STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 11/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the physician about significant medications not being given as	F 157	F 157 1.The Director of Nursing reviewed the medication regimen for Resident #8 on 11/13/15,a Medication Variance Form was completed by the DON on 11/16/15 for ordered medications that were not administered. The Nurse Practitioner was notified by the Unit Manager on 11/12/15 regarding ordered medications that were not administered. Resident #8 is receiving medications as ordered by physician. Resident #8 agreed to change pharmacy providers to OMNICARE on 11/18/15 and changed Attending Physician on11/06/15. Resident #11 discharged from the facility On 11/13/15. Resident #12 was discharged from the facility on 10/02/15. 2.Current Medication Administration Records were audited by the Director of Nursing (DON) and Unit Managers on 11/17/15 to validate medications were administered as ordered. The DON and Unit Managers completed Medication Variance Forms for Physician ordered medications that were not administered and the Attending Physician was notified as required. These audits and notifications were completed on 11/17/15. 3.Licensed Nursing Staff will be re-educated by the Staff Development Coordinator regarding Notification of the Physician. This re-education will be completed by 12/14/15. Further, all new nursing staff and new practitioners will be oriented by Staff Development Coordinator on Notification of Physicians.	

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

Electronically Signed Florence Washburn — 12/15/15

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 157	Continued From page 1 ordered for 3 of 5 residents (Resident #8, Resident #11, Resident #12). Findings Included: 1.) Resident #8 was admitted to the facility with the diagnoses of Anxiety, Rheumatoid Arthritis, and Peripheral Vascular Disease. The Minimal Data Set (MDS) dated 11/5/15 revealed that the resident was moderately cognitively impaired. Physician orders dated 09/1/15 through 09/30/15 revealed that resident #8 was to receive Symbicort inhalation (2) puffs by mouth twice daily for Emphysema at 8:00 AM and 8:00 PM. (Symbicort inhalers are used to prevent bronchospasm in people with asthma or chronic obstructive pulmonary disease (COPD)). One Fentanyl 12 Micrograms (mcg)/hour (hr) patch was ordered to be applied topically every 72 hours for pain at 8:00 AM. (Fentanyl patches are used to treat chronic, ongoing pain.) Methotrexate 7.5 milligrams (mg) (3 tablets) by mouth was ordered to be given every Friday at 8:00 AM. (Methotrexate is used to treat certain types of cancer or to control severe psoriasis or rheumatoid arthritis that had not responded to other treatments.) Seventy mg of Fosamax was ordered to be given weekly on Thursdays at 6:30 AM. (Fosamax is used in men and women to treat osteoporosis.) Five mg of Vericare was ordered on 09/11/15 to be given by mouth every day at 6 PM. (Vericare is used to treat overactive bladder to reduce urgency, frequency and leakage of urine.) The Medication Administration Record (MAR) was reviewed for August, September and October, 2015. The MAR revealed in September, 2015 resident #8 missed one or two of his daily doses of Symbicort inhaler for 25 days. In September 2015, resident #8 also never received	F 157	The DON or designee will randomly audit 10 MARs per Unit weekly for 12 weeks to validate medications are administered according to the Physician's Orders and ensure the physician is notified as required. The results of these audits will be documented on the Facility's monitoring tool and opportunities will be corrected as identified by the DON or designee. 4.The results from the audits will be reported by the DON or designee during the monthly QAPI Meeting and recommendations will be made as needed by the committee. 12/14/15	

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F 157	Continued From page 2	F 157		

a Fentanyl patch as ordered from the dates 09/1/15 through 09/30/15. Resident #8 missed his weekly doses of Methotrexate scheduled to be given on 09/4/15 and 9/25/15 and missed his weekly doses of Fosamax scheduled for 09/3/15 and 09/10/15. Vericare was never given to the resident on 09/11/15 through 10/23/15.
Nurse #6 was interviewed on 11/23/15 at 3:05 PM. Nurse #6 cared for resident #8 on 9/17/15. She stated there had been multiple issues with getting resident #8 family to bring in medications. She had made multiple attempts to remind resident #8 family to bring in medications for the resident. She stated that she called the physician ' s office about the ordered Vesicare not being given and left a message with the nurse but never heard back from the physician. She stated she also put in a handwritten request that stated the Vesicare was not in stock. She could not recall any information about the Fentanyl patch that was ordered and not given to resident #8. She stated she did not notify the physician about the resident ' s Symbicort Inhaler, which was not given but notified the resident ' s family to bring it in. Nurse #6 notified the Unit Manager and stated that she was aware of medications not being given.
Nurse #1 was interviewed on 11/13/15 at 4:05 PM. She stated that the Fentanyl patch was not available on 09/1/15 through 09/3/15 and she notified the unit manager. She stated that she assumed they were waiting on the Fentanyl patch as this was a new order (Fentanyl patch was ordered on 09/2/15). She did not recall anything about the medication Fosamax. She stated that she had mentioned to the Nurse Practitioner (NP) about resident #8 running out of medications and also wrote it in the physician communication book the latter part of September. She stated that she had multiple conversations with the resident ' s

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F 157	Continued From page 3	F 157		

family about bringing in medications.
The Unit Manager was interviewed again on 3:30pm on 11/13/15. The Unit Manager stated the nurse was supposed to notify the MD if any medications were not given. The Unit Manager stated that she had notified the Physician because the nurses stated they had tried to contact him so she contacted him but couldn ' t remember exactly what she contacted him about. She stated this occurred in the middle of October.
Attempts were made to contact three other nurses via phone on 11/23/15, but they were unavailable to be interviewed.
Physician Communication sheets were reviewed from 07/24/15 through 11/12/15. Communication sheet did not show that the physician was notified about any of the medications above not being given to resident #8.
Nursing notes in resident #8 ' s medical records were reviewed from 08/29/15 through 10/31/15. There were no notes that addressed the medications that were not given during that time.
Physician notes from 08/11/15, 08/12/15, 8/21/15, 09/2/15, and 10/8/15 were reviewed. There was no indication that medications ordered were not being given to resident #8.
Resident ' s #8 physician from 08/15 to 10/15 was interviewed via phone on 11/13/15 at 5:10 PM. He stated that resident #8 was receiving medications from a pharmacy through the resident ' s family. He stated he was notified, two weeks ago, by nurses about medications that needed renewal. He was never notified about medications not being given in September, 2015. He stated the nurses could have called his office at any time during the day and that this was the first time that he was notified of the medications resident #8 did not receive in September, 2015.
The facility ' s " Change in Resident Condition "

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F 157	Continued From page 4 Policy (revised in 2008) was reviewed. It stated that " the Resident, attending physician and legal representative are notified when changes in condition or certain events occur. " The Director of Nursing (DON) was interviewed about her expectations on 11/13/15 at 3:15 AM. Her expectation for documentation on the MAR was if the medication was not given then the nurse should circle their initials beside the medication and write a reason on the back of the MAR to why the medication was not given. After 3 times of a medication not being given, the nurse should notify the Unit Manager or the DON. The physician should also be notified that a medication was not given. 2) Resident #11 was admitted to the facility from 9/27/15 to 10/1/15 with a diagnosis of an auto-immune disorder, chronic obstructive pulmonary disease, arthritis, hyperlipidemia, and insomnia for which she was prescribed a combination medication, Stribild 150/150/200/300 milligram (mg) to take 1 tablet by mouth daily with breakfast, Beclomethasone 80 micrograms 2 puffs twice daily, MS Contin (morphine sulfate extended release) 30 mg three times daily, Crestor 40 mg by mouth daily, and Ambien 5 mg by mouth every night. The review of the Medication Administration Record (MAR) indicated that the resident was not given the medications on 9/28/15. The MAR indicated that the medications were administered on 9/29/15 onward. There was no indication on the back of the MAR (a designated area for which nurses can write a brief note for any issues with medications) indicating the reason for not administering the medications. The nurse's notes dated 9/28 stated "(resident) received scheduled medications except MS Contin, awaiting pharmacy to deliver ..." There	F 157		

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F 157	Continued From page 5	F 157		

was no indication that the other medications were not given.
A review of the physician's orders and notes did not indicate that the physician was notified of any medication issues.
The nurse who signed the MAR on the day of 9/28/15 (Nurse #2) was interviewed on 11/13/15 at 12:00 PM. She stated "I usually check the Pyxis machine (an automated medication dispensing machine) for medications that have not been delivered by pharmacy. I gave the medications on 9/28/15 that were available for use from the Pyxis. The other medications were not in the Pyxis so I could not give it to the resident. I called the pharmacy and they said that they would deliver it around midnight. I did not give those medications on 9/28/15 nor did I call the physician to get a hold order for Stribild, Beclomethasone 80 mcg/actuation, MS Contin 30 mg, Crestor 40 mg, or Ambien 5 mg because at that time I felt calling the pharmacy was sufficient."
The Unit Coordinator was interviewed on 11/13/15 at 12:10 PM. She stated "If a resident arrived to us on a Sunday, we would get what medications we could from Pyxis and then call pharmacy for an urgent Sunday delivery of medications. If it is still not available to be given, we would call the physician to explain and get further orders on what to do. All of this should be documented in the chart." She confirmed that there was no documentation in Resident #11 ' s medical record indicating that the described steps had been followed for the missed doses.
The Physician's Assistant was interviewed on 11/13/15 at 12:30 PM. She confirmed " I was not notified that the medications were not administered. "
3) Resident #12 was admitted to the facility on

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F 157	Continued From page 6 10/8/15 with diagnoses that included an auto-immune disorder for which she was prescribed Norvir 100 mg by mouth daily, Abacavir 600 mg by mouth daily, Lamivudine 150 mg by mouth daily, and Prezista 800 mg by mouth daily. The MAR indicated that only the Lamivudine 150 mg was given on the first date of administration, that being 10/8/15. There was no indication on the back of the MAR or on the nurse ' s notes indicating the reason for not administering the other medications. A review of the physician's orders and notes did not indicate that the physician was notified of any medication issues. The Pharmacy Manager was interviewed on 11/13/15 at 3:30 PM. She indicated that Resident #12 had been in and out of the facility twice before and that the medications were not returned to the pharmacy. She stated that " Records show that we attempted to fill the named medications on 10/8/15 but insurance would not let us fill them. We deduced that since we never received the medications as return to pharmacy, they must still be available at the facility for use upon anticipation of the resident ' s return to the facility." Nurse #3 was called on 11/14/15 at 2:00 PM for an interview but was unavailable to comment on the details of this missed medication event. The Physician's Assistant was interviewed on 11/13/15 at 12:30 PM. She confirmed "I was not notified that the medications were not administered."	F 157		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		

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F 329	Continued From page 7 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff, nurse practioner and physicians, the facility failed to require a diagnosis for the use of Permethrin (scabies treatment) for 1 of 3 sampled residents. (Residents #5). The findings included: 1. Resident #5 was admitted to the facility on 12/26/12 with diagnoses of failure to thrive, chronic obstructive pulmonary disease,	F 329		

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F 329	Continued From page 8 hypertension and cerebral vascular disease. Review of the Monthly Progress Note dated 10/15/15 by Nurse Practioner (NP) #1 indicated that Resident #5 complained about the rash all over on his body. He was mostly itching on legs, arms and some on his trunk. Excoriation was present, however no tracking. The NP said the resident had this for four days but this was the first he had complained to her. She ordered Atarax (used to control itching) 25 mg. (milligram) orally, times one. Review of physician order dated 10/21/15 written by Nurse Practioner #1 revealed Hydrocortisone 1% cream twice a day for two weeks with none to face. Review of a Monthly Progress Note dated 11/1/15 by Nurse Practioner #1 indicated that his feet were burning and itching, which was keeping him awake at night. Resident #5 stated this had been ongoing for four weeks. Patient stated nothing was alleviating the symptoms. Continue with Atarax 25 mg, orally, every eight hours for two days, then change to every eight hours as needed for itching. Modify plan as needed. Review of physician order dated 11/5/15 written by the NP #1 revealed Benadryl 25 mg, orally, every six hours as needed. Dermatology consult. Review of physician order dated 11/8/15 by NP #1 revealed Permethrin topical 5%. Apply from neck to soles of feet, wash off after 10 hours then repeat in one week. Review of the Pharmacy Inventory Usage Report dated 11/8/15 revealed that the Permethrin was	F 329	F 329 1.Resident #5 completed the Physician Ordered course of Permethrin on 11/17/18. Facility and physicians will continue to assess and treat rashes per doctors orders. All prophylactic medications and treatments will follow standard practice for that medication or treatment. 2.Current Medication Administration Records were audited by the Director of Nursing (DON) and Unit Managers on 11/17/15 to ensure no other residents were being treated with prophylactic medications and ordered medications are supported by a medical diagnosis. 3.Licensed Nursing staff will be re-educated by the Staff Development Coordinator regarding: Avoiding unnecessary medications and obtaining a medical diagnosis when a new medication is ordered. This re-education was completed on 12/14/14 The Nurse Practitioner was educated by the Physician to notify the Physician when considering a prophylactic treatment. This education was completed on 11/13/15. Further, all new nursing staff and new practitioners will be oriented by the Staff Development Coordinator on Avoiding unnecessary medications and obtaining a medical diagnosis when a new medication is ordered.	

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F 329	Continued From page 9 sent to the facility for Resident #5. Review of the Medication Administration Records for the month of November 2015 revealed Permethrin was signed as given on 11/9/15. Interview on 11/12/15 at 3:36 PM with the dermatologist indicated his diagnosis was based on a clinical impression. The dermatologist said he cannot be 100 % sure of his diagnosis. It could be bad eczema and his feet had severe fungal infection. He continued that he did not feel it was necessary to perform a scraping. On the consult form he wrote " Permethrin. " Observations on 11/13/15 at 9:30 AM revealed a fine red rash on Resident #5 ' s arms, legs and back, and bilateral feet were very red Interview with the Medical Director on 11/13/15 at 12:38 PM revealed the facility tried multiple treatments and could not get resolution for the rash which was atypical in appearance. The Medical Director stated it was difficult to get a positive scrapping and the dermatologist never gave a diagnosis of scabies, he just put the medication name on the consult sheet. The Medical Director stated that this was not a confirmed case and it will not harm the resident if there was no scabies. He said the Permetherin would not have been his first choice for treatment and the Nurse Practioner did not communicate with him with her decisions about treating the resident.	F 329	The DON or designee will randomly audit 10 MARs per Unit weekly for 12 weeks to validate medications are administered according to the Physician's Orders and ensure there is a medical diagnosis to support each medication. The results of these audits will be documented on the Facility's monitoring tool and opportunities will be corrected as identified by the DON or designee. 4.The results from the audits will be reported by the DON or designee during the monthly QAPI Meeting and recommendations will be made as needed by the committee. 12/14/15	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333		

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F 333	Continued From page 10 any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to prevent the occurrence of significant medication errors by not administering medications for serious medical conditions as prescribed for 3 of 4 sampled residents (Resident #8, Resident #11, Resident #12). Findings included: 1) Resident #8 was admitted to the facility on 07/29/15 with the following diagnoses of Anxiety, Rheumatoid Arthritis, and Peripheral Vascular Disease. Physician orders dated 09/1/15 through 09/30/15 revealed that Resident #8 was to receive Symbicort inhalation (2) puffs by mouth twice daily for Emphysema at 8:00 AM and 8:00 PM. One Fentanyl 12 Micrograms (mcg)/hour (hr) patch applied topically every 72 hours for pain at 8:00 AM. Methotrexate (to treat Rheumatoid Arthritis) 7.5 milligrams (mg) (3 tablets) by mouth every Friday at 8:00 AM. 70 mg of Fosamax (to treat Osteoporosis) was ordered to be given weekly on Thursdays at 6:30 AM. 5 mg of Vesicare (to treat overactive bladder) was ordered on 09/11/15 to be given by mouth every day at 6 PM. The resident's Medication Administration Record (MAR) was reviewed for August, September and October, 2015. The MAR revealed in September, 2015 Resident #8 missed one or more doses of his Symbicort inhaler for 25 days. In September 2015, Resident #8 also never received a Fentanyl patch as ordered from the dates 09/1/15 through 09/30/15. Resident #8 missed 2 weekly doses of Methotrexate scheduled to be given on 09/4/15	F 333	F 333 1.The Director of Nursing reviewed the medication regimen for Resident #8 on 11/13/15,a Medication Variance Form was completed by the DON on 11/16/15 for ordered medications that were not administered. The Nurse Practitioner was notified by the Unit Manager on 11/12/15 regarding ordered medications that were not administered. Resident #8 is receiving medications as ordered by physician. Resident #8 agreed to change pharmacy to OMNICARE 11/18/15 and changed Attending Physician in November 11/06/15. Resident #11 was discharged from the facility on 11/13/15 Resident #12 was discharged from the facility on 10/01/15 2.Current Medication Administration records were audited by the Director of Nursing (DON) and Unit Managers on 11/17/15 to validate medications were administered as ordered. The DON and Unit Managers completed Medication Variance Forms for Physician ordered medications that were not administered and the Physician was notified as required. These audits and notifications were completed on 11/17/15. Walgreens is the facility 24 hour backup pharmacy. If medications or treatments cannot be obtained from OMNICARE or the Pyxis System, or there is an emergency need, Walgreens will deliver. No outside medication will be permitted unless they come directly from a pharmacy and they comply with facility policies and procedures.	

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F 333	Continued From page 11 and 9/25/15 and missed two weekly doses of Fosamax scheduled for 09/3/15 and 09/10/15. Vesicare was scheduled to be given every day on the MAR but was never given from 09/11/15 through 10/23/15. Pain Medication sheet revealed that Resident #8 took Hydrocodone-Acetaminophen (ordered as needed) for 16 days out of the 30 days of September for pain. Nurse #1, who cared for Resident #8 six times in the month of September, was interviewed on 11/13/15 at 12:24 PM. She stated that Resident #8 was getting medications by a pharmacy program through the resident ' s family and had issues with medications being brought in by the family. The family only wanted the resident to get the medications that they brought in, which were supplied to them. The nurse was responsible for getting medications from the family and would count the medication after receiving them. The family was responsible for supplying Resident #8's medications. She also stated that other nurses had made phone calls to remind family to bring in Resident #8's medications. Nurse #4 was interviewed on 11/23/15 at 3:05 PM. Nurse #4 cared for Resident #8 on 9/17/15. She stated there had been multiple issues with getting Resident #8's family to bring in medications. She made multiple attempts to remind Resident #8's family to bring in medications for the resident. She stated that she called the physician's office about the ordered Vesicare not being given and left a message with the nurse but never heard back from the physician. She stated she also put in a handwritten request that stated the Vesicare was not in stock. She could not recall any information about the Fentanyl patch that was ordered and not given to Resident #8. She stated she did not	F 333	3.Licensed Nursing staff will be re-educated by the Staff Development Coordinator regarding: the Facility's policy for Medication Management to include ordering and receiving medications, the administration of medications and the documentation of administration on the Medication Administration Record (MAR). This education will be completed by 12/14/15. Further all new nursing staff and new practitioners will be oriented by the Staff Development Coordinator on the Facility's policy for Medication Management to include ordering and receiving medications, the administration of medications and the documentation of administration on the Medication Administration Record (MAR). The DON or designee will randomly audit 10 MARs per Unit weekly for 12 weeks to validate medications are administered according to the Physician's Orders and ensure the physician is notified as required. The results of these audits will be documented on the Facility's monitoring tool and opportunities will be corrected as identified by the DON or designee. 4.The results from the audits will be reported by the DON or designee during the monthly QAPI Meeting and recommendations will be made as needed by the committee 12/14/15	

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F 333	Continued From page 12	F 333		

notify the physician about the resident's Symbicort Inhaler, which was not given but notified the resident's family to bring it in. The Unit Manager was notified and aware of medications not being given.

Nurse #1 was interviewed again on 11/13/15 at 4:05 PM. She stated that the Fentanyl was not available from 09/1/15 through 09/3/15 and she notified the unit manager. She stated that she assumed they were waiting on the Fentanyl patch as this was a new order. She did not recall anything about the medication Fosamax. She stated that she mentioned to the Nurse Practitioner (NP) about Resident #8 running out of medications and also wrote it in the physician's communication book during the latter part of September. She stated that she had multiple conversations with the resident's family about bringing in the residents medications.

Three other nurses, who cared for Resident #8, were attempted to be contacted for a phone interview on 11/23/15 but they were unavailable to be interviewed.

The Pharmacy Manager was interviewed on 11/13/15 at 11:19 AM. She stated that the resident was receiving medications through a hospital pharmacy until October 24th, 2015. On October 24, 2015 the resident started receiving medications through the facility's pharmacy.

Resident's #8 physician from 08/15 to 10/15 was interviewed via phone on 11/13/15 at 5:10 PM. He stated that Resident #8 was receiving medications from a pharmacy through the resident's family. He stated he was notified, two weeks ago, by nurses about medications that needed renewal. He was never notified about medications not being given in September, 2015. He stated the nurses could have called his office at any time during the day and that this was the

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F 333	Continued From page 13	F 333		

first time that he was notified of the medications resident #8 did not receive in September, 2015. The Director of Nursing (DON) was interviewed about her expectations on 11/13/15 at 3:15 PM. Her expectation for documentation on the MAR was if the medication was not given then the nurse should circle their initials beside the medication and write a reason on the back of the MAR to why the medication was not given. After 3 times of a medication not being given, the nurse should notify the Unit Manager or the DON. The physician should also be notified that a medication was not given.

2) Resident #11 was admitted to the facility from 9/27/15 to 10/1/15 with a diagnosis of an auto-immune disorder for which she was prescribed a combination medication, Stribild, to take 1 tablet by mouth daily with breakfast.
The review of the Medication Administration Record (MAR) indicated that the resident was not given the medication on 9/28/15. It was administered on 9/29/15 onward. There was no indication on the back of the MAR (a designated area on which nurses can briefly describe any medication issues) or on the nurse's notes indicating the reason for not administering the medication.
The pharmacy manager was interviewed on 11/13/15 at 11:24 AM. She indicated that records show that the resident's medications orders were faxed to the pharmacy on 9/27/15 at 3:34 PM and that the medications were then sent to the facility on 9/29 around 12:00 AM. She stated "We are not open for regular business on Sundays but a facility can call and tell us they need something right away and we would get the medication to them on that day. This was not done for Resident #11. The nursing home did not call us to say they

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F 333	Continued From page 14 needed medications right away. It is the responsibility of the nursing home to call us and let us know that they need medications on a weekend, otherwise it will get filled and delivered on the following Monday. Our staff is not responsible for calling the nursing home to ensure that they have enough supply of the medication to last through the weekend. That would be the responsibility of the nursing home." The nurse who signed the MAR on the day of 9/28/15 (Nurse #2) was interviewed on 11/13/15 at 12:00 PM. She stated "I usually check the Pyxis machine (an automated medication dispensing machine) for medications that have not been delivered by pharmacy. I gave the medications on 9/28/15 that were available for use from the Pyxis. The other medications were not in the Pyxis so I could not give it to the resident. I called the pharmacy and they said that they would deliver it around midnight. I did not give those medications on 9/28/15." 2) Resident #12 was admitted to the facility on 10/8/15 with diagnoses that included an auto-immune disorder for which she was prescribed Norvir 100 Milligrams (mg) by mouth daily, Abacavir 600 mg by mouth daily, Lamivudine 150 mg by mouth daily, and Prezista 800 mg by mouth daily. The Medication Administration Record (MAR) indicated that only the Lamivudine 150 mg was given on 10/8/15, the first date of admission. There was no indication on the back of the MAR or on the nurse's notes indicating the reason for not administering the other medications. The pharmacy manager was interviewed on 11/13/15 at 3:30 PM. She indicated that Resident #12 had been in and out of the facility twice before and that her previous medications were not returned to the pharmacy. She confirmed that	F 333		

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F 333	Continued From page 15 the resident's previous medication regimen consisted of the same medications as on the current regimen. She stated that "Records show that we attempted to fill the medications on 10/8/15 but insurance would not let us fill them. We deduced that since we never received the medications as return to pharmacy, they must still be available at the facility for use upon anticipation of the resident ' s return to the facility." She further stated "Our staff is not responsible for calling the nursing home to ensure that they have enough supply of the medication ....That would be the responsibility of the nursing home." Nurse #3 was called on 11/14/15 at 2:00 PM for an interview. She was unavailable by phone to comment on the details of this missed medication event.	F 333		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514	F 514 1.The Director of Nursing reviewed the medication regimen for Resident #8 on 11/13/15,a Medication Variance Form was completed by the DON on 11/16/15 for ordered medications that were not administered. The Nurse Practitioner was notified by the Unit Manager on 11/12/15 regarding ordered medications that were not administered. Resident #8 is receiving medications as ordered by physician . Resident #8 agreed to change pharmacy to OMNICARE 11/18/15 and changed Attending Physician in November 11/06/15. Resident #11 was discharged from the facility on 11/13/15 Resident #12 was discharged from the facility on 10/01/15	

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F 514	Continued From page 16 Based on record review and staff interviews, the facility failed to accurately document the Medication Administration Record (MAR) to reflect the administration of a medication for 1 of 5 residents (Resident #8). Findings Included: Resident #8 was admitted to the facility with the following diagnoses of Anxiety, Rheumatoid Arthritis, and Peripheral Vascular Disease. Review of Physician orders dated 09/1/15 through 09/30/15 revealed that Methotrexate 7.5mg (3 tablets) was to be given once a week on Fridays to resident #8 for Rheumatoid Arthritis. Methotrexate is a drug used to treat severe, active Rheumatoid Arthritis (RA) in adults. The Medication Administration Record (MAR) dated 09/1/15 through 09/30/15 was reviewed. Methotrexate was transcribed to MAR to be given once a week on Fridays to resident #8. The MAR was initialed by nurse #1 that Resident #8 received Methotrexate 7.5 Milligrams (mg) tablet on 09/1/15, 09/2/15 and 09/3/15. Methotrexate was not scheduled to be given on 09/1/15, 09/2/15, and 9/3/15. Nursing notes were reviewed from 8/29/15 through 09/11/15. There were no notes about the medication Methotrexate. Nurse #1 that worked 09/1/15 through 09/3/15 was interviewed on 11/13/15 at 12:24 PM. Nurse #1 stated that she would circle her initials if the medication was not given and that she meant to circle her initials for September 1st through 3rd, 2015. She stated that the medication was empty for those dates. The unit manager was notified that the medication was not given. The Unit Manager was interviewed on 11/13/15 at 1:05 PM. The MAR was reviewed with the Unit Manger. She stated she was not notified by nurse #1 that Methotrexate was not given 09/1/15	F 514	2.Current Medication Administration Records were audited by the Director of Nursing and Unit Managers on 11/17/15 to validate medications were administered as ordered and administration was documented accurately. The DON and Unit Managers completed Medication Variance Forms for Physician ordered medications that were not administered and the Physician was notified as required. These audits and notifications were completed on 11/17/15. The nurse will initial and circle the MARS/TARS for medications not given and document on the of the MARS/TARS. If a dose is not given for 3 days, the physician will be notified unless the medication is essential to be given daily. In that case the physician will be notified that day. 3.Licensed Nursing staff will be re-educated by the Staff Development Coordinator regarding: the Facility's policy for Medication Management to include the administration of medications and the accurate documentation of administration on the Medication Administration Record (MAR). This education will be completed by 12/14/15. Further, new nursing staff and new practitioners will be oriented by the Staff Development Coordinator on the Facility's policy for Management to include the administration of medications and the accurate documentation of administration on the Medication Administration Record (MAR).	

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F 514	Continued From page 17 through 09/3/15.	F 514	The DON or designee will randomly audit 10 MARs per Unit weekly for 12 weeks to validate medications are administered according to the Physician's Orders and administration is documented accurately on the MAR. The results of these audits will be documented on the Facility's monitoring tool and opportunities will be corrected as identified by the DON or designee 4.The results from the audits will be reported by the DON or designee during the monthly QAPI Meeting and recommendations will be made as needed by the committee 12/14/15	