STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495268	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND REHABILITATION & HEALTHCARE CENTER	**2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, facility documentation and in the course of an investigation, the facility staff failed to develop and implement a baseline care plan within 48 hours of admission, that included instructions needed to provide effective person centered care for 1 Resident (#2) in a survey sample of 4 Residents. The Findings included: 1a) For Resident #2 the facility staff failed to develop and implement baseline care plan to address weight loss. Resident #2, an [AGE] year old female, was admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. Resident #2's Minimum Data Set with an Assessment Reference Date of 04/24/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for bed mobility was coded as requiring extensive assistance from staff with a 2+ person physical assist for support. Functional status for dressing was coded as requiring extensive assistance from staff with a 2+ person physical assist for support. Functional status for bed mobility was coded as requiring extensive assistance from staff with a 2+ person physical assist for support. Functional status for toileting was coded as requiring extensive assistance from staff with a 2+ person physical assist for support. Functional status for personal hygiene was coded as requiring extensive assistance from staff with a 1+ person physical assist for support. Eating was coded as requiring supervision (oversight, encouragement, or cueing) from staff and set up only for support. Mobility devices normally used were walker and wheelchair. On 8/19/20 during clinical record review it was noted that Resident # 2 was admitted on [DATE]. Among her [DIAGNOSES REDACTED]. Goal Resident will meet 75%-100% nutritional needs via meals and supplementation, while achieving desired weight goal. Created 4/23/20 Created by (Dietician name redacted) Approach Approach start date: 4/23/20. Assess resident for chewing swallowing difficulties, skin integrity, wound healing, and clinical need for therapeutic diet. Created 4/23/20 Created by (Dietician name redacted). Approach start date: 4/23/20 Per MD orders. Record intakes q meal. Created 4/23/20 Created by (Dietician name redacted). Approach start date: 4/23/20 Monitor weight, weight trend, BMI, and order weight checks per facility protocol. Created 4/23/20 Created by (Dietician name redacted) Approach start date: 4/23/20 Provide snacks and or supplements per MD orders. Created 4/23/20 Created by (Dietician name redacted) On 8/18/20 the facility submitted a copy of the Nutrition Assessment filled out by the dietician dated 4/23/20 at 2:15 PM (6 days after admission). On Page 1 the Dietician notes Protein Calorie Malnutrition, Pressure Ulcers, [DIAGNOSES REDACTED], and [MEDICAL CONDITION] Weight goal - Maintain Weight (116.4 lbs.) Oral problems- NONE Page 2 - Nutritional Needs - (box checked) Intake meets 50-75% of estimated needs - Eating well increased k cal/ protein/fluid needs r/t multiple pressure areas. Page 3 - Additional comments: Weights monitored weekly x4 weeks. Intakes have been good. Family provided additional snacks for resident. Recommend a MVI-M (Multi-Vitamin with mineral) and 30 ml Pro-Stat (protein supplement) TID (three times day) X 30 days (300 kcal, 45 grams protein, (50% of est. need) to promote wound healing. RD will follow up as needed. On 8/19/20 at 1:45 PM an interview was conducted with the DON who was asked if the facility kept a log of meal consumption for this resident as stated in the care plan Per MD orders. Record intakes q meal. The DON submitted a copy of the meal consumption log for Resident #2 excerpts are as follows: Search Vitals Results Intake: Breakfast, AM Snack, Lunch, PM Snack, Dinner Vitals from 4/17/2020 to 5/2/2020 (Resident # 2 name redacted) Date/Time 4/17/2020 - Dinner- 76-100% 4/20/2020 - Dinner - 25-50% 4/22/2020 - Breakfast - 51-75% 4/24/2020 - Breakfast - 51-75% When asked for the weights for Resident #2 received document that read: Search Vitals Results (Resident name redacted) 4/17/2020 - 10:01 PM - 116 lbs. 4/20/2020 - 5:08 PM - 116.4 lbs. 4/27/2020 - 3:15 PM - 111 lbs. The Resident had a 5 lb. weight loss (4.3 %) in 10 days. Review of the clinical record revealed that the Prostat, recommended by the dietician, was not started until 4/30/20 at 4:00 PM. The Multi-vitamin was not started until 5/1/20 at which time they also started fortified foods. On 8/20/20 an interview was conducted with the DON who was asked if there was any other meals documented on and she stated I'm just going to be honest, no there isn't, they have didn't put the meal consumption in the computer as they should have. When asked how the dietician made his assessment on 4/23/20 using only the data from 2 meals one on 4/17/20 and one on 4/22/20 she said I don't know. When asked to speak to the dietician she stated Him no longer works here. She attempted to find his contact information but was unable to find it. On 8/19/20 during the end of day meeting the Administrator was made aware of the issues with weight loss and no further information was provided. 1b) For Resident #2, the facility staff did not include hip precautions on the care plan as recommended by acute care provider until 2 days after her discharge from the facility. The discharge summary dated 04/15/2020 from (Hospital #1) was reviewed. Under the header, Assessment/Plan, excerpts documented, L (left) femur fracture .pt s/p (patient status [REDACTED]. Excerpts of the admission physical therapy note dated 04/17/2020 at 6:21 PM documented, Precautions: posterior hip precautions, WBAT LLE, sacral wound stage IV; isolation precautions. physician's orders [REDACTED]. Response to session interventions: actively participates with skilled interventions. The physician orders [REDACTED]. The admission nursing progress note was reviewed. It did not address posterior hip precautions. The baseline care plan was reviewed. A focus edited by Employee E on 05/15/2020 (thirteen days after Resident #2 was discharged from the facility) documented; Category: ADL (activities of daily living) / Rehabilitation Potential - requires assistance with ADLs due to left THA, left clavicle fracture, and pressure ulcers. The problem start date documented 04/20/2020. A goal associated with this focus created by Employee E on 05/15/2020 documented, GG goal: IDT (interdisciplinary team) discussed that (Resident #2's name) will be able to perform sit to lying task independently by the end of her skilled program. An approach created by the DON on 05/04/2020 with an approach start date of 04/21/2020 documented, Left hip precautions to be maintained no bending no turning have elevated seat for commode. An approach created on by the DON on 05/04/2020 with an approach start date of 04/21/2020 documented, Resident is a 2 person assist as she stands and pivots. Interventions pertaining to the hip were added to the care plan 2 days after Resident #2 was discharged from the facility. On 08/19/2020 at approximately 9:25 AM, an interview with the DON was conducted. When asked about the expectation for baseline care plans, the DON stated that all treatments and interventions should be on the baseline care plan within 48 hours of admission. When asked why that's important, the DON stated so they (staff) know how to care for the resident. The facility staff provided a copy of the facility policy entitled, Care Plans, Comprehensive Person-Centered. Section 1 documented, The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Section 2 documented, The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. On 08/19/2020 by the end of survey, the administrator and DON were notified of concerns of items on the care plan being edited and created after Resident #2 was discharged from the facility.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)

F 0658

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure services provided by the nursing facility meet professional standards of quality.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, clinical record review, facility documentation and in the course of an investigation, the facility staff failed to ensure Residents are provided care in accordance with professional standards for 1 Resident (#2) in a survey sample of 4 Residents. The findings included: For Resident #2 the facility staff: 1) Failed to use nursing judgement to hold a medication that was believed by Resident, daughter and nursing staff, to be causing an adverse reaction (hallucinations). 2) Failed to accurately measure intake and output as ordered by physician. 3) Altered the clinical record by editing the care plan up to three and half months after the resident was discharged from the facility. 1) On [DATE] during clinical record review it was noted that the Resident had an order that read: [MEDICATION NAME] extended release 30 mg. every 12 hours start [DATE] end date [DATE] (scheduled for 8:00 AM and 8:00 PM) The progress notes (nurse's notes) in the electronic health record do not mention hallucinations until the entry on [DATE] at 10:15 AM (8 days after admission) the entry read: Resident refused [MEDICATION NAME] dose the am, stating that it is causing her to hallucinate. Resident states that after taking [MEDICATION NAME] she sees people that are not there and that she feels off. Resident informed that if she starts having pain that she can request her PRN medication ([MEDICATION NAME] aka [MEDICATION NAME]) Resident verbalized understanding. Resident's daughter called and informed of resident refusal and residents concern regarding hallucinations. On [DATE] at 10:21 AM the nurses notes read: Resident requested scheduled [MEDICATION NAME] during the AM med pass. Resident was alert and oriented x4. Night shift had reported resident being confused on ,[DATE] shift stating that she had not eaten for over 24 hours. Residents daughter called at 10 AM stating she had just gotten off the phone with resident and that she reported seeing children in her room and hearing them talking. Daughter was informed that she received [MEDICATION NAME] this morning per her request, and daughter has requested (Medical Director name redacted) evaluate residents pain medication on Monday when he comes in and possibly prescribe an alternative pain medication that will not cause her to hallucinate, Resident placed on MD list for tomorrow. On [DATE] at 3:56 the following was documented in the nursing notes: Resident presents with increased confusion and hallucinations this shift reported by family as well as staff. Resident VSS (vital signs stable) Wound vac changed and continues with good seal, and suction. Medicated with scheduled narcotic meds ([MEDICATION NAME]) per order which may be a factor to residents altered mental status. MD made aware and is evaluating resident while in facility this evening. On [DATE] at 3:00 PM, an interview with the Administrator and the DON was conducted. When asked about hallucinations the Administrator stated, The Resident was admitted with a [DIAGNOSES REDACTED]. Prior to that she was referred to as A&O X 3 and A&O X4. When the DON was asked what the prudent nurse would do when she believes a resident is having a reaction to a medication she stated I guess she should have phoned the physician and gotten an order to hold it. Excerpt from Registered Nursing. ORG about the correct action to take if a nurse feels a medication is causing a reaction are : Nurses who assess that the client has been affected with a side effect or adverse effect to mediations and [MEDICATION NAME] therapy must report and record this data immediately and they should hold the medication until a response from the ordering physician gives the nurse further instructions. At times, the medication may be continued and, at other times, the medication may be discontinued and replaced with another medication. Registered Nursing.org. (2020, [DATE]). Retrieved from (https://www.registerednursing.org/nclex/adverse-effects-contradictions-side-effects-interactionsmedications/#:~:text=Nurses%20who%20assess%20that%20the,gives%20the%20nurse%20further%20instructions.) 2) A review of the facility documentation revealed that the resident was on a fluid restriction of 2000 ml (milliliters) per day. The facility provided the order for the fluid restriction as follows: Resident is on 2000 ml fluid restriction ,[DATE] Breakfast dietary sends 400 ml, 100 ml for med pass, Lunch dietary sends 400 ml, 100 ml for med pass, dinner dietary sends 400 ml and 100 for meds, the remaining 500 ml may be used on night shift. On [DATE] at approximately 2:00 PM an interview was conducted with the DON who was asked where the documentation was for the fluid intake. She printed out the MAR and showed the area for documenting the intake. When asked to explain the documentation as it appeared to have several blanks and areas where the incorrect amounts some shifts appear to have no fluids given and others appear to have been given the entire 2000 in one shift. The DON stated I will be honest I don't think they are documenting accurately. On [DATE] the facility provided a copy of the Policy for Fluid Encouragement and Restriction, excerpts are as follows: Page 2-Restricting Fluids 1. Remove water pitcher and cup from room. 6. Record the amount of fluid consumed on the intake and output record. Record fluid in ml (milliliters) Documentation The following should be recorded in the resident's medical record. 1. Any changes in residents condition 2. Any problems or complaints made by the resident. 3. Any evidence of dehydration such as weight loss, confusion, drowsiness, dry skin etc. 4. The amount (in ml) of fluid consumed by the resident during the shift. 5. If the resident refused the reason why and the intervention taken. 6. The signature and title of person recording the data. On [DATE] during the end of day conference the Administrator was made aware of the concerns regarding professional standards and no further information was provided.

3) On [DATE] at approximately 11:00 AM, a copy of Resident #2's care plan was requested and the administrator provided a copy of Resident #2's care plan. A focus created by Employee D on [DATE] at 8:19 PM (the first day of the abbreviated survey and three and a half months after Resident #2's discharge) was entitled, Category: Mood State (Resident #2's name) chooses to be a full code and will receive CPR (cardiopulmonary resuscitation). The problem start date documented [DATE] (Resident #2's date of admission). The goal associated with this focus created on [DATE] by Employee D documented, Resident will remain full code status through next review. The Long Term Goal Target Date was [DATE]. The approach associated with this focus created on [DATE] by Employee D documented, Code status will be reviewed with the resident (and RP (responsible party)) at scheduled care plan meetings. Code status will be honored through next review. The approach start date was [DATE]. A focus created by Employee D on [DATE] was entitled, Category: Behavioral Symptoms - Resident resists care, accepting pain medications, hallucinations at times. The problem start date documented [DATE] (Resident #2's date of discharge). The goal associated with this focus created on [DATE] by Employee D documented, Resident will show no signs or symptoms of negative consequences or outcome secondary to resisting care or hallucinations. The Long Term Goal Target Date was [DATE]. One approach associated with this focus created on [DATE] by Employee D documented, Actively involve the resident in care. Express to resident a willingness to adjust regime. The approach start date was [DATE]. Another approach associated with this focus created on [DATE] by Employee D documented, Clock added to room on the wall for orientation purposes, daylight through the window and visits from daughter to foster feelings of orientation and positivity. The approach start date was [DATE]. A focus created by Employee D on [DATE] was entitled, Category: Pain - has complaints of and at risk for acute pain R/T (related to) R (right) [MEDICAL CONDITION] with THE (total hip arthroplasty), l (left) clavicle, and pressure ulcers. The problem start date documented [DATE]. One approach associated with this focus created on [DATE] by Employee D documented, Encourage resident to take MD (medical doctor) ordered medications and administer requested medications before the pain becomes unbearable. The approach start date was [DATE]. A focus edited by Employee H on [DATE] at 4:00 PM (two days after the day of discharge) entitled, Category: Nutritional Status - At risk for altered nutritional needs and dietary patterns related to [MEDICAL CONDITIONS], protein calorie malnutrition, osteo[DIAGNOSES REDACTED], multiple pressure injuries on a regular diet. The problem start date documented [DATE]. A focus created by Employee E on [DATE] at 1:20 PM (thirteen days after the day of discharge documented, At risk for dehydration due to fluid restriction, fair to poor appetite, and wound vac in place. The problem start date documented [DATE]. The goal associated with this focus created by Employee E on [DATE] documented, Resident will not exhibit signs of dehydration. The goal target date was [DATE]. The approach associated with this focus created on [DATE] by Employee E documented, Assess for dehydration (dizziness on sitting/standing, change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry cracked lips, dry mucus (sic) membranes, sunken eyes, constipation, fever, infection, electrolyte imbalance). The approach start date was [DATE]. A focus edited by Employee E on [DATE] documented, Category: ADL (activities of daily living) / Rehabilitation Potential - requires assistance with ADLs due to left THA, left clavicle fracture, and pressure ulcers. The problem start date documented [DATE]. A goal associated with this focus created by Employee E on [DATE] documented, GG goal: IDT (interdisciplinary team) discussed that (Resident #2's name) will be able to perform sit to lying task independently by the end of her skilled program. An approach associated with this focus created on [DATE] by Employee E documented, PT (physical therapy) as indicated. An approach created by the DON on [DATE] with an approach start date of [DATE] documented, Left hip precautions to be maintained no bending no turning have elevated seat for commode. An approach created on by the DON on [DATE] with an approach start date of [DATE] documented, Resident is a 2 person assist as she stands and pivots. On [DATE] at approximately 1:20 PM, an interview with Employee D, Corporate Director of Clinical

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Services, and Employee E, the MDS Coordinator, were conducted. When Employee E was asked about the expectation concerning care plans when problems are identified, Employee E stated that if a problem is identified, it should go on the care plan at that time (when the problem is identified). When asked if there was ever a reason to edit or add to the care plan after a resident is discharged , Employee E stated, Typically no. When Employee D and E were notified of concerns that items on the care plan were edited and created after Resident #2 was discharged from the facility, Employee D stated that she was doing audits and added to the care plans if there were areas identified that were worked on during the resident's stay but were not added to the care plans. When asked if it was appropriate to alter the clinical record after a resident is discharged , Employee D stated that she wouldn't call it altering the clinical record. Employee D stated that It's an audit. Employee D stated that sometimes after discharges, they would do audits to make corrections if there was staff oversight. When asked if there was an interdisciplinary team meeting about what to add to the care plan, Employee D stated No. Employee D stated that she was made the additions herself. When asked about the purpose or benefit of adding to a care plan after a resident has been discharged , Employee D stated, I understand what you're saying. On [DATE] at 1:25 PM, the administrator joined the interview and was notified of findings. The administrator stated that sometimes there are oversights and we do our best to get it on the care plan at the time. When asked if the care plan should be altered after a resident is discharged , the administrator stated, Let me get the policy on that. When asked what resource for professional standards was used, the administrator stated, Lippincott. A copy of their care policy was requested. On [DATE] at approximately 2:00 PM, Employee D stated that she was not trying to be deceptive (by adding to the care plan after Resident #2 had been discharged). Employee D stated that we know our system does not allow us to back date. Employee D stated that she was trying to put on record what we had actually done for the resident. The facility staff provided a copy of the facility policy entitled, Care Plans, Comprehensive Person-Centered. Section 1 documented, The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Section 2 documented, The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. According to the Lippincott Manual of Nursing Practice, 10th edition, 2014, under the section entitled, Common Departures from the Standards of Care, it was documented, Failure to make prompt, accurate entries in a patient's medical record and Altering a medical record without noting it as a correction . On [DATE] at approximately 3:30 PM, the administrator and DON were notified of concerns. Employee D stated that Moving forward, we will document on another type of form during chart audits.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, facility documentation and in the course of an investigation, the facility staff failed to maintained proper nutrition and hydration for one Resident (#2) in a survey sample of 4 Residents. The findings included For Resident #2, the facility staff failed to timely act upon the Registered Dietician recommendation of Prostat and multivitamin. Resident #2, an [AGE] year old female, was admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. Resident #2's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 04/24/2020 was coded as an admission assessment. The Resident was coded as having a BIMS (Brief Interview of Mental Status) score of 15, indicating no cognitive impairment. The Resident was coded as requiring extensive assistance from staff with a 2+ person physical assist for support for bed mobility, dressing, bathing, and for toileting. She was coded as requiring extensive assistance from staff with a 1+ person physical for personal hygiene. Eating was coded as requiring supervision (oversight, encouragement, or cueing) from staff and set up. The Resident used a walker and wheelchair for mobility. On 8/19/20 a clinical record review was conducted. The review contained a document titled Nutrition Assessment filled out by the dietician dated 4/23/20 at 2:15 PM The Dietician notes on page 1 Protein Calorie Malnutrition, Pressure Ulcers, [DIAGNOSES REDACTED], and [MEDICAL CONDITION] Weight goal - Maintain Weight (116.4 lbs.) Oral problems- NONE Page 2 - Nutritional Needs - (box checked) Intake meets 50-75% of estimated needs - Eating well increased k cal/ protein/fluid needs r/t multiple pressure areas. Page 3 - Additional comments: Weights monitored weekly x4 weeks. Intakes have been good. Family provided additional snacks for resident. Recommend a MVI-M (Multi-Vitamin with mineral) and 30 ml Pro-Stat (protein supplement) TID (three times day) X 30 days (300 kcal, 45 grams protein, (50% of est. need) to promote wound healing. RD will follow up as needed. Review of the clinical record revealed that the Recommended Prostat was not started until 4/30/20 at 4:00 PM and the Multi-vitamin was not started until 5/1/20. On 8/19/20 during the end of day meeting, the Administrator was made aware of the issues with weight loss and no further information was provided.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, facility documentation and in the course of an investigation, the facility staff failed to ensure medications were available, on four occasions, for 1 Resident (#2) in a survey sample of 4 Residents. The findings included: For Resident #2 the facility staff failed to provide medications according to physician orders. Resident #2, an [AGE] year old female, was admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. Resident #2's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 04/24/2020 was coded as an admission assessment. The Resident was coded as having a BIMS (Brief Interview of Mental Status) score of 15, indicating no cognitive impairment. The Resident was coded as requiring extensive assistance from staff with a 2+ person physical assist for support for bed mobility, dressing, bathing, and for toileting. She was coded as requiring extensive assistance from staff with a 1+ person physical for personal hygiene. Eating was coded as requiring supervision (oversight, encouragement, or cueing) from staff and set up. The Resident used a walker and wheelchair for mobility. On 8/18/20 during clinical record review it was noted that the Resident had orders that read: [MEDICATION NAME] extended release 30 mg. every 12 hours start 4/17/20 end date 4/27/20 [MEDICATION NAME] (OTC) Cream 1% 1 application topical twice a day to irritated skin around wound vac. start 4/18/20 end 5/2/20 [MEDICATION NAME] 0.5 mg every 8 hours for Hallucinations start date 5/2/20 end date 5/2/20 A Review of the MAR (Medication Administration Record) revealed that the resident missed several doses of medications. [MEDICATION NAME] extended release 30 mg. every 12 hours start 4/17/20 end date 4/27/20 4/17/20 scheduled time- 8:00 PM - Not Administered not available in stat box. [MEDICATION NAME] (OTC) Cream 1% 1 application topical twice a day to irritated skin around wound vac. start 4/18/20 end 5/2/20 4/18/20 8:03 PM - Not Administered Drug/item not arrived from pharmacy [MEDICATION NAME] 0.5 mg every 8 hours for Hallucinations start date 5/2/20 end date 5/2/20 5/2/20 8:00 AM Not Administered Drug / Item not available awaiting arrival from pharmacy. Dose not available in Stat Box. [MEDICATION NAME] 0.5 mg every 8 hours for Hallucinations start date 5/2/20 end date 5/2/20 5/2/20 8:00 AM Not Administered Drug / Item not available awaiting arrival from pharmacy. Dose not available in Stat Box. On 8/18/20 the facility submitted the Medication Administration Policy excerpts are as follows: Administering Medicine Policy Statement - Medications shall be administered in a safe and timely manner, and as prescribed. Pg 1 3. Medications must be administered in accordance with the orders, including any required times. 4. Medications must be administered within 1 hour of their prescribed times, unless otherwise specified (for example, before and after meal orders).
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, facility documentation and in the course of an investigation, the facility staff failed to ensure Residents were free from significant medication error for 1 Resident (#2) in a survey sample of 4 Residents. The findings included: For Resident #2 the facility staff failed to discontinue a medication that was causing the Resident to hallucinate for 3 days after the doctor ordered it to be discontinued. Resident #2, an [AGE] year old female, was admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. Resident #2's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 04/24/2020 was coded as an admission assessment. The Resident was coded as having a BIMS (Brief Interview of Mental Status) score of 15, indicating no cognitive impairment. The Resident was coded as requiring extensive assistance from staff with a 2+ person physical assist for support for bed mobility, dressing, bathing, and for toileting. She was coded as requiring extensive assistance from staff with a 1+ person physical for personal hygiene. Eating was coded as requiring supervision (oversight, encouragement, or cueing) from staff and set up. The Resident used a walker and wheelchair for mobility. On 8/17/20 during clinical record review it was noted that the Resident had an order that read: [MEDICATION NAME] tablet extended release 30 mg. every 12 hours (scheduled for 8:00 AM and

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) 8:00 PM) On 8/19/20 during clinical record review a hand written note was found in the electronic medical record from LPN B to the Medical Director on 4/24/20 that read: (Medical Director name redacted)- (Resident name redacted) has scheduled [MEDICATION NAME] 30 mg. It is causing her to hallucinate. Her daughter has some concerns about this and would like to know if we can switch her to a different pain medication. Thank you (LPN B name redacted) The handwritten note was initialed by the Medical Director and the date 4/24/20 was written next to his initials under that was the word D/C'd (discontinued) and the initials of RN B and the date 4/27/20 written under the initials. A review of the clinical record revealed that the [MEDICATION NAME] was not discontinued until 4/27/20. On 8/19/20 at 12:40 PM a telephone interview was conducted with the Medical Director who stated that when he initialed the note and put the date that meant that he agrees to discontinue the medication. I come to the facilities on Monday Wednesday and Friday. The 24th was a Friday. It is my recollection that when I saw the note and initialed it I told her to D/C the medication. When asked was he aware the medication was not discontinued until 4/27/20 he stated No I was not aware. It is my expectation that when I sign and date a request that is I agree with it we could stop this medication. On 8/19/20 during end of day meeting the Administrator was made aware of the issues with medication error involving [MEDICATION NAME] no further information was provided.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, facility documentation and in the course of an investigation, facility staff failed to ensure accurate clinical record for 1 Resident (#2) in a survey sample of 4 Residents. The findings included: For Resident #2, the facility staff failed to A) document accurate meal consumption, and B) document accurate fluid intake for a Resident with orders for fluid restriction of 2000 ml per day. Resident #2, an [AGE] year old female, was admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. Resident #2, an [AGE] year old female, was admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. Resident #2's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 04/24/2020 was coded as an admission assessment. The Resident was coded as having a BIMS (Brief Interview of Mental Status) score of 15, indicating no cognitive impairment. The Resident was coded as requiring extensive assistance from staff with a 2+ person physical assist for support for bed mobility, dressing, bathing, and for toileting. She was coded as requiring extensive assistance from staff with a 1+ person physical for personal hygiene. Eating was coded as requiring supervision (oversight, encouragement, or cueing) from staff and set up. The Resident used a walker and wheelchair for mobility. A) On 8/19/20 requested the meal consumption log for this resident. Received a report that read as follows: Search Vitals Results Intake: Breakfast, AM Snack, Lunch, PM Snack, Dinner Vitals from 4/17/2020 to 5/2/2020 (Resident # 2 name redacted) Date/Time 4/17/2020 - Dinner- 76-100% 4/22/2020 - Breakfast - 51-75% 4/24/2020 - Breakfast - 51-75% 4/20/2020 _ Dinner - 25-50% On 8/20/20 an interview was conducted with the DON who was asked if there was any other meals documented on and she stated I'm just going to be honest, no there isn't, they have didn't put the meal consumption in the computer as they should have. When asked if she was indicating the record was not accurate she stated Yes the record is not complete. B) A review of the facility documentation revealed that the resident was on a fluid restriction of 2000 ml (milliliters) per day. The facility provided the order for the fluid restriction as follows: Resident is on 2000 ml fluid restriction 7-3 Breakfast dietary sends 400 ml, 100 ml for med pass, Lunch dietary sends 400 ml, 100 ml for med pass, dinner dietary sends 400 ml and 100 for meds, the remaining 500 ml may be used on night shift. On 8/19/20 at approximately 2:00 PM an interview was conducted with the DON who was asked where the documentation was for the fluid intake. She printed out the MAR and showed the area for documenting the intake. When asked to explain the documentation as it appeared to have several blanks and areas where the incorrect amounts some shifts appear to have no fluids given and others appear to have been given the entire 2000 in one shift. The DON stated I will be honest I don't think they are documenting accurately. On 8/19/20 at approximately 2:15 PM an interview with the Administrator was conducted and she also stated I do not think the records are accurate.