STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215048	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANOR CARE HEALTH SERVICES - WHEATON	11901 GEORGIA AVENUE WHEATON, MD 20902

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

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of clinical and administrative records and interviews with facility staff, it was determined that the facility staff failed to follow physician orders, which led to a significant medication error. This finding was evident for 1 of 5 residents selected for review during the complaint survey and was related to complaint MD 697 (Resident #1). The findings include: On 03-02-2020, surveyor review of Resident #1's clinical record revealed on 02-20-2020, Resident #1 went to a neurology appointment and returned to the facility with a new physician's orders [REDACTED]. [MEDICATION NAME]-[MEDICATION NAME] is a medication used to treat [MEDICAL CONDITION]. [MEDICAL CONDITION] is a progressive nervous system disorder that affects movement. A review of the physician's orders [REDACTED].#1 transcribed the order for [MEDICATION NAME]-[MEDICATION NAME] four (4) times a day, but did not discontinue the previous order for [MEDICATION NAME]-[MEDICATION NAME] three (3) times a day. According to Resident #1's Medication Administration Record [REDACTED]. Further review of Resident #1's MAR indicated [REDACTED]. On 02-22-2020 at 2:00 PM, Resident #1 was noted to have altered mental status and low blood pressure. The attending physician was contacted and ordered to transfer the resident to the hospital. On 02-22-2020 at 6:21 PM, Nurse #3 documented that the nursing supervisor discovered there were duplicate orders of [MEDICATION NAME]-[MEDICATION NAME] since 02-20-2020 resulting in the resident receiving multiple additional doses of [MEDICATION NAME]-[MEDICATION NAME] for two days. In addition, the resident's blood pressure was low (85/56), resulting in the physician ordering to transfer the resident to the emergency room for evaluation. On 03-03-2020 at 9:45 AM, surveyor interview with Nurse #2 revealed she was assigned to Resident #1 on 02-21-2020 and 02-22-2020. Nurse #2 stated she documented that she administered three (3) extra doses of [MEDICATION NAME]-[MEDICATION NAME] to Resident #1 on 02-21-2020 and two (2) extra doses of [MEDICATION NAME]-[MEDICATION NAME] to the resident on 02-22-2020. On 03-03-2020 at 11:30 AM, interview with the Director of Nursing revealed no additional information.
F 0712 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that the resident and his/her doctor meet face-to-face at all required visits.** Based on record review and interview with facility staff, it was determined that the facility failed to ensure residents are seen by a physician at least every 60 days. This finding was evident for 1 of 5 residents (Resident #4) selected for review during the complaint survey. The findings include: On 03-04-2020 at 2:10 PM, surveyor review of Resident #4's clinical record revealed that the resident was admitted to the facility's rehabilitation unit on 01-21-2019 after a brief hospital stay. Further record review revealed that the resident was seen and assessed by the resident's private insurance company's doctor on 01-02-2019. On 05-31-2019, Resident #4 was discharged from the rehabilitation program and was admitted to the facility's long-term care program. The resident was then assigned to one of the facility's physicians for all physician needs and services. Additional record review revealed that the facility physician first visited the resident and completed Resident #4's history and physical on 06-15-2019. The physician visited Resident #4 again on 07-23-2019 and 09-24-2019. However, there was no evidence in Resident #4's clinical record to indicate that the assigned facility physician or an identified Nurse Practitioner had seen or visited Resident #4. This was 150 days since the resident was seen by the facility physician. On 03-04-2020 at 3:05 PM, surveyor interview with the Director of Nursing revealed that the identified physician does not use the services of nurse practitioners and prefers to see his/her residents him/herself. On 03-04-2020 at 3:34 PM, surveyor interviewed the assigned physician on the phone in the presence of the Director of Nursing. The physician stated that, This is an honest oversight. I will come and see the resident as soon as possible. No further information was provided.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with facility staff, it was determined that the facility failed to ensure a resident's drug regimen was free from duplicate drug therapy. This finding was evident for 1 of 5 (#1) residents selected for review during the survey and was related to complaint MD 697. The findings include: On 03-02-2020, surveyor review of Resident #1's clinical record revealed on 02-21-2020, Nurse #2 administered three (3) additional doses of [MEDICATION NAME]-[MEDICATION NAME] at 8:00 AM, 12:00 PM, and 6:00 PM in addition to the the new physician ordered doses at 8:00 AM, 11:00 AM, 2:00 PM, and 5:00 PM. On 02-22-2020, Nurse #2 administered two (2) additional doses of [MEDICATION NAME]-[MEDICATION NAME] at 8:00 AM and 12:00 PM in addition to the new physician ordered doses at 8:00 AM and 11:00 AM. [MEDICATION NAME]-[MEDICATION NAME] is a medication used to treat [MEDICAL CONDITION]. [MEDICAL CONDITION] is a progressive nervous system disorder that affects movement. On 03-03-2020 at 09:45 AM, interview with Nurse #3 revealed no additional information. On 03-03-2020 at 11:30 AM, interview with the Director of Nursing revealed no additional information.
F 0760 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of clinical and administrative records and interviews with facility staff, it was determined that the facility staff failed to verify the accuracy of the physician's orders [REDACTED]. This deficient practice placed the resident at risk for serious medication side effects. This finding was evident for 1 of 5 residents selected for review during the complaint survey and was related to complaint MD 697 (Resident #1). These failures resulted in an immediate jeopardy (IJ) being identified on 03-04-2020 at 11:13 AM related to the facility's failure to administer medications according to physicians' orders (Resident #1). On 03-04-2020 at 1:35 PM, the facility staff submitted an IJ removal plan, which was accepted. The IJ was removed on 03-04-2020 at 4:33 PM after confirmation that the plan had been fully executed. After removal of the immediacy, the deficient practice remained at a scope and severity of D. The findings include: On 03-02-2020, surveyor review of Resident #1's clinical record revealed on 02-20-2020, Resident #1 went to a neurology appointment and returned to the facility with a new physician's orders [REDACTED]. [MEDICATION NAME]-[MEDICATION NAME] is a medication used to treat [MEDICAL CONDITION]. [MEDICAL CONDITION] is a progressive nervous system disorder that affects movement. A review of the physician's order [REDACTED].#1 transcribed the order for [MEDICATION NAME]-[MEDICATION NAME] four (4) times a day, but did not discontinue the previous order for [MEDICATION NAME]-[MEDICATION NAME] three (3) times a day. According to Resident #1 ' s Medication Administration Record [REDACTED]. Further review of Resident #1 ' s MAR indicated [REDACTED]. On 02-22-2020 at 2:00 PM, Resident #1 was noted to have altered mental status and low blood pressure. The attending physician was contacted and ordered to transfer the resident to the hospital. On 02-22-2020 at 6:21 PM, Nurse #3 documented that the nursing supervisor discovered there were duplicate orders of [MEDICATION NAME]-[MEDICATION NAME] since 02-20-2020 resulting in the resident receiving multiple additional doses of [MEDICATION NAME]-[MEDICATION NAME] for two days. In addition, the resident's blood pressure was low (85/56), resulting in the physician ordering to transfer the

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

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F 0760 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) resident to the emergency room for evaluation. On 03-03-2020, surveyor review of the Resident #1's hospital records written on 02-22-2020 revealed the resident was transferred to the emergency room from the facility for altered mental status as a result of [MEDICATION NAME]-[MEDICATION NAME] intoxication. On 03-02-2020 at 11:24 AM, interview with Nurse #1 revealed she received the new order on 02-20-2020 to increase the [MEDICATION NAME]-[MEDICATION NAME] to four (4) times a day but forgot to discontinue the previous order for three (3) times a day in Resident #1 ' s electronic record. Nurse #1 stated Nurse #3 told her about the duplicate order on 2-20-2020 and she asked Nurse #3 to discontinue the previous order. On 03-02-2020 at 11:50 AM, interview with Nurse #3 revealed she worked on 02-20-2020 during the 3:00 PM -11:00 PM shift and realized there was a duplicate order for [MEDICATION NAME]-[MEDICATION NAME]. Nurse #3 confirmed Nurse #1 asked her to discontinue Resident #1 ' s previous order for [MEDICATION NAME]-[MEDICATION NAME] three (3) times a day. Nurse #3 stated she acknowledged the request and promised to do it, but forgot later during the shift. Nurse #3 further stated she documented that she gave the resident the 02-20-2020 6:00 PM dose of [MEDICATION NAME]-[MEDICATION NAME], but in actuality did not give the dose of medication to the resident at 6:00 PM. On 03-03-2020 at 9:45 AM, surveyor interview with Nurse #2 revealed she was assigned to Resident #1 on 02-21-2020 and 02-22-2020. Nurse #2 stated she documented that she administered three (3) extra doses of [MEDICATION NAME]-[MEDICATION NAME] to Resident #1 on 02-21-2020 and two (2) extra doses of [MEDICATION NAME]-[MEDICATION NAME] to the resident on 02-22-2020. On 02-22-2020 at 2:00 PM Resident #1's family noticed the resident was lethargic and requested Resident #1 be transferred to the hospital. On 03-03-2020 at 11:30 AM, interview with the Director of Nursing (DON) revealed the 11:00 PM - 7:00 AM licensed nurses are supposed to check all new electronically transcribed physician orders [REDACTED]. The DON confirmed that this was not done by the nurse who worked the night of 02-20-2020, resulting in duplicate orders for Resident #1 ' s [MEDICATION NAME]-[MEDICATION NAME] medication. In addition, the DON stated she was on leave for multiple weeks and the 11:00 PM-7:00 AM nurses failed to check new electronically transcribed physician orders [REDACTED]. On 03-02-2020 at 12:05 PM, interview with the Assistant Director of Nursing and Administrator revealed the facility administration discovered the medication error on Monday 02-24-2020. The three nurses involved in the incident were provided education regarding transcribing physician orders [REDACTED]. On 03-04-2020 at 11:13 AM, an immediate jeopardy (IJ) was determined due to the facility ' s failure to administer medications according to physicians ' orders (Resident #1). On 03-04-2020 at 01:35 PM, the facility staff submitted the IJ removal plan which included the following: -On 02-22-2020, Nurse #2 informed Resident #1 ' s attending physician of the additional [MEDICATION NAME]-[MEDICATION NAME] doses administered to Resident #1 on 02-21-2020 and 02-22-2020. Resident #1 was transferred to the hospital for evaluation. -On 02-24-2020, the Assistant Director of Nursing identified six (6) residents who went out to a doctor ' s follow up appointment in the month of February 2020 and reviewed recommendations from the appointments to validate that all recommendations were transcribed accurately. -On 02-25-2020, Resident #1 returned to the facility and all orders for [MEDICATION NAME]-[MEDICATION NAME] were discontinued per the attending physician. -100% of active licensed nurses were in-serviced by 03-02-2020 to ensure that current interventions are reviewed prior to initiating new interventions to include accurate transcription, all new physician appointment recommendations are reviewed by the supervisor on duty and new physicians ' orders are placed in the 24 hour report binder, and night shift licensed nurses will audit all new physicians ' orders and make the audit available for morning clinical meeting. -On 03-03-2020, the Director of Nursing reviewed Resident #1's physician orders [REDACTED]. validate that they were transcribed accurately. -Finally, the removal plan stated that the Director of Nursing will perform random audits of new physician orders [REDACTED]. Results of these audits will be reported to the facility ' s Quality Assurance and Performance Improvement Committee (QAPI) for appropriate action to be taken. On 03-04-2020 at 04:33 PM, the administrator and DON were notified that the surveyors had verified that the removal plan had been fully implemented as of 03-04-2020 at 04:00 PM, and the immediacy was removed.
F 0842 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**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 and interview with facility staff, it was determined that the facility failed to accurately document information in a resident's medical record. This finding was evident for 1 of 5 residents selected for review during the complaint survey (Resident #1). The findings include: On 03-02-2020, surveyor review of Resident #1's clinical record revealed on 02-20-2020, Nurse #3 documented that she administered the medication [MEDICATION NAME]-[MEDICATION NAME] to Resident #1 at 5:00 PM and 6:00 PM. [MEDICATION NAME]-[MEDICATION NAME] is a medication used to treat [MEDICAL CONDITION]. [MEDICAL CONDITION] is a progressive nervous system disorder that affects movement. On 03-02-2020 at 11:50 AM, surveyor interview with Nurse #3 revealed that she only administered one (1) dose of [MEDICATION NAME]-[MEDICATION NAME] to Resident #1 on 02-20-2020 at 5:00 PM and did not administer another dose at 6:00 PM. Nurse #3 acknowledged that she inaccurately documented the 6:00 PM dose as administered to Resident #1. On 03-03-2020 at 11:30 AM, surveyor interview with the Director of Nursing revealed no new information.