STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115732	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOSTICK NURSING CENTER	**1700 BOSTICK CIRCLE MILLEDGEVILLE, GA 31061**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility policy titled Change in a Resident's Condition or Status and Notification, and family and staff interviews, the facility failed to notify the physician and family in a timely manner of the significant change in condition for one resident (A) of five residents sampled for the provision of hospice services. Findings include: A review of the policy Change in a Resident's Condition or Status and Notification last updated in 2015 revealed the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition. This includes a significant change or deterioration in the resident's physical, mental, psychosocial status in either life-threatening conditions or clinical complications. A review of the banner area under the resident's profile in the electronic health records revealed staff were instructed to notify the resident's Forensic Community Coordinator and family with all emergent situations. A review of the clinical records for Resident (R)A revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A further review of the clinical records revealed the resident was readmitted to the facility under the care of hospice services on [DATE] after a brief hospital stay. A review of the progress notes revealed a nurses' note dated [DATE] at 7:35 a.m. which documented that the resident was lethargic and weak, and continued to refuse meds and fingerstick blood sugar checks. The note also documented that hospice was notified and hospice staff would come to the facility that morning to evaluate the resident. A further review of the progress notes for R A on [DATE] revealed the next documented activity were four notes from the social worker and charge nurse at 5:02 p.m., 5:04 p.m., 5:22 p.m., and 6:30 p.m., respectively. The first documented that the social worker spoke with hospice personnel regarding the status of the resident and was advised by the hospice clinical manager that hospice staff would be out to assess the resident shortly. The second noted documented that the social worker had returned a call to the resident's sister and left a message informing her that hospice was called. The third note documented that the social worker had called hospice again to obtain a specific time in which hospice staff would visit. This time, a message was left with the on-call operator who promised to have someone from hospice contact the facility within 15 minutes. The fourth note was written by the charge nurse who documented that she found the resident in bed with eyes fixed, no respirations, and no blood pressure, and that she planned to contact hospice regarding this change in status. During an interview with Licensed Practical Nurse (LPN) DD on [DATE] at 3:13 p.m. she revealed when she arrived for her shift around 7:00 a.m. on [DATE], the nurse on the previous shift (7:00 p.m. to 7:00 a.m.) informed her that nurse had called hospice the night before to notify them that R A had a change in condition. The nurse on the previous shift also informed LPN DD that the hospice personnel said they would send someone on the on the morning of [DATE] to assess the resident. LPN DD said she did not know whether the nurse on the previous shift had notified the facility physician or the family of the change in condition during her shift. The hospice chaplain called around 11:00 a.m. on [DATE] and left a message with the nursing staff for her to call him. The hospice nurse had not called or visited when she returned his call sometime between 12:30 p.m. and 1:30 p.m. When she spoke with the chaplain he explained that the resident's family member had called and asked that he enquire as to the resident's condition and relay this information to her because she could not get this information from the facility staff. After speaking with the chaplain, she spoke to the Nurse Practitioner who advised her to monitor the resident until hospice came. LPN DD said she was aware during her shift that day that R A was actively dying. She also said for residents on hospice service who experiences a significant change in condition, the nurse in charge of the resident should notify hospice and hospice will come to assess the resident. The charge nurse then follows whatever directives that are given by hospice. Hospice should notify the next of kin of the resident's change in condition. If hospice does visit after they are notified, then the charge nurse should contact the facility physician. LPN said she was not sure but felt that charge nurse should also contact the family about the resident's change in status if the hospice staff does not. During an interview on [DATE] at 3:46 p.m., the Assistant Director of Nursing (ADON) said the care of residents on hospice is a collaborative effort between the facility and hospice. Hospice is first contacted if there is any change in the resident's condition such as if the resident is actively dying or has died . After hospice is notified, the facility physician is also notified. Hospice is responsible for notifying the family of such changes, but the facility should also ensure that the family has is made aware. During an interview on [DATE] at 4:51 p.m. with LPN FF it was revealed she was the nurse in charge of R A on [DATE], the night before he died . Soon after her shift began at 7:00 p.m. she observed that, he appeared to be transitioning. She called hospice between 7:00 p.m. and 8:00 p.m. and spoke with the staff who answered the phone, informing him that the resident had experienced a change in condition. The hospice person said he would have someone call her back. Someone (she thinks it was one of the hospice nurses) called her within the next hour and she advised that person that the resident was very weak and not taking his medicine. The hospice person on the phone said they would send a hospice nurse the following morning to assess the resident. LPN FF said she passed this information on to the day shift nurse, LPN DD and documented the situation on a progress note before she left the next morning. LPN FF also said the proper process for residents on hospice who experiences a change in conditions is for the nurse in charge to notify the hospice staff, the facility physician, and the family. She did not inform the facility physician, nor did she call the family during her shift starting at 7:00 p.m. on [DATE] and ending at 7:00 a.m. on [DATE]. When she next returned to work, she learned that R A had died . During an interview on [DATE] at 12:42 p.m., Family of R A said the family had not seen R A in-person after the facility restricted visitors in [DATE] in response to the [MEDICAL CONDITION] pandemic. However, the family spoke with him on the phone an almost daily basis. Family of R A said she called the facility around 8:30 a.m. on [DATE] after she received a call from the resident's mother who was upset because she had called the facility and staff would not let her speak with him. Family of R A said staff informed her the resident was tired and weak and could not come to the phone. Family of R A said she called the facility about an hour later and left her name and number with the receptionist and asked for the director and social worker to return her call. Soon after this call to the facility, Family of R A said she called the hospice chaplain to ask if he could call the facility to find out what was going on with the resident. She called the chaplain again about an hour later, but he did not have any information for her. She called the facility again and asked for the social worker (SW). She was told the SW was in a meeting and would call her back. She called the facility nurse again around 4:00 p.m. and spoke with one of the charge nurses. She suggested to the charge nurse that the facility staff should call 911 if R A was too weak to come to the phone. She felt if he went to the hospital, she could visit him there. She said the nurse told her that hospice staff would need to make the decision to send the resident out to the hospital. Sometime after that, Family of R A said she left her home to travel to the facility. On her way there, she called the Forensic Coordinator. The Forensic Coordinator said she too had called the facility that day and was unable to obtain information on the resident. Family of R A told the Forensic Coordinator that

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

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) she was on her way to the facility because she could not get the facility staff to tell her what was going on. When she arrived, she spoke to a hospice nurse who said she had arrived a few minutes before and was told that the resident had died not long before she arrived. Family of R A said at no time that day during her several conversations with nurses at the facility did the facility staff notify her that R A was gravely ill or dying. She was never told that he was in the end stage of his life. He was placed on hospice so that hospice staff would assist him with his Activities of Daily Living and encourage him to take his medications. The resident was his usual self when family last spoke with him on the phone about two days before. During an interview on [DATE] at 2:48 p.m., SW EE revealed that she returned a call from Family of R A between 4:00 p.m. and 5:00 p.m. on the afternoon of [DATE]. During this telephone conversation, the family member said she was concerned because she had not heard from the resident in a couple of days. SW EE said she did not inform Family of R A of the resident's significant change in condition during this telephone conversation because she had not seen the resident that day. After speaking with Family of R A however, she went to the resident's unit to speak with the charge nurse. While on the unit, the charge nurse, LPN DD, informed her that the resident's condition had worsened. LPN DD also informed her that the hospice service was contacted the night before, but hospice had not come out. SW EE said she called hospice after this conversation with the nurse. SW EE said she called the hospice clinical manager and told her that the facility needed someone from hospice to come out to assess the resident because his condition had worsened. She then called the family again but could not reach them. She left a voice message just asking the family to call her back. She did not provide any further information about the resident's condition in that voice message. During an interview on [DATE] at 2:27 p.m. with the behavioral health Forensic Coordinator assigned to R A it was revealed that she too had called the facility on [DATE] (did not document time) to check on the status of the resident. During this call, she spoke with SW EE who said she could not report on the resident's status because she had not seen him for some time. The Forensic Coordinator was transferred to speak to the charge nurse on the resident's unit, but no one answered the phone on the unit and she called again and was transferred to the medical clerk who promised to send a monthly status update. Soon after,(the FC said it was around 5:00 p.m.), Family of R A called the Forensic Coordinator to say she had spoken with the facility about 15 minutes before and the staff there said they had notified hospice since the day before that the resident was not doing well, he was weak and had not eaten in a couple of days. A review of an assessment note by the hospice nurse dated [DATE] revealed the hospice nurse arrived at the facility and was informed of the resident's death by facility staff at 7:00 pm and verified the death at 7:20 p.m. The note also documented this nurse notified the next of kin, the physician, and funeral home. During an interview on [DATE] at 2:45 p.m. with the Nurse Practitioner, she said, when a resident on hospice experiences a significant change in condition, the facility staff should contact the resident's provider (physician) and also contact the hospice. Hospice notifies the family of the change in condition in most instances. If the resident is near death, the hospice should come immediately to assess the resident. Under those circumstances either hospice or the facility staff should notify the resident's family. She knew R A was not doing well when he was readmitted to the facility in March and was aware that he was placed on hospice. However, she was not informed that he was near death on [DATE]. She was away from the facility, but an on-call physician was available that day. Although she was informed of his death afterward, staff did not contact her to inform her of a change in his status before he died . She spoke with the on-call physician for that day and he had no recollection of staff calling to notify him of the resident's change in condition that day.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to follow the care plan related to [MEDICAL CONDITION] medications for one resident (#7) from a sample of five residents reviewed for medications. Findings include: Review of the clinical records for Resident (R)#7 revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. Further review of the clinical records revealed physician orders [REDACTED]. A review of the care plan records for R#7 revealed a plan of care for [MEDICAL CONDITION] medications initiated 12/5/19. Interventions included directives for staff to administer [MEDICAL CONDITION] medications as ordered by the physician, and to administer for side effects and effectiveness. A review of the Medication Administration Record [REDACTED]. A review of the progress notes revealed the nurse documented on those occasions that the medication was not available for administration. A review of the Rx History Report from January 2020 to June 2020 revealed the [MEDICATION NAME] ER 150 mg was first dispensed to the resident on 2/19/20. A review of the MAR for January 2020 through June 2020 revealed that Ingrezza 80 mg was not administered due to unavailability as follows: February - 6 occasions March - 14 occasions April - 19 occasions May - 17 occasions June - 9 occasions Cross-Refer to F755
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 record review, review of the facility policy titled Pharmacy Services Overview, and staff interviews, the facility failed to obtain two medications in a timely manner for one resident (#7) of five residents reviewed for medications. Findings include: A review of the policy titled, Pharmacy Services Overview dated 2001 revealed that the facility is responsible for providing or obtaining pharmacy services for its residents. The facility is to contract with a licensed pharmacist who will collaborate with the facility and medical director to help the facility assure that medications are requested, received, and administered in a timely manner, as ordered by authorized prescribers. If multiple pharmacy services are utilized, the pharmacist is to coordinate those pharmacy services. The pharmacist is also responsible for helping to develop policy and procedures about when to contact a prescriber about mediation issues, and to give the DON, Medical Director, and staff feedback about performances and practices related to med administration, and med errors. A review of the clinical records for Resident (R)#7 revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of the physician's order sheet for the months of January 2020 through June 2020 revealed orders for the resident to receive the antidepressant medication [MEDICATION NAME] ER (extended release formulation) 150 milligrams (mg) daily (beginning 1/22/20) for OCD. This order was changed to [MEDICATION NAME] (the immediate release formulation) with effect from 3/27/20. The physician's order sheets also documented an order for [REDACTED]. A review of the progress notes revealed the nurse documented on those occasions that the medication was not available for administration. A further review of the progress notes revealed a nurse's note on 1/27/20 which documented that the nurse spoke with the pharmacist, a prior authorization was needed, and that the necessary form had been faxed since 1/21/20. A review of the Rx History Report from January 2020 to June 2020 revealed the [MEDICATION NAME] ER 150 mg was first dispensed to the resident on 2/19/20. In a written statement dated 6/29/20, pharmacist, AA wrote: The medication needed a Prior Authorization. Once we received the new order, we immediately sent a PA form to notify the Facility and ask how to handle. We called and resent the form several times within the next several days and had no response. The Facility responded and accepted the cost to pay themselves on 02/19/20 and we sent it out. A further review of the MAR for January 2020 through June 2020 revealed that Ingrezza 80 mg was not administered due to unavailability as follows: February - 6 occasions March - 14 occasions April - 19 occasions May - 17 occasions June - 9 occasions In a written statement dated 6/29/20, pharmacist, BB, said: in this case the drug comes directly from the GA Approved Specialty Pharmacy to the Nursing Center and we are not allowed to dispense it. During an interview on 6/25/20 at 3:46 p.m. with the Assistant Director of Nursing (ADON) it was revealed that the charge nurse who has administered the last prescribed dose of a resident's medication or becomes aware that the resident has only a few remaining doses is responsible for contacting the pharmacy staff to let them know that the medication is out or almost out. If the pharmacy cannot send the medication before the next (or current) administration, that nurse should call the physician for authorization to miss a dose or for some other directive. The charge nurse is responsible for contacting the physician for an order to hold the dose(s) that is being missed and for notifying the nursing supervisor of the circumstances. If the medication needs a prior authorization, the pharmacy normally sends a prior authorization form and the ADON is responsible for contacting the insurance company to obtain this authorization. Sometimes the insurance company will not pay for certain dosage amount or the medication may not be part of the formulary allowed. Whatever the issue is, beyond immediate unavailability, the ADON is responsible for contacting the physician so he can make any necessary adjustments. During an interview on 6/26/20 at 10:32 a.m., Licensed Practical Nurse (LPN) CC revealed that the Ingrezza 80

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) mg at bedtime prescribed for R#7 had been unavailable for administering for several periods of time. In the past, LPN CC said, this medication had been unavailable for a day or so. However, this last period of unavailability had stretched for several weeks. She was not aware of the reason for the latest unavailability of this medication, but said, if a resident runs out of a scheduled medication, the charge nurse should contact the pharmacy. If the pharmacy does not have the medicine available to be sent over or if there will be delay in sending it, the nurse is to notify the physician. LPN CC said the first time she became aware that the Ingrezza was not available for administering she called the contracted pharmacy, they said they did not carry the medication. However, she knew that the contracted pharmacy sometimes obtained medications from other pharmacies and, since they were the only pharmacy she knew to contact, she called them each time she worked on the resident's unit and was aware that the Ingrezza was not available for administering. She also notified the nurse practitioner, the unit manager, and the Director of Nursing (DON). LPN CC said R#7 was prescribed the Ingrezza 80 mg daily for Extrapyramidal Symptoms (EPS). She has witnessed no such symptoms since she has worked with the resident in the last six months or so. She could not recall the period during which the [MEDICATION NAME] ER 150 mg was not available to be administered to R#7. During an interview with the consultant pharmacist BB on 6/30/20 at 2:01 p.m. it was revealed that he reviews all the residents' medications including the [MEDICAL CONDITION] medications during his monthly review to see if the resident is getting the correct dosages, if the medication is associated with an appropriate diagnosis, if the facility is monitoring the use of the medication. He also makes recommendations as to dose reductions. He verified that the [MEDICATION NAME] ER 150 mg prescribed for R#7 in January 2020 needed prior authorization. When the order was received, the prior authorization form was sent to the facility several times with no response. Once the facility accepted responsibility for paying for the medication themselves, it was immediately sent to them. The pharmacist also verified that the Ingrezza 80 mg was not supplied by his pharmacy but through an arrangement the facility had with a specialty pharmacy. Many of the residents are admitted on medications that the facility pays for out of pocket until the resident is approved for Medicaid or if Medicaid refuses to pay. Pharmacist BB said he should have been aware from reviewing the MAR indicated [REDACTED]. However, some nurses documented that the medicine is given and some document that it was not. The facility's MAR indicated [REDACTED]. This is an issue that he continues to notify the administrator and DON about. During an interview on 7/1/20 at 2:45 p.m. with the Nurse Practitioner (NP), she said if a resident is prescribed a medication that is not available from the pharmacy for formulary or other reasons, the nursing staff should let the prescribing physician know so he/she can change the medication to an equivalent medication or have the facility pay for the medication that is prescribed. They have done so in the past. If the resident is prescribed a medication that is not part of the formulary, the pharmacy sends a form to the facility with options the facility can take to ensure the resident receives the medication. This process was followed when, on March 26, she was informed by that the pharmacy that the ER version of the [MEDICATION NAME] was not part of the formulary and she immediately changed the order for R#7 to receive the regular version. She was not made aware by staff in January or February that the resident's prescribed medication, [MEDICATION NAME] ER 150 was not available. R#7 was already prescribed the Ingrezza 80 mg upon her admission in May 2019 and she continued this medication. The Ingrezza was provided to the resident as part of a patient assistance program. The NP said she received a call from the patient assistance program on 4/30/20 saying they had made repeated calls to the previous medical director (who last worked in January) to verify the resident's information before they would send any further Ingrezza. She provided the requested information, but the program wanted to speak directly with the resident to verify other information The NP said she told the resident to expect a call from the patient assistance program, and on 5/3/20 the resident confirmed to her that she spoke with the program and they promised to send the medication. In speaking with a program representative on the day of this interview, the NP said she learned that the resident informed them on 4/30/20 she no longer wanted the medication and no further doses were sent. The program representative confirmed to the NP that the last 30-day supply of the Ingrezza was sent to the resident in January 2020 (not sure the exact date). However, the nursing staff failed to inform her then and after her conversation with the patient assistance program on 4/30/20 that the medication was not and continued to not be available for administering to R#7 until 6/17/20. At that time, she immediately contacted the physician who changed the prescription to another medication that was available. The NP said the resident was prescribed the Ingrezza to address EPS of Tardive Dyskinesia. The resident does not have frank EPS but would sometimes lick her lips. These symptoms have been stable. She has not seen any worsening of her symptoms or any changes. She also did not recall any negative effects suffered by the resident during January and February 2020 or any documented behavioral issues during that time related to her not receiving the prescribed [MEDICATION NAME] ER.
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 record review, review of facility policies, and staff interviews, the facility failed to ensure the licensed nursing staff accurately documented the administration of two medications for one resident (#7) of five residents reviewed for medications. Findings include: A review of the policies titled Administering Medications last updated December 2012 and Documentation of Medication Administration last updated April 2007 revealed that medications must be administered in accordance with the orders including any required time frame and the nursing staff should document all medications are administered to each resident on the resident's MAR indicated [REDACTED]. A review of the clinical records for Resident (R)#7 revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of the physician's orders [REDACTED]. The physician's orders [REDACTED]. A review of the progress notes revealed the nurses documented that the medication was not available for administration on all other occasions. A further review of the progress notes revealed a nurse's note on 1/27/20 which documented that the nurse spoke with the pharmacist, a prior authorization was needed, and that the necessary form had been faxed since 1/21/20. A review of the pharmacy Rx History Report for January 2020 and February 2020 revealed the [MEDICATION NAME] ER 150 mg was never dispensed to the resident until 2/19/20. A further review of the MAR for January 2020 through June 2020 revealed that Ingrezza 80 mg was administered as follows: February - 22/28 occasions March - 17/31 occasions April - 11/30 occasions May - 14/31 occasions June - 8/17 occasions In a written statement dated 6/29/20, pharmacist, BB, said: in this case the drug comes directly from the GA Approved Specialty Pharmacy to the Nursing Center and we are not allowed to dispense it. During an interview on 7/1/20 at 2:45 p.m. with the Nurse Practitioner (NP), she said she spoke to a patient representative of the patient assistant program that dispenses the resident's prescription for Ingrezza via telephone on the day of this interview, and the representative confirmed to the NP that the last 30-day supply of the Ingrezza was sent to the resident in January 2020 (not sure of the exact date). The NP confirmed that there was no Ingrezza available to be administered to the resident since those doses ran out until she learned the medication was still not available on 6/17/20 and called the physician to have the prescription changed to another medication. During an interview on 6/25/20 at 3:46 p.m. with the Assistant Director of Nursing (ADON) it was revealed that on the MAR, the nurse should select the code that best describes the reason for not administering the medication at that time; if the medication is not available, the code is 9 and this will prompt the nurse to document the reason in a nurses' note which should include the fact that the medication was not available and that the MD was made aware. If the medication is not available for administering, the nurse should not indicate on the MAR indicated [REDACTED]. It is possible that there were times she documented that the Ingrezza was administered when it was unavailable. In those cases, that documentation was made in error.
F 0849 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to develop a plan of care for hospice services for one resident (#4) of five residents reviewed for hospice services. Findings include: A review of the clinical records for Resident (R)#4 revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A further review of the clinical records revealed the resident was readmitted to the facility under the care of hospice services on [DATE] after a brief hospital stay. A review of the policy titled, Hospice Program dated 2014 revealed that a coordinated plan of care is to be developed for residents on hospice and reviewed and revised as necessary to reflect the resident's status. A review of the hospice documents for R#4 revealed a hospice plan of care dated [DATE] which outlined the goals and

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F 0849 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) interventions for hospice. A review of the care plan records for R#4 revealed no corresponding plan of care for hospice services. A review of the Minimum Data Set (MDS) records revealed a Significant Change assessment was completed for R#4 on [DATE]. During an interview on [DATE] at 1:11 p.m. MDS Coordinator GG revealed that a care plan for hospice services should have completed for R#4 with seven days after the significant change assessment was completed on [DATE]. Her records show that the MDS coordinator initiated a care plan document to include a plan of care for hospice services on [DATE]. However, this care plan was not completed prior to the resident's death on [DATE].