STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195469	A. BUILDING _____ B. WING _____	**05/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AMELIA MANOR NURSING HOME	**903 CENTER STREET LAFAYETTE, LA 70501**

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 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 and interviews, the facility failed to notify the attending physician in a timely manner regarding the medication regimen for Resident #4 and Resident #5 as evidenced by: 1. S1LPN holding Resident #4 and Resident #5 medications without a physician's order and ; 2. S1LPN failing to notify Resident's #5 Responsible Party of a medication error within 24 hours of occurrence according to the facility's policy. Findings: 1. Resident #4. A review of Resident's #4 Medical Records revealed that, Resident # 4 was admitted to the facility 7/16/2014 with the [DIAGNOSES REDACTED]. Resident # 4 was admitted to a local hospice on 3/14/2019. Resident #4 Minimum Data Set ((MDS) dated [DATE] was reviewed and under the Activity of Daily Living (ADL) section, there was documentation of her being a max assist with all activities of daily living. A review of the Nurses Assessment Notes revealed that on 5/16/2020 at 9:45 AM the following documentation, Incident and Accident Report dated 5/18/2020. S1LPN was passing medications when she went into the wrong resident's room and administered the wrong medication. S1LPN documented that while passing morning medication she became distracted and turned around. S1LPN stated she went into the wrong room. S1LPN added that as she was walking out the room she realized that she went into the wrong room and gave medications to the wrong residents. S1LPN documented that the resident is only oriented to self. A review of the Medication Deviation Report revealed that resident #4 received the following medications: [REDACTED]. Upon further review of the Medication Deviation Report revealed that the resident was treated for [REDACTED]. A review of the Physicians May 2020 orders and Medication Administration Record revealed that resident #4 did not have orders for the above mentioned medications. A review of Resident # 4 Medication Administration Record revealed that on 5/16/2020 the resident did not receive her morning medication, which was the following medications: [REDACTED]. The resident also did not receive her medications which were due later in the day: Aspirin, [MEDICATION NAME] HCL, [MEDICATION NAME] and [MEDICATION NAME]-[MEDICATION NAME]. A further review of the Physician Orders did not reveal an order for [REDACTED]. On 5/16/2020 at 22:35 PM a late entry was reviewed and revealed the following documentation. Capillary Blood Glucose (CBG) checks 2-10 pm: 1400 - blood sugar 58 (gave resident a glass of OJ). 16:30ish blood sugar 31 (gave [MEDICATION NAME] rubbed ice cream and sugar paste on gums). 1730 blood sugar 97, 1830 blood sugar 86, 1930 blood sugar 65, 2030 blood sugar 40 (administered 2nd [MEDICATION NAME] injection and rubbed sugar paste on gums. 2130 blood sugar 89, 2200 blood sugar 101. Note per S1LPN On 5/17/2020 at 00:01 AM CBG 62. Able to consume apple juice. Note per S4LPN On 5/17/2020 at 5:30 AM late entry: CBG 61 at 1:00 AM, 2:00 AM 64, 3:00 AM 68. 5:00 AM 62. Note per S4LPN On 5/17/2020 at 13:06 PM blood sugars at 8:00 AM 48, 9:15 AM 54 (OJ administered and tolerated well), 12:40 PM 54 (OJ administered and tolerated well) and 62 at 1320 PM. Note per S5LPN On 5/17/2020 at 21:55 blood sugar at 1300 was 199 and 155 at 21:30 On 5/20/2020 at 2:55 PM an interview was conducted with S1LPN who confirmed she gave the wrong medication to Resident #4. S1LPN stated that she notified her Supervisor S3RN on 5/16/2020 at 10:00 AM. S1LPN added that she notified the attending physician on 5/16/2020 at 10:20 AM. S1LPN stated that the Responsible Party was notified on 5/16/2020 at 4:00 PM. S1LPN added that the resident's blood sugar kept dropping and the resident had to be constantly monitored and [MEDICATION NAME] injections had to be administered to the resident. S1LPN stated that orders were obtained from Resident #4 hospice Physician. S1LPN stated that the additional orders were obtained 5/16/2020 at 2:00 PM. S1LPN stated the Physician's orders stated that the resident be encouraged to take fluids around the clock, encourage sweets around the clock, every 4 hours blood pressure checks, every 1 hour blood sugar checks. If blood sugar is less than 60 give [MEDICATION NAME] and sugar paste and recheck sugar in 20 minutes. If the sugar is less that 55 after one hour with [MEDICATION NAME] and sugar paste, send to emergency room . S1LPN stated that the above orders ended at 9:00 AM on 5/17/2020. S1LPN was asked about the residents prescribed medications. S1LPN stated that she held the resident morning dose and night dose of medication. When S1LPN was asked about the Physician order to hold the medication, S1LPN stated she did not know she needed a doctor's order to hold the resident's medication. 2. Resident #5 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. A review of the Nursing-Incident and Accident Report revealed that on 5/16/2020 at 9:45 AM S1LPN documented that while passing morning medications she got distracted and turned around. S1LPN documented that she went into the wrong room. S1LPN continues that as she was walking out the room she realized that she went into the wrong room and gave medications to the wrong resident. S1LPN documented that the Nursing Supervisor S3RN was notified immediately. S1LPN documented that the Physician was informed on 5/16/2020 at 10:20 AM and stated to monitor the resident for 24 hours but she should be ok due to it was only a one time dose error. A review of the Quality Assurance Committee Report To The Louisiana Nursing Home Malpractice and A review of the residents Medication Administration Record revealed that the following medications were held from the resident: Cranberry tablet 450 mg, [MEDICATION NAME] suspension 3.5-1000,Myrbetriq extended release 25 mg, [MEDICATION NAME] 5 mg, [MEDICATION NAME] 100 mg, Dorzolamide HCL-[MEDICATION NAME], Refresh [MEDICATION NAME] Gel 1-0.9%, [MEDICATION NAME] HCL 50 mg, General Liability Trust Medication Deviation Report was conducted. The Medication Deviation Report also revealed that the resident was given the following medications in error; [MEDICATION NAME] 5 mg, Apbxaben 5 mg, Celecoxib 200 mg, [MEDICATION NAME] 40 mg, [MEDICATION NAME] 88 mcg, [MEDICATION NAME] ER 25 mg, [MEDICATION NAME] 50 mg, [MEDICATION NAME] 10 mg. A review of the Physician May 2020 Orders did not reveal an order to hold Resident #5 medication. Upon further review the resident was not prescribed any of the above mentioned medications. On 5/20/2020 at 2:55 PM, an interview was conducted with S1LPN. S1LPN stated that when she realized what happened she immediately notified the Nursing Supervisor S3RN on 5/16/2020 at 10:00 AM. S1LPN stated that after she notified her Supervisor she notified the Attending Physician on 5/16/2020 at 10:20 AM. S1LPN stated that she also notified the hospice agency and the on call nurse came out to see the resident. S1LPN stated that the Responsible Party was notified on 5/18/2020 at 2:00 PM. S1LPN confirmed that she should have notified Resident #5 representative immediately or at least before she left the facility for the day. S1LPN was asked if she notified the Physician that the medication for the resident was going to be held. S1LPN stated she did not know she needed a physician's order to hold residents medication. On 5/21/2020 at 11:45 AM, an interview was conducted with S2DON was conducted. S2DON confirmed that when an incident happens, the family is to be notified immediately or at least within 24 hours of the incident. S2DON also confirmed that a physician order is required before holding any medications.S1LPN confirmed that she should have obtained an order from the Physician to hold the medications for Resident #4 and Resident #5. A review of the facility Medication Holds Policy revealed that: Temporary medication holds may be ordered by the resident's Attending Physician. Policy Interpretation and Implementation: 1. A hold order for a medication must be accompanied by a restart date or time. Hold orders without a restart date or time will be considered discontinued 4. The attending physician must provide an explicit order as to when to restart a medication that has been held, either at the time the order is given to hold the mediation or subsequently. If the medication was discontinued, a new order must be given. A review of the facility Change in a Resident's Condition or Status Policy states . 4. Unless otherwise instructed by the resident, a nurse will notify the

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

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.

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F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) resident's representative when: A. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; B. There is a significant change in the resident's physical, mental, or psychosocial status; 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on record review, observation and interview, the facility failed to ensure licensed nurses have the specific competencies and skill set necessary to provide nursing and related services to meet the resident needs safely and in a manner that promotes each resident's physical, mental and psychosocial well-being. This is evidenced by: 1. S1LPN failing to complete an Incident and Accident report according to facility policy and 2. S1LPN failing to secure a medication cart while administering medications. Findings: A review of the facility Incident and Accident report revealed that two residents were administered the wrong medication on 5/16/2020 at 9:45 AM by S1LPN. Resident #4 and Resident # 5 lived in the same room in the facility. On 5/16/2020 at 9:45 AM S1LPN documented on the Incident and Accident Report Form that she went into the wrong room and administered medications not prescribed to Resident #4 and Resident #5. Upon further review it was revealed that the incident occurred on 5/16/2020 but the Incident and Accident Report was not written until 5/18/2020. On 5/20/2020 at 2:55 PM, an interview was conducted with S1LPN who confirmed that she did not write the Incident and Accident Report for the incident that occurred on 5/16/2020 until she returned to work on 5/18/2020. S1LPN confirmed that the facilities policy is that the Incident and Accident Report is to be written within 24 hours of the occurrence. S1LPN confirmed that she should have written the Incident and Accident Report within 24 hours of the occurrence. On 5/21/2020 at 11:05 AM, an observation was conducted with S1LPN. S1LPN was accompanied on a medication pass. After the medication was verified S1LPN proceeded to administer the medication to the resident in room A. While S1LPN was administering the medication it was observed that S1LPN did not lock her medication cart prior to entering into the resident's room. When S1LPN returned to the medication cart she realized that she had not locked the medication cart as per facility policy. An interview with S1LPN was conducted. S1LPN confirmed that she should have locked the medication cart before leaving the cart unattended. On 5/22/2020 at 11:45 AM, an interview was conducted with S2DON who confirmed that the Incident and Accident Reports are to be written no later than 24 hours after the occurrence. S2DON also confirmed that when the nurse is not using the medication cart, the cart should be locked at all times. A review of the Facility Policy on Administering medications: [REDACTED]. During administration of medications, the mediation cart is kept closed and locked when out of sight of the medication nurse or aide . The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. A review of the Facility Accidents and Incident - Investigating and Reporting Policy Interpretation and Implementation 5. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident.

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 record review and interview, the facility failed to ensure it was free of significant medication error as evidenced by nursing staff administering wrong medications to 2 (Resident #4, Resident #5) of 5 sampled residents. The facility had a total census of 92 residents residing in the facility. Findings: On 5/20/2020 at 8:30 AM, a review of the facilities Assessment History Report Nursing Incident and Accident Report revealed documentation that the facility had two medication errors. S1LPN documented in her Incident and Accident Report that on 5/16/2020 at 9:45 AM, while she was administering morning medications, she got distracted and turned around. S1LPN documented that she entered the wrong room and administered the wrong medications to Resident #4 and Resident #5. Resident #4 and Resident #5 live in the same room at the facility. Resident # 4 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Resident # 4 was admitted to a local hospice on 3/14/2019. Resident #4 is incontinent of bowel and bladder. A review of the Physicians Orders and the Medication Administration Record (MAR) for Resident #4 revealed the following medications which were prescribed by the physician: Aspirin 81 mg two times per day, [MEDICATION NAME] HCL 4 mg at bedtime, [MEDICATION NAME]-[MEDICATION NAME] 5-325 mg at bedtime, [MEDICATION NAME] 17 gram daily. A review of the Medication Deviation Report revealed that on 5/16/2020, Resident #4 received the following medications which were not prescribed for her by her physician: [MEDICATION NAME] 100 mg, [MEDICATION NAME] XL extended release 24 hour 25 mg, Potassium chloride ER extended release 10 meq, [MEDICATION NAME] 600 mg,[MEDICATION NAME] release 24 hour 30 mg, [MEDICATION NAME] 10 mg, Toresmide 10 mg, Eliquis 2.5 mg and [MEDICATION NAME] 5 mg. A review of Resident #4 MAR revealed the following prescribed medications that the resident did not receive on 5/16/2020: [MEDICATION NAME] HCL 4 mg, [MEDICATION NAME] Sodium Liquid 100 mg, [MEDICATION NAME]-[MEDICATION NAME] 5-325 mg, Polyethylene [MEDICATION NAME] Powder 17 gram, [MEDICATION NAME] 15 mg, [MEDICATION NAME] 100 mcg, Aspirin 81 mg, Sugarfree Med Pass. A review of Resident #4 Physician May 2020 Orders revealed on 5/16/2020 at 2:00 PM instructions were given to encourage fluids around the clock, encourage sweets around the clock, every 4 hours blood pressure checks, glucose testing every 1 hour and if blood sugar less than 60 , then give [MEDICATION NAME] and sugar paste. Recheck blood sugar 30 minutes after. If glucose is less than 55 after one hour with [MEDICATION NAME] and sugar paste, then send to the emergency room , End order at 9:00 AM on 5/17/2020. A review of the Medication Deviation Report dated 5/18/2020 revealed that the Resident #4 was treated for [REDACTED].#4 was administered [MEDICATION NAME] and glucose paste. Resident #5 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A review of the Physician order [REDACTED].#5 revealed the following medication which were prescribed for this resident by her physician: Cranberry tablet 450 mg, [MEDICATION NAME] suspension 3.5-1000,Myrbetriq extended release 25 mg, [MEDICATION NAME] 5 mg, [MEDICATION NAME] 100 mg, Dorzolamide HCL-[MEDICATION NAME], Refresh [MEDICATION NAME] Gel 1-0.9%, [MEDICATION NAME] HCL 50 mg. A review of the Medication Deviation Report revealed that on 5/16/2020, Resident # 5 received the following medications not prescribed for her by her physician: [MEDICATION NAME] 5 mg, Apbxaben 5 mg, Celecoxib 200 mg, [MEDICATION NAME] 40 mg, [MEDICATION NAME] 88 mcg, [MEDICATION NAME] ER 25 mg, [MEDICATION NAME] 50 mg, [MEDICATION NAME] 10 mg. A review of Resident #5 MAR revealed the following prescribed medications that the resident did not receive on 5/16/2020: Cranberry 450 mg, [MEDICATION NAME] Suspension 3.5-1000-0.1, Myrbetriq ER 25 mg, [MEDICATION NAME] 5 mg, [MEDICATION NAME] 100 mg, Dorzolamide HCL-[MEDICATION NAME] 22.3-6.8 mg/ml, Refresh [MEDICATION NAME] Gel 1-0.9%, [MEDICATION NAME] 50 mg. A review of the Medication Deviation Report for Resident #5 revealed that the resident did not experience any negative effects from the medication. Resident #5 was to be monitored for 24 hours. A review of Resident #5 Physician May 2020 Orders revealed no new orders for 5/16/2020. Further review of Resident #4 and Resident #5 orders did not reveal an order for [REDACTED]. A review of the Personnel File was conducted on S1LPN. The Personnel File revealed that S1LPN began working for the facility 3/23/2020. S1LPN was hired as a unit manager for Hall C. Hall C is a unit designated for residents who are deaf and blind. According to S1LPN file she has had 3 medication administration errors since her employment at the facility. After further review of the Personnel File it was revealed that in all 3 medication error incidents, S1LPN stated that she entered the wrong room and gave the medication to the wrong resident. On 5/21/2020 at 2:55 PM, an interview was conducted with S1LPN who confirmed that she administered the wrong medication to Resident #4 and Resident #5. S1LPN also confirmed that she did not obtain an order to hold Resident #4 or Resident #5 medications but that she should have notified the Attending Physician and obtained the order. On 5/22/2020 at 11:45 AM, an interview was conducted with S2DON who confirmed that a significant medication error did occur involving Resident #4 and Resident #5. S2DON stated that S1LPN did not verify 5 resident rights during medication pass. S2DON also confirmed that before any medication is held, the physician has to be notified according to facility policy. A review of the facility Administering Medications Policy revealed: . 6. Medications errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. 9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: d. Checking photograph attached to medical record; and e. If necessary, verifying resident identification with other facility personnel. 10. The individual administering the medication checks the label times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 11. The following information is checked/verified for each resident prior to administering medications: a. allergies [REDACTED]. Vital signs, if necessary A review of the facility Adverse Consequences

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F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) and Medication Errors Policy revealed: 12. In the event of a significant medication-related error or adverse consequence, immediate action is taken, as necessary, to protect the resident's safety and welfare. Significant is defined as: a. Requiring medication discontinuation or dose modification (A current list of medications that should not be abruptly discontinued should be consulted before discontinuing a medication); . d. Requiring treatment with a prescription medication; e. Resulting in cognitive deterioration or impairment . 13. The attending Physician is notified promptly of any significant error or adverse consequence. a. The physician's orders [REDACTED].