDS, ACU Director. QAA process will assist the facility in identifying trends, developing plans, identifying a process owner and monitoring through resolution. | 2/28/10 |
**NAME OF PROVIDER OR SUPPLIER**
GOLDEN LIVINGCENTER - BRANDYWOOD

**STREET ADDRESS, CITY, STATE, ZIP CODE**
556 E BLEDSOE
GALLATIN, TN 37066

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<td>F 155</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA NUMBER:**
445124

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING
B. WING

**(X3) DATE SURVEY COMPLETED**
01/26/2010

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**SUMMARY STATEMENT OF DEFICIENCIES**

"TO CALL DAUGHTER and 911, RESIDENT IS CONSIDERED A DNR, BUT DAUGHTER WAS CALLED AND 911. V/S, B/P-192/59, P-112, R-34, O2 AT 83%. RESIDENT WAS ASSESSED AND LUNG SOUNDS WERE WET AND CRACKLING AND SHE THOUGHT SHE WAS HAVING AN ASTHMA ATTACK. O2 WAS INCREASED, CHANGED FROM NASAL CANULA TO MASK, RESIDENT WENT UNCONSCIOUS. STERUM [Sternum] RUB WAS INITIATED. NO RESPONSE, AMBULANCE ARRIVED AND TOOK RESIDENT TO [Named hospital]. CALLED TO GET REPORT ON RESIDENT, [Named Nurse], STATED THAT RESIDENT WAS BEING ADMITTED WITH DIAGNOSIS OF POST ARREST, CHF, CHEST PAIN, ASPIRATION AND ATRIAL FIB [fibrillation]. RESIDENT IN CRITICAL CONDITION..."

Review of an emergency room report for Resident #15 dated 4/2/09 documented,
"...DIAGNOSES: 1. Chest Pain. 2. Status post cardiopulmonary resuscitation. 3. Congestive heart failure with pulmonary edema. 4. Altered Mental Status. 5. Hyperkalemia. 6. Hyperglycemia. 7. Likely Aspiration. DISPOSITION/EMERGENCY DEPARTMENT COURSE: While in the emergency room, she [Resident #15] seemed to stabilize somewhat on BIPAP. She [Resident #15] is admitted to the floor as a DO NOT Resuscitate per family wishes with no further aggressive interventions at this point. I did not start any empiric antibiotics. She [Resident #15] did receive some Lasix in the emergency department, and she has nitroglycerin placed on her chest. Comfort medications were written for her... PROCEDURE NOTE: Intubation was not completed per family wishes... Patient..."
F 155 Continued From page 3 was simply bagged..."

Review of a discharge summary for Resident #15 dated 4/6/08 documented, "...DISCHARGE DIAGNOSES: 1. Acute non-ST-segment myocardial infarction. 2. Congestive Heart Failure. 3. Status post cardiac arrest... 4. Hypertension. 5. Diabetes. History: This 81-year-old was admitted from the nursing home after a cardiac arrest with successful resuscitation..."

During an interview in the conference room on 1/26/10 at 1:15 PM, the Director of Nursing stated, "When transferred have to have doctor's order, family notified, call EMS, call report to hospital. Send copy of face sheet, diagnosis sheet, MAR [medication administration record], allergies, recent history and physical, labs [laboratory] that are pertinent, glasses, dentures, POST form front and back. Not sure why CPR was performed, she [Resident #15] had a DNR documented. Typically staff would not perform CPR, if they are a DNR but would still send them out."

During a telephone interview in the conference room on 1/27/10 at 8:45 AM, Resident #15's daughter stated, "[Named nurse] at the time of the incident advised me that she started CPR on my mother. Went to the hospital, was advised by EMS that they were not advised that my mother was a DNR. Later that night the nurse [referring to Nurse #1] came to the hospital and admitted she had not advised EMS that my mother was a DNR."

During a telephone interview in the conference room on 1/27/09 at 9:42 AM, Nurse #1 stated, "She [Resident #15] had complained of gas, gave..."
Continued From page 4

antacid, she continued to complain. Me and
another nurse assessed her and she begged me
not to leave her. I went to call the daughter and
the other nurse stayed with her. The nurse called
me and I went back to room, she [Resident #15]
went bad, myself and other nurse started CPR.
She [Resident #15] had said "Don't let me die." I
took this to mean she was revoking her DNR.
She [Resident #15] was really going; EMS came
in and they picked up on the CPR. Told EMS she
[Resident #15] was a DNR and that she said
please help me, don't let me die. Went to hospital
later that night to see her and told daughter what
had happened."

During a telephone interview in the conference
room on 1/27/10 at 3:00 PM, the EMS personnel
stated, "When we go to get a patient the
paperwork depends on whether it's a emergency
situation. If it's an emergency we get the
necessary paperwork, we don't waste time getting
a lot of paper work. We try to get their allergies
always, we always get a DNR-POST. If the
person is a DNR then we don't resuscitate-do
minimal."

483.10(b)(11) NOTIFICATION OF CHANGES
A facility must immediately inform the resident;
consult with the resident's physician; and if
known, notify the resident's legal representative
or an interested family member when there is an
accident involving the resident which results in
injury and has the potential for requiring physician
intervention; a significant change in the resident's
physical, mental, or psychosocial status (i.e., a
deterioration in health, mental, or psychosocial
status in either life threatening conditions or
clinical complications); a need to alter treatment
significantly (i.e., a need to discontinue an
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<td>F157</td>
<td>Continued From page 5 existing form of treatment due to adverse consequences, or to commence a new form of treatment; or a decision to transfer or discharge the resident from the facility as specified in §483.12(e). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure the physician was notified of an elevated blood sugar (BS) for 1 of 25 (Resident #21) sampled residents. The findings included: Medical record review for Resident #21 documented an admission date of 4/13/09 with diagnoses of Diabetic Mellitus, Diabetic Retinopathy, Hypoglycemia, Altered Mental Status, Hypertension and Hyperlipidemia. Review of a physician's order dated 12/1/09 documented, *ACCUCHECK WITH SLIDING SCALE HUMULIN R [regular] 100 u/ml [units per milliliter] SOL [solution] (INSULIN, HUMAN (REGULAR) ...</td>
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Resident 21 Physician was notified of BS over 400 occurring in December 2009 by the DNS on 1/26/10. Resident with sliding scale blood sugars have the potential to be affected by this alleged deficient practice. Will audit last 30 days of residents with sliding scale blood sugars with parameters for any needed physician notification. DNS and DCE performed audit on the last 30 days on 2/18/10. In servicing to licensed nursing staff on following parameters and notification of physician completed by DNS on 2/4/10, 2/2/10, and 2/8/10. Completion date of 2/28/10 DNS or designee will audit 5 residents sliding scale MARs weekly for following of parameters and notification of physician x 4 weeks, then monthly x 2. Nurses who knowingly fail to follow protocol will receive progressive discipline. Results will be reported in QAA monthly and concerns will be addressed. QAA members include Executive Director, Director of Nursing, Medical Director, Activities Director, Social Services, Dietary Manager, Therapy, MDS, ACU Director. QAA process will assist the facility in identifying trends, developing plans, identifying a process owner and monitoring through resolution.
### F 157: Continued From page 6
NOTIFY PHYSICIAN IMMEDIATELY IF BLOOD SUGAR IS ... OR > [greater than] 400 AC [before meals] & [and] HS [hours of sleep].” Review of Resident #21’s December 2009 Medication Administration Record (MAR) documented a 12/24/09 11:00 AM blood sugar (BS) result of 414. There was no documentation in Resident #21’s medical record that the physician was immediately notified of the BS greater than 400.

During an interview in the conference room on 1/26/10 at 2:30 PM, the Director of Nursing (DON) was asked what she expected the nurse to do for a BS of 414. The DON stated, “Notify the Doctor.” The DON verified that there was no documentation in Resident #21 medical record that the Doctor was notified of the elevated blood sugar.

### F 309: QUALITY OF CARE
483.25 QUALITY OF CARE
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.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interviews, it was determined the facility failed to follow physician's orders for insulin administration or obtain a current physician's order for dialysis treatment for 2 of 25 (Residents #11 and 21) sampled residents.

The findings included:
Residents with sliding scale insulin’s orders have the potential to be affected by this alleged deficient practice. DNS or designee 30 days of residents with sliding scale blood sugars for following physician orders, by comparing acu check log to MAR audit done 2/18/10. In servicing to licensed nursing staff on following physician orders by DNS or designee on 2/8/10. As per company protocol physician will be notified by nurse as soon as possible no longer than 24 hours.

DNS or designee will audit 5 residents sliding scale MARs weekly for following physician orders x 4 weeks, then monthly x 2. Nurses who knowingly fail to follow protocol will receive progressive discipline. Results will be reported in QAA monthly and concerns will be addressed. QAA members include Executive Director, Director of Nursing, Medical Director, Activities Director, Social Services, Dietary Manager, Therapy, MDS, ACU Director. QAA process will assist the facility in identifying trends, developing plans, identifying a process owner and monitoring through resolution.

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<th>F 309</th>
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1. Medical record review for Resident #11 documented an admission date of 5/6/09 with diagnoses of History of Tyealn Overdose, Cerebral Vascular Disease, Chronic Kidney Disease, Diabetes, Anemia and Hypertension. The facility was unable to provide documentation of a physician’s order for dialysis.

During an interview in the conference room on 1/26/10 at 10:00 AM, the Director of Nursing (DON) stated, “I have been looking for an order for dialysis in the hospital discharge summary; I finally called the hospital, the order for dialysis was given by a number and we did not know what the number meant.”

2. Medical record review for Resident #21 documented an admission date of 4/13/09 with diagnoses of Diabetic Mellitus, Diabetic Retinopathy, Hypoglycemia, Altered Mental Status, Hypertension and Hypertipidemia. Review of a physician’s order dated 10/1/09 documented, “ACCUCHECK WITH SLIDING SCALE HUMULIN R [regular] 100 u/ml (units per milliliter) SOL [solution] (INSULIN, HUMAN (REGULAR)) SQ [subcutaneous] 150 - [to] 199 = [amount of insulin to be administered] 1 UNITS; > [greater than] 200 - 249 = 2 UNITS; >250 - 299 = 3 UNITS; >300- 349 = 4 UNITS; > 349 - 5 ...”

Review of Resident #21’s October 2009 Medication Administration Record (MAR) documented the following blood sugar (BS) and insulin administration:

a. 10/2/09 at 7:00 AM, BS of 185 with no insulin given, correct dose = 1 unit
b. 10/2/09 at 8:00 PM, BS of 337 with 5 units given, correct dose = 4 units.

<table>
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<th>F 309</th>
<th>Provider’s Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
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NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER - BRANDYWOOD  
STREET ADDRESS, CITY, STATE, ZIP CODE: 556 E BLEDSOE, GALLATIN, TN 37066

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<td>F 309</td>
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<tr>
<td>c. 10/9/09 at 11:00 AM, BS of 179 with no insulin given, correct dose = 1 unit.</td>
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<tr>
<td>d. 10/12/09 at 4:30 PM, BS of 159 with no insulin given, correct dose = 1 unit.</td>
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<tr>
<td>e. 10/15/09 at 4:30 PM, BS of 170 with no insulin given, correct dose = 1 unit.</td>
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<tr>
<td>f. 10/16/09 at 4:30 PM, BS of 167 with no insulin given, correct dose = 1 unit.</td>
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<tr>
<td>g. 10/16/09 at 7:00 AM, BS of 154 with no insulin given, correct dose = 1 unit.</td>
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<tr>
<td>h. 10/21/09 at 4:30 PM, BS of 153 with no insulin given, correct dose = 1 unit.</td>
<td></td>
</tr>
<tr>
<td>i. 10/30/09 at 7:00 AM, BS of 153 with no insulin given, correct dose = 1 unit.</td>
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<tr>
<td>j. 10/30/09 at 11:00 AM, BS of 202 with 1 unit insulin given, correct dose = 2 units.</td>
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Review of Resident #21's November 2009 MAR documented the following BS and Insulin administration:

| a. 11/1/09 at 8:00 PM, BS of 168 with no insulin given, correct dose = 1 unit.                      |
| b. 11/16/09 at 4:30 PM, BS of 154 with no insulin given, correct dose = 1 unit.                    |
| c. 11/17/09 at 4:30 PM, BS of 150 with no insulin given, correct dose = 1 unit.                    |
| d. 11/21/09 at 11:00 AM, BS of 155 with no insulin given, correct dose = 1 unit.                   |

Review of Resident #21's December 2009 MAR documented the following BS and Insulin administration:

| a. 12/6/09 at 8:00 PM, BS 279 no documentation of insulin administration, correct dose = 3 units.    |
| b. 12/7/09 at 4:30 PM, BS of 172 with no insulin given, correct dose = 1 unit.                      |
| c. 12/7/09 at 8:00 PM, BS 341 no documentation of insulin administration, correct dose = 4 units.    |
| d. 12/21/09 at 4:30 PM, BS of 168 with no insulin given, correct dose = 1 unit.                     |
F 309 Continued from page 9

given, correct dose = 1 unit,

- e. 12/24/09 at 8:00 PM, BS 303 no documentation of insulin administration, correct dose 4 units.
- f. 12/22/09 at 8:00 PM, BS of 165 with no insulin given, correct dose = 1 unit.
- g. 12/26/09 at 4:30 PM, BS of 189 with no insulin given, correct dose = 1 unit.
- h. 12/29/09 at 8:00 PM, BS of 171 with no insulin given, correct dose = 1 unit.

Review of Resident #21's January 2010 MAR documented the following BS and insulin administration:

- a. 1/1/10 at 4:30 PM, BS 154 with no insulin given, correct dose 1 unit.
- b. 1/3/10 at 4:30 PM, BS 175 with no insulin given, correct dose 1 unit.
- c. 1/8/10 at 11:00 AM, BS 213 with 1 unit insulin given, correct dose 2 units.
- d. 1/16/10 at 8:00 PM, BS 176 with no insulin given, correct dose 1 unit.

During an interview in the conference room on 1/26/10 at 2:30 PM, the DON was asked if the nurses followed Resident #21's physician's orders for sliding scale. The DON stated, "The way it [MAR] looks they didn't."

F 431

Table: PHARMACY SERVICES

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.

F 431

Resident 25 record was reviewed and found unable to correct as it is past occurrence.

Residents receiving scheduled II narcotics have the potential to be affected by this alleged deficient practice.

DNS or Designee will In-service licensed nursing staff on policy to reconcile narcotics and the appropriate way to waste narcotics on 1/25/10, 2/14/10, 2/15/10.

DNS or Designee will check controlled narcotic sheets on 5 residents weekly x 4 then monthly x 2 and report in QAA results. Any concerns will be address through this process. QAA members include Executive Director, Director of Nursing, Medical Director, Activities Director, Social Services, Dietary Manager, Therapy, MDS, ACU Director. QAA process will assist the facility in identifying trends, developing plans, identifying a process owner and monitoring through resolution.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessor 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 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.

This REQUIREMENT is not met as evidenced by:
Based on policy review, review of narcotic records, medical record review and interviews, it was determined the facility and licensed pharmacist failed to determine that drug records are in order and periodically reconciled for 1 of 25 (Resident #25) sampled residents.

The findings included:
Review of the facility’s disposal of medications policy documented, "...2. Medications Included in the Drug Enforcement Administration (DEA)"
F 431
Continued from page 11

classification as controlled substances (or those classified as such by state regulation) are subject to special handling, storage, disposal, and record keeping in the nursing care center in accordance with federal and state laws and regulations...

Procedures... A control medication disposition log, or equivalent form, shall be used for documentation and shall be retained as per federal privacy and state regulations. This log shall contain the following information: Resident's name... Quantity/amount disposed, Date of disposition, Signatures of the required witnesses.

3. If a controlled medication is unused, refused by the resident of not given for any reason it cannot be returned to the container. It is destroyed as outlined above and the disposal is documented on the accountability record on the line representing that dose with the required signatures. This same procedure applies to unused portions of single dose ampules and doses of controlled substances wasted for any reason."

Review of the facility's change of shift reconciliation policy documented, "Two licensed nurses (typically, the nurse arriving on duty and the nurse departing from duty) are required to conduct a reconciliation [such as change of shift count] of controlled substances in accordance with facility policy and sign a signature log attesting to the completion and accuracy of the count... Nurses should indicate on the signature log if inaccuracies are noted. If inaccuracies are noted, the DNS [Director of Nursing Services] or designee should be notified immediately. Nurses involved with noting the discrepancy are not permitted to leave the facility until debriefed by the DNS of designee."
Continued from page 12

Medical record review for Resident #25 documented an admission date of 2/14/07, with diagnoses of Hypertension, Anxiety and Cerebrovascular Disease.

Review of Resident #25 individual narcotic record on 1/28/10 at 7:30 AM, with the Director of Nursing (DON), revealed a prescription label for 30 tablets of Alprazolam (trade name of Xanax) 0.25 milligram (mg) (Control Substance IV medication for anxiety) with the dispensing date of 12/5/09 and the directions to take one tablet orally twice daily and one tablet orally daily as needed for anxiety or agitation. Further review of the record revealed one dose of one-half tablet of Alprazolam 0.25mg was signed out as administered on 12/14/09 at 9:00 AM by Nurse #3. Further review revealed there was no notation the other half of the tablet not administered was wasted. The DON confirmed at the time of the review, the waste and the witness of the half tablet not administered were not documented on the record per facility policy and the DNS (or designee) was not informed of the discrepancy at shift change per facility policy.

Further medical record for Resident #25 revealed a signed physician's order by the nurse practitioner dated 12/3/09 for a trial reduction of the routine twice daily dose of Alprazolam 0.25 mg (since 9/3/09) to a routine twice daily dose of Alprazolam 0.125 mg scheduled at 9 AM and 9 PM with a continuing order (from 8/10/09) for Alprazolam 0.25 mg by mouth daily "as needed".

Review of Resident #25's December 2009 individual narcotic records and December 2009 medication administration records (MAR) on 1/26/10 at 8:00 AM in the DON's office with the
Continued From page 13

DON, revealed the following discrepancies:

a. A routine dose of Alprazolam 0.25 mg whole tablet was signed out as administered at 9 AM on 12/11/09, by Nurse #1. Review of Resident #25's MAR revealed Nurse #1 initiated a routine dose of one-half tablet of Alprazolam 0.25 mg was administered at that time. The DON confirmed at the time of the review; Nurse #1 failed to document the unused half-tablet of Alprazolam 0.25 mg on the individual narcotic record was wasted per facility policy and the dose was a routine dose and not an "as needed" dose.

b. A routine dose of Alprazolam 0.25 mg whole tablet was signed out as administered at 9 AM on 12/12/09, by Nurse #2. Resident #25's MAR revealed Nurse #2 initiated a routine dose of one-half tablet of Alprazolam 0.25 mg was administered at that time. The DON confirmed at the time of the review, Nurse #2 failed to document the unused half-tablet of Alprazolam 0.25 mg on the individual narcotic record was wasted per facility policy and the dose was a routine dose and not an "as needed" dose.

c. A routine dose of Alprazolam 0.25 mg tablet was signed out as administered at 9 AM on 12/13/09, by Nurse #2. Resident #25's MAR revealed Nurse #2 initiated a routine dose of one-half tablet of Alprazolam 0.25 mg was administered at that time. The DON confirmed at the time of the review, Nurse #2 failed to document the unused half-tablet of Alprazolam 0.25 mg on the individual narcotic record was wasted per facility policy and the dose was a routine dose and not an "as needed" dose.

d. A routine dose of Alprazolam 0.25 mg tablet
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<td>F 431</td>
<td>Continued From page 14 was signed out as administered at 7:00 PM (for routine 9 PM dose) on 12/13/09, by Nurse #2. Resident #25's MAR revealed Nurse #2 initialed a routine dose of one-half tablet of Alprazolam 0.25 mg was administered at 9:00 PM. The DON confirmed at the time of the review, Nurse #2 failed to document the unused half-tablet of Alprazolam 0.25mg on the individual narcotic record was wasted per facility policy and the dose was a routine dose and not an &quot;as needed&quot; dose.</td>
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<tr>
<td>e. A routine dose of Alprazolam 0.25 mg tablet was signed out as administered at 9 AM on 12/14/09, by Nurse #3. Resident #25's MAR revealed Nurse #3 initialed a routine dose of one-half tablet of Alprazolam 0.25 mg was administered at that time. The DON confirmed at the time of the review, Nurse #3 failed to document the unused half-tablet of Alprazolam 0.25mg on the individual narcotic record was wasted per facility policy and the dose was a routine dose and not an &quot;as needed&quot; dose.</td>
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<td>f. An &quot;as needed&quot; dose of Alprazolam 0.25 mg tablet was signed out as administered at 4 PM on 12/15/09, by Nurse #4. Resident #25's MAR revealed Nurse #4 did not document the dose as administered. The DON confirmed at the time of the review, Nurse #4 did not document the dose as administered on the MAR.</td>
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</table>
| g. A routine dose of Alprazolam 0.25 mg tablet was signed out as administered at 9 PM on 12/17/09, by Nurse #6. Resident #25's MAR revealed Nurse #6 initialed a routine dose of one-half tablet of Alprazolam 0.25 mg was administered at that time. The DON confirmed at the time of the review, Nurse #6 failed to document the unused half-tablet of Alprazolam
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X4) ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X8) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 431</td>
<td>Continued From page 15 0.25mg on the individual narcotic record was wasted per facility policy and the dose was a routine dose and not an &quot;as needed&quot; dose.</td>
<td>F 431</td>
<td>[Signature]</td>
<td>2/28/10</td>
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<td></td>
<td>During an interview in the DON's office on 1/26/10 at 9:00 AM, the DON confirmed the discrepancies as noted above.</td>
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<td></td>
<td>During an interview in the day room by the main nurses' station on 1/26/10 at 9:45 AM, the Consultant Pharmacist confirmed the discrepancies as noted above.</td>
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<td></td>
<td>During an interview in the Executive Director's office on 1/26/10 at 11:20 AM, the Executive Director and Corporate Director of Operations confirmed the discrepancies as noted above. 483.75(1)(1) LABORATORY SERVICES</td>
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<tr>
<td>F 502</td>
<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>
<td>F 502</td>
<td>F502 Resident 7 was assessed and received Hbg A1C per physician order. Resident 18 was assessed and received Digoxin level per physician order. Residents with routine lab orders have the potential to be affected by this alleged deficient practice. DNS or LPN will conduct audit of routine lab orders for current residents completed on 2/24/10. In reviewing lab log for follow up on ordered routine labs will be given to licensed nursing staff by ADNS on 2/14/10 and 2/4/10. DNS or designee will monitor lab log 5 days a week by looking at physicians orders and reviewing with lab log. Will report findings in QAA x 3 months. QAA members include Executive Director, Director of Nursing, Medical Director, Activities Director, Social Services, Dietary Manager, Therapy, MDS, ACU Director. QAA process will assist the facility in identifying trends, developing plans, identifying a process owner and monitoring through resolution.</td>
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<td>SS=D</td>
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</tbody>
</table>
F 502  Continued From page 16

Fibrillation. Resident #7's physician's orders dated 1/22/10 documented, "...A1C every three months..." The facility was unable to provide documentation that the A1C level had been done since 7/27/09.

During an interview in the conference room on 1/27/10 at 9:30 AM, the Director of Nursing (DON) stated, "I can't find any A1C results since 7/27/09, we have ordered one stat and the physician has been notified."

2. Medical record review for Resident #18 documented an admission date of 11/13/02 with diagnoses of Osteoporosis, Atrial Fibrillation, History of Fractured Femur and Dementia. Resident #18's physician's orders dated 1/1/10 documented, "...Digoxin level q [every] 6 months..." The facility was unable to provide documentation that the digoxin level had been done since 5/4/09.

During an interview in the conference room on 1/27/10 at 10:30 AM, the DON stated, "I do not find another digoxin level since 5/4/09."